

On Trial: A Critical Look at the Pfizer Phase 3 Covid Vaccine Study

James M. Eli on 7/10/2022¹

*"I would rather have questions that can't be answered, than answers that can't be questioned."*²

How do you get more than a billion people to take an unapproved medical product?³

The first person in the world to receive an mRNA Covid vaccine outside a clinical trial was Margaret Keenan, a 90-year-old Englishwoman, on Dec. 8, 2020. Since then, 166 countries around the world have received 2.6 billion doses of the Pfizer-BioNTech vaccine. Pfizer and BioNTech have produced 3 billion doses in 2021 and they aim to produce 4 billion doses in 2022.⁴

On Jan 2, 2022, Israel's prime minister announced that the country would offer a fourth dose of the Pfizer Covid vaccine to healthcare workers and people older than 60 years.⁵ A fourth dose was already approved for Israel's immunocompromised groups. Around two-thirds of Israelis have received two doses of the vaccine. 80% of the eligible population have received two doses plus a booster, including 90% of individuals over the age of 60. Israel began vaccinating 5 to 11-

¹ Initially published 2/5/2022.

² Quote widely attributed to Richard P. Feynman, an American theoretical physicist, known for his work in quantum mechanics. However, there is no direct source for the quote.

³ The Emergency Use Authorization authority allows the FDA via the Federal Food, Drug, and Cosmetic Act to authorize *unapproved medical products or unapproved uses of approved medical products* to be used in an emergency to diagnose, treat, or prevent serious or life-threatening diseases or conditions caused by chemical, biological, radiological, and nuclear threat agents when certain criteria are met, including there are no adequate, approved, and available alternatives. The 1938 Food, Drug, and Cosmetic Act is the law that requires companies to test their products for safety before selling them. <https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization>

⁴ <https://www.pfizer.com/science/coronavirus/vaccine/working-to-reach-everyone-everywhere>

⁵ [https://www.thelancet.com/journals/lanres/article/PIIS2213-2600\(22\)00010-8/fulltext](https://www.thelancet.com/journals/lanres/article/PIIS2213-2600(22)00010-8/fulltext)

year-olds in November 2021. The efficiency of the early vaccination campaign, which had delivered two doses to over half of the population by April 2021, means that Israel is well-placed to observe the effectiveness of the Pfizer vaccine.

Israel has recently seen a surge in SARS-CoV-2 infections. Hospitalizations and deaths are also increasing.



Examine what is currently occurring in New Zealand just 44 weeks since both the New Zealand Minister of Health and CNN claimed Covid had been eliminated there. “That does give us confidence that we've achieved our goal of elimination, which never meant zero but it does mean we know where our cases are coming from.”⁶ The country of New Zealand followed one

⁶ <https://edition.cnn.com/2020/04/28/asia/new-zealand-coronavirus-outbreak-elimination-intl-hnk/index.html>

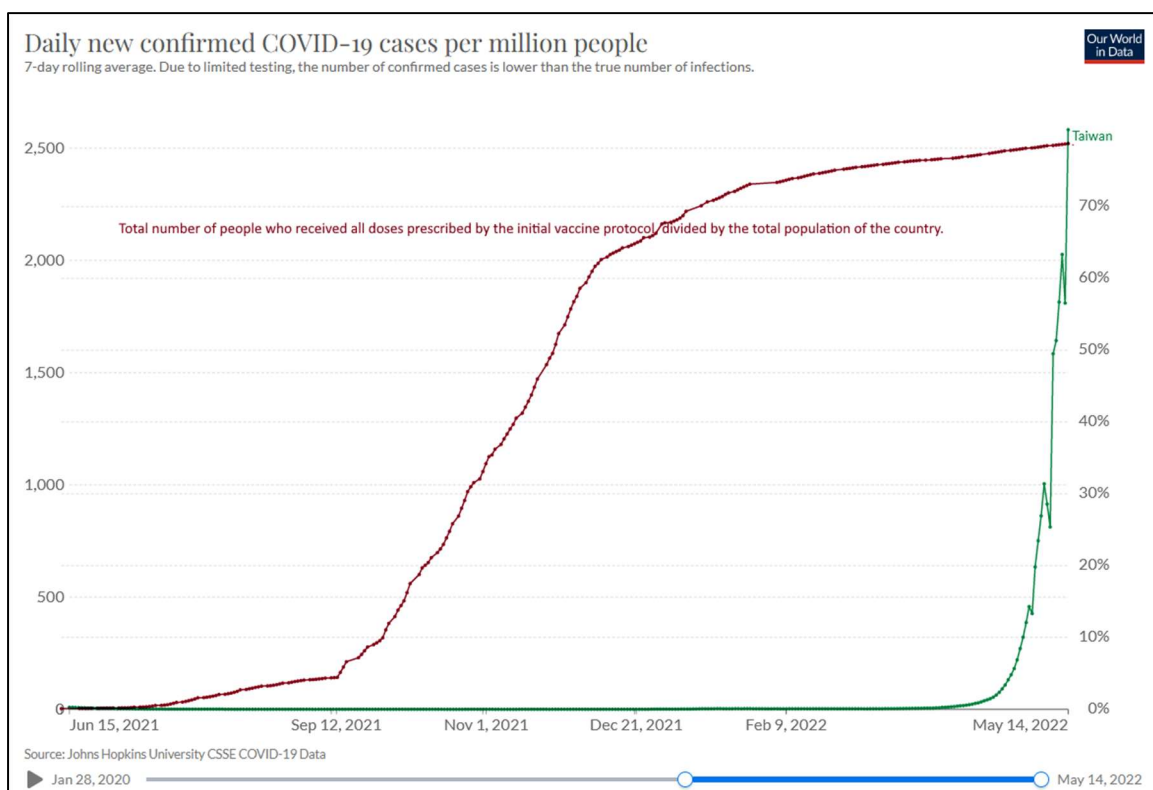
of the longest and toughest ‘Zero Covid’ strategies and persisted with arguably the harshest measures worldwide in attempts to prevent and rid the country of the disease. The New Zealand Ministry of Health claims 94% of the 12+ age group, and 52% of the 5 to 11-year-old category are fully vaccinated with nearly 2.5 million booster shots administered (New Zealand’s population is roughly 5 million).⁷ Yet, at this level of vaccination, new Covid infections are undeniably out-of-control in the country.⁸



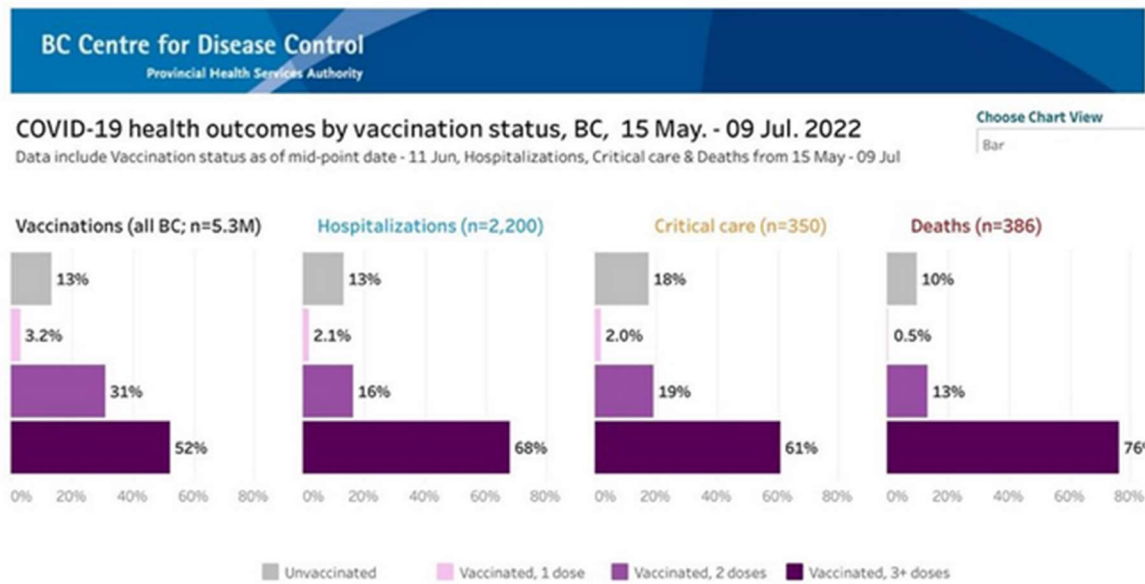
⁷ <https://www.health.govt.nz/covid-19-novel-coronavirus/covid-19-data-and-statistics/covid-19-vaccine-data>

⁸ New Zealand is an interesting study from the vantage point of Covid vaccine safety since, unlike most all other countries, it had nearly no Covid while the vaccines were being rolled out. At the time of this writing, there have been 63 Covid deaths in New Zealand in the span of two years. With such high vaccination rates, the reason they just exceeded the highest worldwide per capita Covid infection rate demands investigation. One plausible suggestion is that there truly is a “negative vaccine efficacy.”

Examine what is unfolding in Taiwan. More than 411,000 Covid cases were newly reported in Taiwan over the most recent 1-week period, while the single-day tally of new cases in the region has exceeded 60,000 for four consecutive days. The surge is expected to peak on May 20, 2022, at about 100,000 new cases in a single day, that according to Taiwan's Central Epidemic Command Center (CECC). Vaccinations in Taiwan commenced on March 2021, and are continuing with over 75% of the population currently inoculated. The CECC announced on May 13 that a fourth dose of the Covid vaccine will be made available to seniors as soon as next week.

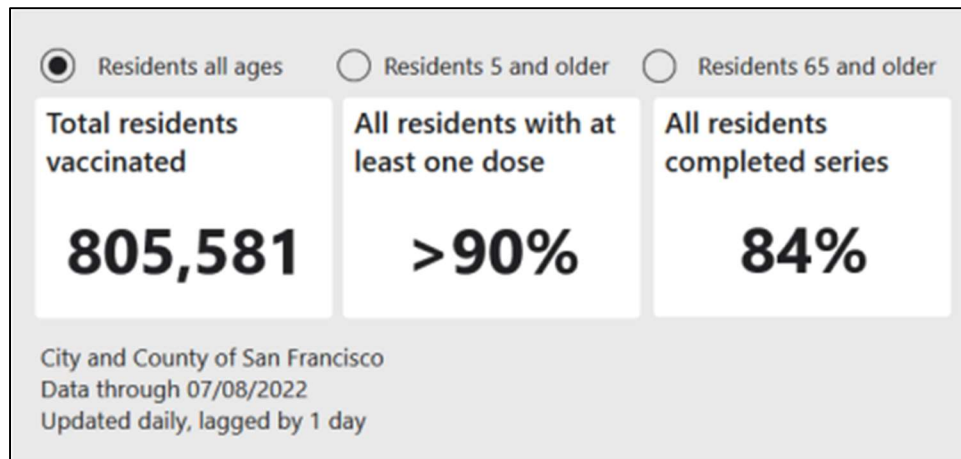


When the data collected for all of British Columbia, Canada started to make them look like they were worse than not being vaccinated (see below), the answer by the Provincial Health Services Authority was to stop reporting it.⁹



How about some evidence sourced closer to home? San Francisco is arguably one of the most vaccinated cities in the world. There are some cities where a higher percentage of adults have been vaccinated, but San Francisco is the leader in vaccinating children, which translates into the most mRNA shots per capita of any city in the world. 75% of children between the ages of 5 and 11 have been subjected to two or more Pfizer mRNA shots.

⁹ <https://bc.ctvnews.ca/bccdc-removes-data-on-covid-19-infection-outcomes-by-vaccination-status-from-dashboard-1.6008336>



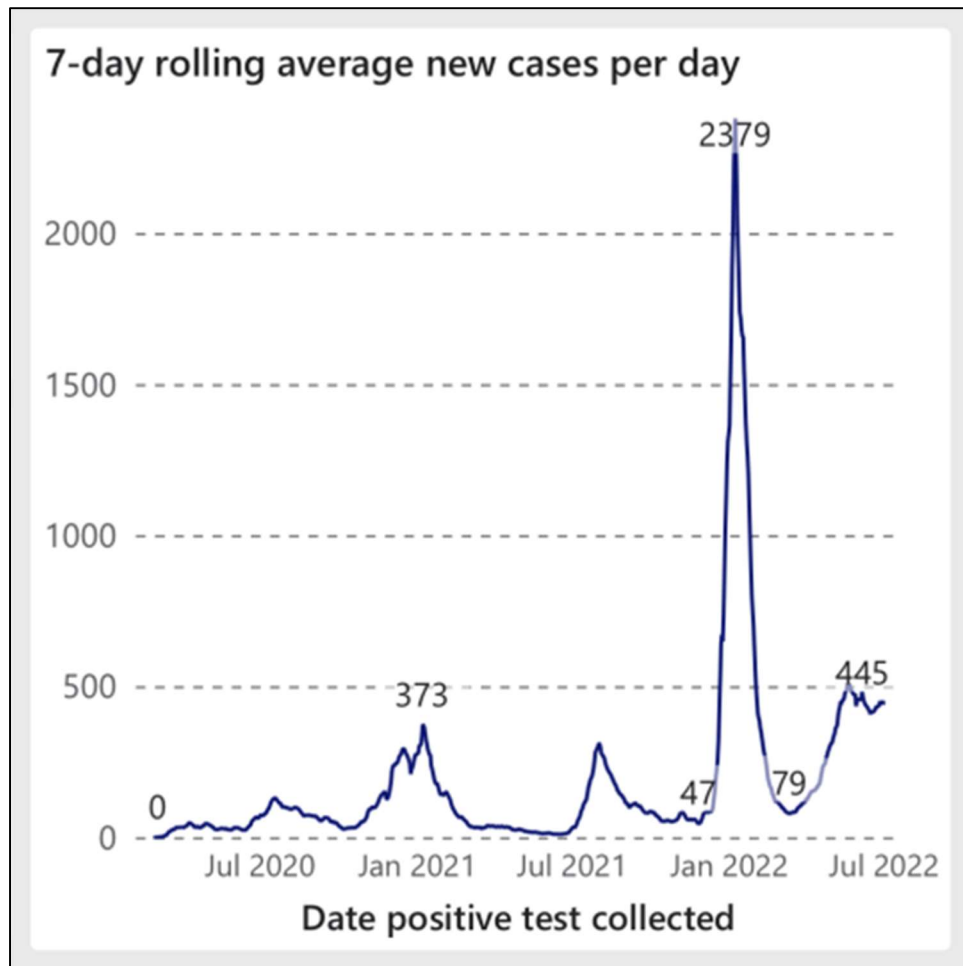
Source: <https://sf.gov/data/covid-19-vaccinations> [accessed 7/10/22]

Age group	Recipients with at least one dose	Recipients with a complete vaccine series	Estimated resident population	Estimated percent at least one dose	Estimated percent completed series
0-4	5,739	2	39,650	14%	0%
5-11	35,856	33,134	44,006	81%	75%
12-17	39,278	36,543	33,938	>90%	>90%
18-24	63,933	55,167	62,127	>90%	89%
25-34	175,440	157,413	204,639	86%	77%
35-44	135,347	125,201	138,390	>90%	>90%
45-54	110,887	104,182	115,527	>90%	>90%
55-64	101,856	96,016	101,483	>90%	>90%
65-74	81,092	76,996	74,120	>90%	>90%
75+	56,153	53,384	60,907	>90%	88%

City and County of San Francisco
 Data through 07/08/2022
 Updated daily, lagged by 1 day

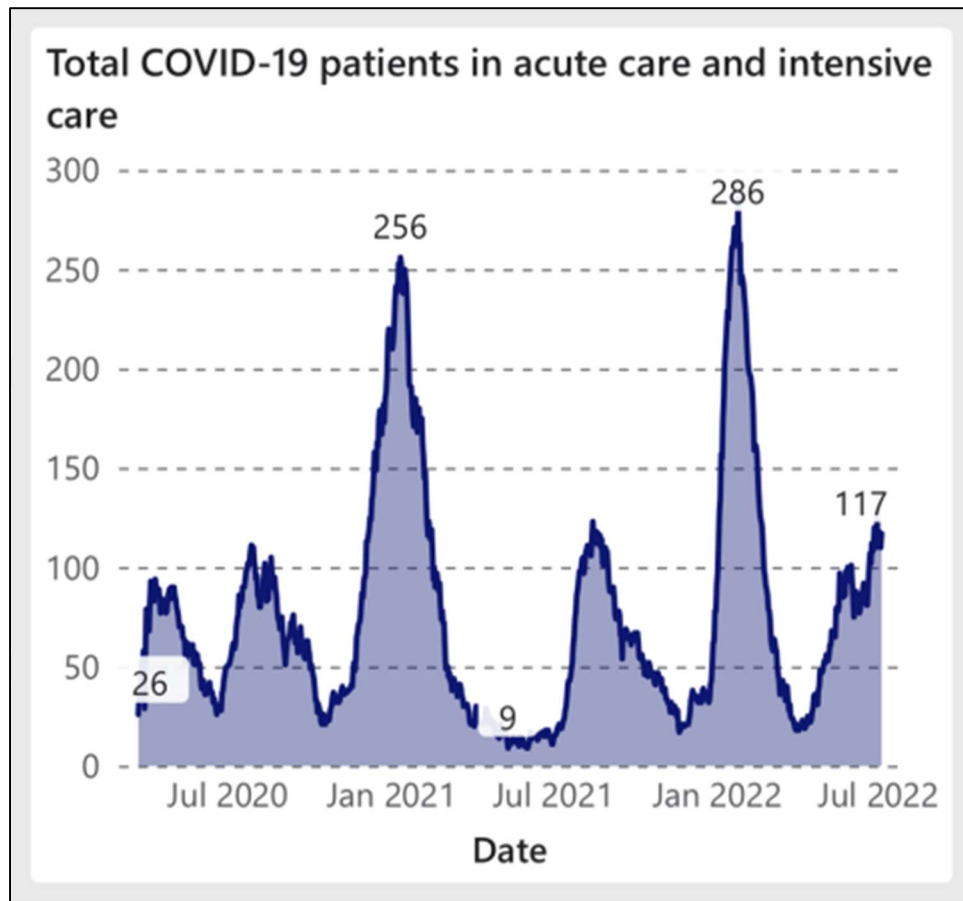
Source: <https://sf.gov/data/covid-19-vaccinations-race-and-age> [accessed 7/10/22]

Nonetheless, San Francisco is currently experiencing its second-largest Covid wave of all-time. And, there is more Covid in San Francisco now than there was in the winter of 2020/21 when virtually no one was vaccinated.



