THE MODEL HEALTH SHOW

EPISODE 477

Covid mRNA Medications: The Peer-Reviewed Evidence

With Guest Dr. Ron Brown

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SHAWN STEVENSON: Welcome to The Model Health Show, this is fitness and nutrition expert Shawn Stevenson and I'm so grateful for you tuning in with me today. This is one of the most important conversations of our lifetime... Or in the midst of a worldwide pandemic and an ever-evolving front with vaccines, there are so many questions that are on people's minds. And I was waiting back, keeping my eye on the data, really looking at things as they were coming out and being published. And I really wanted to be able to have a comprehensive understanding of things and a comprehensive definitive guide for folks.

A lot of people have been asking about this front. But the truth is, there just really isn't enough data available right now. And we don't have much long-term evidence, long-term efficacy, because it just doesn't exist. And so even with that being a part of the conversation, it's important for us to stand in a place of logic and to look at the data that we do have from multiple perspectives. And so what I did was I reached out to people who had some published peer-reviewed evidence, looking at the data regarding the vaccines. And one of the things that I came across, it just shocked me... It blew my mind. And this is a massively shared peer-reviewed study right now, but still a lot of folks don't know about this piece of data.

And this is why I really felt it was important to put this show together now and to not wait any longer on any information coming in about any long-term benefit, any long-term side effects, because a fundamental principle about the efficacy right out of the gate in the clinical trials, there's a big gap missing. And so today we're going to fill that gap in, and you're going to be able to really understand the pieces of evidence that are being used in favor of new pharmaceutical interventions and what's not being shared with the public.

And you should know this is a continuous story with how stuff works in our society, where we really do have a massive sick care system. We don't have a healthcare system. We don't have a system that actually teaches people how to be healthy. Just think about that for a moment. We don't have a system that actually teaches people how to be healthy. We have a symptom-based system. We have a system that is focused on the treatment of symptoms of chronic diseases. We have a symptom system. And for me, just being a logical, rational human being and somebody who really loves signs, if it was different, I would be all for it.

I would be the biggest proponent of our healthcare system. But for me, we just have to really take a step back and look at the results. How's it doing? Is it bearing out really good fruits? Are we having really great results from the way that things have gone? Are we just stamping out our biggest killers and increasing human longevity? Is this the track that we're on? Well, you

already know the answer to this. Right now, here in the United States... Right now, we have about 43% of our citizens are clinically obese. And that was prior to the pandemic.

And the increased rates of sedentary behavior, the increased rates of processed food consumption, the increased rates of sleep deprivation, the increased rates of stress and all manner of intrusions to the healthy performance of ourselves, of our DNA, of our genes, our genetic expression. There's been a big shift. And so it was going to be, according to the latest statistics, about 10 years out when we hit 50% of our citizens being clinically obese. That window has now shortened significantly. And so all the while, with all of our so-called advancements in medicine in technology, we are now the first generation in recorded history, in recent human history that is going to have a shorter life span than our predecessors.

We're at the first point where instead of the life span continuing to grow and extend, now, it's gotten shorter. So just sit with that for a moment. Really think about that. Despite all of our innovations, despite all of our knowledge, we're the first generation in human history, in recent human civilization that is going to die younger than our ancestors, than our predecessors, than the generation before us. Our children on that same track. So we've got to look at this, is it working out? And if you just take a logical assessment... It's not looking too good. We have a healthcare system that in 2019 alone, four trillion dollars were invested into our healthcare system to bear out these types of fruits. These fruits are not... It's not like a nice luxurious avocado. It's like when you open up the avocado and it's like Night of the Living Dead.

It's like, who hurt you? Who did this to this avocado? It's not like an avocado, when you open it up, it just looks like it's raised in a nice home, lots of love, lots of nourishment, healthy access and routines, not that kind of avocado. This the avocado that's possible. But right now, if we look at the fruits of our current system of health care, it's not good, it's not good. But here's the beautiful part, we can change it. Because there's millions of wonderful people working in the system. And what is really needed is just a more evolved education, because people want to save lives, but we've really been focused on treating symptoms and not removing the underlying causes of our greatest challenges.

Which according to the Journal of the American Medical Association, one of our most prestigious journals, the leading cause of our epidemics of chronic disease, hypertension and diabetes, obesity is poor diet. And poor diet, I'm going to keep saying this over and over again, it's just one component of physiological stress. Because stress is really the big killer. Alright. Poor diet is just one form of that. Sleep deprivation pours into that as well. Sedentary behavior, which is another epidemic right now. We are more sedentary than we've ever been. And with this current situation, it's gotten even worse. That pours into that overall stress factor.

And so this is why we see all the different studies on sedentary behavior, increasing risk of death from all causes. Sleep deprivation, increasing risk of death from all causes. Poor diet, increasing risk of death from all causes. You put all these together, these are physiological stressors, chronic stressors that hundreds of millions of our citizens on a daily basis are living by and living with. And these conditions are abnormal. But again, we can change it. Making a shift in our education system, which we're going to talk a little bit about today, and increasing our ability to have critical thinking to not just automatically take on a cookie cutter set of beliefs.

And especially for treatment for our citizens, and this one-size-fits-all drug approach, for example. When we are all so metabolically different. Our immune systems are so dramatically different. And many of these things are not being put into context. And so... But as we progress and move forward and really become advocates for ourselves, advocates for critical thinking, for logic, for evidence-based education... And also being able to understand the data, because it's a language. That's a big part of the underlying launch pad and thrust of The Model Health Show is taking this language when we look at peer-reviewed evidence that we have on so many different topics, and making that make sense for everybody.

And making it in a way that's accessible so that people can know what's really happening. Because what we've been experiencing is that our education gets disseminated from us, from entities that oftentimes aren't functioning from a basic underlying premise of health. And that's where the shift can take place. Because if we can start with health... Let's start there. Let's ask different questions. What creates health? Instead of how do we treat this symptom? What are the components that actually create a healthy sovereign resilient human being? And let's make sure that those are the cultural norms. Let's start from there. Let's start from health.

We can make that a norm. It's going to take some changes to the education system. It's going to take some changes from the dissemination of information, because as you know, you turn on your television... Television... You turn that on, most folks are getting their education through that medium. If they're looking at their news channel and the experts that they put on to the news. And as we've demonstrated in some recent episodes, these folks are often very consciously intentionally curated to have a certain flavor of message that meets the approval of the entity that it's coming from. And every one of these entities, they have their own agenda.

And so now again, today is such an important conversation because we're able to take a peek and really take a deep dive into the very best peer-reviewed evidence that we have right now. And understanding that the very premise of what's being done right now is not what most people think. And once we get this piece, we could start to move on from there in a way that's of a much higher level of efficacy.

So I'm really, really excited about this. And before we get to that, make sure that you are taking care of your immune system with the basic principles. Again, our immune system is literally made from the food that we eat. Everything from our B-cells, our T-cells, our macrophages, neutrophils, natural killer cells, antibodies, all these different things we talk about, these entities are literally made out of raw materials that we provide our body. It's so powerful. And the question is, what are we making our immune cells out of? So this is obviously of the utmost importance, as well as our other lifestyle factors, but obviously our nutrition really does matter.

We've got tremendous amount of peer-reviewed evidence on things that really help, not just to build healthy immune cells, but also the intelligence of these cells. Because some cells, for example, if we talk about the process of angiogenesis or the formation of blood vessels for cells to get nutrition, cancer cells do the same thing. Angiogenesis. And so there are certain foods that have documented peer-reviewed evidence of having selective anti-angiogenesis properties to cut off the blood supply to cancer cells. One of those foods is turmeric. And also scientists from the Department of Neurology at USC found that the active ingredient in turmeric curcumin is able to eliminate metabolic waste and reduce systemic inflammation.

And something else really noteworthy about turmeric is that it's also been found to improve the function of your resident macrophage cells that really operate as a front line of your immune system. All this data exists. And this incredible source of nutrition has been utilized for centuries. But again, we want to make sure we're getting it from a place with high integrity, organic. If we can get it in kind of a super critical extract, so that it's really concentrated with high levels of curcumin, for example, that's what we want. But then you combine that with another study... And this was published in the BMJ. They found that COVID-19 ICU risk is 20-fold greater, in people who are deficient in Vitamin D.

So a combination with turmeric for reduction of inflammation, a source of vitamin D and also vitamin C. This is my favorite formula right now for the immune system, and immune system fortification is the Immunity from Organifi. Because it also has some of the most vitamin C dense super foods ever discovered as well. Along with bioavailable vitamin D3 and turmeric, and it tastes good as well. So pop over there, check them out. It's organifi.com/model. That's O-R-G-A-N-I-F-I.com/model. Check out the Organifi: Immunity. And on that note, let's get to be Apple Podcast review of the week.

ITUNES REVIEW: Another five star review titled, “always learning the science” by OA Science. “This is a go-to for practical help for health and wellness, but you are not just getting tips. The science is solid and accessible top notch for why and how. Thank you for doing the hard work and bringing it to us.”

SHAWN STEVENSON: Thank you so much. That means everything. And that really leads into today's guest as well. Because this individual has authored over a dozen peer-reviewed studies in the US National Library of Medicine, of the National Institutes of Health, and many of the most prestigious medical journals. And in addition to his epidemiological research on infectious disease and vaccines during the COVID-19 pandemic, his current areas of research include prevention of cancer, cardiovascular disease, dementia and other chronic diseases. And his name is Dr. Ronald Brown. And Dr. Brown just really blew me away when I got a chance to review one of his most recent peer-reviewed studies, really looking at the difference in vaccine trials with relative risk and absolute risk.

And this is one of the most important insights that we're really going to have in all of this experience with COVID-19 and the evolving conversation with vaccines. If we don't understand the difference with a relative risk and absolute risk, we're really missing on a huge chunk of the conversation. So really, really excited about this episode, and really excited to bring this conversation to you and keep this conversation going. Expand it, expand our thinking and really start to look at things from multiple perspectives, so we can really usher in some positive change and help to move our society forward. So let's jump into this conversation with the incredible Dr. Ronald Brown.

Dr. Brown, can you share the details of your recent peer-reviewed study on the COVID-19 mRNA vaccine clinical trials?

DR. RON BROWN: I would be glad to Shawn. I just want to say that this problem between getting the information about the relative risk reduction versus the absolute risk reduction has been known for decades. And I'll get into the details as you said. But I just want to just outline the overall problem. So people are not aware of this. It's not just the public, it's the practitioners, it's the clinicians, it's the doctors. They're not aware of this either. The people who are the most aware of it are the actual researchers who collect the data on these clinical trials, and they use relative risk reduction to compare the efficacy of vaccines between trials.

So relative risk reduction, actually, that's the statistical version of what we call vaccine efficacy. Efficacy means how well does the vaccine work under experimental conditions as opposed to out in the population where you have unhealthy people, healthy people and those conditions. So vaccine efficacy is really relative risk reduction. And those are the numbers, as you said, that are usually advertised for the Moderna and the Pfizer vaccines. The Moderna was 94.1%... Something like that. And then 95.1% for the Pfizer. So that's pretty high. So the public, thinks, "Hey, what do you got to lose?"... Instant protection.

