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The COVID Emergency as Autoimmune Disease

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Abstract

This article analyzes the United States biosecurity state's orchestration of the COVID-19 phenomenon into a public health emergency, tracing the legal platforms that made this mobilization possible. Leaning on the longstanding reverberations between political and biological discourses around immunology, I argue that the polis entered into a state of autoimmune disease where its public/private biosecurity organisms attacked its own body politic. COVID-19 constitutes the culmination of a development that had been in the making for several decades. Besides parsing the central legislative inventions that form the basis of this operation, the article analyzes the most central medical countermeasure deployed as the ostensible remedy to the public health emergency. A novel technological platform (mRNA transfection) is introduced as the solution to the threat of infection (falsely promising immunity). This platform is equally built on autoimmune logic, not traditional immunity. Unlike previous vaccine technologies, synthetic mRNA transfections coerce the body's cells to produce the antigen against which the immune reaction is mounted. The immune system will then attack those cells that express the antigen, the most publicly acknowledged example being myocarditis. The feedback loop between biological and political discourses on autoimmune disease has begun to restructure societies globally.

Keywords

autoimmune disease, COVID-19, biosecurity state, transfection, public health emergency

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> It is not surprising that for the virus one speaks of war. The emergency measures obligate us in fact to life in conditions of curfew. But a war with an invisible enemy that can lurk in every other person is the most absurd of wars. It is, in reality, a civil war. The enemy is not outside, it is within us.
> —Giorgio Agamben, quoted in Cynthia L. Haven,"Giorgio Agamben on Coronavirus: 'The Enemy Is Not Outside, It Is Within Us'""

> Today, America would be outraged if UN troops entered Los Angeles to restore order. Tomorrow they will be grateful! This is especially true if they were told that there were an outside threat from beyond, whether real or promulgated, that threatened our very existence. It is then that all peoples of the world will plead to deliver them from this evil. The one thing every man fears is the unknown. When presented with this scenario, individual rights will be willingly relinquished for the guarantee of their well-being granted to them by the World Government.
> —Henry A. Kissinger, at the 1991 Bilderberg Conference

> Americans live in a cavern of fear, a psychic, numbing force manufactured by the so-called entertainment industry, reified by the psychological industry, and buttressed by the coercion industry…The state's coercive apparatus of "public safety" is erected as a needed protective counterpoint.
> —Mumia Abu-Jamal, quoted in Dylan Rodríguez, "The Political Logic of the Non-profit Industrial Complex"

> The human body is mortal by nature. Hence illnesses are inevitable. Why does a man only go to the doctor when he is ill, and not when he is well? Because not only the illness, but even the doctor is an evil. Under constant medical tutelage, life would be regarded as an evil and the human body as an object for treatment by medical institutions. Is not death more desirable than life that is a mere preventive measure against death?
> —Karl Marx, "On Freedom of the Press"

Preliminaries

Many of the figureheads of the COVID-19 public health establishment are familiar faces from the AIDS epidemic. That medicine is an overtly political practice has again become abundantly clear since 2020. The nexus between politics and medicine that will be explored here more specifically is autoimmune disease, both as a metaphor for health emergency politics and as a bodily logic in relation to the COVID countermeasures. Autoimmune disease was initially denied by immunology for nearly half a century: "The idea of autoimmune disease—a

destructive reaction of the immune system against one or another of the body's own constituents—was unthinkable" (Mackay 2010, A252). The history of immunity and the "immune system" has a long political trajectory, never too far from political violence and war logics (Neocleous 2022, 58). To state my central contention upfront, it is useful to analyze the political and scientific events of the COVID crisis along immunological, and specifically autoimmunitary, lines: not only because of the longstanding entanglements of politics and immunology; not only because COVID emerged as an infectious disease and therefore an immunological problem; not only, further, because there is a special argument to be made about autoimmune disease and transfection (the gene technology employed in the majority of COVID "vaccines"); but mainly perhaps because the terror that governments and their emissaries have begun to visit upon their populations in the "free West" (much like the long-familiar state terror in many countries of the Global South and East) have turned to public health and biomedicine as their main vectors of implementation. Perhaps like in psychiatry, pharmaceutical substances and digital technologies have become the new straightjackets, superseding the classical biopolitical institution of the mad house. The more overt violence of classical biopolitics, which, in the name of safety, has sought to exert control and surveillance, and enforce compliance, is paradigmatically superseded by biomedical and high-tech procedures (Preciado 2012, 34).