Source: <https://sf.gov/data/covid-19-hospitalizations> [accessed 7/10/22]

Furthermore, contrary to the CDC and media false narrative, the vaccines do not appear to be preventing hospitalizations either. San Francisco has already surpassed its covid hospitalization peak from both last summer and the previous summer to that.



Source: <https://sf.gov/data/covid-19-hospitalizations> [accessed 7/10/22].

What is going on?

People don't realize that these vaccines are vastly different from the many childhood vaccines we received early in life. According to the CDC, a vaccine is "a product that stimulates a person's immune system to produce immunity to a specific disease, protecting the person from that disease." Immunity, in turn, is defined as "Protection from an infectious disease," meaning that "If you are immune to a disease, you can be exposed to it without becoming infected." However, Pfizer doesn't claim this to be the case for its Covid "vaccine." In their clinical trials, Pfizer specifically did not test for immunity.

Unlike the vaccines of our youth, which use an antigen of the disease they're trying to prevent, the Covid injections contain synthetic RNA fragments encapsulated in a carrier compound. The mRNA vaccines do not train your immune system to recognize the nucleocapsid of Covid, because they don't contain it. What they do is teach your cells to express proteins on their surfaces that look like those created by cells infected with Covid and to then elicit an immune response. This is a narrow and intense form of immune training.

The sole purpose of the Pfizer vaccine is to lessen the clinical symptoms associated with the S-1 spike protein, not the actual virus. They're not imparting immunity or inhibiting the transmissibility of the disease. Stated otherwise, they don't keep you from getting sick with SARS-CoV-2. As such, these products do not meet the legal or medical definition of a vaccine, and as you can guess, there are concomitant immense legal ramifications for this deception.¹⁰

There are several factors associated with the Pfizer vaccine that lack precedent:

- The first-ever use of mRNA gene transfer technology against an infectious agent.
- The first-ever use of PEG in an injection.
- The first-ever coronavirus vaccine ever tested on humans (previous coronavirus vaccines all failed due to antibody-dependent enhancement, a condition in which the antibodies facilitate infection rather than defend against it).

¹⁰ https://www.theepochtimes.com/covid-19-vaccines-a-case-of-false-advertising_4321714.html

- The first-ever use of genetically modified polynucleotides in the general population.

Pfizer claims they evaluated the vaccine suitably, however, the studies included in the approval package were for a variety of versions of the product with no comparable assessment, in this manner no comprehensive appraisal of product safety is possible. As the following excerpts from Pfizer's Nonclinical Overview¹¹ show, Pfizer skipped major categories of safety testing.

2.4.2.1.12. Secondary pharmacodynamics

No secondary pharmacodynamics studies were conducted for the COVID-19 vaccine candidates.

2.4.2.1.13. Safety pharmacology

No safety pharmacology studies were conducted as they are not considered necessary according to the WHO guideline (WHO, 2005).

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2.4.2.1.14. Nonclinical pharmacology - Conclusions

All nonclinical pharmacology studies and their analysis are ongoing.

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2.4.4.4. Genotoxicity

No genotoxicity studies are planned for the COVID-19 vaccine candidates, as the components of all vaccine constructs are lipids and RNA that are not expected to have genotoxic potential (WHO, 2005).

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2.4.4.5. Carcinogenicity

Carcinogenicity studies with the COVID-19 vaccine candidates have not been conducted as the components of all vaccine constructs are lipids and RNA that are not expected to have carcinogenic or tumorigenic potential. Carcinogenicity testing is generally not considered necessary to support the development and licensure of vaccine products for infectious diseases (WHO, 2005; WHO, 2014).

¹¹ <https://www.judicialwatch.org/wp-content/uploads/2022/04/JW-v-HHS-FDA-Pfizer-BioNTech-Vaccine-prod-3-02418-pgs-268-331.pdf>

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2.4.4.6. Reproductive and Developmental Toxicity

Reproductive or developmental toxicity assessments have not been conducted with the COVID-19 vaccine candidates.

Pfizer claimed to the FDA that none of these studies were necessary, justifying the claim by referring to World Health Organization’s Guidelines for Vaccine Development from 2005, even though mRNA vaccines didn’t exist in 2005 when the WHO guidelines were written. Yet, in 2020 the FDA published “Development and Licensure of Vaccines to Prevent COVID-19 Guidance for Industry” that clearly states, “For a COVID-19 vaccine candidate consisting of a novel product type and for which no prior nonclinical and clinical data are available, nonclinical safety studies will be required prior to proceeding to FIH clinical trials 21 CFR 312.23(a)(8).”¹²

Why were the WHO recommendations from 2005 and not the law and the FDA industry guidance from 2020 used as the basis for design of the non-clinical testing program?

Pfizer deceptively used an unrelated product surrogate and made the claim that the toxicity and safety results are representative of its mRNA active ingredient encoding spike protein.¹³ For example, in the studies designed to test whether the vaccine remains near the injection site, Pfizer did not use a test article representative of the vaccine. They instead studied biodistribution by administering “modRNA encoding luciferase formulated in LNP comparable to BNT162b2 with trace amounts of [3H]-CHE as nondiffusible label” to mice and rats — a “surrogate” mRNA producing the luciferase protein.

¹² <https://www.fda.gov/media/139638/download>

¹³ <https://home.solari.com/review-of-pfizers-non-clinical-program-by-sasha-latypova/>

This surrogate is clearly not coding for the spike protein, and therefore no conclusions could be drawn from it. Additionally, the LNP delivery formulation used is not the same, but “close enough” to the final vaccine. Therefore, claims unsupported by any data in the study of the product formulation are scientifically dishonest. It’s very shocking that the FDA did not find this unacceptable too. No rationale for not testing the mRNA coding for spike protein has been provided.

Remember, an mRNA vaccine was never tested on humans until 2020. The new technology behind the mRNA and DNA vaccine¹⁴ brings with them many potentially unknown consequences to health. Vaccines normally take ten to twelve years to develop with roughly a 6% success rate,¹⁵ but these unprecedented vaccines were developed and brought to market in less than a year. As a consequence, we lack direct knowledge of any effects that the vaccines might have on our health over the long term or how they may interact with other medicines.

Somewhat more worrisome is the possibility these vaccines may be a pathway to crippling disease¹⁶ in the future. Unfortunately, it will be difficult to determine whether the vaccines cause this increase, because of the lengthy time between vaccination and disease diagnosis. This would be a very convenient situation for a vaccine manufacturer, who would hugely profit from our misfortunes — both from the sale of the vaccines and from the large medical cost of treating any following debilitating disease.

However, in the environments evidenced above it is starting to appear as if the vaccines with a limited capacity to prevent symptomatic disease are driving the evolution of more virulent strains. In a PLOS Biology Journal article from 2015, Read et al. observed that,

¹⁴ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6631684/>

¹⁵ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3603987/>

¹⁶ <https://www.ijvtpr.com/index.php/IJVTpr/article/view/23>

“Conventional wisdom is that natural selection will remove highly lethal pathogens if host death greatly reduces transmission. Vaccines that keep hosts alive but still allow transmission could thus allow very virulent strains to circulate in a population.”¹⁷

So, rather than the unvaccinated putting the vaccinated at risk, could theoretically the vaccinated be putting the unvaccinated at risk?

Certainly, shouldn't the question be asked? Maybe, before we reach a foolishly obtained point of no return.

Pfizer's vaccine was approved for emergency use based on both minimal and inadequate studies to evaluate their safety and effectiveness. Should we find it shocking that vaccine developers, government officials, media, and vaccine fanatics are pushing these vaccines at breakneck speed on an unsuspecting population?

Are you ready for this?

One needs to look no further than the Pfizer reports^{18, 19, 20, 21} and the FDA's authorization documents^{22, 23} to make jaw-dropping discoveries about the Pfizer Covid vaccine. These primary documents are the source for everything noted herein. Currently, all of these documents are publicly available. However, recently the FDA removed the Summary Basis for Regulatory

¹⁷ <https://pubmed.ncbi.nlm.nih.gov/26214839/>

¹⁸ <https://www.nejm.org/doi/full/10.1056/NEJMoa2034577>

¹⁹ <https://www.nejm.org/doi/full/10.1056/NEJMoa2110345>

²⁰ <https://www.nejm.org/doi/full/10.1056/NEJMoa2034577>

²¹ <https://www.nejm.org/doi/full/10.1056/NEJMoa2110345>

²² <https://www.fda.gov/media/144245/download>

²³ <https://www.fda.gov/media/144245/download>

Action on the Moderna vaccine from their website,²⁴ so the availability of these documents in the future is not guaranteed.

Yet, many of the Pfizer and FDA vaccine documents have not been made public. The FDA argued in court, against a FOIA request asking for the release of thousands of documents outlining the raw data underpinning the trials.²⁵ Yet the FDA is the public agency entrusted with confirming the vaccine's safety and approving its use. All this is especially dubious, given that the American public has paid for both the research and production of these vaccines and Congress has given Pfizer total immunity from liability.²⁶ This liability relief is on top of what Congress already did in 1986 by passing the National Childhood Vaccine Injury Act. The act includes the National Vaccine Injury Compensation Program, which is designed to protect vaccine companies from lawsuits not supported by scientific evidence.

Why did the government increase the liability protection for the vaccine manufacturers?

Furthering the suppression of valuable information is the Centers for Disease Control and Prevention, commonly referred to as the CDC. While the CDC has no direct involvement in the vaccine approval process, the agency's policies and recommendations have profound implications for drugmakers as it collects, processes and maintains a significant amount of data on the performance of the vaccines. Also, in concert with the FDA, the CDC co-sponsors the Vaccine Adverse Event Reporting System (VAERS), a national vaccine safety surveillance program. Because of this, the CDC is a fundamental player in the initial acceptance,

²⁴ https://www.theepochtimes.com/fda-document-on-moderna-vaccine-approval-removed-from-agencys-website_4254453.html

²⁵ <https://phmpt.org/wp-content/uploads/2022/01/044-PL-PHPMTS-MOL-IN-OPPOSITION-TO-DEFENDANTS-MOTION-TO-MODIFY-THE-SCHEDULING-ORDER-OF-THE-COURT.pdf>

²⁶ PREP Act immunity covers all liability except death or serious physical injury caused by misconduct greater than any form of recklessness or negligence, <https://crsreports.congress.gov/product/pdf/LSB/LSB10443>

deployment, and surveillance of all vaccines. The New York Times recently reported that the CDC is withholding crucial vaccine information:

“Two full years into the pandemic, the agency leading the country’s response to the public health emergency has published only a tiny fraction of the data it has collected, several people familiar with the data said. Much of the withheld information could help state and local health officials better target their efforts to bring the virus under control.”²⁷

The CDC claims one of the reasons for not releasing their data, “is fear that the information might be misinterpreted.” It’s as if Jack Nicholson as Colonel Jessep was in charge at the CDC saying, “You can’t handle the truth.” Sadly, it seems the CDC is not honoring its pledge to the American people, which is to “Base all public health decisions on the highest quality scientific data that is derived **openly and objectively**”²⁸ (emphasis added).

Why doesn’t Pfizer, the FDA, and the CDC want this information made public?

The top executives at Pfizer and partner BioNTech have made billions of dollars since the beginning of the pandemic selling their vaccines. The Pfizer company forecasts \$54 billion in Covid-related sales for 2022.

Is it reasonable to ask the Pfizer executives to remain objective about what they sell with so much money at stake?

²⁷ <https://www.nytimes.com/2022/02/20/health/covid-cdc-data.html>

²⁸ <https://www.cdc.gov/about/organization/mission.htm>

Those that steadfastly believe that the pharmaceutical industry and our government is incapable of making grave errors as regards to public health need look no farther than the horrendous start to the polio vaccine. In April 1955, more than 200,000 children in five U.S. states received a polio vaccine in which the process of inactivating the live virus proved to be defective. Subsequent investigations revealed that the vaccine, manufactured by the California-based Cutter Laboratories, had caused 40,000 cases of polio, leaving 200 children with varying degrees of paralysis and killing ten. While Cutter had followed stringent government regulations, the process of making a polio vaccine was not far enough advanced to allow any company to make a vaccine that could be declared, with confidence, free from the live virus. Even the company's own employees believed the vaccine safe enough to vaccinate 450 of their own children.²⁹ The government and pharmaceutical industry had prematurely rushed to use an unsafe vaccine.

Pfizer didn't become the third-largest pharmacological company in the world without employing every conceivable ploy and ruse in their drug trials when attempting to gain approval from the FDA. And not every Pfizer ploy and ruse has been legal.

Pfizer's past is filled with fraudulent drug development. For example, in late 2009, Pfizer and a subsidiary agreed to pay \$2.3 billion, the largest health care fraud settlement in the history of the Department of Justice,³⁰ to resolve criminal and civil liability arising from the illegal promotion of certain pharmaceutical products. In 2008, experts who reviewed thousands of Pfizer documents in a lawsuit testified that Pfizer manipulated the publication of scientific studies to bolster the use of its epilepsy drug Neurontin for other disorders while suppressing research that did not support those uses.³¹ Additionally, according to a document released in

²⁹ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1383764/>

³⁰ <https://www.justice.gov/opa/pr/justice-department-announces-largest-health-care-fraud-settlement-its-history>

³¹ <https://www.nytimes.com/2008/10/08/health/research/08drug.html>

litigation,³² Pfizer managers paid academics \$1,000 per paper to publish research they didn't conduct. Most companies have sworn off the practice of writing "research" papers for doctors and then paying them to add their names as authors even when they had little involvement or the results were trivial.

Concerning the Pfizer Covid vaccine, one of the biggest problems is the inadequate evidence supporting that the benefits outweigh the risks. The question turns out to be far more complicated than simply determining if the vaccines reduce the number of infections, serious disease, hospitalizations and death. Moreover, the question is especially worrying for people under 50, who have a much lower risk of serious illness or death from Covid but often suffer severe short-term side effects after vaccination.

A fundamental yet essential step in the development of a vaccine is demonstrating that they help people make protective antibodies that attack the virus. Without a doubt, the Pfizer vaccine does help make antibodies. But we also know that older people generally make fewer antibodies than younger people,³³ and in their trial report, Pfizer didn't disclose anything specific about how older people responded to their vaccines.

Throughout the vaccine approval process, Pfizer has used neutralizing antibody titers as a surrogate for immunity in order to receive authorizations by the FDA. However, a recent Israel study³⁴ in healthcare workers demonstrated that while neutralizing antibody titers rose tenfold after a fourth vaccination, 2 months later, the Pfizer vaccine had only 30% efficacy against infection. This seems to indicate that the high antibody titers are a meaningless metric.

³² <https://www.cbsnews.com/news/inside-pfizers-ghostwriting-shop-friendly-drug-studies-for-just-1000/>

³³ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1315345/>

³⁴ <https://www.medrxiv.org/content/10.1101/2022.02.15.22270948v1.full.pdf>

Is Pfizer using the wrong factor in claiming their vaccine is effective?

This is also important because Pfizer has been relying on titers to get their vaccines approved for the younger age groups. Pfizer doesn't have data showing the vaccines are actually reducing cases by 50% or more, which is the standard the FDA said was necessary, and they don't have data showing that the vaccines prevent serious cases or deaths.

Pfizer ultimately reported 170 Covid infections in their trial, beginning 7-14 days after the second shot. This is supposedly the timeframe when the vaccine becomes fully effective—more about this later. Eight of the infections occurred in vaccine recipients, while the other 162 occurred in those who received the placebo, out of more than 40,000 participants.

First, the trial was designed to tabulate final efficacy results after roughly 160 trial participants develop symptomatic Covid. Medscape's editor-in-chief, Eric Topol believes, "these numbers seem totally out of line with what would be considered stopping rules. I mean, you're talking about giving a vaccine with any of these programs to tens of millions of people. And you're going to base that on 100 events?"³⁵ By contrast, the Salk Polio vaccine had a field trial composed of 420,000 children injected with the vaccine, 200,000 injected with a placebo and 1.2 million given nothing—a total of about 1.8 million participants. "More Americans had participated in the funding, development, and testing of the polio vaccine than had participated in the nomination and election of the president."³⁶

³⁵ <https://www.bmj.com/content/371/bmj.m4037.full.print>

³⁶ Offit, P, *The Cutter Incident*, Yale University Press, 2005, pg. 54.

Second, what most didn't notice was that the majority of these infections did not require hospitalization or intensive care. They were principally mild to moderate cases involving a positive Covid test in concert with symptoms such as a cough or low-grade fever. Serious illness from Covid in the trial was rare among both vaccine and placebo recipients. Of those who received the placebo, only nine became what Pfizer termed "severely" ill, compared to one vaccine recipient. No one died of Covid in the trial, and only six people died for a reason other than Covid (two people who received the vaccine and four who received the placebo).

Tal Zaks, chief medical officer at Moderna stated that his company's trial lacks adequate statistical power to assess hospital admissions or deaths. "The trial is precluded from judging [hospital admissions], based on what is a reasonable size and duration to serve the public good here," he said. The same is true of its ability to save lives or prevent transmission. Zaks also said, "Would I like to know that this prevents mortality? Sure, because I believe it does. I just don't think it's feasible within the timeframe [of the trial]."³⁷

Given the trial size, does such a small difference provide compelling evidence that the vaccine saves lives?

Why did so few people die in the trial if Covid has killed more than 910,373³⁸ Americans (1 out of roughly every 600 people)? Was it because Pfizer tested their vaccines primarily on healthy people and those under 65? According to the CDC, as of February 2, 2022, 53% of the total U.S.

³⁷ <https://www.bmj.com/content/371/bmj.m4037.full.print>

³⁸ <https://covid.cdc.gov/covid-data-tracker/#datatracker-home>, accessed 2/11/2022.

Covid deaths occurred in the 75-plus age group,³⁹ (3,680,069 total), while 74% of the deaths were in the 65-and-over age group⁴⁰.

A review of recent data released by the U.K. government in response to a FOIA⁴¹ request shows that the number of deaths during 2020 in England and Wales, where Covid was the sole cause of death, was 9,400. Of those, 7,851 (83%) were aged 65 and older. The median age of death was 81.5 years.