By the way, protection from what? It's not protection from death from the coronavirus, it's not even protection from the hospitalization from the coronavirus, or even severe illness from the coronavirus. And it's not protections from asymptomatic infections from the coronavirus. All it is, is protection from mild infections. In other words, you have a positive infection test plus at least one clinical symptom, that's it. That's a problem because what we have... What we call breakthrough infections, or infections in people who have been fully vaccinated, the problem is, if you've been fully vaccinated and you think you're protected and you wake up one day with a sore throat, mild, how likely are you to report that and go back and get tested again?

Well, I'm a fully protected I just have a little sore throat. Now, I don't know the answer. But I'm just proposing that those breakthrough infections are probably under-reported. And the effect of that is that it makes the vaccines appear much more effective than they are. So getting back to the vaccine efficacy, the relative risk reduction. Before I describe exactly how that's calculated, let's talk about the absolute risk reduction. Okay. And to understand that, you have to understand a little bit of how a trial works.

So here we go. You have a randomized trial. That means that you take all the people who are going to be in the trial and you randomly assign them to two different groups, the vaccine group, and the group that gets an injection, but it's not the vaccine it's saline solution, so the placebo group. Okay. Now why do we randomize people? We do that so that we evenly distribute all what we call the confounding factors between those two groups. Confounding factors are factors that give you the same result you're looking for, but for another reason. So how do you account for that? The best way to do that is to evenly distribute them between the two groups, at least theoretically.

And therefore what the difference that emerges between the two groups has nothing to do with anything other than the treatment itself. So that's why a randomized trial is considered the gold standard. So let's say you have a 100 people, just as an example, in the vaccine group and a 100 people in the placebo group. And let's say you have one person in the vaccine group who gets an infection. Because remember what we're looking for in this trial is whether people get a SARS COVID-2 infection along with at least one symptom.

That's it. So let's say there is, in this case, this example, there is one person in the vaccine group that gets the infection. And let's say there's two people in the control group that get the infection. Okay? So we call those infections events. And the event rate in the vaccine group is 1 out of a 100, so 1%. And the event rate in the placebo group is 2 out of 100. So that's 2%. So what's the difference between 2% and 1%? 1% right? There's your absolute risk reduction. The reduction from the treatment reduced the risk by 1% compared to the placebo group.

That's all you need to know. That's the clinically relevant statistic, the absolute risk reduction. But that statistic is rarely given to the public. So where does the relative risk reduction come? Well, if you take the absolute risk reduction divide it by the event rate in the control group that gives you a relative risk reduction. In our example, that would be not just 2% or 1%, it would be 50%, because you're dividing 1% by 2%. See, there's a mathematical property about dividing by percentages. You divide a number by a percentage, and which is really just a decimal or a fraction, you get a larger number, not a smaller number.

Usually when you divide numbers, you get a smaller number, right? In the case of a number, that's a fraction or a percentage or a decimal, when you divide a number by a percentage, you get a larger number. So there's... That's the mathematical magic behind converting an absolute risk reduction to a relative risk reduction. So why do that? Well, because technically think of it this way: If you take the reduction in the risk of the disease from the treatment, that's the absolute risk reduction, right? How is that relative to the people who didn't get the treatment, the control group? So basically, you're dividing the event rate in the vaccine group, the 1%, that absolute risk reduction by the 2% in the control group. 1% divided by 2% is 50%.

There's the magic. Okay? Now, the FDA and some other groups had said when you're dealing with the public, you have to let them know what both numbers are, not just the absolute risk. You got to let them know both... And the relative risk. Why? Because the relative risk isn't really relevant to public health and clinical outcomes, it's the absolute risk that people need to know.

SHAWN STEVENSON: This is specifically what I want you to say. We know the relative risk, so the relative risk with Pfizer 95%. The relative risk with Moderna 94%. What is the actual absolute risk for both of those?

DR. RON BROWN: For the Pfizer, the absolute risk is 0.7%. And for Moderna it's 1.1%. Now, I have to tell you, when I did the calculations for the Pfizer and I saw 0.7%, I just stared at it. Like, "Wait, what is this? Is that 70%? No, is it 7%? No. It's seven-tenths of 1%, 0.7, is seven-tenths of one... It's less than 1%.

SHAWN STEVENSON: So that's the absolute risk reduction of the Pfizer vaccine?

DR. RON BROWN: Yeah. That's right. And for Moderna it's not much difference, it's 1.1%.

SHAWN STEVENSON: That's dramatically different from the 95%...

DR. RON BROWN: Yeah, tell me about it. You think?

SHAWN STEVENSON: That's marketing. But the thing is, the 95% is true as well, it's just what's being...

DR. RON BROWN: Yes.

SHAWN STEVENSON: Shared with the public, there's a part being left out.

DR. RON BROWN: Exactly. So you're misleading people by leaving out other information to put the information you get into proper context. Right? There's a word for that. Misleading by omission. Something like that, right? So yes, it's true. It's 95% and 94% vaccine efficacy according to the standard way of doing it, the relative risk reduction. And by the way, they've done it that way for decades. Nothing new about that. Except for decades, the journal article editors and all these other agencies are saying, we need more information than that, especially when you're dealing with the public. And for decades it's been ignored. That's why, and we're going back to how we started this conversation, the timing was right now to put this information in front of the public. If there was no Coronavirus, now, if there was no pandemic, and if there was... There were no vaccines, and I'd put out an article like this, would anybody read it? No, that's the difference.

SHAWN STEVENSON: Yeah, it wouldn't be of a concern. So with this said, you said something a little bit earlier, which is important. If we're talking about risk reduction from what exactly, all the things that you mentioned are not proven to reduce the risk of death, for example, reduce the risk of severe symptoms and hospitalizations. What are we actually looking at a reduction of? Mild symptoms because that's what was found in the clinical trials that did find efficacy. And I want you to talk about this a little bit because I went... Because of your inspiration, I went and dug in even deeper, and something jumped out at me that it just didn't jump out before. Which was the fact that the outcomes from the clinical trials were largely based on healthy people, not the people who are most at risk for SARS COV-2 in the first place. All they needed to have in the clinical trials was 25% of these folks, maximum 40. But it's such a fraction of people who actually could use some protection, hopefully, if this was done correctly.

DR. RON BROWN: You know what? You're opening up the conversation now into what we call observational studies, because that's what you have to deal with in real life. Not just all healthy people, right? Even if... Even the older healthy people, or rather, even the older people in the trial were healthy, basically. But, in reality, most of the unhealthy people are the older people, so how is the vaccine going to work there? Now, there have been some, what they call post-marketing... I love that word. Post-marketing studies by the FDA and by the CDC to evaluate how well are these vaccines working now that it's out there. Now that it's being sold, right?

And, of course, they're saying, "Oh, it's wonderful. Look, you see all the people that we looked at, they're all in great health."

Except there are several problems here that an observational study cannot control for. Number one, an observational study cannot establish causality. You don't know if any of these symptoms, or lack of them, are... Actually have anything to do with being caused by the vaccine itself. You just don't know, there's no way to show that. In a randomized trial, you do have causality. This is the whole point of the randomized trial. So, you can't just look at some observational studies and say, "Oh, this contradicts everything we knew about in the randomized trial." No, you can't do that, because the level of evidence is way, way lower. You can never prove causality in observations, and why is that? Because there are so many confounding factors that you can't always control, even though they try to control them. They use these logistic regression models, and they have all these variables for all these other confounding factors. But how do you know how to estimate that properly, and how do you know which confounding factors you don't even know about?

So, that's the problem with observational studies, and one of the biases in observational studies, and I mentioned this in one sentence in my article, is what we call Healthy Vaccinee Bias. So, as it turns out, people who are healthier tend to be more likely to get vaccinated. I don't know why. Well, I guess they think... 'Cause they think it's going to make them even more healthy. So, if you have healthy people who are more likely to be vaccinated, and you go out and then you observe how many infections are we getting in the vaccinated people versus the unvaccinated people. And by the way, the young vaccinated people are the people who tend to be more... It goes across all socio-economic levels, but the lower socio-economic levels tend to be less likely to become vaccinated. And, they also tend to have greater incidents of Coronavirus for other reasons, which we can go into that later. So, you have built-in bias when you're trying to conduct these observational studies, you can never use those to overrule what you found in the clinical trial. So I hope I answered your question a bit there.

SHAWN STEVENSON: Of course. Of course, yeah. That's the thing too, I've been staying on top of the data of like what's coming out in the population, because I know that it's going to be leveraged. But it doesn't account for anything that we know for certain to be true. It's just like using this data, just be like, "Everything... Look how everything's going, everything's going really well." But what we... What I'm concerned about, again, is informed consent and what was used to leverage this and put it out on the market in the first place, which was withholding the absolute risk reduction. Which as you mentioned, with the Pfizer vaccine is less than 1%, and with Moderna being 1.1%, and on top of that, not... For the most part, and again, this is why we've seen so many of these very different tactics and mandates done was to protect those who are most susceptible, right?

So we know today, here with the CDC, their latest report, 94% of the people who lost their lives in association with SARS COV-2 had an average of four pre-existing chronic diseases and/or comorbidities, right? And we know that about 80% of folks were obese or overweight. We know that diabetes, hypertension, obesity, these were all three of the biggest comorbidities. So we know that this is the case, and we know that advanced age is the case, but yet in the clinical trials, only a small percent of people were of advanced age and also only a small percentage of people had a chronic disease or both. The majority didn't have chronic diseases, and were not of advanced age, and so it's not even getting viable data to protect those most vulnerable.

DR. RON BROWN: That's a great observation. Shawn. Good for you.

SHAWN STEVENSON: Thank you. It was your inspiration.

DR. RON BROWN: I don't want to really have much more to add to that. You know, your point is totally valid. Good job.

SHAWN STEVENSON: Thank you. When you start to dig into this, and you look at it from multiple perspectives, that's the thing, it's so overwhelming, there's a lot of data and you can bury some things as well pretty easily, and omit things. And that's another big concern that I have is even going through this and trusting these entities in the first place, because this is what I want to talk to you about right now because I'm very... I'm very pro things-that-work, so if we do have an ethical, manufactured drug, for example, that is going to be effective, whatever, I'd be the biggest proponent for it.

DR. RON BROWN: Me too.

SHAWN STEVENSON: However, understanding... I know, this is why I love talking with you because we're coming from that place. We got to look at, what are the systems and the metrics that are behind the scenes right now, because I don't think folks really understand. And I want to... Want you to talk a little bit about this, is that this technology is brand new. It's never been approved by the FDA. What we have on the market right now is not approved by our gold standard of medical testing with the FDA, we bypassed that with this emergency access for folks, which even that... That just came to fruition a couple of years ago, making that legal to do in the first place. I think it was like 2017, conveniently. So, even this new technology being available, this isn't... It's bypassing our normal systems of testing.