The period between the emergence of the US federal public health response to the AIDS crisis in the early 1980s and the appearance of COVID in 2020 constitutes the historical moment in which the public/private apparatus of "pandemic emergency response" is built and refined along neoliberal lines, conjoining massive corporate interests with the centralization of political power. This is what I will call the *antibody industrial complex*, which has not only transformed the legal and political frameworks of the American polis over this period in question, but also bent a significant portion of immunology and virology to its purposes. Mark Neocleous recently summarized the tremendous paradox between security and lethal violence against the very body politic that securitization is meant to protect: "Sovereignty thrives on fictions, most notably the fiction of immunity. But it equally thrives on the fiction of security. Perhaps that is why security and immunity live and kill together, even to the extent of destroying the very body we think they are protecting" (2022, 30). We must understand the security/violence nexus to grasp how this system of health-based public safety operates. Like the infamous drug cartels (more overtly acting in countries where all semblance of the rule of law has already been eviscerated), the public-private health juncture (governments, corporations, philanthropist foundations) protects *and* oppresses. It protects those who do its bidding and annihilates those who defy it. It also protects *and* oppresses those who do its bidding in less conspicuous ways. In the name of security, its authoritarian goal is ultimately to convert constitutional rights into permissions that are granted rather

than guaranteed. Under the emergency provisions, the citizen is habituated to applying for permissions, exemptions, provisional freedoms *if available*. As such, the authoritarian state of emergency is of course all too familiar to populations in the Global South (a geographic designation linked to the history of colonialism and racism), but also to racialized and/or immigrant populations within the "free" West/North for whom constitutional rights were never a reality. This "uncontrollable search for security" (Neocleous 2022, 28) will be shown to be at the heart of how the system catapulted people into panic and compliance in 2020. Particularly the "middle managers" would have been driven by this security logic of their actions that implemented the countermeasures ("keeping people safe," "saving lives"), even if this cannot be true for the elites, lead scientists, and upper echelons of the government agencies who have carefully constructed the legal, political, and scientific entrapments over the period in question, and have always disposed of the data that proved their harmful effects.

The first part of this article will explain the history of public health politics as an autoimmune disease where the state as metaphoric immune system turned against the body politic by means of profound legal, institutional, and scientific transformations. The second part will analyze in technical terms how transfection (mRNA "vaccination") as a technology applied to public health operates in lockstep with this same autoimmune turn—that is, how it represents a heightened degree of autoimmune logic in comparison with older forms of immunization to the point where immunity is no longer even the investigational end point.

PART I

Setting the Stage for 2020

Even though Jacques Derrida is one of the more prominent recent voices to have employed immunology, and particularly autoimmunity, for philosophical and political purposes, his use of the terms, as Warwick Anderson and Ian R. Mackay have noted, is "eccentric" (2014, 149), off center of immunological discourse. Furthermore, Derrida's commentary on autoimmunity in the 9/11 context becomes useful for my purposes only to the extent to which I interpret its "eccentricity" in light of a certain *unspeakability* of the ideas that Derrida might have intimated.