The demographics of the Pfizer study participants show that most (79%) were under the age of 65. Only 1,700 of them were over 75, and only half of those received the vaccine. This represents less than 2% of the study participants. Additionally, Pfizer enrolled only five people over 85. Furthermore, these older people were relatively healthy. In fact, “healthy participants”⁴² were specified by Pfizer as an eligibility criterion for the trial. 79% of the trial’s enrollees had zero comorbidities. Lacking comorbidities like high blood pressure, diabetes, cardiovascular disease, dementia, etc., contrasts sharply with the fact that most people who died of Covid had multiple comorbidities.⁴³

The British Medical Journal, a weekly peer-reviewed trade journal, published by the British Medical Association (BMA) said just as much, “If frail elderly people, who are understood to die in disproportionate numbers from both influenza and covid-19, are not enrolled into vaccine

³⁹ Provisional COVID-19 Deaths by Sex and Age, Deaths involving coronavirus disease 2019 (COVID-19), pneumonia, and influenza reported to NCHS by sex, age group, and jurisdiction of occurrence.

<https://data.cdc.gov/NCHS/Provisional-COVID-19-Deaths-by-Sex-and-Age>

⁴⁰ <https://www.cdc.gov/nchs/covid19/mortality-overview.htm>

⁴¹ The FOIA request to the ONS asked for all deaths in which Covid had been given as the sole cause on the death certificate, which is about a tenth of the generally stated toll, <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/preexistingconditionsofpeoplewhodiedduetocovid19englandandwales>

⁴² https://cdn.pfizer.com/pfizercom/2020-11/C4591001_Clinical_Protocol_Nov2020.pdf

⁴³ 94% of deaths mention more than one condition, https://www.cdc.gov/nchs/data/health_policy/covid19-comorbidity-expanded-12092020-508.pdf

trials in sufficient numbers to determine whether case numbers are reduced in this group, there can be little basis for assuming any benefit in terms of hospital admissions or mortality. Whatever reduction in cases is seen in the overall study population (most of which may be among healthy adults), this benefit may not apply to the frail elderly subpopulation, and few lives may be saved.”⁴⁴

One method to give your clinical drug the illusion of better effectiveness is to enrich your trial. Clinical trial enrichment strategies are a well-documented subject. Think of “enrichment” as virtually pressing one’s thumb on the scale of efficacy. “Those who conduct clinical trials ‘enrich’ study populations in a variety of ways to identify a population of patients in whom a drug effect, if present, is more likely to be demonstrable.”⁴⁵ But many times, the deceitful trial design goes too far. “Trials also sometimes actively recruit patients who are likely to respond well to treatment.”⁴⁶

Did Pfizer purposely not test the vaccine on the “right” people?

Pfizer’s original trial report was published in the New England Journal of Medicine on December 21, 2020, and showed just 2 months-worth of safety and efficacy data. It was a randomized double-blind placebo-controlled trial, widely considered the “gold standard” of epidemiologic studies. It described starting with 43,548 people divided into two groups, a treatment (received inoculation) and a control group (received placebo). The trial lasted for 2 months to see who developed Covid. Pfizer claimed that the inoculations were safe and showed 95% vaccine efficacy 7-14 days after the 2nd dose.

⁴⁴ <https://www.bmj.com/content/371/bmj.m4037.full.print>

⁴⁵ <https://pubmed.ncbi.nlm.nih.gov/20944560/>

⁴⁶ <https://www.ncbi.nlm.nih.gov/labs/pmc/articles/PMC1488890/>

While the vaccine efficacy of 95% was being celebratorily hyped, nothing in the report indicated confirmed infections rates for the population where the study took place. Thus, it would be impossible to know actual infection rates in the total population. If there was very low exposure in the study group, efficiency could seem very high when in fact the results were not significant due to very low infection rates in the total population. Since the study was conducted during a period of lockdowns, limited interactions, and ongoing infection control measures, the actual infection rate for the entire population in which the study was conducted should have been tracked.

Why didn't Pfizer want to know?

As it is, the oft-quoted 95% vaccine efficacy is just another name for “relative risk reduction”. A relative risk reduction sounds impressive because of the high number, which is why it's used in widely disseminated press releases. But, if the relative risk reduction is presented alone, it introduces a reporting bias⁴⁷ and tells only half of the story. Because, first if you consider just the placebo recipients, you'll see that out of 18,325 people in that group, only 162 went on to get sick with Covid, which is only about 0.88%. Therefore, one could say the placebo-boosted human immune system had a “99.2% efficacy” in stopping Covid.

Dr. Malcolm Kendrick, author of *Doctoring Data* explains the inherent delusion of relative risk this way:

47 Outcome Reporting Bias in COVID-19 mRNA Vaccine Clinical Trials, *medicina*, 26 February 2021, Ronald B. Brown, <https://www.ncbi.nlm.nih.gov/labs/pmc/articles/PMC7996517/>

“One hundred people start taking a blood pressure medication and one hundred do not. At the end of a year, one person in the group taking the medication has died; and two people in the group not taking medication have died.

- The absolute difference in deaths is 1 person per 100 vs. 2 people per 100 = 1 in 100, or 1%.*
- The relative difference in deaths is 1 vs. 2 ($\frac{1}{2} = 50\%$).*

“I shall now claim that if you take my medication, your risk of dying has been reduced by 50% i.e. halved (which is true – sort of).

“Let’s try this again, with numbers that are 10 times as big.

“1,000 people start taking a blood pressure medication and 1,000 do not. At the end of a year, 1 person taking medication has died, and 2 people not taking the medication have died.

- The absolute difference in deaths is 1 person per 1,000 or 0.1%.*
- The relative difference is 1 vs. 2 ($\frac{1}{2} = 50\%$).*

“I shall now also claim that if you take my medication, your risk of dying has been reduced by 50% (which is also true – sort of).

“But, but, but. Yes, but, but, indeed. In the first scenario, the absolute benefit was 10 times greater than in the other. However, the relative risk reduction remains exactly the same. Given this, what does relative risk reduction actually mean? It means, my friend, almost nothing at all. It is most often used as a technique to inflate the benefit of taking drugs.”⁴⁸

⁴⁸ Kendrick, Malcolm, Dr. Doctoring Data, Columbus, 2014. <https://www.amazon.com/Doctoring-Data-medical-advice-nonsense/dp/1907797467>

“Absolute risk reduction” is more relevant to the person getting the vaccine because it’s the difference between attack rates with and without a vaccine and considers the whole population. Relative risk reduction assumes that everyone is infected at the same time. The absolute risk reduction tells us about the effectiveness of the vaccine as it is related to an individual. For Pfizer’s trial, the unpublished values indicate their vaccine prevents Covid in just 8 out of 1,000 people or an “absolute” risk reduction of 0.84%.⁴⁹

The Pfizer data, absent absolute risk reduction, was reviewed and approved by members of the FDA’s Vaccines and Related Biological Products Advisory Committee. Revealing evidence of “regulatory capture⁵⁰”, the omission of absolute risk reduction contradicts the FDA guidelines for communicating evidence-based risks and benefits to the public. The FDA ignored its own guidance, which clearly states (my emphasis):

“Provide absolute risks, not just relative risks. Patients are unduly influenced when risk information is presented using a relative risk approach; this can result in suboptimal decisions. Thus, an absolute risk format should be used.”⁵¹

Dr. Malcolm Kendrick states it succinctly, “If the absolute risk is hidden away, then you can confidently assume that it is so vanishingly small that the authors chose not to highlight it, as it would significantly weaken their message.”⁵²

⁴⁹ COVID-19 vaccine efficacy and effectiveness—the elephant (not) in the room, The Lancet Microbe, Volume 2, ISSUE 7, e279-e280, July 01, 2021, Piero Olliaro, Els Torreele, Michel Vaillant, [https://www.thelancet.com/journals/lanmic/article/PIIS2666-5247\(21\)00069-0/fulltext](https://www.thelancet.com/journals/lanmic/article/PIIS2666-5247(21)00069-0/fulltext)

⁵⁰ <https://www.e-education.psu.edu/ebf483/node/683>

⁵¹ Fischhoff, B.; Brewer, N.; Downs, J. Communicating Risks and Benefits: An Evidence-Based User’s Guide; Food and Drug Administration (FDA), US Department of Health and Human Services: Silver Spring, MA, USA, 2011.

⁵² Kendrick, Malcolm, Dr. Doctoring Data, Columbus, 2014. <https://www.amazon.com/Doctoring-Data-medical-advice-nonsense/dp/1907797467>

Would people have taken the vaccine knowing that it only reduced their chance of infection by less than 1%?

Many believe the FDA unequivocally suffers from “regulatory capture.”⁵³ Regulatory capture is broadly defined as when a regulator, such as the FDA is co-opted by industry interests to serve a particular agenda favorable to that industry. None other than *Science* magazine— a center of important scientific discovery since its founding by Thomas Edison in 1880, reported that both the FDA's decision and the EU authorizing remdesivir came about under unusual circumstances that are highly suggestive of regulatory capture.⁵⁴ The FDA never consulted a group of outside experts it uses to assist on complicated antiviral drug issues. The EU agreed to the remdesivir purchase price exactly 1-week before the disappointing WHO Solidarity trial results came out, even while Gilead — the drug’s maker knew the WHO’s trial indicated failure since it had already begun to review the data.

“This is a very, very bad look for the FDA, and the dealings between Gilead and EU make it another layer of badness,” says Eric Topol, a cardiologist at the Scripps Research Translational Institute. AMDAC member David Hardy, an HIV/AIDS scientist of the University of California, Los Angeles, is “amazed” the agency didn't consult it in this case. “This sets the standard for the first COVID-19 antiviral,” he said. “That really is something that's very, very important.”

These organizations suffer from regulatory capture because their employees are paid by the very industry they regulate. Over a four-year period, the top five scientists at the National Institute of Health (NIH) received 1090 royalty payments from the pharmaceutical industry.⁵⁵ During the same period, none other than Dr. Anthony Fauci, the longtime head of the NIH’s National Institute for Allergies and Infectious Diseases (NIAID), as well as chief medical adviser

⁵³ <https://www.trialsitenews.com/a/regulatory-capture-in-the-fda-the-revolving-industry-regulatory-agency-doors>

⁵⁴ <https://www.science.org/doi/full/10.1126/science.370.6517.642>

⁵⁵ <https://www.openthebooks.com/substack-investigation-faucis-royalties-and-the-350-million-royalty-payment-stream-hidden-by-nih/>

to President Joe Biden received at least 23 royalty payments. Open the Books, a nonprofit government watchdog revealed the information on royalty payments. “We estimate that up to \$350 million in royalties from third parties were paid to NIH scientists during the fiscal years between 2010 and 2020,” Open the Books CEO Adam Andrzejewski told reporters.

Would these payments be termed “bribes” in any other environment?

Regulatory capture is not only a function of the way in which agencies are funded, but also staffed. A “revolving door” exists where many agency officials end up working or consulting for the same companies they once regulated.⁵⁶ At the FDA, nine out of 10 of its past commissioners between 2006 and 2019 went on to secure roles linked with pharmaceutical companies and its most recent, Stephen Hahn, is working for Flagship Pioneering, a company that acts as an incubator for new biopharmaceutical companies.⁵⁷

One study found more than a quarter of the FDA employees who approved cancer and hematology drugs between 2001 and 2010 left the agency and now work or consult for pharmaceutical companies.⁵⁸ Beyond the FDA, Ian Hudson, chief executive of the UK’s MHRA between 2013 and 2019, now serves on the board of biotech company Sensyne Health and is a senior adviser for the Bill and Melinda Gates Foundation. Before joining the MHRA, Hudson held various senior roles at pharmaceutical giant SmithKline Beecham.

⁵⁶ <https://www.bmj.com/content/377/bmj.o1538>

⁵⁷ LaHucik K. He authorized Moderna’s vaccine 6 months ago. Now, ex-FDA chief Hahn joins biotech’s backer. Fierce Biotech. 2021.

⁵⁸ Bien J, Prasad V. Future jobs of FDA’s haematology-oncology reviewers. BMJ2016;354:i5055. doi:10.1136/bmj.i5055 pmid:27677772

A particularly egregious example of regulatory capture was demonstrated by the FDA when they granted a waiver⁵⁹ for a voting VRBPAC member during the vote for expanding vaccines to children as young as 6 months old. The individual was employed by a college that was the location of one of trials.

Recently a judge ordered Pfizer and the FDA to produce all of the Pfizer trial data documents,⁶⁰ and Pfizer has complied. It should come as no surprise that the data has been almost entirely ignored in the press. Worse still, it's nearly incomprehensible because of its terrible 'picture of paper' formatting.

What does that say about Pfizer's openness?

But this court-ordered document release uncovered more Pfizer deceit. Here's the explanation.

When confirming who did and didn't get Covid in the trial, cases were determined by positive PCR test and at least one specified symptom.⁶¹ This is how Pfizer got 162 placebo cases, and 8 vaccinated cases.

But as the documents show, Pfizer also tested for N (nucleocapsid) antibodies of the trial participants as part of their regular clinical checks. This test measures whether your body has developed antibodies to the N protein of the SARS-Cov-2 virus. A positive anti-N test confirms

⁵⁹ <https://t.co/DUWUbJlx3F>

⁶⁰ <https://phmpt.org/pfizers-documents/>

⁶¹ https://cdn.pfizer.com/pfizercom/2020-11/C4591001_Clinical_Protocol_Nov2020.pdf

previous infection.⁶² More crucially, you can't get anti-N antibodies from the vaccine, they are only produced from a meaningful exposure to the Covid virus. So, detecting them in the participants means those patients were infected with SARS-Cov-2.

Counting up the number of trial participants who were negative at visit one and then positive at visit three would show those who got infected with Covid during the study period. This method results in 160 cases in the placebo group, but 75 in the vaccinated.⁶³ This shows conclusively that Pfizer knew the vaccine was hiding something.

Wouldn't a completely open and honest report of Pfizer's vaccine performance require disclosing this information?

Pfizer documented 166 participants (80 in the treatment and 86 in the placebo arm) as "Lost to Follow Up," with another 3,410 participants categorized as "suspected, but unconfirmed cases" (1,594 in the treatment and 1,816 in the placebo arm). Additionally, there were 311 cases excluded for protocol deviations in the treatment arm along with 60 placebo exclusions. Pfizer excluded, without documenting their justification, over 9% of the trial participants.

Could exclusions of this magnitude call into question the validity of the trial?

Upon further examination of the Pfizer data, in both arms of the trial, prior to one dose, exactly 26 people withdrew, then after the first dose, exactly 108 people each withdrew—and very

⁶² <https://www.gov.uk/government/publications/antibody-testing-for-sars-cov-2-key-information/antibody-testing-for-sars-cov-2-information-for-general-practitioners>

⁶³ <https://twitter.com/Jikkyleaks/status/1529076982281285633>

oddly, 25 placebo arm individuals had an adverse event from the saline solution. Six became pregnant, and two died in each arm, while 89 (vaccine) and 90 (placebo) were then “lost to follow up”. What are the odds that each arm had these identical numbers of withdrawals? At best, Pfizer’s figures seem very unusual.

With so many questions and concerns about the trial data, can it be trusted?

Dr. Peter Doshi is an associate professor of pharmaceutical health at the University of Maryland School of Pharmacy, as well as a senior editor at the British Medical Journal. In a recent FDA Vaccines and Related Biological Products Advisory Committee meeting Dr. Doshi noted the lack of FDA oversight of the Pfizer trial process. He told the FDA about Brook Jackson, a whistleblower from Ventavia, which ran Pfizer’s vaccine trials. He discussed how unblinding of trial participants seems to have occurred and how this creates serious concerns about data integrity. Dr. Doshi also highlighted the lack of FDA inspection.

“One hopes Ventavia is an extreme outlier, but we need more than just hope. We need evidence that the data were dealt with properly. We need regulatory oversight. But despite whistleblower Brook Jackson’s direct complaint to the FDA, FDA never inspected Ventavia. In fact, FDA only inspected 9 of the trial’s 150-plus sites before approving the vaccine. Just 9 sites. And Pfizer continues to use Ventavia for trials.”⁶⁴

The FDA had over a year and inspected just one of the 99 Moderna trial sites.

⁶⁴ April 6, 2022 FDA Vaccines and Related Biological Products Advisory Committee meeting video. <https://www.youtube.com/watch?v=x8rq247E80I>

How can FDA feel confident in the trial data?

The basis for the FDA's Emergency Use Authorization was the confirmed Covid cases of eight versus 162. But when dealing with such a small number of cases, a minor change would have a meaningful impact on the results.

Why were five times as many cases in the treatment excluded versus the control arm for protocol deviation? And what were the protocol deviations— could they possibly have died?

“Lost to follow up,” means they lost touch with those subjects and can't confirm whether they got sick or not. Considering that “people who drop out of trials are statistically much more likely to have done badly, and much more likely to have had side-effects. They will only make your drug look bad.”⁶⁵

“Suspected, but unconfirmed cases” means these people were Covid symptomatic but never tested. 3,410 unconfirmed cases of Covid in this trial is like having a cancer trial of 1,000 participants and excluding 90 of them with tumors that increased in size simply because you didn't measure them.

The fact that the “lost to follow up” and “suspected but unconfirmed” numbers are significantly higher than the trial endpoint number conceivably indicates “attrition bias,”⁶⁶ and at least signifies that the data is suspect and untrustworthy. For example, a mere 4.5% of just the lost participants alone could have completely reversed the outcome of the trial. This is not normal

⁶⁵ Goldacre, Ben, *Bad Science, Quacks, Hacks and Big Pharma Flacks*, Faber and Faber, 2010

⁶⁶ <https://s4be.cochrane.org/blog/2017/02/13/attrition-bias-randomized-controlled-trials/>

scientific practice by anyone's standard. The study should never have been accepted in this state.

Why didn't Pfizer investigate further?

Therefore, absent a test, asymptomatic infection was completely missed. Pfizer noted this in the test limitations section stating, "These data do not address whether vaccination prevents asymptomatic infection." So, prevention or reduction of transmission of Covid was not studied in the trial, and it was never appropriate to assign that capability to these inoculations. There was no evidence that the vaccine reduced the spread of disease or transmission; it wasn't one of the study's endpoints. This begs the question, how can we even call these inoculations, "vaccines?" Vaccine trial endpoints have to do with immunity and transmission reduction, neither of which was measured. It also makes the characterization that one takes these vaccines to protect others a complete falsehood.

Why didn't Pfizer want the vaccine's (in)ability to provide sterilizing immunity, a very fundamental aspect of a vaccine to be uncovered?