DR. RON BROWN: Okay. Let me try to follow up on what you just said, 'cause you brought up at least three or four different issues here. So let me go back to the issue of, who's responsible for telling the people the information they need for informed consent? Well, one of the

organizations is the Food and Drug Administration, and in my article, I cite a document, and I actually quote a passage from it that says, "It is a responsibility of the researchers to release all the information, the absolute risk reduction and the relative risk reduction to the public." This is the FDA that said that. Who conducted the Advisory Committees to authorize these vaccines? It was the FDA. The FDA Advisory Committee didn't follow the FDA's own guidelines on how to communicate with the public. Now, in my article, and I didn't want to really bring this out, but this is a good time because you can see I'm getting a bit emotional about this. There's one citation reference that lists all the people who are on that Advisory Committee, and it's very easy to look up their contact information. And I had already thought, "Why don't I email all these people and say, 'How did you ignore the FDA's own guidelines? What's your excuse? What's your explanation?'" And I was just about to do that, and I thought, "What's the point?" Really, I mean, think about it.

Are they going to say, "Oh, you're right. Oh, we made a big mistake. Let's go back and do it over." No. Come on, come on. They're not going to do that. So then what's the point? They're going to ignore me, that's probably the main thing, but if enough people start asking that same question to the FDA Advisory Committee using the evidence that I put into my article, maybe something will start to happen. And I'm glad that we're doing this interview now, so that I can put that idea in front of the public. Thanks to you, you're allowing me to share that idea. So if you look at my article, there's all the information you need to track down all the people who are responsible or irresponsibly not allowing this information to get out to the public. So that's the first thing. You have to refresh my memory. The other points...

SHAWN STEVENSON: Well, listen. This... First of all, thank you so much for sharing that, because we don't really understand. Again, a lot of folks are just very hands-off with the situation, and you said this earlier, and this is prior to us even getting going. I don't know if we got this in here or not, but you really brought forth one of the most important things, which is when you initially started working on your first degree, you had to go to a library. You had to go and like search for information. Now we've got everything at our fingertips, but in a sense it hasn't made us any more knowledgeable. We have access to a tremendous amount of data, but folks are just kind of scanning and taking bits and pieces and not actually sitting with things and thinking about things. We're still getting our ideas kind of sold to us or even inundated in our lives based on these other entities outside of ourselves who are clearly more smarter than us.

DR. RON BROWN: Let me talk about that.

SHAWN STEVENSON: Yeah, sure, sure, sure.

DR. RON BROWN: Those entities are experts, okay? So, we rely upon experts, and in our complicated society it's the more efficient way to do things, right? But when our experts are unreliable, we have a problem, and this goes all the way back to my first article that I published on the Coronavirus with the Director of the National Institutes of Allergies and Infectious Diseases, telling the public that the Coronavirus was 10 times more deadly than the flu. In front of Congress, it turns out that was wrong, and my article proved it. I put together all the information to track down how those calculations were made and where the errors were. So you could read that and figure it out. It has to do with the difference between an infection fatality rate and a case fatality rate. I can get into all of that.

But here's the real point, if we can't trust our experts, and if the experts themselves aren't vetted by other experts and they become little dictators and autocrats, and just say whatever they want to say to control people, we've got a big problem. So, I can't... You can't expect the public to go and look at all the data and do it all themselves. Maybe a guy like you, and a guy like me enjoy doing that, but you can't expect the public to do it. All you can expect is that the experts are going to be knowledgeable and honest and open enough to give the public all the information it needs, and if they're not getting it, the public should stand up and demand it. That's, again, and to circle back once more, that's why this kind of an interview podcast is really important, to put that in front of people. Now I can talk a little bit more about infection fatality rate and the case fatality rate, if you want. It's like the absolute risk reduction and the relative risk reduction, it's all this jargon, right?

SHAWN STEVENSON: Yeah. I definitely... I want to talk about that. And I want to highlight something really quickly to put an exclamation point on your last statement, and I refer to it as this education bias, right? We tend to believe that somebody has this education in a particular track, right? A particular way of thinking, but not really realizing that the education in and of itself can be incredibly deficient or can be misdirected and misguided in and of itself. And what that leads to is, "Well, I have a degree in this thing, but yet I don't really understand this thing." And so, just to give a context with health really quickly is that, if we go to school... Many of my friends and colleagues... I have a traditional education as well, but we can go to school for 12 years to get a medical degree and do clinicals and all that kind of stuff, and then we're focused on cardiology and the human heart. And if you ask somebody, which I have, "What is the heart made of?" And then it's cells. That's kind of the thing that jumps up, "Well, what are those calls made of?" They're made of food. So, where's the connection here with food and the tissue of the heart? The myocardio... The muscle and also the fat.

The heart is about 20% fat. Where are all these resources, these raw materials coming from? And then we see such a lack of education around what the heart is made of in and of itself. Not that it's everything, but it's one of the most important things, and it's lacking in the education in and of itself.

DR. RON BROWN: You know, I'm trying to restrain myself from interrupting and just jumping in with my thoughts before I lose them, right? Education, exactly. We need to be educated in research methods.

SHAWN STEVENSON: Yes.

DR. RON BROWN: This is the problem. And I actually mentioned this in my first article. How many times have I talked to people who don't understand the difference between causation and correlation? About 99% of them. You know, when I took my first research method that was the whole point of that course. If you didn't learn anything else, at least leave the course understanding the difference between causation and correlation. In other words, just because two bits of anecdotal evidence occur at the same time or go together, or before something else happens, doesn't mean that that caused something else to happen. You can't just go by the temporal relationship. There are other factors you have to look at to establish causality, and people just don't understand that. They think, "Well, you know, we had a lockdown and the cases went down." Well, yeah, you're going into the summertime, cases always go down in the summertime. "Well, that has nothing to do with it." Well, it has a lot to do with it.

You can't say that it was caused by the lockdown. How do you know? Maybe it was. And again, I'm being fair too. I'm not saying it wasn't, but they're saying it is without considering other things. And I'm saying, "No, you have to consider everything." And then we have to decide through experimentation, which is... And randomization trials and all that kind of stuff. What is the cause here, right? But we're not educated to do that, that's the first thing. The only people that are really educated to do that in the health area are epidemiologists. They know that, because you can't get anything published if you're just going to express your opinion and make declarative statements that this causes that unless you prove it or at least show the evidence that can lead to more experimentation. 'Cause... So you learn to think that way as an epidemiologist. The people, the public, can't think that way, they don't think that way. Now, maybe we should teach them to think that way a little bit, it wouldn't hurt, reading, writing, arithmetic and, oh yeah, research methods. At least just one course. One course to think that way. And so... And the other thing is even the educated people, they're so narrow in their little silo that the information they have is almost irrelevant to anything around them, you know? There's a saying that an expert is somebody who knows more and more about less and less until they know about...

They know absolutely everything about nothing. So, that's what we've got here. And we need interdisciplinary approaches. We need trans-disciplinary approaches, where you get people who know a little bit about that heart muscle that you were talking about, and a little bit about the nutrition, right? And a little bit about the diseases. And then you get the big picture, and

you can see how it all fits together in a puzzle, and that's when you start coming up with insights about, "Okay, how can we... How can we change the outcome of this?" Right? It's not just a question of what drug are we going to take or what operation, alright. And, by the way, it's not just a question of what food we're going to eat either, you have to look at all of it. There are some people who are very skeptical and they won't look at anything except what they know, right? On the other hand, there are other people who are completely open-minded, but too open-minded, they're not rigorous enough in making determinations, so they accept everything. And just like I said, the expert knows more and more about less and less until they know everything about nothing. A philosopher, for example, knows less and less about more and more until they know nothing about everything. So, take your choice of whether it's... You spread out too thin, or you're just going too deep and narrow.

You need something in between, something all around that embraces all of that stuff. And you're not getting that when you have public health people who are just, I hate to say this, I'm going to get in trouble. I don't care. No, I do care. Physicians, if you're an MD, great, but unless you're a PhD also, you don't have that research method training. You can't look at the cases and the ICU's being filled up and determine exactly what's causing it and what we can do to address a problem, because you don't have that training in the research methods to identify causative determinants, right? And how to modify those determinants. You just don't think that way, and yet, those are the people that are running the show.

SHAWN STEVENSON: Yeah. You know, I'm so grateful to have this conversation, because... I mean, right now, this is... The beautiful part about all of this mess, is that we have an opportunity to change it. Because again, folks, these are very smart people, but if we're not trained in the proper way of thinking, and especially critical thinking and especially research methods and being able to put stuff together and make sense of things, rather than this very dogmatic view of how things are supposed to be. And so one of the biggest breakthroughs that I've seen, with myself and also people who are really at the top of this field, I got to a place where I realized that everything is an option. Everything is an option and a possibility, even stuff that I don't know, that I'm not associated with, and to have this kind of curiosity and openness, but also knowing that there's a tenet. There's a basic... There's some basic principles that we do know. Just like with the laws of physics, there's... Even the way that we operate with medicine, it's just not even in basic principles of physics, which is... And this is one of the things I was told with dealing with the health problem, "Well, this is something that just happens." Nothing just happens, there's always that causative force behind everything.

We might not be able to explain it. And so, this is a good place where I would love... And I mentioned this to you also in our conversation that we had a couple of the days ago. The first person I reached out to when all of this stuff started to happen was a prestigious epidemiologist friend of mine, right? That's the first person that I reached out to, to make

sense of this stuff, because of the ability to analyze and understand the data. Because what... Even with some of the, again, most intelligent, educated in their framework, folks, my colleagues, for example, some of my colleagues, they'll grab a piece of data and ride that out as the truth, because this set of other people gave it to them.

DR. RON BROWN: Let me jump in. An epidemiologist needs to do follow-up studies. You can't make snap decisions. You need case control studies, you need serosurveys to analyze the severity and the prevalence and the incidence of the disease. That takes a long time. So in the... So the epidemiologists are kind of being pushed out of the equation right now. So you have the technicians who are coming up with all these new genomic sequences for these viruses that probably have been around forever. We don't know. Again, I'm not saying they have, they are or have been, but I'm saying we don't know. But people are making decisions as if they do know that it's brand new virus that's never been seen before, and therefore, we all... The sky's falling, we all need to lock everything down. So you're missing a link. That information should go from the technicians over to the epidemiologists, who can say, "Okay, let's see how dangerous this really is. Let's do a serosurvey. Let's see how many antibodies people have to this in the entire population, so we can see how widespread it is." It takes two years to do that.

In the United States, right now, there's a serosurvey being conducted by Dr. Fauci's own institute, and he has never mentioned it, never. It's a serosurvey that was started in March 31, 2020, and it will end a year... Two years later, in March 31st, 2022. It's going to be a representative sample of the United States population to see how widespread the Coronavirus is. Because when you see these infections, you include all the people who were never sick, and that dramatically lowers the fatality rate. That's why the infection fatality rate is always lower than just the case fatality rate. Which what you get is... You get that at the beginning of the outbreak when you're just looking at only sick people.

