Doctor Robert Malone

Inventor of mRNA Vaccines

SPEAKS OUT

COVID
REVEALED

Introduction

When it comes to vaccines, Dr. Robert Malone is a true believer. His career has revolved around the research and development of vaccines and vaccine technology.

As such, his knowledge of the extent of work it takes to bring a vaccine or new medical technology to market is unparalleled. He possesses in-depth knowledge spanning from the ethics to the technicalities of these processes.

At what point does a man like Dr. Malone wave the red flag of warning and speak out against what he has worked on his whole career?

Simply put, he feels compelled to do so when it is clear to him that his work is being improperly used. His deep commitment to ethics and the Hippocratic Oath compel his actions, and he fears that a technology is being widely disseminated that is not yet ready for prime time.

Dr. Malone's story is best told in his own words. Be sure to catch the entirety of his compelling interview with Dr. Patrick Gentempo in Covid Revealed.

Who is Doctor Robert Malone?

Dr. Malone is the discoverer of in-vitro and in-vivo RNA transfection and the inventor of mRNA vaccines, while he was at the Salk Institute in 1988. His research was continued at Vical in 1989, where the first in-vivo mammalian experiments were designed by him.

The mRNA, constructs, reagents were developed at the Salk institute and Vical by Dr. Malone. The initial patent disclosures were written by Dr. Malone in 1988-1989. Dr. Malone was also an inventor of DNA vaccines in 1988 and 1989. This work results in over 10 patents and numerous publications, yielding about 7000 citations for this work.

Dr. Malone has extensive research and development experience in the areas of pre-clinical discovery research, clinical trials, vaccines, gene therapy, bio-defense, and immunology. He has over twenty years of management and leadership experience in academia, pharmaceutical, and biotechnology industries, as well as in governmental and non-governmental organizations.

Dr. Malone specializes in clinical research, medical affairs, regulatory affairs, project management, proposal management (large grants and contracts), vaccines, and biodefense. This includes writing, developing, reviewing and managing vaccine, bio-threat, and biologics clinical trials and clinical development strategies.

He has been involved in developing, designing, and providing oversight of approximately forty phase 1 clinical trials and twenty phase 2 clinical trials, as well as five phase 3 clinical trials. He has served as medical director/medical monitor on approximately forty phase 1 clinical trials, and on twenty phase 2 clinical trials, including those run at vaccine-focused Clinical Research Organizations. His proposal development work has yielded clients billions of dollars.

Scientifically trained at UC Davis, UC San Diego, and at the Salk Institute's Molecular Biology and Virology laboratories, Dr. Malone is an internationally recognized scientist (virology, immunology, molecular biology) and is known as one of the original inventors of mRNA vaccination and DNA Vaccination.

His discoveries in mRNA nonviral delivery systems are considered the key to the current COVID-19 vaccine strategies. Dr. Malone holds numerous fundamental domestic and foreign patents in the fields of gene delivery, delivery formulations, and vaccines.

He received his medical training at Northwestern University (MD) and Harvard University (Clinical Research Post Graduate) medical school, and in Pathology at UC Davis.

Dr. Malone has close to 100 peer-reviewed publications and published abstracts and has over 11,477 citations of his peer-reviewed publications, as verified by Google Scholar. His Google Scholar ranking is “outstanding” for impact factors. He has been an invited speaker at over 50 conferences, has chaired numerous conferences and he has sat on or served as chairperson on numerous NIAID and DoD study sections.

Visit him at his website: https://www.rwmalonemd.com/

This Bio can be found online at:
https://www.rwmalonemd.com/about-us

His CV can be viewed on LinkdIn at:
https://www.rwmalonemd.com/s/RWM-CV-22-July-2021.pdf

The Interview

The following are highlights from Dr. Patrick Gentempo's riveting interview with Dr. Malone. Don't miss COVID Revealed to catch every fascinating minute.

Dr. Patrick Gentempo: since your voice is contrary to what seems to be the agenda around this, they want to discredit you and they're trying to find ways to do it. And you mentioned earlier that the Atlantic article... they published in the Atlantic and they were struggling trying to discredit you. But in my mind, I read it. I said, wow, they just very much validated his position here.

So now here we are. And suddenly all these years go by, nobody's ever heard of mRNA vaccines before. And one question I have around that incidentally is, cause there's even debate around whether this technically is a vaccine... you're saying, *Hey, you're injecting something that creates an immune response. It helps you resist disease.*

In that sense, it's a vaccine, but is there a separate FDA definition of vaccine that this would not meet, or in your mind, is this a vaccine?