Pfizer also concealed an interesting statistic about natural immunity in their trial report and overlooked an opportunity to enlighten the world by failing to draw attention to it. The trial evaluated the vaccine under two separate endpoint conditions; how well did the vaccine perform in individuals "with and without" evidence of prior Covid infection. What was passed over by everyone, was that during the trial, in the individuals "with" prior infection, there was only one vaccinated individual and no one in the placebo arm infected. So, Pfizer's trial proved the case for natural immunity, but they declined to highlight this very significant revelation.

If they had highlighted the success of natural immunity would that have diminished the need for Pfizer's vaccine?

The phase 3 portion of the study was designed to evaluate the safety and efficacy of the Pfizer vaccine for the prevention of Covid disease occurring *at least 7 days after the second dose of the vaccine*. Seven to fourteen days after the second dose is supposedly when the vaccine provides an acceptable level of immunity to Covid. That is all well and good, except, what if something bad happens before day 7 post-dose number two? What then? One can't simply withdraw the vaccine from the body once the process has started.

A perfect analogy of this illogical accounting would be to compare it to the landing on the Normandy beachhead in WWII. Do we count among the D-Day injured and dead **ONLY** those that crossed the open beach and attained the relative safety of the rock cliffs? Are those injured and dead in the ocean and on the beach attributed to something other than D-Day?

Once you start down the road of inoculation, every adverse reaction, disease, and infection counts, regardless of when it happens. Ignoring all consequences for an initial interlude of up to a month is like a childish schoolyard "timeout break" which completely violates the basic "intention-to-treat"⁶⁷ principle. This is an egregious abuse of trial design intended to deceive all those who are unaware of it. Pfizer is among the best in the world at designing trials. They don't make mistakes, they make choices. If it's this easy to spot, they must have purposely cooked it into the trial. This hiatus timing is well optimized by Pfizer for maximum apparent effect.

⁶⁷ <https://www.ncbi.nlm.nih.gov/labs/pmc/articles/PMC3159210/>

Why this is especially damning is because the vaccine (and boosters) appears to generate at least a roughly 2-week window of immuno-suppression post-administration.⁶⁸ The hiatus period allows entities like Pfizer, the FDA, and the CDC to perform statistical shenanigans, where they not only avoid counting the high-risk period that must be negotiated in reaching “vaccinated,” status, but they also shift this risk into the cohort of the “unvaccinated.”⁶⁹ During this hiatus, they count the “vaccinated” people as “unvaccinated.” Therefore, any statistics published by the CDC comparing the vaccinated with the unvaccinated must be regarded as prejudicial and suspect.

Evidence which conclusively demonstrates the statistical jugglery played with the vaccinated vs. non-vaccinated is everywhere. A UK Government agency, known as the Office for National Statistics (ONS), published data on deaths by vaccination status. The information is entitled, ‘Deaths by Vaccination Status, England, 1 January 2021 to 31 May 2022.’⁷⁰

Table 1 of this dataset contains figures on the mortality rates by vaccination status for all cause deaths, deaths involving Covid, and deaths not involving Covid. It is here that we are able to

⁶⁸ In self-incriminating fashion, this period of immuno-suppression is undeniable and clinically proven in a later Pfizer trial. For the details, see the “early postbooster group” category in Table 2, Poisson Analysis of Confirmed Infection in Different Groups from the Pfizer publication, Protection against Covid-19 by BNT162b2 Booster across Age Groups published in the NEJM. Also note the deceitful categorization of “boosted” (post day 12) and “early postbooster” (3-7 days) – where are days 1-2 and 8-11? Accounting for the missed days and properly classifying “early postboosted” results in a negative VE for all cohorts. Furthermore, this study just compares boosted individuals to those vaccinated-unboosted, it completely neglects the lower rates of the unvaccinated. The bottom line is simple, don’t trust any Covid vaccine study that excludes those who got their dose 7-14 days prior. Treat any study using such definitions with deep skepticism. <https://www.nejm.org/doi/full/10.1056/NEJMoa2115926>

⁶⁹ Over 900 Swedish deaths with Covid have been misrepresented as occurring in the unvaccinated. Individuals dying within 2 weeks of vaccination have been classed and counted as unvaccinated. This applies to the 14-day period after the second as well as the first dose. The numbers involved are certainly non-trivial. See: <https://lakaruppropet.se/public-health-agency-reporting-has-distorted-mortality-rates-for-the-unvaccinated-and-vaccinated/>

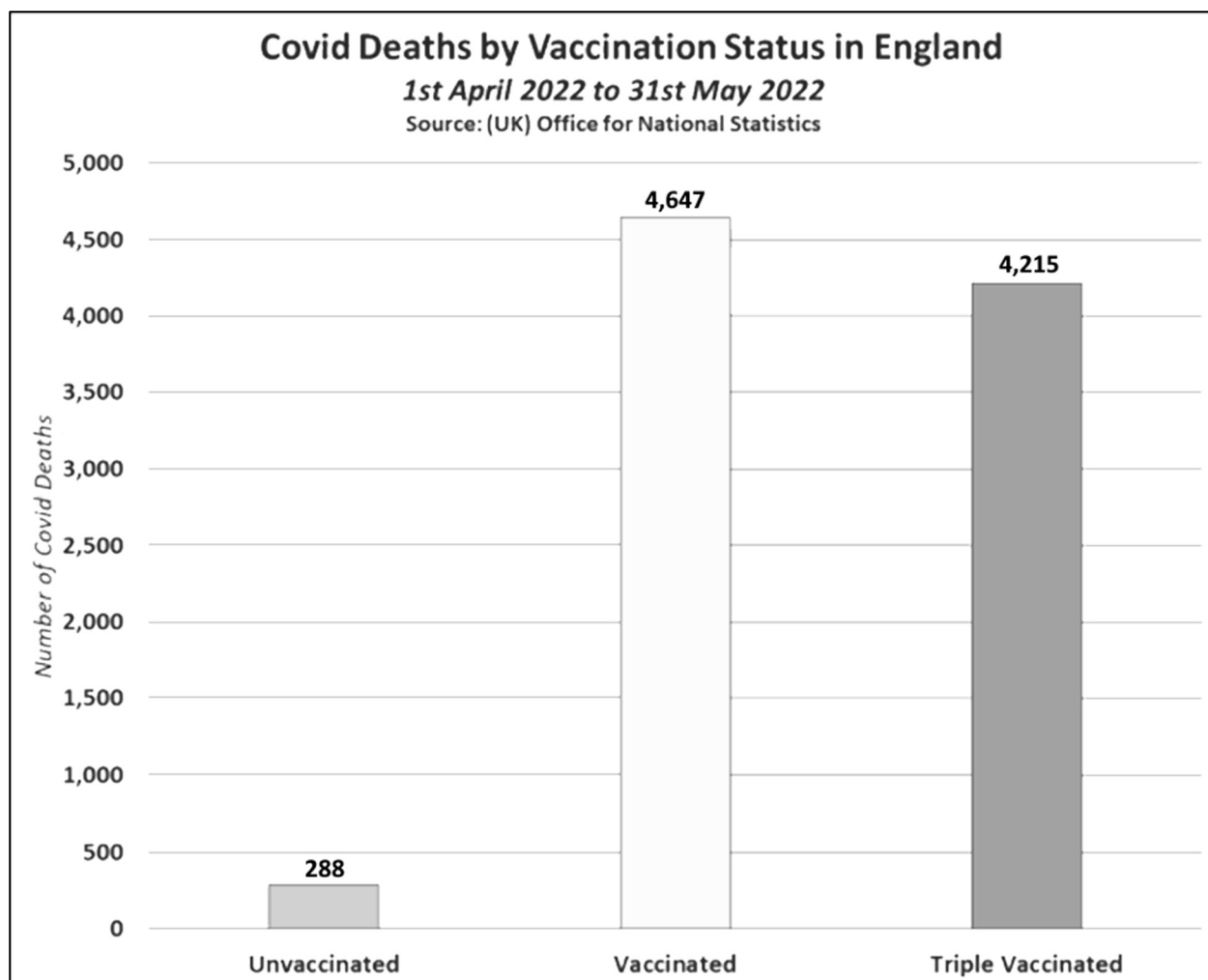
⁷⁰ Located here:

<https://www.ons.gov.uk/file?uri=/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/deathsbyvaccinationstatusengland/deathsoccurringbetween1january2021and31may2022/referencetable06072022accessible.xlsx>

ascertain the vaccination status of everyone who has died of Covid since the beginning of April 2022. In the except below, the ONS presents the figures for the month of April 2022, and they alone are very damning.

Cause of Death	Year	Month	Vaccination status	Count of deaths
Deaths involving COVID-19	2022	April	Unvaccinated	206
Deaths involving COVID-19	2022	April	First dose, less than 21 days ago	1
Deaths involving COVID-19	2022	April	First dose, at least 21 days ago	45
Deaths involving COVID-19	2022	April	Second dose, less than 21 days ago	0
Deaths involving COVID-19	2022	April	Second dose, between 21 days and 6 months ago	13
Deaths involving COVID-19	2022	April	Second dose, at least 6 months ago	246
Deaths involving COVID-19	2022	April	Third dose or booster, less than 21 days ago	3
Deaths involving COVID-19	2022	April	Third dose or booster, at least 21 days ago	3057
Deaths involving COVID-19	2022	April	Ever vaccinated	3365

However, when these figures are produced in chart form, the evidence of the jiggery-pokery becomes clear. By placing all of the “Vaccinated” with the “Unvaccinated”, as the FDA and CDC did, they are able to hide the extent of the complete failure of the vaccines.



And if you still doubt the accuracy of the CDC's data reference vaccinated vs. unvaccinated status, consider the following loophole. Upon hospital admission, one had to have received a vaccine from a primary care physician's clinic and that the shot needed to be previously documented in a person's electronic medical record to be classified as "Vaccinated". If you received a vaccine from anywhere outside of a medical clinic, chances are you would be assigned an "Unknown", or "Unvaccinated" status in your electronic medical record.

How much has this play been used to slant the CDC's data to promote false positive vaccine performance?

As if that's not enough deception, Pfizer's investigators in the trial were instructed by protocol to ignore various Covid-like symptoms during this period also:

*"During the 7 days following each vaccination, potential COVID-19 symptoms that overlap with specific systemic events (ie, fever, chills, new or increased muscle pain, diarrhea, vomiting) should not trigger a potential COVID-19 illness visit unless, in the investigator's opinion, the clinical picture is more indicative of a possible COVID-19 illness than vaccine reactogenicity."*⁷¹

As if this willful ignorance is not stunning enough, Pfizer didn't include these cases as adverse events either:

*"As specified in the protocol, suspected cases of symptomatic COVID-19 that were not PCR-confirmed were not recorded as adverse events unless they met regulatory criteria for seriousness."*⁷²

Why would Pfizer instruct trial investigators to ignore Covid symptoms and adverse events?

⁷¹ PF-07302048 (BNT162 RNA-Based COVID-19 Vaccines) Protocol C4591001, A PHASE 1/2/3, PLACEBO-CONTROLLED, RANDOMIZED, OBSERVER-BLIND, DOSE-FINDING STUDY TO EVALUATE THE SAFETY, TOLERABILITY, IMMUNOGENICITY, AND EFFICACY OF SARS-COV-2 RNA VACCINE CANDIDATES AGAINST COVID-19 IN HEALTHY INDIVIDUALS

⁷² Pfizer-BioNTech COVID-19 Vaccine Emergency Use Authorization Review Memorandum, <https://www.fda.gov/media/148542/download>

Most importantly, bad things did happen in the trial during this 7 to 14-day interlude period. From the trial report: “Suspected COVID-19 cases that occurred within 7 days after any vaccination were 409 in the vaccine group vs. 287 in the placebo group.”⁷³

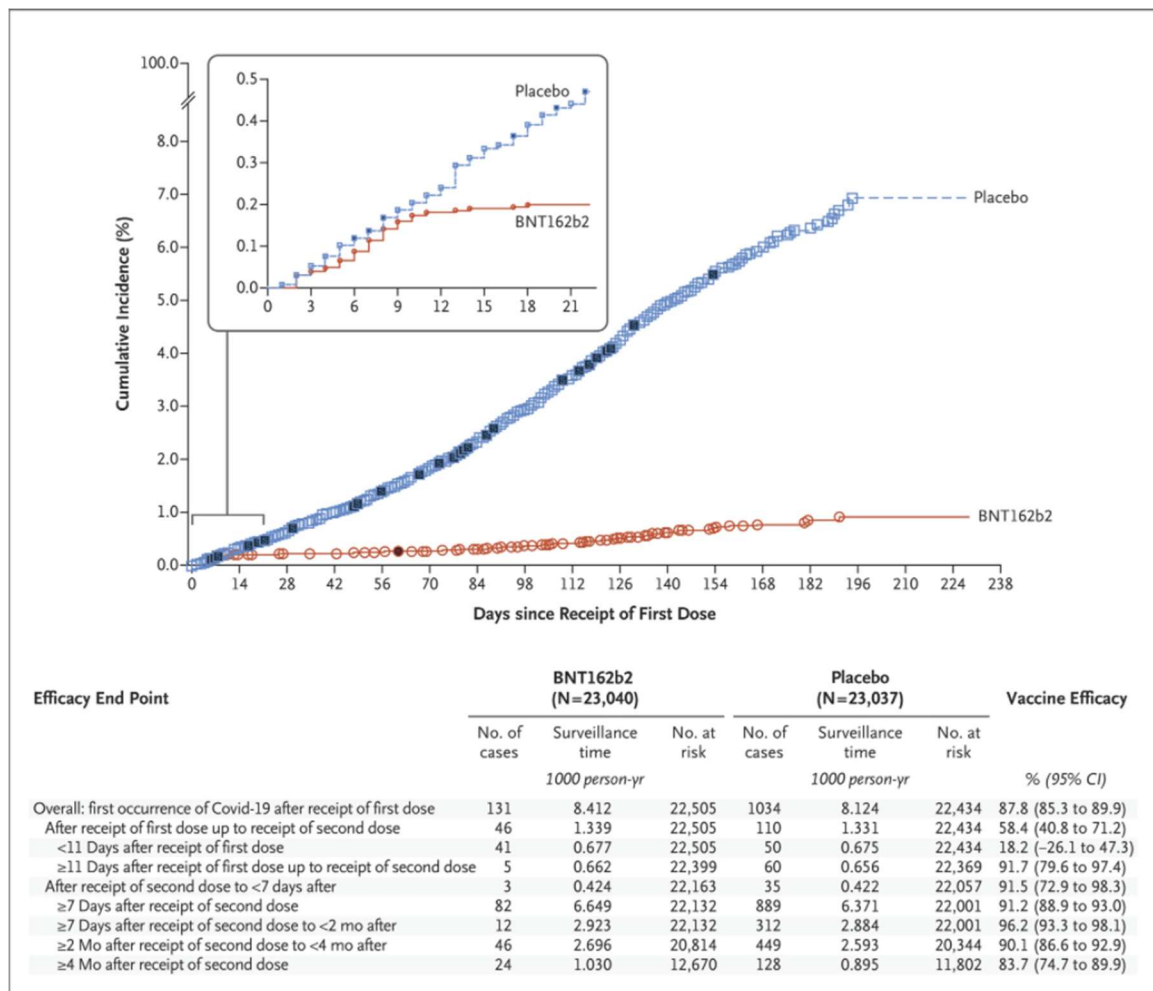
Assuming all of the 287 placebo positives are excluded from the trial results as the 409 vaccine recipients were, the total cases should have been 417 versus 449. This would have lowered the vaccine efficacy to only 7%, and obviously meant complete and abject failure for the vaccine.

Would a vaccine efficacy of only 7% have received a EUA?

You might have the best vaccine in the world, but if it increases your chance of getting the disease before you are protected from it then is it really the best vaccine in the world?

Included below is Pfizer’s graph of the cumulative incidence for the two trial arms over the six months of the study period. This graph reputedly shows how the symptomatic Covid PCR-positives added up following receipt of the first dose. Of curious note, is that vaccine efficacy abruptly kicks in on day 12 after the first dose, before that it’s nearly zero. Then, as if hitting a wall, suddenly the vaccinated arm virtually halts infections and efficacy becomes nearly perfect and stays there. Second doses were administered at 21 days, but there’s no sign of any efficacy improvement at that point.

⁷³ Pfizer-BioNTech COVID-19 Vaccine Emergency Use Authorization Review Memorandum, <https://www.fda.gov/media/144416/download>



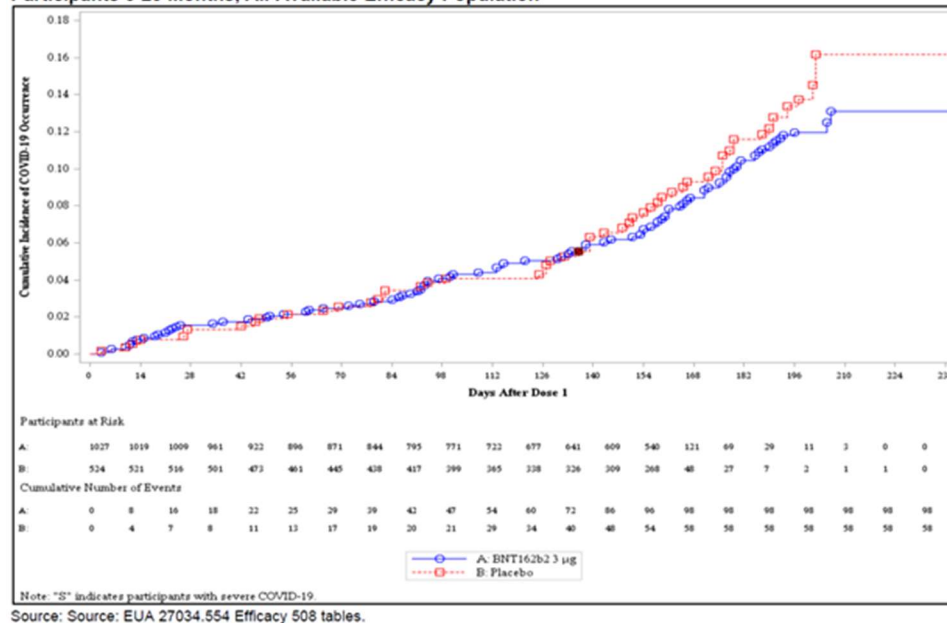
Another curious point is that the trial shows a vaccine efficacy drop to 83.7% after 6-months. This is a decrease of around 3% per month. This contrasts with the far sharper declines seen in virtually all follow-on studies.