In the interview "Autoimmunity: Real and Symbolic Suicides," in which Derrida, in conversation with Giovanna Borradori, analyzes the significance of the 9/11 attacks for the rise of the "autoimmunitary," one of the central terms, terrorism, is defined as "autoimmunitary terror" in the 9/11 era (Derrida 2003, 96). Now more than twenty years ago, Derrida anticipated future "autoimmunitary" terror to happen at a nano-scale: "Nanotechnologies of all sorts are so much more powerful and invisible, uncontrollable, capable of creeping in everywhere. They are the micrological rivals of microbes and bacteria" (102). Ultimately, terrorism

now "covers a new concept and new distinctions" because the inside/outside, the friend/foe, the self/other, the visible/invisible distinctions have all been breached to an unprecedented extent (102). In some sense, 9/11 violence is autoimmunitary because Bush's "war on terror" that ensues in the aftermath of the attacks is only in appearance engaging the old immunitary rhetoric of war, reprisal, and justice, but in reality is already itself a "perverse effect of the autoimmunitary" in that it "ends up producing, reproducing, and regenerating the very thing it seeks do disarm" (99). The war on terror ushered in government-run surveillance programs; legal suspension of the very foundation of immunitary logic, the *habeas corpus* (Cohen 2008, 110); the creation of global deterritorialized "black holes" (torture centers that exist outside of political space and time), and thus the destruction of many notions of justice and law guaranteed by the Constitution of the United States.

While Neocleous shows Derrida's understanding of autoimmunity to be confused, particularly around the distinctions between autoimmunity and autoimmune disease (2022, 25–26), in my reading Derrida's discourse remains so "messy," "eccentric," and contradictory because he never explicitly analyzes the literal connection of 9/11 with the "nanotechnologies" and the "micrological" (Derrida 2003, 102) to which he alludes "eccentrically." Why was 9/11 terrorism more "autoimmunitary" than previous instances of terrorism? His brief and cryptic allusions seem to be withdrawn as quickly as they are made. Did Derrida decide to "stay in his lane" (philosophy) because the political terrain was too "hot"? Was the chance of being labeled a "conspiracy theorist" too much of an aversive for him to be clearer?

Let's remember that the attacks on September 11, 2001, were followed on their heels by the anthrax attack on Congress on September 18, 2001. It was an anthrax component of 9/11 that would have provided the link to Iraq, delivering the justification for its invasion without having to engage in the drawn-out and contrived seeding of the weapons-of-mass-destruction narrative. It did provide the link for building up an entire "bioterrorism" branch, and extensive legislation, for the US security agencies. However, instead of implicating Iraq, the anthrax attacks linked right back to the US government, which had developed anthrax as a bioweapon since the demise of the Soviet Union. Ultimately, the FBI framed Bruce Ivins, who was a military scientist at Fort Detrick, one of the Army's Medical Research Institutes of Infectious Diseases. Ivins allegedly committed suicide, which facilitated the framing of him as a "lone wolf" in committing the attacks, exculpating Stephen Hatfill, the original main suspect.[1] Many have contended that the attack could not have been carried out by one person. For the purposes of this article, I am unable to dive any deeper into 9/11 and its anthrax component, which was an important relay in the intensification of US government developments that Derrida may have understood as "autoimmunitary" in this interview: "pandemic preparedness," the development of countermeasures that

are always "dual purpose" (both weapon and countermeasure), and the need to experiment with these countermeasures on sectors of the US population. Experimental anthrax vaccines that were mandated on US Department of Defense (DoD) personnel are a case in point, and the District Court ruling in *Doe #1 v. Rumsfeld* that struck down the mandates left no doubt about this in pointing out that US soldiers had been used as "guinea pigs."[2] Suffice it to say that Derrida's commentary makes a lot more sense when read as a reference to the involvement of the US government in the weaponization of microorganisms, and the various forms of aggression against its own citizens enshrined in the Patriot Act. Terrorism, then, is not so much random acts of violence perpetrated by outsiders to the community (or even insiders who are "other-able"), but rather the terror that the state (as "immune system") visits on its own body politic; the kind of state-sponsored terror that citizens of many nations around the globe most readily associate with the term terrorism; a terror that is often supported, organized, and financed by US security and intelligence bureaucracies; a terror that has struck out against Black and Indigenous populations for centuries. With 9/11, this violence comes home to roost in the "homeland," as allegorized by the creation of the quasi-military Department of Homeland Security in 2002.