Dr. Robert Malone: this is a gene therapy product, applied for the purpose of gene therapy technology, applied for the purpose of vaccination. Both of these are ad vectored in the mRNA. They are both fundamentally gene therapy technologies applied. One of the applications for these gene therapy technologies is for vaccination. Moderna and Pfizer's SEC reports explicitly acknowledged that these are gene therapy products and that the FDA at the time of those reports regulates them as gene therapy products.

So are they vaccines in my opinion? Yes, they are. They are intentionally devised and formulated and licensed or not

licensed yet. There have been packages submitted for requesting licensure for the purpose of vaccination, prophylactic vaccination. Vaccination has got a lot of different kinds of branches... we have cancer vaccines. We have prophylactic vaccines that are preventative. We have therapeutic vaccines that are meant to enhance your immune response against something that you've already got as a disease. And each of these has different regulatory considerations that have to be dealt with.

In the United States, you're seeking not only market authorization, but interstate commerce authorization because that's the purview that the FDA has. So you have to say what you want it to be used for. You have the latitude to define that in a lot of different ways - in these cases, they appear to primarily be prosecuting for disease and death as endpoints, not prevention of infection. So that's something that it's a nuance that you're not going to hear in the main press where it kind of matters.

Dr. Patrick Gentempo: It matters a great deal for two reasons. Number one, I think like you said, for what regulatory structure is applied to it. But number two, they don't try to assert that this vaccine that's out right now prevents you from getting to the disease or prevents you from spreading it necessarily.

Dr. Robert Malone: It's important to understand that I didn't just parachute into this with SARS-Cov 2. I've been doing multiple outbreaks. I was at the tip of the spear in bringing the Ebola vaccine forward and getting Merck engaged, et cetera.

And in this case, I got a call from a CIA officer that was in Wuhan in the fourth quarter of 2019, who alerted me on January 4th, that I needed to get my team spun up and start going because this virus looked like it was going to be a problem.

And I made a threat assessment, which is my usual practice. And I determined that based on what was known about Coronavirus vaccines and the difficulties associated with developing such, and the risk of antibody-dependent enhancement, and the timeline that's going to be required for the development of a safe and effective vaccine.

The only option that we had in the short term was to identify repurpose drugs and develop those for this indication where they can repurpose drugs. Repurpose drugs are ivermectin, hydroxychloroquine, famotidine, fluvoxamine, celecoxib. Dexamethasone is a repurposed drug. It was not originally licensed for this purpose.

And that's a whole nother rabbit hole we can go down is how we approach that and what we've been doing since, but I've been working on the repurpose drug indication. In fact, just last week, we finally got FDA clearance to proceed with our large randomized clinical trials, outpatient and inpatient, for testing the drug combination that I've been prosecuting and leading the group on, which is the combination of high dose of famotidine plus celecoxib. So I've been very sensitized and aware of everything that's going on, but not focusing on vaccines intentionally.

I got kind of drawn into this whole controversy because people were seeking answers. I didn't seek out this role of truth-teller or disambiguation wizard or whatever it is that I am these days... We've been focusing on repurposed drugs.

So, the vaccine story. I had made the assessment that there were too many risks and it was going to take too long and to my great surprise OWS happened, Operation Warp Speed.

ít's important to understand for your listenership, that Moderna was to a significant extent a failing company prior to this that had been launched largely with DARPA money.

Dr. Patrick Gentempo: DARPA is military...

Dr. Robert Malone: it's really kind of a branch of our intelligence service. DARPA are the people that actually did develop the internet ... and many other things. Their role is to be out on the edge, coming up with new tech. So DARPA in the United States had funded Moderna.

The German government had funded BioNTech, which is kind of interesting. Historically, if you remember, there was a time when the Trump administration was trying to buy out the

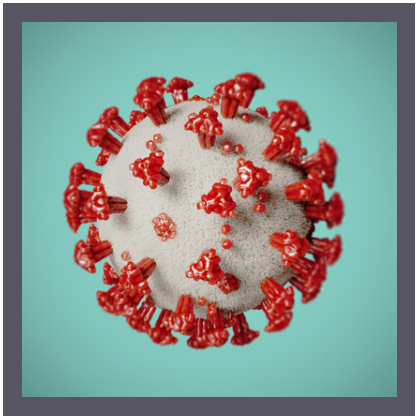
German company, BioNTech. BioNTech then licensed its product and technology to Pfizer. So really the Pfizer vaccine is the BioNTech vaccine and Pfizer and BioNTech made a conscious decision not to participate in accepting government dollars. And they didn't participate in OWS. It was Moderna.