Isn't it miraculous how the vaccine performed so much better during the trial?

Have a look at the same chart from the trial for children between the ages of 6 months and 6 years old. Try to spot the difference in Covid cases between the vaccine and placebo groups in

the Pfizer graph. The lines don't even start to split until 140 days, or almost 5 months has passed, and then both groups still climb at similar rates.

Figure 1. Cumulative Incidence Curves for the First COVID-19 Occurrence After Dose 1, Participants 6-23 Months, All-Available Efficacy Population



Here is a look at the vaccine efficacy (VE) throughout the inoculation process from the children's trial:

Table 19. First COVID-19 Occurrence Any Time After Dose 1, Blinded Follow-Up Period, Participants 6-23 Months of Age, All-Available Efficacy Population, Study C4591007

Efficacy Endpoint	BNT162b2 3 µg (N ^a =1178) Cases, n ^{1b} Surveillance Time ^c , (n ^{2d})	Placebo (N ^a =598) Cases, n ^{1b} Surveillance Time ^c , (n ^{2d})	Vaccine Efficacy % (95% CI ^e)
First COVID-19 occurrence after Dose 1	98 0.456, (1027)	58 0.232, (524)	14.0 (-21.2, 38.4)
Dose 1 to before Dose 2	13 0.063, (1027)	5 0.032, (524)	-29.7 (-364.7, 56.6)
Dose 2 to <7 days after Dose 2	3 0.019, (1002)	3 0.010, (517)	48.4 (-285.0, 93.1)
≥7 Days after Dose 2 to before Dose 3	80 0.338, (998)	48 0.173, (512)	14.5 (-24.9, 41.0)
Dose 3 to <7 days after Dose 3	1 0.006, (336)	0 0.003, (147)	UND (NA, NA)
≥7 Days after Dose 3	1 0.030, (277)	2 0.015, (139)	75.5 (-370.1, 99.6)

Table 20. First COVID-19 Occurrence Any Time After Dose 1, Participants 2 to <5 Years of Age, All-Available Efficacy Population, Study C4591007

Efficacy Endpoint	BNT162b2 3 µg (N^a=1835) Cases, n1^b Surveillance Time^c, (n2^d)	Placebo (N^a=915) Cases, n1^b Surveillance Time^c, (n2^d)	Vaccine Efficacy % (95% CI^e)
First COVID-19 occurrence after Dose 1	127 0.661, (1673)	92 0.323, (834)	32.6 (10.8, 48.8)
Dose 1 to before Dose 2	21 0.100, (1673)	8 0.050, (834)	-32.1 (-244.8, 43.8)
Dose 2 to <7 days after Dose 2	4 0.031, (1639)	5 0.016, (819)	60.1 (-85.6, 92.1)
≥7 Days after Dose 2 to before Dose 3	100 0.464, (1630)	74 0.228, (814)	33.6 (9.1, 51.3)
Dose 3 to <7 days after Dose 3	0 0.010, (553)	0 0.004, (222)	NE
≥7 Days after Dose 3	2 0.056, (481)	5 0.025, (209)	82.3 (-8.0, 98.3)

Between the first and second doses, the vaccine has a *negative* VE, which shows it increases one's chance of getting Covid by 30%. Then the vaccinated children need to wait until 7 days after the booster shot, about 6 months from the start of the process, when the vaccine finally reaches the claimed 75-82% effectiveness. This claimed effectiveness is based upon a difference between the vaccine and placebo groups of 3 total cases in the study. Summing all of this for both sets of kids and normalizing for person years of exposure nets a total 23.9% VE from day one.

To say the vaccine has a VE of 75-82% requires one to ignore 97% of the Covid cases that occurred during the trial. Recommending this inoculation is akin to saying in the middle of a hurricane storm, “you’ll be safer if you leave your house and walk through the hurricane.”

Furthermore, look at the confidence intervals in the trial results, the endpoint efficacies are circled in red. They’re completely off-the-chart. For those unaware, a confidence level says, “we believe with 95% confidence, the actual vaccine effectiveness falls somewhere in this range.” Nearly 400% negative efficacy on the lower end(s). This means that the children could have an almost 4-times greater chance of getting sick with Covid just because they took the vaccine.

There is absolutely no statistical significance in this study of vaccinating children, and the results lack any certainty. This is dart board stuff, far past incompetence and accidents; this appears to be on the level of criminal negligence.

By the way, the trial only followed the children for 1-month after the booster shot. Why wouldn't they test any longer?

Was Pfizer too afraid the world would see how quickly the protection wanes and how far negative the effectiveness would progress?

There is absolutely no statistical significance in this study, and the results lack any certainty. This is dart board stuff. We're way past incompetence and accidents here. This is criminal negligence.

An additional concern that was almost completely overlooked, was the possibility of antibody dependent enhancement (ADE) which is a common occurrence in past attempts to create a coronavirus vaccine.⁷⁴ If you are not familiar with ADE, you should be. It is a very serious risk with a coronavirus vaccine.⁷⁵

It may be informative to look at what happened with a dengue fever vaccine first. Dengue fever is a viral illness passed to humans from mosquitoes. Because there are different serotypes of dengue fever, even if you had it once, you can be reinfected up to four times.⁷⁶ Worldwide,

⁷⁴ <https://www.ncbi.nlm.nih.gov/labs/pmc/articles/PMC8438590/>

⁷⁵ Information on ADE: Antibody dependent enhancement: Unavoidable problems in vaccine development, here: <https://www.ncbi.nlm.nih.gov/labs/pmc/articles/PMC8438590/> and A review: Antibody-dependent enhancement in COVID-19: The not so friendly side of antibodies, here: <https://www.ncbi.nlm.nih.gov/labs/pmc/articles/PMC8512237/>

⁷⁶ <https://www.who.int/news-room/fact-sheets/detail/dengue-and-severe-dengue>

there is thought to be 50 million infections every year and 22,000 deaths, mostly in very young children.⁷⁷

In 2016, the Philippines launched an aggressive campaign with the goal to vaccinate a million children against dengue fever with a brand-new vaccine. The vaccine had completed safety trials, the results of which were published in the New England Journal of Medicine. The study stated that “risk of hospitalization among children 2 to 16 years of age was lower in the vaccine group than in the control group.”⁷⁸ This industry-sponsored peer-reviewed study was the cornerstone for the authorization to start vaccinating children in areas of the world where dengue fever could make them sick.

However, when some children caught dengue fever after being vaccinated, they sometimes had worse outcomes than children who had not been vaccinated. The vaccine seemed to be causing a potentially lethal vascular disorder termed ‘plasma leakage syndrome,’⁷⁹ which is also associated with the disease itself. It took almost two years, but the WHO’s recommendation to vaccinate children ages 9 to 16 against dengue fever was rescinded. In April of 2019, it was reported⁸⁰ that forensic investigators were looking into the cause of death of some 600 children who died after the vaccine.

⁷⁷ <https://www.niaid.nih.gov/diseases-conditions/dengue-fever>

⁷⁸ <https://www.nejm.org/doi/full/10.1056/NEJMoa1506223>

⁷⁹ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4334930/>

⁸⁰ <https://www.scmp.com/magazines/post-magazine/long-reads/article/3006712/philippines-suspicion-dengue-vaccine-linked>

Returning to Covid, according to the authors of a study linking ADE with Covid,⁸¹ ADE “can occur when non-neutralizing antibodies or antibodies at sub-neutralizing levels bind to viral antigens without blocking or clearing infection.” Evidence is now uncovering that it is common for people vaccinated against Covid to be infected and re-infected⁸² by it. The antibodies generated from the vaccines are not sterilizing and non-neutralizing, which is to say, they are not clearing infection.

Pfizer reported only “nonclinical studies,” and stated that, “None of the challenged animals showed clinical signs of significant illness, indicating that the 2-4 years old male rhesus challenge model is primarily an infection model for SARS-CoV-2, not a COVID-19 disease model”. No clinical symptoms of covid illness were elicited in either the inoculated or control animals. It seems that for Pfizer and the FDA, studying a non-disease model to make claims about lack of the enhanced disease is acceptable. Furthermore, just how few animals were in such an important study?

Pfizer was “reassured” by their non-clinical studies of ADE, are you?

Curiously, the Pfizer study selected the inappropriate clinical endpoints. It should have focused on “all-cause mortality and illness.” The risk versus benefit of Covid vaccines is arguably most accurately measured by comparing the all-cause mortality rate of the vaccinated against unvaccinated since it not only avoids most confounders relating to case definition but also fulfills the WHO/CDC definition of “vaccine effectiveness” for mortality. Why is “all-cause mortality” the most appropriate measure for the overall risk-benefit analysis of Covid vaccines?

⁸¹ Antibody-dependent enhancement and SARS-CoV-2 vaccines and therapies, here: <https://www.nature.com/articles/s41564-020-00789-5>

⁸² COVID-19 reinfections among naturally infected and vaccinated individuals, here: <https://www.nature.com/articles/s41598-022-05325-5>

- Simply put, the count of all-cause deaths should be higher among the unvaccinated than the vaccinated (in all age groups), confirming that the benefits of vaccination outweigh the risks.
- Counting all-cause deaths completely bypass the problem of defining what constitutes a 'Covid case' or a 'Covid related death'—definitions that can be easily manipulated to fit different narratives.
- It defines a person as 'vaccinated' if they have received at least one dose. Since we are not interested in whether a person becomes a 'Covid case', any other definition is flawed as it will fail to acknowledge that adverse reactions (including death) from vaccines often occur shortly after vaccination.
- The fact that the CDC and other agencies now count a person as 'unvaccinated' if they die within 14 days of the second dose, or after just one dose, might make some sense if we are interested only in the vaccine's ability to stop infection. But in the context of death attribution, it makes no sense.

The fear with Covid was that it was going to either kill people or make them sick. So, any Covid vaccine clinical trial should set out to ask the question "Do people who take the vaccines have less illness and death than those who don't?" Illness and death should have been the clinical endpoint of the trial. And not just illness and death with Covid, but any illness and death, to make sure that the vaccines are not causing harm.

This is well known. It was learned decades ago with cancer drug trials. Because cancer trials first used a clinical endpoint of “Did the drug shrink the cancer?” If it did, they called it effective. But it turned out trial drugs were not only killing the cancer; they were killing patients. This forced a change to the design of trials and a switch to “all-cause mortality” as the primary endpoint.

“Therefore, as it has now been established in numerous studies, vaccines may have completely unexpected effects on overall mortality, different from what could be anticipated based on the protection against the vaccine-targeted disease. The current system for testing vaccines does not incorporate this possibility.

...

Hence, though it was anticipated that the new COVID-19 vaccines would reduce overall mortality, especially in the context of a pandemic, this has not been formally studied.”⁸³

What does an examination of the early trial data show about mortality? A Danish study⁸⁴ reviewed pooled vaccine Randomized Controlled Trial data submitted to the FDA. The study found no evidence the mRNA vaccines from both Moderna and Pfizer reduced mortality. For every 100 deaths among the unvaccinated, there are 103 deaths among the vaccinated, with a 95% confidence interval of 63 to 171 deaths. That is, the mRNA vaccines may slightly reduce mortality, or they may increase it. We don’t know. The Pfizer and Moderna vaccines contributed equally to this result, so we can’t say that one is better or worse than the other.

⁸³ Benn, Christine Stabell and Schaltz-Buchholzer, Frederik and Nielsen, Sebastian and Netea, Mihai G. and Netea, Mihai G. and Aaby, Peter, Randomised Clinical Trials of COVID-19 Vaccines: Do Adenovirus-Vector Vaccines Have Beneficial Non-Specific Effects?, available on Preprints with THE LANCET.

⁸⁴ https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4072489

The study also found the vaccines increased cardiovascular deaths, but not necessarily at a statistically significant level. The strength of the Danish study is that it is based on randomized controlled trials. The primary weakness is that the follow-up time is short. This is because the manufacturers ended the clinical trials prematurely, after receiving emergency use authorization. Another weakness is that the data does not allow us to determine how these results may differ by age. The study has yet to be peer-reviewed.

On July 28, Pfizer and its partner BioNTech posted a six-month data update from their original clinical trial. Pfizer claimed the vaccine's efficacy remained relatively strong, at 84% after six months. It also reported that 15 of those who received the vaccine in the trial had died, compared to 14 of the people who received a placebo. Most of these deaths were not from Covid, as only three people in the trial died of Covid-related illnesses, two who received the vaccine, and one who received the placebo. In the vaccine arm, one of the deaths was labelled from "Covid pneumonia", and that play-on-words was used to preclude counting it as a Covid-death (which Pfizer didn't). The other deaths in the trial were from illnesses and diseases not related to Covid, mostly cardiovascular.

Although the researchers released their update in July, the data was already more than four months old. They stopped collecting information about deaths on the "data cut-off" date of March 13. Conveniently, Pfizer buried these details in an appendix to their report.

In their initial safety report to the FDA, which contained data through November 2020, the researchers said four placebo recipients and two vaccine recipients died, one after the first dose and one after the second. The July update reversed that trend. Between November 2020 and March 2021, 13 vaccine recipients died, compared to only 10 placebo subjects.

Further, nine vaccine recipients had died from cardiovascular events such as heart attacks or strokes compared to six placebo recipients who died of those causes. This imbalance while small is notable, especially considering that regulators worldwide had found that Pfizer's mRNA vaccine was linked to heart inflammation in young men. At best, these results suggest that the Pfizer vaccine did ultimately nothing to reduce overall deaths.

Later, on November 8th, the FDA released its "Summary Basis for Regulatory Action,"⁸⁵ a 30-page explanation of why it granted full approval to Pfizer's vaccine, which replaced its emergency authorization of December 2020. In this report the FDA unexpectedly stated:

*"From Dose 1 through the March 13, 2021 data cutoff date, there were a total of 38 deaths, 21 in the COMIRNATY [vaccine] group and 17 in the placebo group."*⁸⁶

Pfizer said publicly in July it had found 15 deaths among vaccine recipients by mid-March. But it told the FDA there were 21 at the same data cutoff date. So, 21 had died and not 15 as Pfizer had stated. The placebo numbers in the trial were also wrong. Pfizer had 17 deaths among placebo recipients, not the previously stated 14. Nine extra deaths overall, six among vaccine recipients. The FDA did not report any additional details about these deaths.

How could Pfizer publicly misreport the number of deaths in one of the most important clinical trials in the history of medicine?

More importantly, if overall mortality was the same in both the vaccine and placebo arms (21 vs. 17 respectively), then the vaccine does nothing. Death is the most unambiguous metric

⁸⁵ <https://www.fda.gov/media/151733/download>

⁸⁶ <https://www.fda.gov/media/151733/download>

possible, there is no disputing it. Pfizer proved the vaccine is worthless, and no one listened to them.

We know that Pfizer overlooked at least 3 deaths to vaccine recipients in their trial and didn't perform adequate investigations. The first of the deceased participants, a 56-year-old woman known as subject #10071101, was given two doses of the vaccine and died from a cardiac arrest two months later. In Pfizer's report on the participant states:

“In the opinion of the investigator, there was no reasonable possibility that the cardiac arrest was related to the study intervention of clinical trial procedures, as the death occurred two months after receiving Dose 2. Pfizer concurred with the investigator's causality assessment.”⁸⁷

But it's not clear how Pfizer's investigator can be so sure the death was unrelated to the vaccine when there was no autopsy and no thorough medical assessment. Anyone is aware that within a “reasonable possibility” that a temporal gap alone is not justification to make the statement. No follow up or inquiry into whether an autopsy was performed is further evidence of willful ignorance in a trial of this significance.

A second deceased participant was a 60 year-old man known as subject #11621327, who died three days after his first dose of vaccine. The report says that the “probable cause of death was progression of atherosclerotic disease”. However, the subject had no known history of the

⁸⁷ https://pdata0916.s3.us-east-2.amazonaws.com/pdocs/070122/125742_S1_M5_5351_c4591001-fa-interim-narrative-sensitive.pdf

condition, although he was reported as obese. While the investigator again deemed there to be “no reasonable possibility” of a link with the vaccine, seeing that it happened three days after the injection and “autopsy results were not available at the time” of the report.

A third deceased participant was a 72 year-old man known as subject #11521497, who received the first vaccine dose and then 19 days later, was admitted to hospital because “he fainted in the middle of the night”. Reported as a syncope (temporary loss of consciousness usually related to insufficient blood flow to the brain), 16 days later he died. The investigator again claimed there was “no reasonable possibility that the syncope was related to the study intervention” and Pfizer said the syncope was “most likely coincidental”. But it’s unclear what this assessment is based upon as the cause of death was reported as “unknown” and neither the investigator nor Pfizer attempted to investigate.

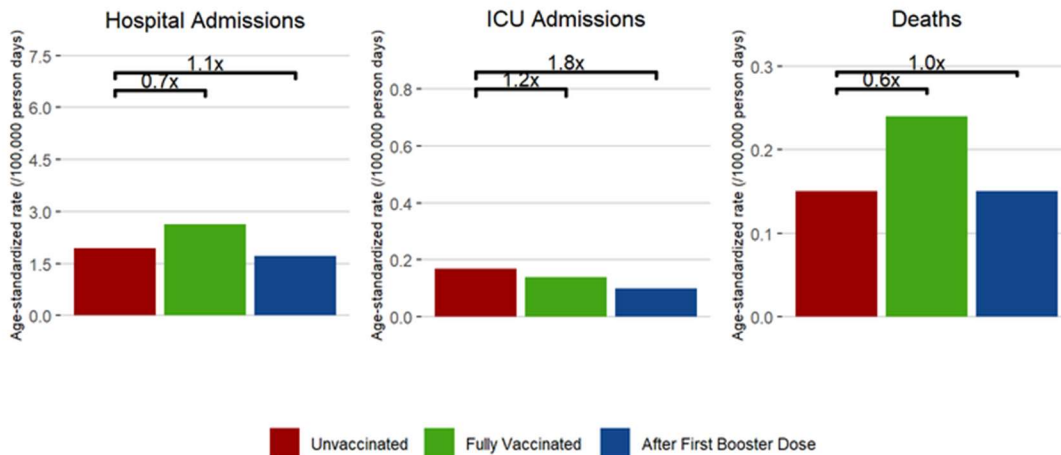
Do you feel comfortable with this level of investigation into trial participant deaths?