When you look at the whole population, you come up with an entirely different number. Now what if that number turns out to be the same as Influenza? Then all of this was over nothing. Well, not nothing, but it's no dangerous than Influenza, right? How do we know that? Well, we won't even know that for another year, but is that stopping people from doing these crazy lockdowns and all these other non-pharmaceutical interventions that the World Health Organization itself said had, "Weak evidence to support their use?" No, we're going right from the genome sequences to the public health authorities and politicians who are making these dumb decisions, and in the process violating all of our rights and our freedoms. That's a whole other problem. Because this never started until China locked down its society, and the World Health Organization said, "Oh look, China locked down everything, and the cases went down by 80%."

They did, in February 2020. And then they said, "Everybody should stop doing what they're doing, and start doing what China did." And guess what? They did. Except we're not getting the same results. What's the difference? The difference is, and this is a third article that's under peer review right now, China changed their case definition. In China, you are not infected with the Coronavirus unless you have pneumonia. But even more than that, even if you have pneumonia, only if they can't find any other pathogen normally associated with pneumonia, and they find the Coronavirus, only then will you be considered a case. That eliminates practically all the cases, 'cause the fact is 86% of people who have SARS Cov-2 infection have co-infections. They have other infectious. If you're eliminating those cases, what's left? There's nothing left. And if you look at any graph on the number of deaths in China over the past 11 months or so, the number of deaths from the Coronavirus... Do you know how many there were?

SHAWN STEVENSON: Tell me.

DR. RON BROWN: Take a guess.

SHAWN STEVENSON: It's... I think we can maybe even count on our hands.

DR. RON BROWN: Two. One hand. Two people. Two...

SHAWN STEVENSON: That doesn't make any sense. That makes no sense.

DR. RON BROWN: It makes sense, when you think of the reason why. Because they changed their case definition.

SHAWN STEVENSON: And we did the opposite, didn't we? We did the opposite.

DR. RON BROWN: We broadened our case definition. The World Health Organization said, "You know what?" If you ask the World Health Organization, what's the name of the coronavirus. What's the viral name? They won't say it's SARS COVID-2. They call it the novel coronavirus 2019. That's why the disease is novel coronavirus 2019. Which is another problem, 'cause you're not supposed to name a disease after an infection. You don't name AIDS after HIV. You don't call AIDS, HIV disease. They're separate. Because once you make the infection, the disease, anybody who has an infection, even if they're not sick, has a disease.

And so how does that affect your mortality rates? Now you're including all these people who are asymptomatic. Right? And they might die of cancer or heart disease or anything else, but if they had that asymptomatic infection, now they've also died of coronavirus. All because of the definition. And the World Health Organization definition specifically took out the word

SARS. Do you know why? Because in 2003, during the SARS pandemic or epidemic... I think it was the pandemic, China suffered economic results... Adverse effects. And so the World Health Organization decided they weren't going to allow that to happen to China again.

And in the process they threw out the baby with the bath water. I have nothing against protecting countries from something that they don't deserve. But when you change the whole name of the virus and the case definitions and you broaden it like that, and the mortality rates skyrocket, even though these people aren't really sick, and then the public health people use that to frighten people. And then use China's totalitarian lockdowns to lock down people when China's lockdowns never reduced the cases in the first place. It was their case definitions that did. Now, this is coming out in my third article being peer-reviewed right now.

And this is the kind of evidence that people need to talk about and to demand answers and to further investigate. Don't just take my word for any of this, investigate it, it's all based upon evidence. I don't write articles of where I just spout off my opinions. I have no opinions when I go into writing an article. I'm a blank slate, kind of like what you were saying. I let the evidence tell me... Follow the trail, of the evidence. Where is it going to end up? And this is what I found. And I didn't use any other information that is not available to anybody else. So anybody can verify this.

But until we get out of this problem... The genie's out of the bottle. Once a society learned how to use totalitarian lock-downs we'll always be susceptible to having them imposed upon us again, unless we stand up together as a society and demand an outlaw to lock-downs forever. We should never have this. The normal way this is done is if a new pathogen emerges, public health investigates it within the framework of our rights and freedoms. They don't say, "Oh, we don't know anything about this." Shut everything down. We never did that before. Why are we doing it now? Because the World Health Organization said, "Well, China did it and it worked." It didn't work. It didn't work. You can verify that. So...

SHAWN STEVENSON: Yeah. This is powerful.

DR. RON BROWN: We have to have a grassroots up movement because the people at the top are not going to reverse themselves. It's too late now. Too much sunk costs as it says. Sunk cost bias. So how's this going to change? We have to demand the answers from the bottom. So I've been talking about writing to the FDA advisory committee and demanding answers. Why aren't we getting all the information we need to inform consent? Asking the World Health Organization and all the people that are supposed to be in contact with the World Health Organization, what's going on here? You're giving us faulty information. And look at the results, and this fear-based campaign. Why does Dr. Fauci go out and scare everybody and say, this is ten times more dangerous than the flu?

You know what, he wrote an editorial with two other people back before his congressional testimony in February in 2020. And he said the case fatality rate of influenza was 0.1%. No, it's not. That's the infection fatality rate. He doesn't even know the difference between the two. They're two completely different groups of people. And you know that the infection fatality rate is way lower than the case fatality rate.

SHAWN STEVENSON: Can you talk about this? This was in your first study that I got a chance to review. Peer-reviewed study... Amazing, this is the exact information in there.

DR. RON BROWN: And so then he goes to Congress and he says, "Well, the coronavirus case fatality rate based upon the information we have now from China, it's 2% to 3%." Okay, that's right. Actually, the case fatality rate of influenza like in 1918 was also 2% to 3%. That should tell you something right there. We're not dealing with anything much more different than influenza. But then he said, "Let's compare that to the 0.1% case... Oh, he didn't use the word case fatality rate in the testimony. He just compared... He reduced the 2% to 3% percent to 1%, and then he compared it to the infection fatality rate of 0.1% in influenza. So he's comparing a case fatality rate with coronavirus, which he reduced from 2% to 3% to a 0.1%, infection fatality rate of influenza. This is like comparing apples and oranges.

You can't compare two different groups like that. But he didn't care. He just said, "Well, look, this coronavirus is 10 times more deadly than influenza." It's silly. Now, I'm trying to figure out how he made his mistake. He could have made it another way. He could have just said, "Well, you know, 2% to 3%, if we take into account all the asymptomatic and mild infections that would have reduced it to 1%. So in in other words, he's trying to approximate an infection fatality rate. That would be good if he did that, and then compared it to 0.1% of influenza, except for one major problem, where do you come off just pulling 1% out of the air. Based upon what?

I'm sorry I'm getting... Why didn't he say 0.5%? Why didn't he say 0.2% or 0.1%. He's just making things up. I can't waste my time trying to figure out how Dr. Fauci messes things up because it'll drive you crazy. I don't know. But it's messed up. It's not true. He's un-dependable. This is the type of expert that we're relying upon to make these decisions for us. That's why it's important to understand, to go back and look at the evidence and how he gets everything wrong. Whether it's vaccines or the case fatality rate of influenza, or the World Health Organization in China. I mean, this is a big mess. This is a total mess. And for people who sit back and say, "Well, you know, as long as we get the vaccines, everything will be okay and we can forget about this." Give me a break. What's going to happen next fall when we go into the next influenza season again? And the cases start rising again. Remember I said, the genie's out of the bottle.

SHAWN STEVENSON: Yeah.

DR. RON BROWN: We're going to go right back to lock downs again. We're never going to get out of this until we expose how this... We were misled into this by the World Health Organization. And by the way, when I'm talking about China, I'm talking about the government. Okay? This is just a dictatorship, a communist, authoritarian, totalitarian government. And we're adopting their techniques? And you know what, I've made some speeches about this but this is a sound bite. Okay? Here it is. They tore up our rights, right in front of our faces. They tore up our freedoms right in front of our faces and told us it was for our own good. Think about that. And they'll do it again.

SHAWN STEVENSON: You just said it. You just said it. We took that model and we put it in place. It was a new thing we had never done before based off of very loose information in the first place. But instead of admitting that it didn't work, they've just continued to double down on it. Right? Initially it was just to flatten the curve and then another curve happened and another curve, and it's just gotten more and more curvy, but...

DR. RON BROWN: Well now. Can I interrupt? With these variants it's another... Yet another excuse to continue to broaden the case definition.

SHAWN STEVENSON: And as you talked about earlier, when we talked, you said, we've let it out of the box.

DR. RON BROWN: Yeah.

SHAWN STEVENSON: And so now it's just a tactic that you can go to, but instead of, again, admitting that it hasn't worked. And here the... I want to ask you about this, because when it's put in place and it doesn't work, we don't get the outcome. Because here in Los Angeles, when I went out during that time, during this lock-down, because I had physical therapy, I got on the highway and I could look both directions and there was nobody. It was like a movie. It was like a dream. It was like some kind of weird scenario to see in the first place. People did the thing, but yet it's framed as though if people would just listen. If people would just do what we're saying to do all this would go away.

DR. RON BROWN: Oh, it's our fault 'cause we're not doing it good enough. The politicians, instead of admitting their incompetence or at least being willing to consider that they're making incompetent decisions are blaming the people. Enough of this. We have to stand up. We have to resist. We have to fight for our rights and our freedoms. This is the only way out of this.

SHAWN STEVENSON: I want to talk to you about your understanding of... Okay, so we know that coming into it... Like for example, you have to check your biases at the door. It's one of the things that you talked about a little bit earlier. Coming into the data with an open clean slate, right?

DR. RON BROWN: Right.

SHAWN STEVENSON: So we all being human, we have a natural tendencies biases. You got to check your biases at the door. And so for myself personally, I've got a bias towards wellness, doing things that I know based on the most literature that we have, what our... Kind of our DNA expects from us. You know movement, food, sleep, these basic tenets. And anything outside of that, it rubs... It starts to rub up against my bias, but I got to check myself. Because I've seen it in my clinical practice, Lisinopril being effective, Metformin. Everything has its place. Now, here's the thing. When we hear the news that we've got a vaccine, it's been found to be 95% effective, immediately, not my bias against the thing. I'm more like, "Wow, that sounds amazing. That's incredible that they were able to do this so quickly." But that's not the true. I mean, there's the thing. I want you to share with me. It is true...

DR. RON BROWN: Exactly.

SHAWN STEVENSON: But it's the framing of it because the absolute risk reduction again is less than 1%. And also what is... And I'm so glad you brought this up earlier. What are we reducing the risk of? It's not reducing the risk of death, it's reducing the risk of mild symptoms.

DR. RON BROWN: Yeah. That's it.

SHAWN STEVENSON: In the clinical trial, going back and looking into this data more thanks to your encouragement, it was somewhere in the ballpark of one in 35,000 people passing away during the clinical trial. Whether it's the control group or placebo group. We just didn't see it, not even from the controls who weren't even getting the vaccine. We see this slew of side effects resulting and the clinicians... The people who were conducting the trial, letting folks know, "Hey, if you start to get some symptoms of chills, fever, take some drugs to suppress the symptoms."