So we have these, gene therapy products, and they were rushed and we were told that they weren't going to cut any corners, but they did.

I mean, you can't take, what's normally a decade-long process for developing a product, and ensuring its safety and efficacy, and compressing it into six to nine months and not cut some corners. That's just absurd. But yet that's what we were told they were doing.

Dr. Patrick Gentempo: So they're pre-authorized under emergency use... so there's an emergency. We're going to basically throw out the rule book... So you had safety concerns. What were the safety concerns you had?

Dr. Robert Malone: it goes back and I mentioned this, this is the first thing that I got fact-checked on by Reuters... I had an ongoing dialogue every other week with three other senior scientists at the FDA that are outside of the review branch. It's how DC works. We had kind of an ongoing dialogue of what's going on and what's going on with drug repurposing. And what do you think about ivermectin? And last fall as they were rushing these spike-based vaccines forward, I contacted them.



I was sensitized to the fact that spike was not biologically inert... Literature clearly demonstrated that there are two proteins in the SARS-1 virus, which directly activate the Cox-2 promoter to produce Cox-2. And then the arachidonic acid metabolites that are at the basis of some of the inflammatory cascade that happens that kind of kicks off, lights the fire. It's kind of the match that lights the fire that results in biologic response.

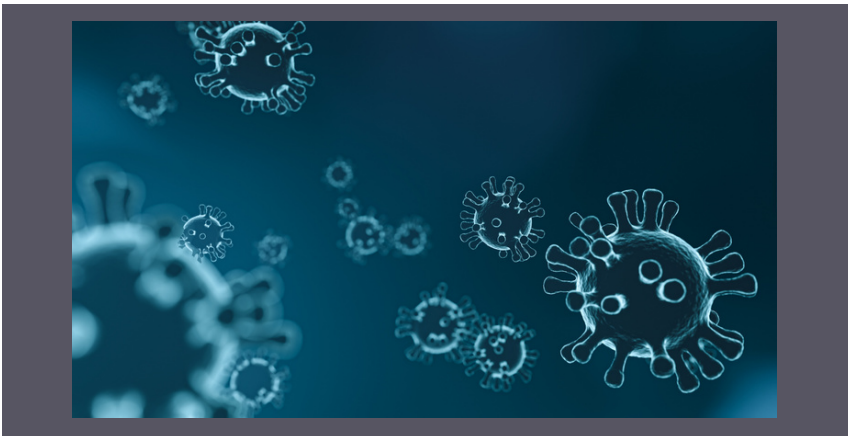
Again, I forgot to get back to a comment you made earlier - the virus doesn't cause the disease, it's your body's immune response against the virus.

So it's kind of an important thing to segregate is we have the prodrome, which is the viremia prodrome, and then we have the hyperinflammatory response that happens in a subset of patients. And that's the one that really puts you in the hospital and kills you.

The good news is there's a bunch of anti-inflammatory drugs that can be used for that second phase. And we've just gone over that list in part, right?

So I was aware that there are two proteins in one of those, two proteins that turn on Cox-2, which lights the fire in this whole thing. This is the spike protein on the outside of the

virus. So with any of these viruses, they're under incredible evolutionary pressure to pack as much functionality in each of their proteins as they can.



Protein is among those that have multiple functions. And one of these functions seems to be NF-kappa B mediated signaling. That turns on Cox-2.

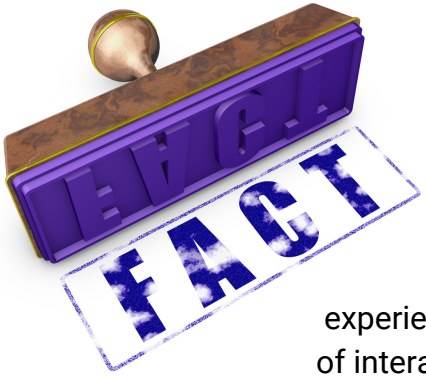
So I notified my colleagues at the FDA. I said, guys, you know, no one seems to be paying attention that spike has other activities. It's not biologically inert. It's not just a receptor-binding protein that binds ACE-2.