And now, according to official government estimates from the Canadian province of Manitoba,⁸⁸ the vaccinated are now more likely to be hospitalized or die from Covid, even after adjusting the data to account for the vaccinated being older than the unvaccinated.

The most recent data for the month of May, shows only 9% of Covid deaths and 14% of hospital admissions in Manitoba occurred among unvaccinated people, even though they make up 17% of the population. Furthermore, the vaccinated but un-boosted people were about 50% more likely to be hospitalized or die of Covid than unvaccinated people, while those who had received boosters had roughly the same risk of hospitalization or death as the unvaccinated.

⁸⁸ <https://www.gov.mb.ca/health/publichealth/surveillance/covid-19/index.htm>

Figure 6. Age-Standardized Rate (/100,000 person days) and Risk of Severe Outcomes Associated with COVID-19 Manitoba, May 1, 2022 – May 31, 2022



Note: Hospital admissions include ICU admissions.

This data differs markedly from those the CDC provide for American Covid deaths. However, they are likely to be far more accurate since American hospitals and health authorities classify Covid deaths and hospitalizations as occurring in the unvaccinated until proven otherwise. Countries such as Canada with national health insurance can much easily match their vaccination registries against hospital admissions and deaths, and they have consistently shown much higher percentages of Covid deaths in vaccinated people. This data from Manitoba appears to mark the first time that any government agency has admitted a higher risk of death in vaccinated people.

Returning to Pfizer's children trial report for a moment, they documented that the trial started with 4526 participants, of which approximately 3000 didn't make it to the end. Two-thirds didn't make it. All they said about the ones excluded was, "participants may have been excluded for more than one reason." And from dose 1 through the data cutoff, 2 placebo

recipients and 6 vaccine recipients met the criteria for severe Covid, while only one child was hospitalized for severe Covid (fever and seizure) and that child was vaccinated. So, the vaccine doesn't prevent Covid, AND it doesn't prevent severe outcomes either. Furthermore, in the child study withdrawals due to adverse events in participants were reported in 6 vaccine recipients but only 1 placebo recipient.

Pfizer began their phase 3 trial on July 27, 2020, as a blind study. On Dec 31, 2020, Pfizer released the 2-month data report and then unblinded the trial several months earlier than initially planned. This meant the participants from the placebo group were allowed to take the inoculation. By early 2021, the majority of them had crossed over to the inoculated group. Therefore, the study is no longer a randomized control trial, as the control group doesn't exist anymore. Bye-bye gold standard—actually, bye-bye everything.

Pfizer contended this was an ethical decision. At a Dec. 10 meeting of an FDA advisory committee regarding the emergency use authorization, it was discussed how the placebo crossover should be handled. At that session, Steven Goodman, associate dean of clinical and translational research at the Stanford University School of Medicine, argued that there was no ethical reason that volunteers in the placebo group deserved to receive vaccines before the general public.⁸⁹ Consent forms given to volunteers made no mention of when or if those who received a placebo would get the vaccine.

Pfizer set the future date of May 2, 2023, as the original end for the phase 3 clinical trial. The long-term safety data that was supposed to be assessed at this point is now no longer possible. Pfizer destroyed our best chance to compare the long-term health of the vaccine recipients

⁸⁹ <https://www.statnews.com/2021/01/01/pfizer-and-biontech-speed-up-timeline-for-offering-covid-19-to-placebo-volunteers/>

with a scientifically balanced group of people who had not received the drug. The July 28 report appeared to be the last clean safety data update the world will ever have.

What vaccine safety information has Pfizer lost forever?

This marks the end of the clinical trial, because it essentially means Pfizer and the regulators no longer have a clean comparison group. Everyone in the trial has received the vaccine. The FDA allowed this move, on the theory that the vaccines had been proven safe, and no one needs to collect long-term data comparing the two groups. But this ignores some very important facts. The mRNA vaccines work in a completely different way than other vaccines. They had shown evidence of toxicity with repeated use, and they had never been used before in humans outside of a handful of clinical trials.

Was this planned by Pfizer from the outset of the trial?

Pfizer took the results from their adult trial, which started July 27, 2020, and then added the results from the 12 to 15-year-olds' trial, even though the adolescent trial started four months later. Since it's well known that the efficacy of the inoculation wanes over time, this gives a false boost to the efficacy numbers. Vaccine efficacy for these two cohorts should have been reported separately, not presented as a combined result.

Doesn't that seem like outright fraud?

Many are reassured by the fact that the FDA did finally approve a version of the Pfizer vaccine, named Comirnaty.⁹⁰ However, in regards to producing Comirnaty, Pfizer played a deceitful shell game on the unsuspecting and unaware public. Only the emergency authorized version has ever been produced, distributed or used. Pfizer originally claimed they weren't making the "approved" version by calling the issue an inventory problem that had nothing to do with the legal distinction between an experimental EUA product and an FDA-approved vaccine. Up until just a few weeks ago, this was the statement on the CDC website (emphasis added):

"Pfizer received FDA BLA license on 8/23/2021 for its COVID-19 vaccine for use in individuals 16 and older (COMIRNATY). At that time, the FDA published a BLA package insert that included the approved new COVID-19 vaccine tradename COMIRNATY and listed 2 new NDCs (0069-1000-03, 0069-1000-02) and images of labels with the new tradename.

"At present, Pfizer does not plan to produce any product with these new NDCs and labels over the next few months while EUA authorized product is still available and being made available for U.S. distribution. As such, the CDC, AMA, and drug compendia may not publish these new codes until Pfizer has determined when the product will be produced with the BLA labels."

In May 2022, Pfizer quietly updated this statement to mention the licensed Comirnaty product. But then, just last week, Pfizer finally acknowledged that its FDA fully approved original licensed product will never be distributed. In an unreported update on the CDC website, Pfizer told the agency (emphasis added):

⁹⁰ <https://www.fda.gov/news-events/press-announcements/fda-approves-first-covid-19-vaccine>

*“Pfizer received initial FDA BLA license on 8/23/2021 for its COVID-19 vaccine for use in individuals 16 and older (COMIRNATY). At that time, the FDA published a BLA package insert that included the approved new COVID-19 vaccine tradename COMIRNATY and listed 2 new NDCs (0069-1000-03, 0069-1000-02) and images of labels with the new tradename. **These NDCs will not be manufactured. Only NDCs for the subsequently BLA approved tris-sucrose formulation will be produced.**”*

The key distinction between the originally approved formulation and the tris-sucrose formulation is that — according to manufacturers — the latter can be held for a longer time outside of an ultra-cold freezer. Improper storage can render the vaccine unstable. But the clinical trials for the Pfizer shot were conducted without the modified tris-sucrose ingredient, and it is unclear whether this is significant.

Pfizer admitted the vaccine arm of the trial (those who received the actual vaccine vs. the placebo) suffered from 12.1% and 36.1% more systemic Adverse Events than the placebo group. These side effects are indistinguishable from Covid in most cases.

Table 14. Study C4591001 Safety Overview- Ages 16 years and older

Participants Experiencing at Least One:	BNT162b2 n/N (%)	Placebo n/N (%)
Immediate unsolicited AE Within 30 minutes after vaccination ^a		
Dose #1	78/18801 (0.4)	66/18785 (0.4)
Dose #2	52/18494 (0.3)	39/18470 (0.2)
Solicited injection site reaction within 7 days ^b		
Dose #1	3216/4093 (78.6)	525/4090 (12.8)
Dose #2	2748/3758 (73.1)	396/3749 (10.6)
Solicited systemic AE within 7 days ^b		
Dose #1	2421/4093 (59.1)	1922/4090 (47.0)
Dose #2	2627/3758 (69.9)	1267/3749 (33.8)
From Dose 1 through 1 month after Dose 2 ^a		
Unsolicited non-serious AE	5071/18801 (27.0)	2356/18785 (12.5)
SAE	103/18801 (0.5)	81/18785 (0.4)
From Dose 1 through cutoff date (safety population)		
SAE	124/18801 (0.7)	101/18785 (0.5)
From Dose 1 through cutoff date (all-enrolled) ^c		
Withdrawal due AEs	37/21621 (0.6)	30/21631 (0.5)
SAE	126/21621 (0.6)	111/21631 (0.5)
Deaths	2/21621 (0.0)	4/21631 (0.0)

Source: c4591001-safety-tables-ae3.pdf pages 216,446,459,463; c4591001-safety-tables-cos-reacto.pdf, pages 113-114.

n= number of participants with the specified reaction or AE.

^a N: number of participants in the phase 2/3 safety population.

^b N: number of participants in the reactogenicity subset of the phase 2/3 safety population.

^c N: number of participants in the all-enrolled population.

Data analysis cutoff date: November 14, 2020.

So, it is undeniable that the vaccines caused a wide array of adverse events, not all of them fully understood. While the side effects are somewhat abundant,⁹¹ they are almost entirely ignored. Pfizer was swamped attempting to process the VAERS reports and found it had to prioritize serious cases, make technological changes and hire 2400 new employees to handle the bombardment.

“Due to the large numbers of spontaneous adverse event reports received for the product, the MAH has prioritised the processing of serious cases, in order to meet expedited regulatory reporting timelines and ensure these reports are available for signal detection and evaluation activity.

...

Pfizer has also taken a multiple actions to help alleviate the large increase of adverse event reports. This includes significant technology enhancements, and process and

⁹¹ <https://openvaers.com/>

workflow solutions, as well as increasing the number of data entry and case processing colleagues. To date, Pfizer has onboarded approximately 600 additional fulltime employees (FTEs). More are joining each month with an expected total of more than 1,800 additional resources by the end of June 2021.”⁹²

As of December 3, 2021, the U.S. Vaccine Adverse Event Reporting System (VAERS) has logged an astounding 927,738 Covid vaccine-related adverse events, including 19,886 deaths. VAERS can receive reports from vaccine manufacturers and other international sources, and excluding those, the death toll reported in U.S. territories stands exclusively at 9,136. The Pfizer vaccine accounts for the vast majority of the VAERS deaths and hospitalizations. It’s essential to note, that it is widely agreed⁹³ that VAERS is notoriously underreported, so the real-world impact of these shots is far greater than those that the data suggest. While it’s hard to assess the population-wide impact of the adverse effects, it is no longer reasonable to doubt that they’re substantially more dangerous than ordinary vaccines. Rough calculations from the VAERS data suggest that they’re at least several hundred times more dangerous than flu shots.

As it turns out, the CDC isn’t even looking for safety signals in the VAERS data. They said they were going to use the most basic standard pharmacovigilance method of calculating what are called proportional reporting ratios (PRR’s) to monitor VAERS. But they didn’t even do these most basic checks as they admitted in a response to a FOIA request.⁹⁴ Then they turned around and said they weren’t seeing any safety signals in VAERS, forgetting to mention that they weren’t looking for any. For the CDC to not look for safety problems, and then claim that absence of evidence is evidence of absence is negligent.

⁹² BNT162b2 5.3.6 Cumulative Analysis of Post-authorization Adverse Event Reports (CONFIDENTIAL), Pfizer, April 30, 2012.

⁹³ “VAERS is a passive surveillance reporting system and is subject to reporting biases and underreporting,” <https://www.cdc.gov/mmwr/volumes/70/wr/mm705152a1.htm>

⁹⁴ <https://jackanapes.substack.com/p/new-foia-release-shows-cdc-lied-about>

Analysis of the VAERS data using the Bradford Hill criteria—a set of nine questions that are used by epidemiologists to determine whether any given factor is likely the cause of an observed health effect, indicates that many of the adverse effects are more than just a coincidence. In determining a causal link between an adverse event and the vaccination, consider the vaccine comes in two doses. A random adverse event unrelated to the vaccine should be dose agnostic. For example, a random stroke coinciding with vaccination should equally occur after either dose. However, in the VAERS data, a number of the reported problems are dose-dependent. Myocarditis in teenagers (see below), is reported several times more often after the second dose than after the first one. Following a booster shot, in contrast, the frequency is significantly lower than after the first dose. Dose-dependency shows up in the VAERS data for other problems too.

A recent paper published by the CDC in *The Lancet*⁹⁵ shows just how substantial severe side effects became. In their usual implausible fashion, the legacy media immediately promoted the *Lancet* document as proof that the vaccines are safe and effective. Here is a typical headline referencing the study, this one from *USA Today*, “Huge study finds most COVID-19 vaccine side effects were mild for Pfizer-BioNTech and Moderna.”⁹⁶

In contrast to the headline, the *Lancet* paper found the frequency of severe adverse events (see below definition) near commonplace at 1 in 11,056 for each dose administered (risk increasing with each dose). The study documented the percent of severe adverse events (6.6%) as

⁹⁵ However, as with anything published about the vaccines by the CDC, there are caveats. The period covered is only the first 6 months after vaccine roll out, so no children and practically no teens were vaccinated during this period. Why the cut-off at 6 months? When the paper was written, there existed 14 more months of available data. Furthermore, the literature search employed by the study was far too restrictive and quite frankly, laughable. And finally, consider the conflicted interests of the authors; they are employees of the CDC!

⁹⁶ <https://www.usatoday.com/story/news/health/2022/03/07/covid-19-vaccine-mild-side-effects-moderna-pfizer/9376671002/>

compared to non-severe adverse events (92.1%). Death was a separate category determined to be around 1.3% of all adverse events. Including the deaths brings the severe event ratio to 7.9% of all reported adverse events. This should be recognized as shockingly high. 12.6% of adverse events are severe as defined by the VAERS system. Quoting the study:

“VAERS reports were classified as serious if any of the following outcomes were documented: inpatient hospitalisation, prolongation of hospitalisation, permanent disability, life-threatening illness, congenital anomaly or birth defect, or death.”⁹⁷

One out of every eight reported adverse events were classified as serious, but the USA Today headline concluded that “most” side effects are “mild.”

This vaccine miserably fails the most rudimentary harm-benefit analysis. Per a recent study by Dr. Peter Doshi, et.al., “In the Pfizer trial, the excess risk of serious AESIs (10.1 per 100,000) surpassed the risk reduction for COVID-19 hospitalization relative to the placebo group (2.3 per 10,000 participants).”⁹⁸ In other words, for every 2.3 people Pfizer kept out of hospital, it inflicted 10.1 serious AE’s.

Dr. Doshi’s new scientific study⁹⁹ provides the best evidence yet concerning the safety of the mRNA Covid vaccines.

⁹⁷ [https://www.thelancet.com/journals/laninf/article/PIIS1473-3099\(22\)00054-8/fulltext#%20](https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(22)00054-8/fulltext#%20)

⁹⁸ Fraiman, Joseph and Erviti, Juan and Jones, Mark and Greenland, Sander and Whelan, Patrick and Kaplan, Robert M. and Doshi, Peter, Serious Adverse Events of Special Interest Following mRNA Vaccination in Randomized Trials. JVAC-D-22-01206, Available at SSRN: <https://ssrn.com/abstract=4125239>

⁹⁹ https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4125239

Both the Pfizer and Moderna mRNA vaccines were approved for emergency use based upon only two randomized trials. The trials were not designed to evaluate long-term efficacy or the more important outcomes of preventing hospitalization, death, or transmission. However, the randomized trials did collect adverse event data. Most vaccines generate mild adverse reactions in some people, and there were considerably more adverse such reactions after the mRNA vaccines compared to the placebo.

This new study is a unique look at these adverse reactions while using the same data from the Pfizer and Moderna-sponsored randomized trials, but with two innovations providing additional information. First, the study pooled data from both mRNA vaccines to increase the sample size, those decreasing the uncertainty. And second, the study focuses only on the severe adverse events plausibly due to the vaccines by ignoring many serious adverse events that would be implausibly due to the vaccines. For example, cancer is unlikely to be due to a vaccine immediately after vaccination. By removing such random noise, the potential to statistically detect genuine problems increases.

What the study found is shocking. There were a combined 12.5 vaccine-induced adverse events of special interest (AESI) for every 10,000 people vaccinated, with a 95% confidence interval of 2.1 to 22.9 per 10,000 people. That is very high for a vaccine, and no other vaccine on the market comes close.

Why is the CDC, FDA, Pfizer and the media ignoring the shocking amount of serious adverse reactions?

The study didn't calculate composite estimates that included the reduction in serious covid infections, but we have such estimates for mortality. However, an additional study¹⁰⁰ conducted by Dr. Christine Benn and colleagues calculated a combined estimate of the effect of vaccination on all-cause mortality using the same randomized trial data. They found no mortality reduction for the mRNA vaccines (relative risk 1.03, 95% CI: 0.63-1.71).

There is an important limitation to both of these studies since we know that the vaccine benefits are not equally distributed, with Covid mortality far more prevalent in older people. Therefore, they do not distinguish the adverse reactions by age, comorbidities, or medical history. But that is not their fault as neither Pfizer nor Moderna have released that information.

But maybe VAERS isn't your thing?

Consider EudraVigilance, the European database for suspected adverse drug reactions. As of March 5, 2022, it reports 18,497 (41,328 total) *deaths* among 817,574 (1,583,580 total) Pfizer injected individuals who have reported adverse reactions after vaccination. EudraVigilance totals all vaccines to show a 0.012% fatality rate which equates to 1 death in 8,333 people. Accumulated monthly counts continue to rise in the database at a near-linear rate estimated at 118,413 total reports per month.

Did the Pfizer and the mainstream media deliberately ignore the objectionable evidence about the vaccine?

¹⁰⁰ https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4072489

Moreover, by not advertising their vaccine by name, Pfizer is not obliged, under current FDA regulations, to list the risks and side effects of the vaccine. The vaccine manufacturers have not advertised their vaccines at all. As further example of a disregard for side effects,¹⁰¹ Pfizer reported four cases of Bell's Palsy among the vaccinated but none among the control group. They stated that this was within the normal rates that would occur in the population and was therefore not statistically significant nor a concern.

This doesn't seem to jive with the fact that Bell's palsy only affects about 40,000 people in the U.S. each year. It can affect anyone of any gender and age, but its incidence seems to be highest in those in the 15 to 45-year-old age group.¹⁰² It is also believed by some that the Governor of California contracted Bell's palsy after receiving a vaccine booster shot.¹⁰³

Since Bell's Palsy is an infection-related neurological phenomenon, it seems it would have been prudent to expand the study to a larger group before continuing population-wide application. Only 40,000 participants are inadequate to pick up rare side effects. And two months is just not long enough to pick up longer-term adverse effects.