To suggest that the United States, and to various degrees the Western world more broadly, has been taken over by an overt autoimmune pathology, is to employ a productive metaphor. The autoimmune model becomes productive particularly in dialogue with Neocleous's conceptual framework on security, state power, and immunity where the immune system is understood as a kind of "sophisticated 'intelligence community,'" a "paranoid system of corporeality" (2022, 47). To be clear, however, I do not wish to argue that the condition is a fateful and mysterious illness that has no intention, no planned execution, and therefore no redress. Unlike Mattias Desmet's theory of mass formation developed in *The Psychology of Authoritarianism* (2022), which suggests a spontaneous and undirected structural mechanism of fear and irrationality within populations, I plan to demonstrate that the collective state of panic—of inflammatory "cytokine storm" of the body politic—was carefully orchestrated by an "immune system" that had turned against its own "tissues."

Conspiracy

To leave no doubt, I am actually engaging in conspiracy analysis. A few words to rehabilitate the useful legal term *conspiracy*. The dictionary offers as one of the definitions of *conspiracy* "the action of plotting," and a plot is a plan to do something illegal or harmful. The underlying basis of *pharmocracy*—a term coined by the medical anthropologist Kaushik Sunder Rajan (2017) to analyze the legal, political, and scientific structures that have produced a transnational pharmaco-biotech-medico-governmental industrial complex (equal in economic power to formations like the weapons-military-intelligence industrial complex, and deeply

embedded within the latter) is a conspiracy. Pharmocracy is a global conspiracy, rooted in the United States and a few Western European countries as the centers of neoliberal empire, to produce and implement research that results in the prescription, particularly in the US population, of the highest amount of drugs possible while erasing the evidence of their harms. Joseph Dumit has described this phenomenon as "prescription maximization" and understands it as creating structures that guarantee "the overall availability of an individual's metabolism for the maintenance of pharmaceutical flows" (2012, 82). Much of the "evidence-based" framework of this pharmocratic paradigm, and the authoritarian and "protective" (securitizing) role of biomedicine and public health within it, forms the basis for pandemic politics through which the channels for vast new pharmaceutical flows are fulfilled. But without acute danger, there is no use for protection. The prominent academic immunologist and vaccine-development entrepreneur Anne De Groot leaves no doubt as to the role of fear in the implementation of such pharmaceutical flows: "The market for vaccines is driven by perception, not by actual need…When the perception of risk for disease is lower, or the disease is less prevalent, so too, demand wanes, and concern about potential side effects may eventually drive the demand for a vaccine (and its return on investment) towards zero" (De Groot and Berzofsky 2004).

Even classical capitalism itself is already a conspiracy to sell us products we don't need and that often harm us, or at the very least hook us into dependency. The neoliberal, International Monetary Fund–centered seduction into debt and subsequent coercion and extortion of Global South nations is another major conspiracy. These conspiracies are precisely why regulatory agencies exist, but with the autoimmune turn, these agencies have been largely bought through regulatory capture. Regulatory capture, however, will be shown to be too mild and too imprecise a concept to deal with the autoimmune turn, mainly because the government bureaucracies that enact these policies are no longer victims of corrupt corporate power, but have themselves become the motor of this dynamic. In addition, the autoimmune turn, which culminated in the COVID crisis, also follows a new structure of subjectivity itself. In what Paul Preciado (2012) has called the pharmacopornographic era (post 1950s), capitalist conspiracies are no longer implemented through "external products" to the subject, but through the molecular invention of human subjects that are themselves constructed through the product: the selective serotonin re-uptake inhibitor (SSRI) subject, the contraceptive pill subject, the statin subject, the vaccine subject, and now the mRNA subject. Dependency—that is, the collapse of individual constitutionally guaranteed sovereignty—is now manufactured at the level of cells, tissues, proteins, nucleic acids.