That alone would be enough because ACE-2 is an incredibly important protein for regulating all kinds of biological effects, not the least of which is blood pressure. So I let them know some of the papers, and what came back was,

well, we sent these over to the review department and they really don't think that they're significant enough to cause any concerns and any hesitation in proceeding with the development of these strategies.

I can't get into the brains of what goes on in the regulatory branch... Then the data came out more and more and more about spike and spike cytotoxicity. And so by the time that Bret Weinstein podcast rolls around, there was already the disclosure from the Salk Institute, for instance, that spike was directly cytotoxic - spike as produced by the virus.

So I made this statement, and Reuters fact-checked me and said, *no, no, you're wrong. Spike is not cytotoxic. The spike produced from the virus is cytotoxic, but not the spike produced from the vaccines.*



A lot of these fact-checkers do this little game where they'll take what you say and they'll twist it slightly, create a straw man, and then they'll refute the straw man. This has all been a big learning experience. I've never had this kind of interaction, you know, being fact-checked and attacked.

In fact, now there's more and more data that have flooded out that, that the spike protein does open the blood-brain barrier. It is directly cytotoxic. It does affect vascular endothelium spike.

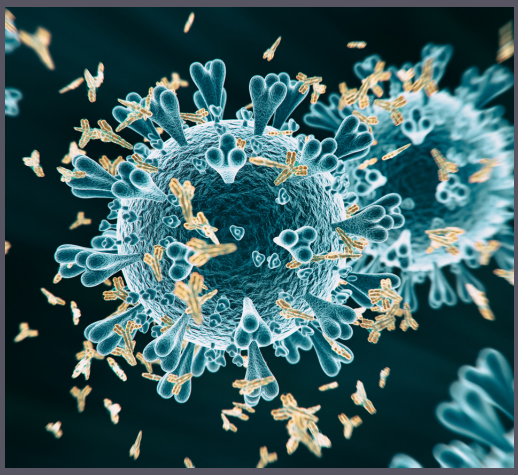
And then there was a series of statements made that, well, they knew this and they engineered the spike that they put into the vaccine so that it would be safe. This came out in the mainstream media as their reaction logic to what I had floated.

That's got an intrinsic flaw. I like to talk about the time machine. Okay, for them to have engineered spike back then when they were rushing this thing through in early 2020 would have required that they had foreshadowing of all of these spikes cytotoxicities that weren't discovered until almost a year later. A series of events happen in terms of molecular realignment in the structure of these proteins

that injects the genome of the virus into the cell, infects the cell, that's how that cascade happens...

So they engineered spike to stay open, so the pocket would be available. And that's not even what you really want antibodies against in the first place, if you want to get a good immune response against it, but that's what they did, but it had nothing to do with making it less toxic.

The rules are, and it's the job of the pharmaceutical company or the NIH since they engineered the modern vaccine, or whomever in your regulatory portfolio, before you ever go into humans, you got to prove that things aren't toxic.



I've never seen the documentation that shows that the engineered spike has been demonstrated to not have the known toxic biologic activities of the native spike to argue as the press does, and even the Salk Institute then kind of partially retracted and modified their statement. And they said, well, what we've claimed about direct cytotoxicity

associated with spike applies to the native spike, but it doesn't necessarily apply to the vaccine spike, but they don't actually do any studies to show that it doesn't apply.

And I try to live in the world of, do we have data, right? We shouldn't make assertions about is something safe or not safe. Well, unless we can demonstrate it, I mean, this is what you're supposed to do before you take it to market. You're supposed to before you even put it into humans.

Dr. Patrick Gentempo: I mean, this is what you're supposed to do before you take it to market.

Dr. Robert Malone: You're supposed to, before you even put it into humans.

Dr. Robert Malone: It binds to ACE 2. And ACE two is everywhere. It's in your vascular endothelial cells. It's all over the place.

Dr. Patrick Gentempo: Is this why myocarditis, pericarditis? And these other...

Dr. Robert Malone: That seems to be more of a coagulopathy. I think that's another problem. But yes, spike goes all over. And the amount that you detect as free protein is probably just a tiny fraction because it's in equilibrium with bound to ACE 2 protein, which is going to be a big sink.

And that's in equilibrium with a spike that hasn't been cut off of cells yet. No one's ever measured all this stuff, which gets into another one of the huge bear traps here in terms of what the FDA did.

If you could take the Pfizer dossier... from the Japanese government as face value for what they knew at the time when they moved this into humans in a big way, they didn't actually test the final drug product.