Pfizer did acknowledge that the frequency and severity of adverse events increases as the age of the recipient decreases. "The frequency and severity of systemic adverse events (AE) were higher in the younger than the older age groups. Within each age group, the frequency and severity of systemic AEs was higher after Dose 2 than Dose 1, except for vomiting and diarrhea, which was generally similar regardless of dose."¹⁰⁴

¹⁰¹ See this report on developing tinnitus after vaccination for a truly distressing account, <https://www.medpagetoday.com/special-reports/exclusives/97592>

¹⁰² https://www.ninds.nih.gov/Disorders/Patient-Caregiver-Education/Fact-Sheets/Bells-Palsy-Fact-Sheet#3050_4

¹⁰³ <https://stevekirsch.substack.com/p/gavin-newsom-is-out-of-sight-likely>

¹⁰⁴ <https://www.fda.gov/media/144416/download>

Subject #12312982 in the Pfizer study is Augusto Roux, a 35-year old lawyer from Buenos Aires, Argentina who volunteered for the phase 3 trial.¹⁰⁵ His story highlights some of the sneakiness evident at Pfizer's trial sites and the phase 3 trial in general.

On the way home after his second dose on Sept. 9, 2020, Roux began feeling unwell, developed a high fever and felt terribly ill fainting two days later. Augusto finally went to the hospital on Sept. 12 (different hospital than the trial site). They did a thorough work-up, including a CAT scan of his chest that showed an abnormal collection of fluid around the outside of the heart confirming he had pericarditis. On Sept. 14, Roux was discharged. The doctor wrote in his chart that he had suffered an adverse reaction to the vaccine.

It would be noteworthy if Augusto Roux's issue was just a simple case of pericarditis alone. However, this is only the beginning of the trickery, and we know all of this because Augusto, a lawyer, successfully sued to get his medical and trial clinical records.

Even though Augusto had a negative PCR test at the hospital, and even though the doctor at the hospital wrote that his condition was due to the vaccine, when Augusto called the trial site on Sept. 14 to notify the trial investigators, they annotated in his clinical trial record that he had been admitted for a bilateral pneumonia which had nothing to do with the "investigational product."

On October 7, the clinical trial notes that "at the request of the sponsor" (AKA Pfizer), the adverse event code was updated to Covid disease. And as such, Pfizer made a case of

¹⁰⁵<https://davidhealy.org/disappeared-in-argentina/>

pericarditis disappear. Moreover, the diagnosis of Covid would not count against the efficacy calculations, since those required a positive PCR test to confirm diagnosis. Two-birds were killed with one stone.

Two days later On Oct. 9, Roux was formally unblinded. The principal investigator for the trial, Fernando Polack, had told him that Augusto could only be unblinded if his life were in danger (which is simply not true). So, Augusto appealed to ANMAT, the Argentinian FDA. In a formal hearing they forced the trial investigators to tell Augusto if he had received the vaccine or not. He had.

A day before the hearing, Polack wrote in Augusto's clinical trial records that he had had an attack of severe anxiety starting on September 23, not caused by the vaccine, and that Augusto suspected a conspiracy, described his anxiety as constitutional, and noted that it was ongoing. Then two days after the ANMAT hearing, Polack had the mental health diagnosis added to Augusto's actual medical records. Of course, a pediatrician like Polack has no business making mental health diagnoses, especially without any formal assessment.

Note that Polack was the first author listed on the December, 2020 NEJM paper on the safety and efficacy of the Pfizer vaccine.

Let's briefly examine the Pfizer adolescent trial since Pfizer liked to mix results. First, the nearly complete lack of a need for a pediatric vaccine can be shown by comparing Covid and the

annual flu (see table below). While there can be big year-to-year variation in the CDC flu numbers, the pediatric flu burden has almost always been higher¹⁰⁶ than Covid.

CDC Pediatric Flu Death Central Estimates			
Year	0 to 4	5 to 17	0 to 17
2019-20	254	180	434
2018-19	266	211	477
2017-18	115	528	643
2016-17	126	125	251
2015-16	180	88	268
2014-15	396	407	803
2013-14	74	56	130
2012-13	291	870	1,161

CDC Reported Pediatric Deaths w/Covid (NCHS 5.11.22)			
Year (Oct 1 to Sep 30)	0 to 4	5 to 17	0 to 17
2021-22	176	253	429
2020-21	190	302	492
2019-20	47	77	124

Pediatric Covid Deaths Adjusted for 35% Overascertainment			
Year (Oct 1 to Sep 30)	0 to 4	5 to 17	0 to 17
2021-22	114	164	279
2020-21	124	196	320
2019-20	31	50	81

Second, the 12 to 15-year-old's trial was severely underpowered, with an inoculated group of 1,005 (0 tested positive for Covid), and a placebo group of 978 (18 tested positive for Covid). Such a small study will noticeably conceal many risks.

Was the small size selected on purpose?

¹⁰⁶ See: <https://www.cdc.gov/flu/about/burden/index.html>, <https://data.cdc.gov/resource/9bhq-hcku.csv?sex=AllSexes>, and <https://www.cdc.gov/mmwr/volumes/70/wr/mm7014e2.htm?s%20cid=mm7014e2%20x>

Pfizer claimed the results were great, but keep in mind that there were no severe Covid cases in either the treatment or placebo groups, therefore any serious adverse event (AE) should be grounds for denial of authorization. But while adolescents are at a statistically zero risk of death from Covid and a very low risk of severe illness, the inoculation is obviously of little benefit to them.

Yet the vaccination presents a very real risk of adverse events, and shamefully, the adolescent study wasn't designed to find these. Serious AE, including death, occurring at a rate of 1 in 800, might not even show up in a sample of 1,005 people. But in this case, it did. Among the 1,005 adolescents, there were several serious adverse events:

- 1 related life-threatening fever
- 1 related life-threatening anaphylaxis
- 1 related with “reasonable possibility” myopericarditis, hospitalized, with “limited activity” advised at 2 months
- 3 on SSRI medication for depression, each hospitalized with symptom “exacerbation”

There was also an event in the open-label study of a life-threatening serious AE which hospitalized a 16-year-old with “depression.” There is no indication the youngster was taking an SSRI or depressed before.

And then there is Maddie de Garay.

Maddie de Garay is a 12-year-old trial participant who developed a serious reaction after her second dose and was hospitalized within 24 hours.¹⁰⁷ Maddie developed gastroparesis, nausea and vomiting, erratic blood pressure, memory loss, brain fog, headaches, dizziness, fainting, seizures, verbal and motor tics, menstrual cycle issues, lost feeling from the waist down, lost bowel and bladder control, and had a nasogastric tube placed because she lost her ability to eat. She has been hospitalized many times, and for the past 10 months, she has been wheelchair-bound and fed via a tube. In their report to the FDA, Pfizer described her injuries as “functional abdominal pain.”

“One participant experienced an SAE reported as generalized neuralgia, and also reported 3 concurrent non-serious AEs (abdominal pain, abscess, gastritis) and 1 concurrent SAE (constipation) within the same week. The participant was eventually diagnosed with functional abdominal pain. The event was reported as ongoing at the time of the cutoff date.”¹⁰⁸

Did Pfizer Intentionally and consciously fail to report this as a serious adverse event?

Aside from the seven youngsters exhibiting serious AEs mentioned above, lymphadenopathy, and swollen lymph nodes occurred at a statistically significantly higher rate in the treatment group (nine versus two). Related events of lymphadenopathy as a consequence of treatment occurred in an additional 7 vaccine recipients (only 1 in the placebo group). The reactogenicity

¹⁰⁷ <https://www.foxnews.com/media/ohio-woman-daughter-covid-vaccine-reaction-wheelchair>

¹⁰⁸ <https://www.fda.gov/media/148542/download>

safety data is dramatic. Post dose 2, in the treatment group, 51% used antipyretic medication while only 9% used it in the placebo group.

Further, in the 5 to 11-year-old cohort in the table below, Pfizer used predictive modeling to acknowledge that their inoculations will cause myocarditis, but optimistically claimed there will be zero deaths from myocarditis in any of their model scenarios.¹⁰⁹

Sex	Benefits				Risks			
	Prevented COVID-19 Cases	Prevented COVID-19 Hospitalizations	Prevented COVID-19 ICU Admissions	Prevented COVID-19 Deaths	Excess Myocarditis Cases	Excess Myocarditis Hospitalizations	Excess Myocarditis ICU Admissions	Excess Myocarditis Deaths
Males & Females								
Scenario 1	45,773	192	62	1	106	58	34	0
Scenario 2	54,345	250	80	1	106	58	34	0
Scenario 3	2,639	21	7	0	106	58	34	0
Scenario 4	58,851	241	77	1	106	58	34	0
Scenario 5	45,773	192	62	3	106	58	34	0
Scenario 6	45,773	192	62	1	53	29	17	0
Males only								
Scenario 1	44,790	203	67	1	179	98	57	0
Scenario 2	54,345	250	82	1	179	98	57	0
Scenario 3	2,639	21	7	0	179	98	57	0
Scenario 4	57,857	254	83	1	179	98	57	0
Scenario 5	44,790	203	67	3	179	98	57	0
Scenario 6	44,790	203	67	1	89	49	29	0
Females only								
Scenario 1	45,063	172	54	1	32	18	10	0
Scenario 2	54,345	250	78	2	32	18	10	0
Scenario 3	2,639	21	7	0	32	18	10	0
Scenario 4	57,938	215	67	2	32	18	10	0
Scenario 5	45,063	172	54	4	32	18	10	0
Scenario 6	45,063	172	54	1	16	9	5	0

Scenario 1: COVID-19 incidence as of September 11, 2021, VE 70% vs. COVID-19 cases and 80% vs. COVID-19 hospitalization.
Scenario 2: COVID-19 incidence at peak of U.S. Delta variant surge at end of August 2021, VE 70% vs. COVID-19 cases and 80% vs. COVID-19 hospitalization.
Scenario 3: COVID-19 incidence as of nadir in June 2021, VE 70% vs. COVID-19 cases and 80% vs. COVID-19 hospitalization.
Scenario 4: COVID-19 incidence as of September 11, 2021, VE 90% vs. COVID-19 cases and 100% vs. COVID-19 hospitalization.
Scenario 5: COVID-19 case incidence as of September 11, 2021, VE 70% vs. COVID-19 cases and 80% vs. COVID-19 hospitalization, COVID-19 death rate 300% that of Scenario 1.
Scenario 6: COVID-19 incidence as of September 11, 2021, VE 70% vs. COVID-19 cases and 80% vs. COVID-19 hospitalization, excess myocarditis cases 50% of Scenario 1.

Afterward, an Israeli study¹¹⁰ observed that 30 days after the second vaccine dose a rate ratio of 1 in 6637 in male recipients between the ages of 16 and 19 years. Furthermore, a huge British study¹¹¹ released in late December 2021, showed that the risk of myocarditis almost

¹⁰⁹ For a clear link between Covid vaccination and myocarditis, see this study:
<https://jamanetwork.com/journals/jamacardiology/fullarticle/2791253?guestAccessKey=b76ffbb1-d5c4-4f00-add1-a30d0dce45e7>

¹¹⁰ <https://www.nejm.org/doi/full/10.1056/NEJMoa2109730>

¹¹¹ <https://www.medrxiv.org/content/10.1101/2021.12.23.21268276v1.full.pdf>

doubled after the first Pfizer shot in men under 40. It then doubled again after the second and doubled again after the third shot. That's almost eight times the baseline risk.

The Mayo Clinic said, "severe myocarditis weakens your heart so that the rest of your body doesn't get enough blood. Clots can form in your heart, leading to a stroke or heart attack."¹¹² Likewise, a study published in the Journal of Cardiovascular Magnetic Resonance claims, "the mortality rate is up to 20% at 6.5 years."¹¹³

Remember when the powers-that-be tried to promote the belief you were more likely to get myocarditis/pericarditis from Covid? A recent study¹¹⁴ published in the Journal of Clinical Medicine looked at the incidence of myocarditis and pericarditis in post Covid unvaccinated patients. It was undertaken by the University of Jerusalem and Tel Aviv University and looked at 213,624 adult patients who had a documented positive Covid test. 16,632 patients with a vaccination received before Covid infection were excluded, leaving 196,992 patients versus 590,976 in the control group. The control group consisted of patients with one or more negative Covid tests and no vaccination.

When the authors looked at the results of their study, they concluded that there was "no statistical difference in the incidence rate of both myocarditis and pericarditis...between the COVID-19 cohort and the control cohort" Covid did not increase the risk of myocarditis or pericarditis when compared with those who did not get Covid.

¹¹² <https://test.kcms.mayoclinic.org/diseases-conditions/myocarditis/symptoms-causes/syc-20352539?p=1>

¹¹³ <https://jcmr-online.biomedcentral.com/articles/10.1186/1532-429X-13-S1-M7>

¹¹⁴ <https://www.mdpi.com/2077-0383/11/8/2219>

Is Pfizer overlooking the seriousness of myocarditis? ¹¹⁵

Oddly, the CDC Director claimed none of these complications even exist. On Dec. 10, 2021, she told ABC News that the CDC had seen no adverse events among vaccine recipients, and denied seeing any cases of myocarditis among vaccinated kids between 5 and 11.¹¹⁶ On that same day, data released by her agency showed the CDC was aware of at least eight cases of myocarditis¹¹⁷ within that age group, making her statement demonstrably false.

Back during the 1960s, the United States switched from Salk's to Sabin's Polio vaccine. Sabin's vaccine was more attractive for several reasons, primarily because it protected 100% of children from polio. In comparison, Salk's protected about 80% of those inoculated. Sabin's also protected people who were in contact with vaccinated children even though they hadn't been immunized, a phenomenon known as "contact immunity".

However, shortly after switching between vaccines, it was learned that Sabin's shot was capable of paralyzing people after passing through immunized children's intestines. Fifty-seven cases of paralysis occurred following Sabin's vaccine. Although paralysis caused by natural polio virus was eliminated by Sabin's vaccine, paralysis caused by Sabin's vaccine wasn't. Every year between 1980 and 1996 in the U.S., six to eight children were paralyzed by Sabin's vaccine viruses.

What level of harm or death from a vaccine is acceptable?

In the late 1970s, Jonas Salk pleaded for the government to switch back to his vaccine. He argued that no cases of paralysis caused by a polio vaccine "*should be regarded as acceptable if*

¹¹⁵ <https://www.nature.com/articles/s41467-022-31401-5>

¹¹⁶ <https://abcnews.go.com/Health/cdc-director-rochelle-walensky-concerns-myocarditis-million-children/story?id=81659883>

¹¹⁷ <https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2021-12-16/05-COVID-Su-508.pdf>

avoidable.” The United States eventually switched back to Jonas Salk’s vaccine, but during the interim, Sabin’s vaccine caused another 8 to 10 polio cases annually. In 1998, the Advisory Committee for Immunization Practices—the principal body advising the federal government about vaccine use—recommended to the CDC that children use Salk’s vaccine exclusively, and now Sabin’s polio vaccine is no longer available in the United States.¹¹⁸ Likewise, if zero Covid is a target, and similar safety levels are the goal then obviously Pfizer’s vaccine is way out of line.

Strangely, agencies that are currently calling the shots do not have the authority to dictate how medicine is practiced. The FDA, for example, has no power to tell doctors what to do or how to treat patients. The NIH is a government research organization and cannot tell doctors how to treat patients. Likewise, the CDC is an epidemiologic analysis organization. It is the job of practicing doctors to identify appropriate and effective treatment protocols.

Yet the CDC which was founded in 1946 as a quasi-governmental agency with a negligible budget and a handful of employees and tasked with a simple mission of preventing malaria from spreading across the nation. Seventy-five years later it has metastasized into a multi-billion-dollar bureaucratic behemoth that oversees and controls virtually all aspects of public health programs, policies, and practices and is currently attempting to insert itself between you and your doctor.

Throughout, the mantra has always been to follow the “science,” as if scientists were imbued with a magical ability to discern and pronounce absolute truth. When vaccine effectiveness quickly started to wane, the trope was surpassed by claims that the variants caused the science to change. While it’s acknowledged that science is rarely settled before more-recent discoveries alter previous ones, the vaccines from the start were inaccurately promoted as sterilizing, capable of preventing infection, serious illness and death. Misrepresentations were made not because the science was necessarily wrong, but rather because the science was being willfully

¹¹⁸ Offit, P, *The Cutter Incident*, Yale University Press, 2005, pg. 127.

ignored. Truth was no longer the standard, and the burden of proof level was lowered by the participants.

Science is a process, not an institution, and it's ultimately a process we derive conclusions from, not necessarily absolute truths. However, anytime you hear universally absolute statements like, "the science is settled," you know we're dealing with a cult, and not science. It became clear early during vaccine deployment, that questioning the so-called-science in an attempt to strengthen the truth would be summarily subjugated for political purposes. Throughout the pandemic, the CDC—whose leader was a political appointee—and other health agencies have promoted inconsistent policies and recommendations. Many Americans who voiced concerns about these shifting policies have been subjected to ridicule, vilification and censorship.