DR. RON BROWN: Oh wait a minute. I got to interrupt you.

SHAWN STEVENSON: Yep.

DR. RON BROWN: I thought that was the whole point of taking the vaccine was that you wouldn't have those symptoms. So now you're telling me... Think about it. That was the whole point of taking the vaccine. Oh, and by the way, you're going to have the symptoms 'cause that's one of the effects of the vaccine. Wait, I thought I wasn't going to have symptoms. That's the whole point. Well, how can you not have symptoms unless you have symptoms? It's double talk. It doesn't make any sense. And I have to be honest, I haven't studied the safety issues, 'cause there's nothing to study, there's no data there. For crying out... Do you know... Do you know... I think I told you this. The joke about the lab mice. And one lab mouse says to the other, "Are you going to get the coronavirus vaccine? The other mouse says, "Are you kidding they haven't even finished testing it on the humans yet." There's nothing there. We don't even know. We just don't know. Okay, there's the answer. So I can't say...

SHAWN STEVENSON: That's the thing, we don't know.

DR. RON BROWN: Yes, it's dangerous. No, it's not dangerous. Nobody knows. Let's be truthful about it.

SHAWN STEVENSON: Nobody knows. That's the exact thing I was going to ask you about.

DR. RON BROWN: That's the correct answer.

SHAWN STEVENSON: That's the exact thing I was going to ask you about. And there seems to be this ground swell of certainty and any concerns get brushed under the table. So here's... I'm going to share this direct quote. This is from the Johnson & Johnson vaccine trial. "Following the administration of the vaccine, fever, muscle aches, headaches appear to be more common in younger adults and can be severe. For this reason, we recommend you take a fever reducer or pain reliever if symptoms... "

DR. RON BROWN: Oh, wait a minute.

SHAWN STEVENSON: "Appear after receiving the vaccination."

DR. RON BROWN: But what are the symptoms of mild of coronavirus infection? Fever, muscle aches. Yeah, the same thing.

SHAWN STEVENSON: And what this could have led to, and this is a BMJ review of the data, this could have led to a greater suppression of COVID-19 symptoms following vaccination, translating to a reduced likelihood of being suspected for COVID-19, reduced likelihood of getting tested and therefore reduced likelihood of meeting the primary end point. But in such a scenario, the effect was driven by the medicine and not the vaccine.

DR. RON BROWN: Were they told to take... I don't know. I'm asking were they told to take the medicine during...

SHAWN STEVENSON: They were told...

DR. RON BROWN: The trials?

SHAWN STEVENSON: Yes.

DR. RON BROWN: Oh, so that's the point you're... So they're introducing another factor. A confounding factor.

SHAWN STEVENSON: It makes no sense, but nobody knows this stuff.

DR. RON BROWN: Did they control for that factor? Did they say, "Well, we'll take these people out because they had this... I know it makes...

SHAWN STEVENSON: And also what that leads to as well...

DR. RON BROWN: You know it's like that Dr. Fauci thing, you'll drive yourself nuts trying to figure out exactly how they messed up.

SHAWN STEVENSON: And what that leads to, as well, is an un-blinding. An inadvertent un-blinding potentially, because... The physician, if they find out that the person is having some symptoms and knowing that, "Hey, there's a chance it's probably the vaccine... Or even with the person like, "I know I got this vaccine so I'm having these symptoms." It can just create some muddy water, I think, in the data.

DR. RON BROWN: Exactly. How do you distinguish the adverse effects of the vaccine from the mild effects of the infection? They're the same. We got a problem here, folks. So it's totally arbitrary as to how it gets diagnosed.

SHAWN STEVENSON: And you would think that they would just test people anyways, but in one of the other studies, they said that investigators should use their clinical judgement to decide if an NP swab should be collected. So if somebody... So it's not just doing the thing just because to test them if they got an infection, but based on your assessment...

DR. RON BROWN: Exactly.

SHAWN STEVENSON: Based on your judgement.

DR. RON BROWN: So a guy who gets the vaccine and they have all the symptoms of an infection, but the doctor says, "Well, we're not going to take a nasal swab. Here... Here's the medicine. It's just a side effect of the vaccine. How do you know? You don't. It's just an arbitrary decision.

SHAWN STEVENSON: Yeah, it's nuts. And one of the craziest things, I might have said this already, like how crazy... One of the craziest things is. But one of the most remarkable things that I really found was that the study was mapped out to be a two-year study, for example, to get more conclusive data. This was what... The terms they use. But it hasn't been remotely close to two years yet. That's the craziest part about it. Is that it's mapped out to be a two-year study, but it came out into the market and in people's bodies within a couple of months.

DR. RON BROWN: Well, I have a little bit of different information about that. I thought the study was designed... Maybe that might have been in the early plans, but ultimately they decided to terminate the study when they reached a specific number of cases in the control group. Why did they do it that way? I think for ethical reasons, if they started to see, like cases piling up in the control group at that point, they'd have to end the study because it's unfair to keep the control group from the benefits of the treatment. Right.

SHAWN STEVENSON: You're already right. That was just in a follow-up to see if there's any side effects long-term. But you said exactly, the trial itself is really over. But that's the part that I wanted to talk to you about. And you've already kind of answered this, but we don't know any long-term ramifications. We just don't know yet. And this is the big part of the conversation that I really think people should know about, which is... Moderna, for example, the mRNA technology, they haven't had anything approved prior to this. It's literally since December of 2020, this technology has never been approved for use in humans, like at wide scale like this, it's a new thing. And so now we get into this conversation about how does it work. We've got, just from basic science class in high school, DNA to RNA to protein. And so we've got something...

DR. RON BROWN: Okay.

SHAWN STEVENSON: To kind of interject in there and kind of encourage ourselves to create this spike protein on their own. Right?

DR. RON BROWN: Yeah.

SHAWN STEVENSON: And then they replicate and then we get an immune response to go and try to target these infected cells, seemingly infected, synthetically infected cells. And with that immune response, we've got all these different immune system weapons, but one of those is the antibodies for example.

DR. RON BROWN: It's a great fairytale. Too bad, none of it's true. None of it. Everything you just said is all anecdotal. It's all theoretical. It's all... And it's bad theory. There's good theory, like the way I put them together, inductively up from evidence, and then there's the bad theory where... You just... Something that's convenient and you can sell and market and then, "Oh, we'll cherry pick some evidence for it." That's just what you've described. And that's my fourth article that's coming out in peer review... That's being peer-reviewed right now. And let's talk about messenger RNA. How much time do we have? I can go on forever. I don't care.

SHAWN STEVENSON: We need this. This is the most important conversation of our time.

DR. RON BROWN: So the vaccine is supposed to work by, as you said, creating the... Having the body create the S protein, which is the handle that's on the coronavirus. Okay? Which helps allow it to be targeted by the immune system. And you do that by supplying the genetic code to the S protein, so that the cells can make that S protein. And that genetic code is stored in, we call RNA. RNA is transcribed from DNA. The DNA contains the genes in the cell. The nucleus of the cell. That's just the blueprint to tell the cell how to make proteins. That's all it is, right? 'Cause your cell's made up of proteins. And every day, by the way, your cell loses some proteins and it replaces them with new proteins, so it's a continuous process. Okay?

So the proteins aren't made in the nucleus. They're made outside the nucleus in the cell, in the cytoplasm in a organelle, called the ribosome. So the ribosome needs a copy of that blueprint. That's the job of the RNA. The DNA unzips itself, and there's an RNA created that transcribes the code, the genetic code. And then it leaves the nucleus, the RNA does, as a messenger to the ribosome. That's why it's called messenger RNA. That's all it does. It's just a postman or a post-woman.

Once the RNA is delivered to the ribosome, the ribosome reads it, and then collects the amino acids to synthesize a string of protein. What happens to that RNA when it's done? I'll tell you what happens. It's waste. It's a waste product. It doesn't do anything, it's not alive, it's just a copy of genes. It's all it is. It's fragmented into eight fragments and it's packaged as a waste into a bubble in the cytoplasm called an exosome. Now, exosomes have all kinds of functions. And one of them is to remove waste from the cell. Scientists, virologists have looked at those exosomes, and they can't tell the difference between an exosome packed with the genetic waste and a non-infectious virus. They're the same.

It could be, now, it's not proven yet, that what we call viruses are really just waste products of cells. The repackaged, fragmented RNA of the cell that's been used. And in the exosome, it's transported out of the cell into what we call viromes. You've heard of the microbiome, well there are viromes also made up of variants... Or variants or viruses. And those also get transported out of the body through the gastrointestinal tract and through the nasal pharynx, as part of the mucosal immune system. If your mucosal immune system becomes backed up, those viruses can't be shed.

They can't leave the system. So it looks like they're replicating. They're not. They're just accumulating. They're dead, how can they replicate? Well, they're genetic materials, so they get into the genes in the cell and the cell... No. That's all fantasy. It sounds good. There's no proof of that. There's no evidence of that. What's happening is things that cause your mucosal system to work less effectively, remove all that garbage less effectively, and that makes it appear like they're accumulating. Well, it is accumulating, but they're not replicating. It's like, if you walk out on the street during a garbage strike, a garbage collection strike, and you're walking down the street and say, "Oh, look honey, the garbage is replicating."

It's getting bigger. It's not replicating, it's just not being removed because the system is breaking down. So instead of the viral infections causing the problem, the problem is causing the viral infections. It's causing the accumulation of these waste products of the cell. These genetic waste products. That's all it is. Now, this is theoretical, but it challenges... It's out of the box type of thinking that challenges the whole paradigm of virology, which is what this whole pandemic is predicated upon.

So that article... That article is going to go into more detail about that. So we're looking at dietary factors that suppress the nasal mucosal system, immune system. That's called nutritional immunology, it's a new field. And one of the factors that I'm looking at is sodium chloride. Sodium chloride paralyzes the little fingers in your nasal mucosal system, the cilia. And when that happens, you get that backed up accumulation of the viruses and other things too, that normally are breathed out.

And it so happens that sodium chloride also causes symptoms when it's delivered in an intravenous saline solution, like fevers, shortness of breath, pulmonary edema. So that you get clogging of the air sacs in the lungs with fluid. This is all related to coronavirus when you think about it. And the vaccines in the placebo group were all saline solutions, 100% saline, okay? And we know the adverse effects of saline are the same as those aches and pains and fevers and things that we were talking about from the coronavirus. Now, this is just evidence. I'm not making any hard conclusions, but think about how this all... What this is all pointing to. There's something here that we need to investigate further. It may be that we're not catching viral infections. Sure, you can breathe in somebody else's virus, but the literature is pretty adamant

that it takes more than just breathing in a few variants to overcome barriers to infection. You have an immune system. You can't infect people that way.