Dr. Robert Malone: They didn't actually use the final formulation you're supposed to use. Everything I've always been taught and what I've always thought we had to do - you have to use a near GMP or GMP manufactured, final product to do the pivotal toxicology tests of biodistribution, duration of expression, cell location, all this kind of stuff. They did none of that, but the governments just let them get away with comp.

It appears taking data off the shelf that they had developed for other purposes and kind of slammed it all together. And, you know, to bless it and off we go. As a consequence of that strategy and not insisting that the gene therapy checklist be applied, we have no real information about how much protein is being made, where it's being made, and for how long.

Dr. Patrick Gentempo: So we're flying blind in essence. Maybe it's the idea that we're going to just put it out in the world and then collect our data after we do it. I mean, it seems irresponsible.

Dr. Robert Malone: I concur. That's why I had made the threat assessment that we should focus on repurposed drugs because to do it right, is going to take a long time. And furthermore, to establish safety when there's this history of antibody-dependent enhancement.

And this history of autoimmune disease, and with vaccines in general, which often manifests over time, usually you need at least a year's data, usually two years data after you've administered to a very large number of patients, willingly accepting that participation in those clinical trials, not forced or enticed, and you have to follow them rigorously to make sure that they don't develop long-term adverse events like autoimmunity. So they just flushed all that.

In this case, the FDA basically gave the pharmaceutical companies a complete pass, and they said, we're not going to ask you to do anything in terms of safety follow-up... even though they said in their emergency authorization that antibody-dependent enhancement was a risk... It remains unresolved...they did nothing.

Dr. Patrick Gentempo: What is antibody-dependent enhancement?

Dr. Robert Malone: it's one of a spectrum of processes whereby a vaccine causes enhanced disease.

The hallmark of antibody-dependent enhancement in the context of this particular virus, when you think about it, is going to be increased levels of virus replication, that's the measurable thing. That's the answer. It's not the disease enhancement, it's the virus replication.

And what are we seeing with Delta? We're seeing levels of viral replication... But the studies are coming in even more now, the levels of virus being produced in the previously vaccinated with Delta in the infected subjects. So the breakthrough infections are at least as great as those that have not been vaccinated. And in some cases, there's evidence that they're higher.

Dr. Patrick Gentempo: So the reality is there's some evidence that maybe ADE is happening, and there's really not enough research to say that it wouldn't happen. You have to disqualify it saying that's a concern, right?

Dr. Robert Malone: the truth is in the FDA's own documents. And then in this recent correspondence that I saw from Janet Woodcock, the acting director when the FDA granted emergency use authorization to Pfizer in their summary document, they specifically said that antibody-dependent enhancement was a risk and known risk, and that it could not be evaluated based on the data that they had provided.

And they encouraged that such studies be performed in clinical studies, but they did not mandate those studies. I think that was another one of the major regulatory oversights of basically giving a major vaccine manufacturer pass. Why did they do that is speculation.

Dr. Patrick Gentempo: Let's talk about agenda. There's an, there was an agenda, an obvious agenda, an overt agenda to get these vaccines out.

Dr. Robert Malone: It was not subtle... it was stated government policy. There was a lot of messaging in the media that no shortcuts were taken, but it's self-evident that

a process that normally takes a decade, do it in a matter of months, there will be shortcuts taken. What's rolled out over time is the depth and breadth of those shortcuts is profound. Standard norms that would be implemented for any other vaccine in any other context that I've ever known were overlooked. And they had to do with safety. I haven't been into the data as deep as some people have in the clinical trials, but I hear again and again about oddities in those clinical trials and their interpretations, they were very abbreviated trials.

All the evidence is that we're getting recall immune responses against prior coronavirus infection. What does that mean? So what it means is - so we've all had... the common cold, these circulating Coronaviruses, and there's enough overlap in terms of the immune response that's generated against those with SARS-Cov2 that antibodies against those viruses and cellular immune SARS-Cov2 that antibodies

against those viruses, and cellular immune response against those viruses are provoked when you get infected or vaccinated with the COVID vaccines or infected by SARS-Cov2.