In their exuberance to suppress every contrary message, media entities like Twitter even place censor warnings on the Journal of the American Medical Association (JAMA). In this example, JAMA published data showing rapid waning of COVID vaccines in children. The JAMA case-negative control study found Pfizer vaccine effectiveness against symptomatic infection in children age 12 to 15 dropped to zero in 4 months and went negative (vaccinated are more likely to have symptomatic infection than unvaccinated) at 7 months. The innocent tweet received the following warning:

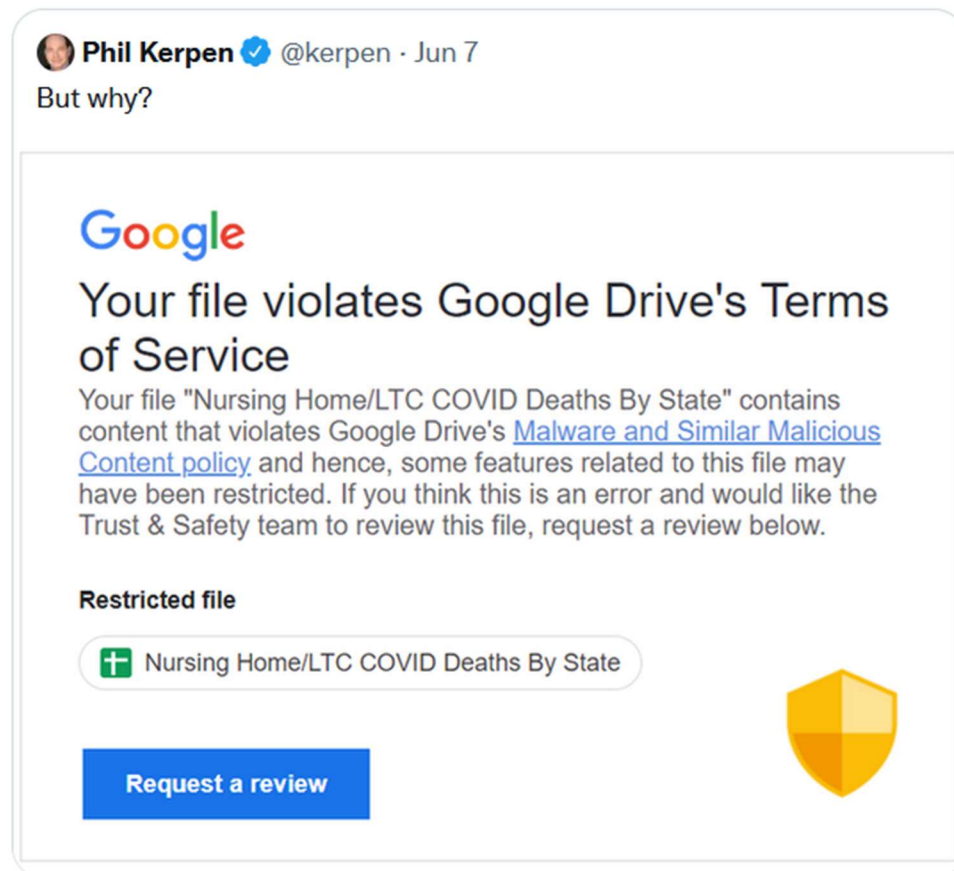
Warning: this link may be unsafe

<https://jamanetwork.com/journals/jama/fullarticle/2792524>

The link you are trying to access has been identified by Twitter or our partners as being potentially spammy or unsafe, in accordance with Twitter's [URL Policy](#). This link could fall into any of the below categories:

- malicious links that could steal personal information or harm electronic devices
- spammy links that mislead people or disrupt their experience
- violent or misleading content that could lead to real-world harm
- certain categories of content that, if posted directly on Twitter, are a violation of the [Twitter Rules](#)

Even raw data were suppressed:



Is this evidence that the vaccine advocates are more cult-like than professionals?

One of the great ironies of this pandemic is that the people most exercised about the spread of false information are frequently the peddlers of it. Fact-checking throughout the pandemic has primarily been an easy way for one side to lend peremptory authority to badly argued opinions and to undermine defensible arguments as “false” or “mostly false” or “lacking context.” In many instances these allegedly scrupulous fact-checkers would count true statements “false”

even as they conceded the statements were true. Their complete lack of self-understanding arises from the belief that the primary factor separating them from the other side is that the raw data requires no interpretation and no argument over its importance. There is a huge distinction between disagreeing with the opinion of an expert, and fact-checking that person as “wrong.”

In an interview on March 3, 2022, at the Washington University in St. Louis, Dr. Walensky, the CDC director admitted her ignorance of science by stating, “I can tell you where I was when the CNN feed came that it was 95% effective, the vaccine. So many of us wanted to be hopeful, so many of us wanted to say, okay, this is our ticket out, right, now we’re done. So, I think we had perhaps too little caution and too much optimism for some good things that came our way.”¹¹⁹ Her statement epitomizes the antithesis of science as a place where theory trumps evidence. Science requires people to be certain of something because of proof and verification, and to discount bad reasoning and not rely on optimism.

In the middle of the pandemic, the CDC changed its definition of a vaccine. And while many think this was just a simple updating of the facts, what the CDC did was align the definition with the characteristics of the mRNA vaccines which do not provide immunity. What you may not know, is other CDC deceptions are slowly being altered to align with reality to hide their flagrant ineptness. A previous version of a CDC webpage¹²⁰ about the vaccines (archived version from July 22, 2022) claimed the vaccines “do not affect or interact with our DNA **in any way.**” The CDC webpage went on further stating, “**That mRNA and the spike protein don’t last long in the body.**” And that “**Our cells break down the mRNA and get rid of it within a few days after vaccination.**” My emphasis added. Now, it’s as if they never said this.

¹¹⁹ Video recording of the interview located at: <https://infectiousdiseases.wustl.edu/dr-rochelle-walensky-cdc-director-2022-gerald-medoff-visiting-professor/>

¹²⁰ <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines/mrna.html>

Does it shock you that the CDC has removed these statements from their website?

Facts About COVID-19 mRNA Vaccines

COVID-19 mRNA vaccines cannot give someone the virus that causes COVID-19 or other viruses.

- mRNA vaccines do not use the live virus that causes COVID-19 and cannot cause infection with the virus that causes COVID-19 or other viruses.

They do not affect or interact with our DNA in any way.

- mRNA never enters the nucleus of the cell where our DNA (genetic material) is located, so it cannot change or influence our genes.

The mRNA and the spike protein don't last long in the body.

- Our cells break down mRNA and get rid of it within a few days after vaccination.
- Scientists estimate that the spike protein, like other proteins our bodies create, may stay in the body for up to a few weeks.

Previous version of CDC website.

Facts About mRNA COVID-19 Vaccines

mRNA COVID-19 vaccines cannot give someone COVID-19 or other illnesses.

- mRNA vaccines do **not** use any live virus.
- mRNA vaccines **cannot** cause infection with the virus that causes COVID-19 or other viruses.

They do not affect or interact with our DNA.

- mRNA from these vaccines do **not** enter the nucleus of the cell where our DNA (genetic material) is located, so it cannot change or influence our genes.

New version of CDC website.

Recently, Walensky started pushing for more vaccine doses in 12 to 15-year-olds, against the advice of the FDA advisory committee and WHO guidance. When it comes to vaccination, the CDC has a single policy; all Americans should get three doses, regardless of age or medical conditions. This is not science as such, but science as political propaganda. If that sounds like an exaggeration, consider the CDC's near-total dismissal of natural immunity. Many other countries consider recovery from prior infection as a vaccination equivalent or better. All this, while keeping key Covid data cloistered and hidden from the public.¹²¹ It is left to the reader to draw the line between hiding critical data and supplying fraudulent data.

Exactly who is anti-science?

In October 2021, Pfizer announced the results from their Phase 3 randomized, controlled trial evaluating the efficacy and safety of a booster dose. Pfizer claimed the trial showed vaccine efficacy of 95.6% for a boosted individual.¹²² Pfizer has chosen not to release the trial report, and the CDC has only published selective bits overwhelmingly in support of boosters. However, a curious aspect emerges when the public results of the booster trial are related to the earlier initial trial. Most notably, the incidence rate of symptomatic Covid among the vaccinated people with no booster in the second trial is more than 40% higher than the rate among the unvaccinated in the early trial.¹²³ Either Pfizer's numbers don't add up, or something is seriously wrong with their vaccine.

Or is it both?

¹²¹ <https://www.nytimes.com/2022/02/20/health/covid-cdc-data.html>

¹²² <https://www.pfizer.com/news/press-release/press-release-detail/pfizer-and-biontech-announce-phase-3-trial-data-showing>

¹²³ <https://www.bmj.com/content/375/bmj.n2814/rr-0>

Evidence-based medicine has been corrupted by governments, hospitalists, academia, big pharma, tech, and social media. But just don't take my word for it.

“Drugs are tested by the people who manufacture them, in poorly designed trials, on hopelessly small numbers of weird, unrepresentative patients, and analysed using techniques which are flawed by design, in such a way that they exaggerate the benefits of treatments. Unsurprisingly, these trials tend to produce results that favour the manufacturer. When trials throw up results that companies don't like, they are perfectly entitled to hide them from doctors and patients, so we only ever see a distorted picture of any drug's true effects. Regulators see most of the trial data, but only from early on in a drug's life, and even then they don't give this data to doctors or patients, or even to other parts of government. This distorted evidence is then communicated and applied in a distorted fashion.... And finally, academic papers, which everyone thinks of as objective, are often covertly planned and written by people who work directly for the companies, without disclosure. Sometimes whole academic journals are even owned outright by one drug company. Aside from all this, for several of the most important and enduring problems in medicine, we have no idea what the best treatment is, because its not in anyones financial interest to conduct any trials at all.” ¹²⁴

And:

“The release into the public domain of previously confidential pharmaceutical industry documents has given the medical community valuable insight into the degree to which

¹²⁴ This quote is from the introduction to Ben Goldacre's book, written pre-pandemic in 2012. Ben is a self-described “doctor, researcher, author, Bad Science person,” who is very outspoken in his support of the covid vaccines. Goldacre, Ben, *Bad Pharma-How Drug Companies Mislead Doctors and Harm Patients*, Faber and Faber, 2012, pg. x.

industry sponsored clinical trials are misrepresented. Until this problem is corrected, evidence based medicine will remain an illusion.” ¹²⁵ ¹²⁶

And, how about a former editor-in-chief of the New England Journal of Medicine:

“It is simply no longer possible to believe much of the clinical research that is published, or to rely on the judgment of trusted physicians or authoritative medical guidelines. I take no pleasure in this conclusion, which I reached slowly and reluctantly over my two decades as editor of The New England Journal of Medicine.” ¹²⁷

And finally, Richard Horton, editor-in-chief of The Lancet:

“The case against science is straightforward: much of the scientific literature, perhaps half, may simply be untrue. Afflicted by studies with small sample sizes, tiny effects, invalid exploratory analyses, and flagrant conflicts of interest, together with an obsession for pursuing fashionable trends of dubious importance, science has taken a turn towards darkness.” ¹²⁸

As the US approaches the 1 million-mark in deaths, it is clear that the response to the pandemic has been tragically flawed. Public health officials have sown fear and earned distrust. From nearly the beginning of the pandemic, we were told that the only way out was via vaccination.

¹²⁵ <https://www.bmj.com/content/376/bmj.o702>

¹²⁶ For another perspective see Marcia Angell, MD, (former editor-in-chief of the *New England Journal of Medicine*), *Drug Companies & Doctors: A Story of Corruption*.

¹²⁷ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4572812/>

¹²⁸ Horton R. Offline: What is medicine’s 5 sigma? *The Lancet*. 2015. www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736%2815%2960696-1.pdf

Vaccines were rapidly developed and their emergency use was quickly adopted worldwide. They were pushed via vaccine drives and clinics, and before long boosters became part of the scenario. Then came the mandates, even for people who had acquired natural immunity, followed by vaccination of children. Meanwhile, the silencing of any negative information about vaccines, including vaccine safety, continued. The combination of devious testing by Pfizer, promotion by the government, and enthusiastic endorsement by the media created an illusion of certainty.

According to CDC data¹²⁹, more than 1 million excess deaths above the historical average have been recorded since the pandemic began. This excess cannot be explained by Covid alone, with deaths from heart disease, diabetes, high blood pressure, dementia and many other illnesses increasing during this time also.¹³⁰ “We’ve never seen anything like it,” Robert Anderson, CDC’s head of mortality statistics told The Washington Post in mid-February, 2022.¹³¹ According to University of Warwick researchers, “the scale of excess non-Covid deaths is large enough for it to be seen as its own pandemic.”¹³² A number of explanations have been offered, including a theory that lockdowns and other restrictions discouraged or prevented people from seeking care.

But is it possible that a least discussed factor is at play? Worldwide, death rates have risen in tandem with Covid vaccine administration, and the troubling part is the most-vaccinated areas surpass the least-vaccinated in terms of excess mortality and Covid-related deaths. All of this is

¹²⁹ https://www.cdc.gov/nchs/nvss/vsrr/covid19/excess_deaths.htm

¹³⁰ <https://www.marketwatch.com/story/u-s-excess-death-toll-has-climbed-above-one-million-during-the-pandemic-weve-never-seen-anything-like-it-says-cdc-official-11645025606?mod=home-page>

¹³¹ <https://www.washingtonpost.com/health/2022/02/15/1-million-excess-deaths-in-pandemic/>

¹³² <https://journals.sagepub.com/doi/full/10.1177/23210222211046412>

highly suggestive that the official claim of the shots preventing severe Covid infection and lowering one's risk of death, be it from any cause is a false narrative.¹³³

Consider the positive bias given a trial published in a high-impact scientific journal. These journals are designed to influence the media and result in a recommendation of the drug by our health agencies. Further, only a small minority of physicians read and think critically about the full study manuscript. Even less read the full abstract, while the overwhelming majority simply read the abstract's conclusion. In this manner, a published study baselessly and erroneously convinces the vast majority of doctors and citizens that the vaccine is safe and effective. What should occur is next is a consultation between the patient and his physician about the best treatment for the individual. However, in the Covid vaccine trial-to-market experience, all types of additional entities intervened. All arms of the government compelled its citizens and even attempted to force the inoculation in many cases. Employers demanded it. Businesses stipulated it. The media relentlessly hounded everyone with incessant pressure.

By now, it should be abundantly clear that there is insufficient scientific or medical basis for these vaccines preventing anyone from either getting Covid or transmitting it to others. In an interview, Bill Gates comes close to summing up the failure of the process we followed, "We didn't have vaccines that block transmission. We got vaccines that help you with your health, but they only slightly reduce the transmission. We need new ways of doing vaccines."¹³⁴ He speaks of medicine as if it were software. Create a mixture, try it, observe how it works, then debug the problems. Every new version is an experiment and eventually over time, he hopes to find the answer to the problem of blotting out pathogens. Do take note however, that you are the guinea pig in this experiment.

¹³³ <https://www.cdc.gov/mmwr/volumes/70/wr/mm7043e2.htm>

¹³⁴ Policy Exchange interview conducted by Jeremy Hunt MP, Chair of the UK Health Select Committee. <https://www.youtube.com/watch?v=CZplF4qdwII>

But not only doesn't the vaccine fail in preventing the infected from transmitting Covid, a new study published in the New England Journal of Medicine showed that people vaccinated remained contagious with the virus for a longer period of time than the unvaccinated.¹³⁵ The study was a critical response to the CDC's recent recommendation shortening the isolation period for infected persons from ten to five days. The study claims that within the first ten days of contracting the virus 69% of unvaccinated subjects were no longer contagious. In contrast, just 30% of vaccinated and 38% of boosted people were no longer contagious. Therefore, the vaccine is providing no direct public health benefit. None.

Did your understaffed community hospital ever become overwhelmed?

Vaccine use is truly a personnel-care issue, that at best may moderate the effects of Covid in an individual. Yet, all along it has been all about vaccines, and less about the disease.

Simply put, the vaccine was not effective at preventing infection, replication, and transmission of the virus. This was known to Pfizer, the CDC and the FDA prior to emergency authorization of the vaccines. The clinical trials were not designed to assess whether the genetic vaccines could enable herd immunity. Herd immunity would be impossible to achieve through the use of these vaccines since it requires a product that can block or seriously reduce transmissibility of the pathogen.

Dr. Deborah Birx was the response coordinator for the White House Coronavirus Task Force in 2020. In testimony before the House select subcommittee on the coronavirus crisis, she was asked the question; "When the government told us that the vaccinated couldn't be

¹³⁵ <https://www.nejm.org/doi/full/10.1056/NEJMc2202092>

transmitted, was that a lie? Or was that a guess? Or is it the same answer?” To which Dr. Birx responded, “I think they were hoping, but you should know in those original phase three trials that were done in this country, that we only measured for symptomatic disease...”¹³⁶

The Tenth Amendment to the U.S. Constitution states: “The powers not delegated to the United States by the Constitution, nor prohibited by it to the states, are reserved to the States respectively, or to the people.”¹³⁷ The Constitution does not mention regulation of public health or medical practice as a federal government role or responsibility and therefore the right to manage public health and medical practice vests with the states and not with unelected federal bureaucrats.

Suffice it to say, *hope* concerning effectiveness of a vaccine using previously untested genetic modification technology is not sufficient justification for federal action to block early treatment options, mandate administration of unlicensed Emergency Use authorized vaccine product candidate to all members of the US Military, airline personnel, federal employees, contractors, and hospital employees, and attempt to mandate administration to private sector employees. There is no clause concerning *hope* as an indicator of efficacy or effectiveness in the Emergency Use Authorization statute 21 U.S. Code 360bbb-3.

And finally, when the vaccine proponents contend that in the U.K. the vaccines saved between 395,000 and 1.1 million lives up to the end of 2021, they make absolutely no sense. A recent study published in the Lancet¹³⁸ makes just those incredulous claims. But consider that up to the end of 2021 the official U.K. Covid death toll stood at 149,000, of which 74,000 occurred in 2020 before the vaccines were rolled out, and 127,000 occurred before March 2021, when few

¹³⁶ <https://coronavirus.house.gov/subcommittee-activity/hearings/hearing-trump-white-house-coronavirus-response-coordinator-dr-deborah>

¹³⁷ <https://constitution.congress.gov/constitution/amendment-10/>

¹³⁸ [https://www.thelancet.com/journals/laninf/article/PIIS1473-3099\(22\)00320-6/fulltext](https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(22)00320-6/fulltext)

were fully vaccinated. Then it stretches credulity to the breaking point to suppose that post-vaccine there were between 395,000 to 1.1 million deaths averted, particularly when in the prior 12 months without vaccines there were only between 74,000 and 127,000 Covid deaths. The vaccine camp clearly is making things up trying to cover their tracks.

Do you find their desperation trying to make the vaccines appear as if they worked laughable?

This brings us to the final question. How do you get more than a billion people to take an unapproved medical product? You employ the same method Hitler and the Nazis¹³⁹ did in the Holocaust to systematically kill more than 6 million European Jews and 5 million non-Jews before and during World War II. ¹⁴⁰

Hide the truth from them. ¹⁴¹

¹³⁹ There. I invoked Godwin's Law. See: https://en.wikipedia.org/wiki/Godwin's_Law

¹⁴⁰ Andrews, Andy, How Do You Kill 11-Million People? Why the Truth Matters More Than You Think, Thomas Nelson, 2012.

¹⁴¹ "For more than a year, the Centers for Disease Control and Prevention has collected data on hospitalizations for Covid-19 in the United States and broken it down by age, race and vaccination status. But it has not made most of the information public.", <https://www.nytimes.com/2022/02/20/health/covid-cdc-data.html>