This was proven in 1918 by the United States Navy. The United States Navy during the epidemic then, or the pandemic, took about 60 sailors in Boston, brought them into a hospital with severe cases of influenza back then, and brought the people, their sailors into direct contact with the patients, the patients would cough on them, would breathe on them, their sputum would be injected into these people, into the sailors. Nothing happened. They replicated the study in San Francisco, 60 more sailors. Same thing, nothing happened. They published the results. We don't know what happened. Nothing happened. We have clinical evidence that that infection, that problem is caused by something else. You can't just catch an infection. You can catch a virus in the sense that you breathe it in, but that's not the same as catching an infection. The infection comes from within, from other things that are impairing your immune system. And one of those things that impairs your immune system causes that aggregation of the viruses in your nasopharynx. Right? So you look at all this information and you think, "Are people coming to the wrong conclusions about all this?" And my opinion is, yeah, they are, and we need to look at more of this.

Now, getting back to the vaccine, that Messenger RNA, 'cause this goes all the way back to the Messenger RNA, right. If you inject Messenger RNA to a cell, the cell immediately destroys it. It's foreign substance, it doesn't belong there. It has its own Messenger RNA, who are you to put somebody else's in there? It doesn't work that way. So they have to figure out a way to protect the Messenger RNA. You know how they did it? They use these nano lipid particles. So they encased it in fat, basically. Okay. And guess what? It wasn't being decomposed. Now, let me ask you something, now that you know a little bit about cell biology, how is the ribosome supposed to translate the G, the genetic code in that nano lipid particle without stripping it apart? It can't. This whole thing, this whole mechanism is ridiculous! It doesn't work. If you were a seventh grade science student and you came up with a project with this as your project, I'd have to say, go back and re-think this because it doesn't make any sense. Does it matter? Well, let's see with the relative risk reduction of 95% when it's really just a 1% absolute risk reduction. Who cares? It doesn't matter. Do whatever you want. Call it whatever you want. You're still going to wind up selling it anyway. Stop me at any time.

SHAWN STEVENSON: This is so crazy. This is so powerful. I got to say this going back to what you just said, and by the way, so when I just was fluttered a little bit, I had to take that in for a second, what you just said. That was remarkable. Alright. Oh my God.

DR. RON BROWN: No, leave that in, I like the remarkable statement. Leave that in.

SHAWN STEVENSON: Okay, yes.

SHAWN STEVENSON: Leave that in, okay. Now this is beyond powerful, and you just said something that is really overlooked in our way of testing today, which is built around being much more ethical, and this is the fact that we're talking about back in the earlier part of the 1900s and proactively exposing people to the stuff that we believe makes people sick, like...

DR. RON BROWN: Exactly.

SHAWN STEVENSON: And in none of these clinical trials are we doing any such thing. We're not actually exposing anybody to a virus to demonstrate any protective effect. It's just like... It's so much we don't know, but what's communicated is that we act like we know, and it's so far from being the case.

DR. RON BROWN: I know. Those are called challenge studies, by the way, and we've always had challenge studies, and they usually all always fail. They really do. It's just there are too many other factors that go into making you sick. And now people are going to say, "Well, that Navy experiment, that was influenza." This is not influenza remember? This is 10 times more deadly. So they'll use that excuse.

SHAWN STEVENSON: Yeah. And specifically talking about exposing people to things that are dangerous, if you look into a company's history like Pfizer, just go to Dr. Google and look up Pfizer and Nigerian children, and have a field day and look at what that looks like. But what I want to really communicate for everybody, because you just mentioned this, we really just kind of turn off our lives, we can put our faith into these entities as if they are really doing something that is righteous and of high efficacy, when in reality, a company like Pfizer, for example, is a consistent committer of felonies with all of the different lawsuits, all of the different deaths association. For example, Pfizer had to pay out $1.2 billion to settle lawsuits stemming from side effects of Prempro that caused women to develop breast cancer. But what's built into their metrics is they already know that there's going to be these lawsuits, so they just...

They're more so looking at the money that can be made. Now, I'm just sharing one. If you dig in here and you see consistently again and again and again, all the different... And this is with "normal" FDA approval, and then so many people having these dangerous side effects or dying in relationship to taking these medications, and this is the point, if we take all of this into context and we understand... And of course, if we're talking about pharmaceuticals, we can be looking at a simple cost-benefit analysis, maybe the benefit does outweigh the potential danger, and I can sit with that, but when we have data, you can go and look at something at some of these lawsuits themselves and you could see the emails that were captured where they know, they know that the drug is dangerous, they know that they have some clinical

evidence that people are probably going to die, and they put it on the market anyways, and then we believe that these companies are looking out for our best interest, this is where the real problem is. And here's the point, and this is what I want to talk to you about, we take all of that into context.

So we've got $1.2 billion paid out just in that one individual for that one drug, not to mention the hundreds of other drugs, so we've got that, but then we have this stratosphere of vaccines that don't come with that legal obligation. And so a company would see that, a pharmaceutical company, where we can produce these vaccines without any legal liability if anything goes wrong, that would immediately bring up a logical bias of like, "Why would I take your product if I don't even have... There's not even a liability if I am hurt." Not to say that it will be, but it should still be in place. Why does that not exist?

DR. RON BROWN: Okay. From my understanding, we have vaccines 'cause the public demands it. From my understanding, the pharmaceutical companies knew it was a losing proposition. They didn't want to do it. They said, "If we're going to do this, then you have to give us protection," and the government said, "Sure." Why? Because this is what the people wanted. To me, the root of the problem is that the people need to be educated. They need to understand that diseases aren't caused by lack of vaccines. Think of all the diseases treated by vaccines. Is any one of them caused by the lack of a vaccine? No. What's different about this? Nothing. And yet people say, "We'll get the vaccine and we won't have to worry again." Really? What have you done to remove the cause of the problem? Nothing. You're living in a fantasy world. And I don't want to live in a world where it's being ruled by people that are living in a fantasy, because I'm living in reality. I don't know about you. These vaccines, what can I say, are just... They're the cost of doing business for the pharmaceutical companies. If they get sued, that's just their business expense, that's all. What does this have to do with health? It has nothing to do with health.

The people need to be educated about this. And how many people are looking at what's causing the Coronavirus? Now, I just went into that whole big spiel about what is Messenger RNA, and how is it a waste product, and how is it packaged to an exosome, and how is that like a virus, and what happens to that, and what causes it to be backed up, and what if those causes are also making you sick too? Then that means that the infection itself is not causing the sickness, the infection is the result of the sickness. So what are we doing about investigating the determinants of that sickness? The answer is nothing. And we got a big problem.

SHAWN STEVENSON: Yeah. Clearly.

DR. RON BROWN: As long as people think the vaccine ends the problem, sorry, you're in a fantasy world. We still got the same problem. 'Cause you know what, I'm in right of putting an

end to these... I'm in favor of putting an end to the lockdowns, but that doesn't mean I'm in favor of exposing people to diseases. That's not it at all. In fact, it's the exact opposite. We're doing all the things wrong to protect people, not the right way, we're doing them all the wrong way. We got to start looking... And you'll like this. We have to start looking at our lifestyles, 'cause those are the causes of these problems, not the lack of drugs, not the lack of lockdown, not the lack of vaccines. I think that's pretty much it.

SHAWN STEVENSON: It is, it is so powerful, so powerful. So just in recap, legislation was passed, and this was not that long ago, to basically shield vaccine manufacturers against any legal liability related to injuries or deaths that occur from their vaccinations, which again, it's a public demand, but it's based on education of the public. This is even how it was able to bypass, the even so-called stringent metrics for approval with the FDA, this emergency access, this emergency use, it was demanded by the people, and also this political, which is the craziest part, when this is political pressure, and that's why something gets approved, which has never been done before.

DR. RON BROWN: Can I say something?

SHAWN STEVENSON: Absolutely.

DR. RON BROWN: That's why I got so angry. This is a rat's nest of anecdotal, unsupported, just speculative guesswork. None of it is science. None of it is evidence-based. It has to come to an end. And it's only going to come to an end if people are informed about it.

SHAWN STEVENSON: Absolutely, absolutely. Thank you so much for sharing your brilliance and insight...

DR. RON BROWN: Thank you, Shawn, for the opportunity to put this all in front of people. Everything I said, don't take anything I've said on face value. Look it up. 'Cause that's what I did. I'm not out here expressing opinions, although I do have opinions, of course, like everybody else, but they're based upon evidence. It's the evidence that brought me to do what I'm doing right now, and to write the articles that I've written, and hopefully for the good that people can gain some insights and some understanding about how these problems develop, and the right way and the wrong way to address them. It's so important right now. See, right now, that's the number one priority. I feel we're doing it the wrong way.

We still have the Coronavirus to deal with, but we're dealing with it the wrong way. That is another problem on top of the problem of the Coronavirus. So one problem at a time. And then once we figure out, "Okay, Ron, we won't do it that way anymore, so what's the right way?" then we can start asking the right questions, 'cause you can't get the right answers until

you start asking the right questions, right? Then we can start talking about things like nutritional immunology and how that's related to these diseases, and how we can protect the people who are the most vulnerable from this disease. That's what this is really all about. We're going the opposite direction. We're not protecting anybody. We're just doing more damage. We have to take this one problem at a time, and I know we can solve this.

SHAWN STEVENSON: Absolutely. You just... Listen, I can't let you go now. I've got to ask you one more question.

DR. RON BROWN: Okay sure.

SHAWN STEVENSON: This is going to come up for folks. I know it's come up for me. And as I was watching all of this progress from the very beginning, I saw the data coming out of Italy, and I saw pre-existing diseases being a big issue here, and I stayed on top of the data when the lockdowns happened and thereafter, and looking at sedentary behavior, looking at the increased consumption of processed foods, the higher rates of mental health issues, the list goes on and on, the unemployment, all these different things transpiring. And I was saying very early on, just citing the data and looking at what we already had previously, and getting some estimates on what these numbers could look like for excess depths, not related to COVID, but from the treatment, our societal treatment of COVID, and I was just like, in the long term, this is going to be a really bad... The ramifications are going to be pretty negative. But in the short term, they can be pretty bad as well. And so my question that I want to pose you, if we know, for example, that this issue that we're facing as a society, if you go back and cite some of the data...

So there's two parts: Number one, recap the study that you published looking at the comparison with the flu that was used by Fauci to SARS-CoV-2, can you cite that and also look at, well, where are we at then with the excess deaths, and how can we explain that? And you just mentioned nutritional immunotherapy, we have psychoneuroendocrinology, we have psychoneuroimmunology, and understanding all of these different things, our life has been so changed and become so constrictive and dangerous that that can in itself contribute to some of the fallout. So part one, recap the study that you published, and part two, how can you explain the excess deaths that we have seen in fact from everything that's taken place?

DR. RON BROWN: Okay, so people don't think that this is influenza. Why? 'Cause they were told it wasn't influenza. Who told them? Experts who are not knowledgeable enough about this. They're not epidemiologists, they don't understand clearly the difference between case fatality rate and infection fatality rate more than just in a superficial manner, so that when they actually do some calculations, they wind up just scaring people and telling people, "If you're overreacting, you're doing the right thing." Since when is overreacting ever doing the right

thing? You need new experts, okay. It's time for new experts. That's number one. As far as all the deaths, there's two causes. One, as you mentioned, we have to, sooner or later, drill down to the actual determinants of why people are getting sick with these types of respiratory diseases.