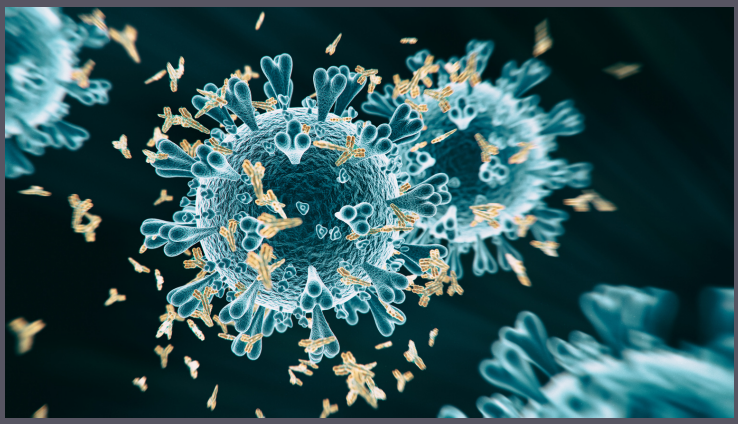
This is called a recall immune response. One of the practical consequences of this that really hasn't been adequately addressed right now... we heard all of this talk about neutralizing antibodies, neutralizing antibodies are not a correlate of protection. They haven't been proven to relate to anything relating to whether or not a vaccine will protect you.

I don't know if you recall all of that buzz that was happening about a year ago now, where we were hearing that this neutralizing titer was higher with this vaccine versus that vaccine... those neutralizing antibody responses were already known to be provoked as recall responses after infection, it's recalling a prior infection.

Dr. Patrick Gentempo: That's why they call it recall response, right?

Dr. Robert Malone: you're amplifying the reactive cells, B and T cells that were previously educated during the prior infection. And you're causing those to expand... when your

immune system is primed to respond in a certain way to a prior closely related infection, and it receives a signal from a new pathogen that's closely related, the immune response will be dominated by the reactive memory cells that were educated from the prior infection. And they will partially block the ability to develop new responses against the new pathogen.



And then these neutralization assays are the ability to block either a pseudovirus or a live virus in cell culture with a defined cultured cell line. That really is a long way away from whether or not it has anything to do with your body in the real state, in which you've got all of the things going on that are going on in your body. And the honest truth is the vaccinologists like to tell ourselves that we're so sophisticated and we've got all these great assays, a lot of them developed during the AIDS years. And if we take a good

hard look at ourselves in the mirror, the truth is that we're deceiving ourselves about a lot of that stuff. It's been more of the core problems is we've assumed that the assays that we've developed are measuring something that really matters.

And that's part of what prompted this monoclonal antibody excursion that I talked about, that did the mapping, was the discovery with Ebola, that a lot of the antibodies that are neutralizing don't work for beans.

They don't protect, and other antibodies that are non-neutralizing turned out to work really great. So it turns out that we were fooling ourselves and throwing away the baby with the bathwater probably for years and years and years because we convinced ourselves that we had an assay that related to protection. That's kind of what we had going on in the early days with this one.

Dr. Patrick Gentempo: Well, is it true now that also, maybe if I'm interpreting correctly, just because you have antibodies in the blood or so-called humoral immunity, that does not translate directly into cellular immunity.

Dr. Robert Malone: That's true... this is the T effector cells versus B cell antibody-driven responses... We always assumed that innate immune responses are innate immunity, This is our lizard brain version of the immunity, right?

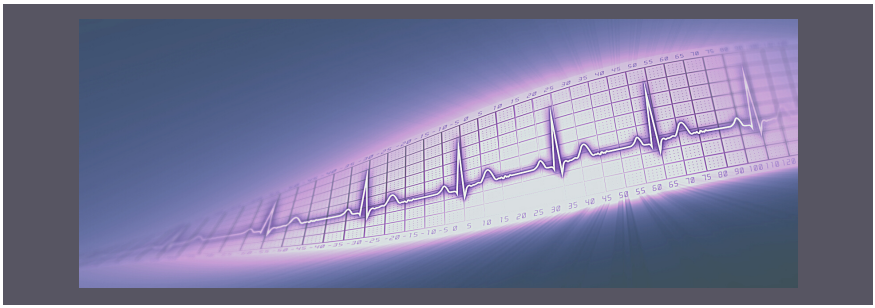
Now we have what are called PAMPs and DAMPS, so pathogen-associated molecular patterns and danger-associated molecular patterns, that we have detectors for. But we also have natural killer cells. And it turns out to my surprise and many others that in fact, the innate immune response is also adaptive.

So when we get a vaccination or you get an infection, you're not just tweaking the B-cell compartment, that's the antibody driven group or the T-cell compartment, which by the way, interacts with the B cell compartment, but is famously associated with cytotoxic T lymphocytes.