It is always conspiracies, at the highest levels of industry and government, that sell us harmful and expensive phenomena that, without fraud-induced fear, no one would want, like, say, war (for example against Iraq, made palatable by

means of the neocons' "weapons-of-mass-destruction conspiracy"). Conspiracy analysis is and must be about discovering the fraud that underpins the construction of these phenomena (most notably statistical, legal, and scientific fraud). Why would critical intellectuals fall for the thought-terminating cliché of the "conspiracy theorist," now more widespread than ever among academics and other liberal elites, which was coined by the US military/intelligence complex already nearly seventy years ago to shut down investigations into its own involvement in crimes. In other words, there has been plenty of time to think this through critically, and dare I say to "do one's own research," the condemnation of which is another thought-terminating cliché that has been successfully deployed since 2020 to enforce authoritarian expertism. Of course, these public/private conspiracies overtly and covertly also conspire to terminate critical thinking, throwing billions of dollars of government grants and direct propaganda payments at academics and journalists to force their practice into narrow disciplinary expertism. The Sartrian expert *technicien du savoir*, produced by means of these elaborate incentive structures, will not look beyond the horizon of their own narrow terrain and thus deliver the deployable narrow knowledge required for the conspiracies to work without getting in the way of the larger scheme.

The Accusation of "Conspiracy Theorist" as *Horror Autotoxicus*

It is well known that immunology failed to entertain the possibility of the existence of autoimmune diseases for half a century. This denial was metaphorized in Paul Ehrlich's expression *horror autotoxicus* (1906, 82). The idea that the body's "security forces" could possibly attack their "own" tissues had to reek of "conspiracy theory." Immunology was strongly influenced in its scientific search for truth by Western cultural prejudice concerning the notions of selfhood and nation state (Mitchell 2017, 88). Could it be that the same cultural mechanism of denial, the need for a "safe interior," the foundational taboo against doubting the goodness and safety of "one's own" group, is at the root of continued and repeated dismissals of evidence that "our own" security forces have turned against us? Is the accusation of engaging in "conspiracy theory" equivalent to Ehrlich's dismissal of autoimmune disease because it would constitute an unacceptable *horror*? Can Tuskegee now be acknowledged only because it wasn't done to "us" but to a racialized "other," and so biomedicine and public health can be seen as reformed now that it nominally embraces "diversity, equity, and inclusion" and anti-racism, even when similar types of experimentation continue, and once again primarily on the backs of racialized "others" taking the form of a "selective genocide" (Rajan 2017, 3)?

Curiously we see the same need to project the enemy outward even and especially in attempts to shed light on conspiracies, such as the recent *Sunday Times* article that finally openly names COVID-19 as a bioweapon, but then fails to

acknowledge US and Western involvement in its creation and puts the blame on China (Calvert and Arbuthnott 2023). Even the potential for world war is evidently preferable to facing the truth about "our own immune system." Ultimately, even the early dismissal of lab origin hypotheses in 2020 in favor of a National Institute of Allergy and Infectious Diseases–directed "consensus" on zoonosis follows this logic of *horror autotoxicus*: nature as humanity's ultimate exteriority is being, and has for decades been, demonized and weaponized to advance the securitization of humanity by the antibody industrial complex as the successor complex and upgrade to the cold-war military industrial complex. This weaponization is "dual purpose": viruses, microorganisms, and various naturally occurring molecular substances are turned into both bioweapons and countermeasures (drugs, biologics) through gain-of-function and biomedical research. On the other hand, the demonization of nature in zoonotic explanations, rooted in racist and colonialist ideologies, projects millenary cultural practices of interacting with "nature" such as "wet markets" and "bushmeat consumption" as dangerous and barbaric (while white Global North populations are tied into practices of factory farming, slaughterhouses, and hunting, which are deemed civilized, safe, and effective). The projective logic of *horror autotoxicus* ("it's nature/virus, not your immune system") in these explanatory models for pandemics is self-evident.