Again, the cause of these diseases is not lack of treatments. It has to do with our lifestyle. Specifically, it has to do with things as you mentioned, like nutritional immunology. I have more information coming out on that. But there's another reason why the deaths appear so high. It's because of our broadened case definitions. According to the World Health Organization, as long as you have a positive PCR test, even if you have no symptoms, you are diseased, you're sick, you are sick with the disease, and if you die of something else and you die with that sickness, that sickness, that Coronavirus disease is also listed on your death certificate, even though it had nothing to do with the real reason why you died. SARS, Severe Acute Respiratory Syndrome was taken out of the case definition. It was taken out of the name of the virus by the World Health Organization.

So why are we saying that people who don't have Severe Acute Respiratory Syndromes are dying of the Coronavirus? That's a big problem. As soon as you did that, now it's opened up to everybody. You know what, when I looked at the amount of people who died by the end of the flu season, which was last October, and I only counted up the deaths that had anything to do with Severe Acute Respiratory Syndrome, and then take into account the number of times comorbid conditions for each case, in my exploratory data analysis, I eliminated about two-thirds of the deaths right there, 'cause two-thirds of the deaths have nothing to do with Severe Acute Respiratory Syndrome. That's the name of the virus. How can you say you've died of that virus when what you died of has nothing to do with Severe Acute Respiratory Syndrome? So that explains, as an answer to your question, why the death rate is so high. They're artificially high. Now, people are going to look at the overall mortality for the year and see if there really were more deaths, or did we just move over the influenza deaths and all these other deaths and just called them COVID-19?

I think it's the latter, right? That's exactly what we did. But you can't really depend upon those types of mortality studies, again, because there are so many confounding factors. Mortality rates from year to year change because the populations change. Demographics of the population has changed. People like me now, more of the older people are now in the higher risk category, more so than we were five years ago. All these things change. There are more people in the population. The governments and the health care systems and how you count up all the deaths and how you categorize them, everything changes. And also, that's why it's difficult to make comparisons between countries. Countries in different latitudes have different reactions to upper respiratory diseases. I'm up in Canada, you can't compare us to

Miami, which is a sub-tropical region. It's not the same. So you have to take all these other confounding factors into consideration. And it's almost... It's almost...

I'm not going to say it's a waste of time, but I don't really put much into those types of studies. Let's talk about the things that we can control right now, okay. Let's talk about how lockdowns are affecting our lives every day, and where that came from, and how we need to expose that and outlaw them, outlaw them, so we never have them again. Now, that's something that we can do. And then we can continue on, going on to the other problem, that Coronavirus, and then the variants that come up.

By the way, the variants... Remember I talk about that fragmentation inside the exosomes? So think of that as like a garbage can, okay, and you have the, let's say the banana peels on top of the soup cans. What if you switch the fragments around? Now you have the soup cans on top of it. That's a new variant. It's still a garbage can. It's no different. It's ridiculous, but no, we've never seen it before, so run for the hills. Where are the epidemiologists saying, "Hey, relax, it's just... “It’s not any more of a bigger problem than we've always had before we ever did the lockdowns. So we need to straighten all this out, and it's going to take a little bit of time, but we need to stand up for what we know is right, and it's not right, that we are living now in a totalitarian society. When they say we're all in this together, yeah, we're all in this together. We're in a totalitarian society together. They say "Stay safe"? Yeah, Safe from what? From truth and knowledge? Well, I can get truth and knowledge from the media, can't I? Uh-uh. They censor that.

So we're all in this together. So there you go. That's all we get from these politicians and public health people, and they will never, never admit they're wrong. We have to resist and fight for our freedoms and our rights.

SHAWN STEVENSON: That's why you're so important right now. Dr. Brown, I appreciate you so much. Thank you so much for sharing your insights, for sharing your data, for sharing your passion, and helping to get us educated, because truly, we're the ones entrusted with making the change. It's really up to us. And thank you so much for being a part of this and really helping to spark a change in our thinking.

DR. RON BROWN: Thank you, Shawn.

SHAWN STEVENSON: Awesome. This topic obviously deserves a lot more analysis and we'll have all the different studies for you in the show notes, so make sure to check those out. We're living at an incredibly important time. We're really writing the story of our society moving forward. How we're going to handle situations like this, we're writing that story right now. And so it's also important to understand who are we looking towards, who are we leaning on for

solutions in this time period, and looking at first and foremost, and being very honest about it, has what has transpired thus far hasn't been working? Because right now, here in the United States, we are the sickest society, self-inflicted, in the history of humanity. Right now we have about 242 million of our citizens are overweight or obese right now at this very moment. We have about 60% of our citizens have some degree of heart disease right now.

We have about 130 million of our citizens have Type 2 diabetes or pre-diabetes right now. And the issues just keep getting worse and worse and worse with no end in sight. And these chronic pre-existing diseases have really set us up for our rampant issues with infectious diseases, because that's where we're really seeing the heaviest weight taking place. And this isn't being talked about, getting to the heart of the solution, making us more resilient as a society, as a culture, and there's been so many excuses made obviously about, we can't get people to do this, we can't get people healthier overnight. It's been over a year, there's been hardly any conversation about addressing the real underlying issues with our society's health crisis. And I believe that we can start to steer the conversation in the right direction, and it's going to be up to us. And with that said, one of the things that we highlighted in this episode was the fact that, again, according to the CDC, 94% of the folks who've lost their lives in association with SARS-CoV-2, we know this already, have four pre-existing chronic diseases and/or comorbidities listed on their death certificate. Four! This is crazy. And this issue is not being talked about.

The highest incidents being those that we refer to as lifestyle-related diseases being hypertension, Type 2 diabetes, and obesity being kind of the biggest drivers of our susceptibility, and yet again, it's not being talked about. One of the recent CDC reports have found that about 80% of the folks who've been hospitalized in association with SARS-CoV-2 were clinically obese or overweight. And if we look at just the demographic of healthcare workers who are definitely hardest hit, as far as all different vocations, being there on the frontlines, being there, interacting and having close proximity to sickness, we would think that there would be some significant numbers, of course, but what's not talked about is that 90% of the healthcare workers hospitalized with SARS-CoV-2 had one or more pre-existing chronic diseases. It's the biggest susceptibility.

It's not 50%, it's not 10%, which we could be just like, "You know what, 10% of people had these issues, it's not even 50%." 90%, the vast majority, and yet we're not talking about this. 75% of our healthcare workers hospitalized were clinically obese or overweight, and we're not talking about this issue. These are things that we can do something about, but we keep on window dressing with the next latest hottest new drug, and I would be all for it if it was effective.

But as you can see, just as prior to all of this happening, the companies that are controlling this conversation, continuously use misleading tactics to make it look like they're doing something,

when in reality, it's very different. So as we talked about, and what was highlighted, and the data exists, you can go and look it up for yourself, but what was highlighted in Dr. Brown's studies, peer-reviewed study was the fact that, okay, we've got this 95% effectiveness, we've got this 94.1% effectiveness with Moderna, 95% effectiveness with Pfizer, but in reality, that's relative risk reduction; the actual absolute risk reduction in the population with Pfizer's vaccine is less than 1%, and folks simply don't know this, they haven't had the opportunity to have informed consent to know that... Because for me, again, 95% sounds amazing. Less than 1% sounds troubling. But that exists. That's the absolute risk reduction. The same thing with the Moderna, 1.1% absolute risk reduction. The numbers exist. How are they able to pass this? They weren't. It's not FDA approved. How are they able to pass this with the normal bodies of approval? Well, using the relative risk reduction, using that number, highlighting that and making this other number disappear as if it doesn't exist, but it does, you deserve to know about it.

And these companies, they're doing the same patterns of behavior that they've always done, and so this is who we're looking to for the solution; when in reality, Pfizer, for example, had to pay out a $1.2 billion settlement stemming from side effects, causing women to develop breast cancer, $1.2 billion! That's just one. There are so many lawsuits. It's insane, purposefully knowing that these side effects can happen. Pfizer was also caught testing an experimental drug on Nigerian children, lives were lost, and it took 15 years for those families to be compensated. Pfizer also agreed to sponsor health projects in Nigeria, and creating funds to help to compensate those infected, that was $35 million that they paid out, scraps to them. But again, most folks don't know about this, but here's one of the biggest things, Pfizer had to pay the largest healthcare fraud settlement in the history of the Department of Justice, paying $2.3 billion after pleading guilty to a felony violation of the Food, Drug, and Cosmetic Act. It's kind of like somebody murders a bunch of people, and you're like, "Oh, you're not going to murder anymore, are you? You're done murdering, right?"

What are we doing? We're looking to these organizations that have a history, a massive history of criminal activity, of fraud, of bribery, of knowingly putting unsafe drugs into circulation for our citizens. Where do you think the opioid crisis that is destroying hundreds of thousands of lives every year, killing! Where are the drugs coming from? Knowingly putting these things on the market. But that's just Pfizer. Let's talk about another one of these massive multi-billion dollar entities that we're putting our trust into to have a strain of efficacy and to protect us. Let's look at another one. According to the Justice Department, Johnson & Johnson agreed to pay $2.2 billion in criminal and civil fines to settle lawsuits demonstrating that it improperly promoted an anti-psychotic drug to older adults, children and people with developmental disabilities. As part of the settlement, Johnson & Johnson has agreed to plead guilty to a criminal misdemeanor, acknowledging that it improperly marketed their drug to older adults for unapproved uses.

It did not admit wrongdoing for the civil portion of the settlement, which involves claims that the company promoted the drugs used in children, and in the developmentally disabled, as well as accusations that had paid kickbacks to doctors and pharmacists in exchange for writing more prescriptions. The company agreed to pay criminal fines of $48 million, and the civil penalties of $1.72 billion, civil, but they didn't admit to any wrongdoing, but they pay $1.72 billion. That's the beauty of the system. They can still make it look like they cannot admit to things, they can manage and shift things around so that they don't plead guilty to anything substantial and just pay it out, pay people off. And most people just want something for the damage that they've seen with their families being destroyed, that's why they continue to do it, because we allow it, we allow this behavior to continue. And here's the truth, in the stratosphere with vaccines, and why... I was just sitting back and waiting for enough data to be compiled to give some hard evidence as to the efficacy, or things to be cautious of, but it is all so murky, and really understanding if there is any downstream side effects we don't know.

We don't know. This is why we need to be much more cautious about having this one-size-fits-all approach, this one-size-fits-all vaccination movement to take place and not really understanding what are the downstream effects; and just taking it at face value that this is safe, or that this is advantageous in any way, because at the end of the day, if we look at where the root of the technology is going, we've got this mRNA technology, which seems to be incredible on the surface, but we don't know long-term what the ramifications might be, we simply do not know. If we understand where it's operating, and in cell replication, for example, when we get that synthetic spiked protein, that protein then if we're going to have this replication, the cell replication process to start printing out more of it, potentially that's how it's designed to be, and get that stimulation of the immune system that responds. But in that cell replication process, could something go wrong? If we use cancer, for example, when we start to have abnormalities take place with cells not replicating properly, or hitting the Hayflick limit where they are supposed to stop replicating and they continue on, they don't have that programmed cell death, that apoptosis.