Whereas the antibodies mostly are about binding neutralizing antibodies, or there's some antibody-dependent cytotoxicity... so now this third arm that we thought was kind of passive and there has got an adaptive component. Now, when we talk about the problems with universal vaccination, remember what I just said to you.

Dr. Patrick Gentempo: One of the things that I think we can conclude from what you're saying... you're asserting that there's a possibility that there could be long-term chronic effects of this vaccine, that it hasn't been out there long enough to even know if we have that yet or not.

Dr. Robert Malone: Well, it's not just me fantasizing it. We now know that Guillain-Barre syndrome is a problem. That's an autoimmune disease... I was saying that cardiomyopathy was there. It was discovered by a biostatistician from Oracle, not paid by the FDA... that first found the signal of the cardiomyopathy and cardiotoxicity, they then notified the CDC.



So in the case of finding the cardiotoxicity signals in the adolescents - adolescents have almost no background cardiac events. And so it was easy to discern those data in the background, in the setting of no background signal. Does that mean that they aren't occurring in the adults? Talk to cardiologists, pathologists that looking at this. Of course they do, but they're not detecting the signal officially.

And yet, because of the decision by the FDA to not require prospective rigorous capture of adverse events, as well as other safety and efficacy signals during this emergency use authorization period, we're left arguing again and again, unprovable things about whether or not a given adverse event is occurring because the data are so horrible.

And what we have now is a situation in which docs can't talk about it. Patients can't disclose it on Facebook, right? There was the whole Facebook group that was set up for people who believed they had experienced adverse events, post-vaccination, that was deleted by Facebook.

So think about these poor souls. They're surrounded by their friends and neighbors and family members that all tell them that they're crazy, right? They couldn't possibly be experiencing this. And they go on their favorite social media site. And these days, if you say I experienced this adverse event, you're immediately blocked by Facebook. It goes no further. And back then there was a Facebook user group of many hundreds of people sharing their adverse events. And they all got deleted. This is like the ultimate gaslighting. You're told that you are crazy.

Dr. Robert Malone: I pulled up multiple peer-reviewed publications that say flat out that the method that the CDC is using to report risk right now is obsolete and inaccurate and not sensitive. And it's not the preferred method in the world of epidemiology, why'd they do that? It's one of these oddities that is sprinkled throughout this, where you just have to say it sure looks like somebody is attempting to minimize the signal here.

Dr. Patrick Gentempo: Well, the way they're reporting, it does enhance the sense that this is safe or how much protection it provides. So, because basically, they're saying that... it's 95% effective. They don't describe what effective is. And you know, what does that mean?

Dr. Robert Malone: Yeah. So they have defining effectiveness in those papers. That's another one of this nuance that I said, what they seem to be prosecuting is death and disease, not infectivity and transmissibility. And yet out of the other side of their mouth, and there's a quote from Gates directly that he believes that a vaccine that's 60% to 70% effective, will be sufficient for containing the outbreak. So this has been the party line. You have not been able to go against that party line.

So the reproductive coefficient for this vaccine has been such that you would have to have basically full saturation to

get even close to herd immunity at a 70% protective vaccine. And then the bomb dropped. And the bomb was the CDC slide deck that was released to the Washington Post, was leaked.

It's marked as confidential. So it was a ton of stuff. Just a ton of bombshell mic drop moments. One of them was that the reproduction coefficient for Delta is about the same as chickenpox by their own words and texts. That's an R0 of eight. And that for the alpha strain, it was 2.5. So it's about threefold more infectious. And in this is something that just blew the whole narrative apart.

We cannot stop the spread of Delta in the United States, even if we had a hundred percent vaccine uptake and full compliance with excellent mask use, you know, N-95, it's sealed all the way around every time you go out, and everybody else. That's even if we did all that, we could still not stop the spread of this.

Dr. Patrick Gentempo: So this is internal per the CDC, and they don't want anybody to know, but it leaked.

Dr. Robert Malone: But it leaked. And the press hasn't really examined it. Even the Washington Post in their one article about it, had an interesting statement that now the CDC is going to have to pivot from its messaging previously in full view of the public.

And they basically have disregarded it. They're not, you know. Is your, is your viewership aware of what I just said? Instead what we've heard is that the infections are all occurring in the unvaccinated, right? Yeah. That's a lie. I'm sorry. It's just a flat-out lie.

Joe public in good faith has accepted the vaccine and they bought the storyline that this vaccine is going to protect them. Now they're now out of the woods, they've taken risks. Most of them know there's some risk associated. At least now they know that there are some risks with vaccines, but they've accepted that risk.

They've done their good thing for their community because that's what they've been told to do. And they assumed that they were going to be protected. And now, boom, here comes the CDC slide deck. And it says, no, I'm sorry. You're not going to be protected from infection.

If you get infected, the levels of virus may be at least as high, if not higher, from what you would have had if you were not ever vaccinated. And if you are infected, it's not going to protect you from infecting your children or your grandmother or whomever else might be around you.

So it's not providing full protection from infection. It's not protecting you from virus replication. If you do get infected and it's not protecting you from infecting others.

Dr. Patrick Gentempo: Well, you know, for the people who said, I'm taking one for the team, you know, we'll help. That's a whole other conversation. They actually may be super spreaders.

Dr. Robert Malone: Yeah. Well put. Because they have less disease. So that's another one of the big lies now that's being chalked up.

Dr. Patrick Gentempo: So traditionally, with other infectious diseases, I mean, mumps, measles, what have you, you get the disease, you're going to have immunity for life, and then suddenly that's no longer true, or maybe it's not true, but we start to see that these lies are being propagated, or it's misinformation. Yet they're accusing everybody of what they do, which is the misinformation.

Is it absurd based on risk that we should be vaccinating kids right now and have the agenda to get all kids vaccinated?

To my reading of the data, and I disagree with the evaluation of the advisory committee that the CDC is relying on. To my eyes and that of many physicians and data scientists all over the world, the risk-benefit ratio, even if you only take into account the cardiomyopathy and pericarditis, is upside down.

The total deaths in the United States in infants through 18 is less than 400 since the beginning of the outbreak. And again, a Nature article has dived into those data and checked the pre-existing conditions for every one of those reports...

We're talking about infection-related deaths is less than 400 in that age cohort. And the number of children adversely affected according to VAERS with these cardiac damage events is in that same number or greater.

We know that VAERS grossly underreports adverse events, and that's only one of the many adverse events that occur, right? So that's just taking one tiny slice.

And when I look at those ratios, they're both small numbers, small numbers of kids that die and small numbers of kids that get these cardiac events. Now, I've spoken to pediatric cardiologists that suggest the numbers are far higher. Likewise, pathologists reporting about adults in Germany and the United States, even if we take that to face value, the risk in children is extremely low for hospitalization and death. And the risk from vaccine is not trivial.

Dr. Patrick Gentempo: Have you ever in your life and career seen this type of censorship where qualified experts are speaking about their view of things, giving expert opinion based on what's happening, and it's completely shut down?

And people are applauding the fact that the censorship is happening because they don't want to scare people or spook people away from getting the vaccine... That's the only thing that matters is that people get this vaccine.

Dr. Robert Malone: And that we get universal vaccination. No, it's unprecedented. I've never seen it. My peers have never seen it. There is in the federal register, honest to God, 1984.

There is a section that, speaking about polio vaccines, in which the federal government asserts that any information, whether true or not, which would cause a vaccine hesitancy is to be suppressed. So this is out there. It's documented, it's in US policy.

I assert that what we've got is 20th-century thinking about communication and information management, coupled with amazingly powerful 21st-century technology fueled by this cross horizontal integration of the pharmaceutical industry and the tech industry.

And media is able to enforce a narrative and they're doing it in a way that's never been possible before. So that's where we're at right now. There's a lot of scare going on and it drives people to want to accept authority.

I received phone calls asserting that I'm killing people by speaking out... So right now we have unlicensed products being provided under emergency use authorization. So therefore it is medical experimentation. I'm sorry. That's what it is. They're not approved products.

Final Thoughts

Censorship... informed consent... criticizing Dr. Fauci... taking on Big Pharma... Dr. Malone is ready to tackle all of these subjects and more. This book is only a taste of what he shared in his extensive interview, and we encourage you to watch every fascinating minute of it.

In recent years, people have tossed around references to Orwell's *1984*, perhaps a little too loosely. Because now that we are facing forced mass vaccination with dubious research to back it up, at the cost of our safety and livelihoods, it appears that 1984 has truly arrived.

But try to speak out about it and Big Brother is quick to censor you. Revealed Films continues to battle that censorship to bring this information to you, and we promise to keep up the fight.

The time to watch Covid Revealed - and share it with your friends - is now. Join us in sounding the alarm, before it's too late.

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