What can cause a cell to do that? Could this intervention potentially create some abnormalities in cell replication? We don't know! When we have a cancer tumor that we could monitor through our normal technology that we have today, of measuring the manifestation of a tumor, it could be years before we can actually measure and notice that a tumor's there; years, before we actually know. Do we know? Is it a possibility? Yes, it's a possibility that this could be a side effect, five years, 10 years from now, we don't know. We don't know, but everybody's running out. Not everybody, but a lot of folks are running out and they're not asking questions, they're taking it at face value that these entities are looking out for them. I wish it was true. This is what makes me different. I wish it was true. I would be happy if it was true, I would be over the moon excited if these publicly traded pharmaceutical companies really were looking

out for our best interests; and the people working within it, with most of the time being really, really good people, very smart people, they're going into these organizations, they're going into learning about pharmaceutical drugs and pharmacology to help people to save lives. That's what they're doing it for.

However, we touched on this a little bit, which is this education fallacy that we really have, and understanding, if we're training very smart people to think the wrong way about things, to continue to treat symptoms of diseases and not address the underlying root cause of the disease, we become a nation that is hyper-focused on treating the symptoms of disease, and looking for a "cure" to a disease, when all you have to do is remove the cause of the disease; which according to the Journal of the American Medical Association, the leading cause of our chronic disease epidemics, hypertension, diabetes, obesity, is poor diet, it's the leading cause. But that's on the surface that, it's great that they admit or acknowledge that, but there are deeper issues here because poor diet, what is that? It's a physiological stressor, that's just one of the stressors, one of the many that we're exposed to that is incredibly abnormal that our DNA has never experienced before.

Our genes are expecting certain things from us, and when we don't provide these inputs of movement, of sun exposure to produce vitamin D, and all the other things that sun exposure does for us, if we don't have inputs of high quality sleep and recovery, we know... Again, the Mayo Clinic did a fascinating study and finding that just a short stint of sleep deprivation directly increases our susceptibility to contracting a viral infection, but there hasn't been a movement towards, in popular media towards making sure our nation is sleeping well, or even putting any emphasis on that whatsoever. There's been none. There's been a movement to get another drug, which again, they're using that same manipulative tactic to make it seem like this is the end-all, be-all, this is some kind of savior. And when we talk about... And it's free for everybody, but it's not free, if our government is paying, that means we're paying for it, and they're set to make somewhere in the ball... We're talking tens of billions of dollars easily right out of the gate, but two of the biggest pharmaceutical companies in this, they're all prime to make somewhere in the ballpark of 60 billion right out of the gate.

Not to mention all of the booster shots that are going to be coming, because conveniently it's coming out right at this time where we're moving into summer, out of spring and into summer where you're going to see the rates of symptomatic infections going down, all that stuff. But guess what happens, when the "cold and flu season" comes back around, you already know what's going to happen, we're going to get another spike. And what are we going to do, we're going to lock down again? Is this what we're going to continue doing? And also, that's going to be the big push, and you're hearing it here first, it's going to be the big push for the booster shots because it's all these different variants. Right? And this is... I literally said this at the very beginning, at the very beginning, we release episodes of the show, and I was highlighting how,

already, and this was back in May, May and June, and we already had multiple confirmed manifestations of mutations of the virus back then. This is how it works, that's how it works, it's going to continue to mutate. That's how it's become endemic, it's no longer really even pandemic or epidemic, it's endemic, it's integrated itself into our population.

Right now, whatever number we have, we know through epidemiology, we've got at least 10 times more the population has the infection, or as even when we talk about infection, are we talking about symptomatic, or just simply contracting a virus in your body responding, making the immunological adaptation, but we know 10 times more people in the population have the thing. That's any basic principle of epidemiology, 10 to 15 times. We just know what's been tested, the folks that have been tested. Alright, so I want you to really just keep an eye of for what's to come, but the good news is that we can do something about this. History is not written in stone, but it's going to take a lot. It's going to take a lot of work, it's going to take a big movement towards what's real, towards what's sustainable, towards taking back control of our thinking, logic, critical analysis, understanding data, and these are things that hopefully moving forward are taught to our children.

Critical thinking has been more and more bled out of the system, and it's more thinking within the construct of rote memorization and putting people into boxes, and right now we're facing a time where there's such a lack of critical thinking, but there's such an abundance of data, there's such an abundance to access, but most people aren't really looking at things in a in-depth way. We don't have a lot of deep thinking, there's a lot of skimming, there's a lot of little brain snacks, and then we run with it, instead of taking time to really sit with information, think about it from multiple perspectives; and that's why conversations like this are so important because they spark that thinking, they spark a conversation, they spark looking at things from another dynamic. And one of the big takeaways that I really hope that you bring with you, the organizations that we're really entrusting with our health and the health of our society right now, routinely pay out billions of dollars in fines and settlements because of the damage that they do to our society, that's the truth. And so not to say that something good can't come from that, but we have to have a much more balanced perspective, because the truth is, it takes a minor miracle to actually prove that they did harm.

So when we're talking about the billions paid out, many of these studies, if you go and look at the data, lots of folks who have claims, they're not getting any of these settlements, that's because they have the most powerful legal teams on planet earth who are already well-versed and making it look like it's something else other than their drug that caused the problem. The same thing is happening right now, if you're paying attention to not just the mainstream media, which some local news reports will share, folks having adverse reactions, folks unfortunately losing their lives in the context of what's happening right now with this new drug intervention, it's a minority, let's keep that in context, but it exists nonetheless; and the

routine analysis, the routine statement used when they have the medical professional come on is that, "Well, there's really no way to tell whether or not this was vaccine-related until we do further testing, there's really no way to tell." And that's the thing, that's the loophole that they use. But that's not used with SARS-CoV-2, if anything looks like, sounds like, smells like SARS-CoV-2, they don't even...

Thousands, thousands of diagnoses have been based on just an assessment of symptoms and not actually based on clinical testing, and then we get into conversations of clinical testing, and the PCR test and all the different conflicting things going on there, it's just a big mess. And in times when things are really messy, it creates an opportunity for us to clean things up, for us to really get face-to-face with what's causing the mess, and to do something different. And so even though we're experiencing a lot of turbulence right now, this is a time for us to band together, not in a superficial way, where folks are coming together and just following the words of a celebrity because with this not being approved by the FDA, the pharmaceutical companies can't legally market the drug themselves, so they've hired out marketing companies, they're reaching out and getting celebrity endorsements, and letting the people do the marketing for them. And that's the most powerful form of marketing, when you don't even have to do the thing, you get people to do it for you.

And so, you can just sit back, and this is how the legislation with vaccines came to be what it is today already, where pharmaceutical companies have immunity if anything goes wrong from their product, is because of the groundswell of importance drilled into the minds of the citizens that we need those things. But if they're not risky, why not take legal liability? It just makes logical sense. And so just think about that a little bit. And so I'm not talking about that kind of banding together where we see the celebrity endorsement and we're just like, "Oh, this is all good." This is a time to stop outsourcing our thinking and to really band together in a much more sustainable way, in a way that's based on principles of health, foundations that are built on health, and not foundations that are built on disease and the treatment of symptoms, doing the things that our genes expect us to do, the inputs that healthy cell replication require in the first place; real food, the cells themselves are made of food; our immune cells, our NK cells, our neutrophils, they're all literally made from the food that we eat, and the water that we drink, and the air that we breathe, these are the things that make them up, it matters.

And understanding even in that same context, with that input for healthy cell replication, healthy expression of our DNA, genetic expression, we need real food, we need adequate sleep, rest and recovery. These are epigenetic controllers. We need adequate management of stress because as of now, and we'll put another study for you in the show notes, somewhere in the ballpark of 80% of all physician visits are for stress-related illnesses, because our lack of sleep is a stressor, our abnormal diet is a stressor, our lack of movement and sedentary behavior is a stressor, and each and every one of these items has gotten progressively worse throughout

this experience. And so when we're thinking about the context of the excess deaths that would come up in association with this, yes, we have a problem with the virus; but if you look at the data, the whole story is not there, it's not accounting for all the abnormal changes that we've been inundated with, where we're now eating worse than we ever have, moving less than we ever have, sleeping more erratically than we ever have, more stress than we ever have.

And one of the most recent papers identifying the psychosomatic effects of COVID-19 and looking at how it increases our incidents of poor outcomes, number one, susceptibility to viral infections, but also poor outcomes and having severe reactions. Because of the pro-inflammatory state that's created in the body when we are stressed, because our thoughts create chemistry in our bodies; every thought that we think has correlating chemistry that's released into our bodies, that are more powerful than anything we can even realize, but that's not given any credit in this conversation as well. Have we been put in a situation where we get "scared to death", and if this isn't even a part of the conversation, we're missing out on where science is really at, and we're doing the same old thing that we've been doing, we've got an issue, do we target the symptom of the issue with drugs?

Right now, 70% of our citizens are already on pharmaceutical medications, yet we're the sickest nation in the world. Nothing is getting better, everything keeps getting progressively worse, and yet we're outsourcing our thinking to the same models of healthcare, the same systems of pharmaceutical industry, and their dominant control over so much that we're exposed to in our lives today, over media, over our healthcare system, our same systems of food and big food companies, processed food companies, that have manipulated our citizens in so many different ways, and led to these, again, greatest epidemics of disease, self-inflicted disease in human history. We're still looking towards those entities, it's time to take back control of our thinking. Alright. That's the dominant way, but I know that a tipping point is close. This is why conversations like this are important, this is why I'm so grateful for you being a part of this movement. And if you could, make sure to share this out with the people that you care about, and keep this conversation going. Think about things, think about things rationally and have simple cost benefit analysis for the choices that you make. This doesn't mean that taking an action towards a medication as a solution can't be effective. Alright.

However, we have to maintain a meta-perspective, we have to maintain a sense of sovereignty, we have to maintain a sense of logical thinking, and most importantly, we need to maintain a sense of medical freedom and being able to make choices for ourselves, and not based on this very strange societal pressure to do something that's not proven to be effective, take back control of our minds. That's the mandate. I appreciate you so much for tuning into the show today, we've got some epic powerhouse shows coming your way very soon, we're not stopping, we're just going to keep it coming. Gas pedal down. Let's go. I'll talk with you soon.

And for more after the show, make sure to head over to themodelhealthshow.com, that's where you can find all of the show notes, you could find transcriptions, videos for each episode, and if you got a comment, you can leave me a comment there as well. And please make sure to head over to iTunes and leave us a rating to let everybody know that this show is awesome, and I appreciate that so much. And take care, I promise to keep giving you more powerful, empowering, great content to help you transform your life. Thanks for tuning in.