The Necessary Augmentation of the Immune System

The mRNA subject (and the vaccine subject more broadly) is said to have an immune system understood as in and of itself hapless ("naive" and incompetent in the face of "novel" pathogens). The scientific construction of this concept of the immune system can be historicized along the period in question from the 1980s onward and maps onto the development of a national vaccine program, culminating in the 1986 National Childhood Vaccine Injury Act (NCVIA). The NCVIA immunized pharmaceutical corporations against vaccine-related liability, stimulating them to produce an increasing amount of vaccines at greater speed, putting the industry in the role of Neocleous's ambassador: "The servants of the state who conduct its violence do so as its *ambassadors.* As such, they have inherited the kind of immunity historically granted to the figure of the Ambassador. They are protected" (2022, 29). Why exactly this term "servants of the state" is so particularly fitting for the role of the pharmaceutical industry will become more fully transparent as I discuss the nature of the COVID-related contracts between the government and the pharmaceuticals below. In any case, the NCVIA paves the way toward a more and more capacious legal framework that aims at eclipsing the foundational medical concept of informed consent. This development comes to full fruition during the rollout of the "COVID-19 vaccines" where the precise content of the products is unknown to both healthcare professionals and recipients (to be more fully explained in the vaccine section below).

This altered scientific understanding of the immune system largely bypasses the innate immune system and downplays the role of natural acquired immunity. In fact, the immune system is presumably built ("educated," "taught") through this biotech product and the specific B-cell-derived antibodies it produces. The almost exclusive focus on B-cell-derived antibodies in the definition of immunity is another feature of the workings of the antibody industrial complex, reducing the complexity of the immune system to the easily quantifiable concept of immunoglobulins seropositivity.

As can be appreciated in the controversies around the "hygiene hypothesis" (Bloomfield et al. 2016), natural infection as an immunity mechanism has been repudiated by this new conception of the immune system that requires the public/private protective intervention for human and nonhuman organisms to be viable, supplanting evolution and natural biology. Just as Preciado shows the contraceptive pill to have supplanted gender/sex, Viagra to have become erection, SSRIs mental health (2012, 34), vaccines come to equal immunity. Due to this antibody-industrial-complex-sponsored concept, a mass panic could break out around SARS-CoV-2 as a "novel" pathogen (even though it had less than a 1 percent mortality rate in the non-elderly). Why? It was portrayed as killing potentially all of us because we presumably had no immunity against the "novel" virus, as if cross-coronavirus immunity didn't exist, as if no one had an innate immune system, as if natural immunity could not be developed. A "novel" virus plus no vaccine equals doom.

The Four Pillars of Emergency

Between 1983 and 2015, a legal structure was erected that enables the autoimmune aggressions of the antibody industrial complex against the body politic. This complex is a security arrangement to be understood as a corporate, military, intelligence, public health, and academic partnership under federal bureaucratic orchestration. Like is the case with all origin stories, it is hard to pinpoint a definitive moment in time as there are always precursors. That being said, I suggest 1983 with the Public Health Service Act as the most concrete starting point. The frame of the edifice that housed the COVID response was completed in 2015 with military contract legislation called Other Transaction Authority/Agreement (OTA), although other meaningful additions were added after 2015. Significant portions of the frame were established as amendments and expansions to existing health emergency legislation during the years following 9/11. This edifice is further buttressed by the creation of several new federal agencies under the umbrella of the existing public health, military, and intelligence bureaus (such as the Department of Homeland Security, or DHS, the Biomedical Advanced Research and Development Agency, or BARDA, the Defense Threat Reduction Agency, or DTRA, the Administration of Strategic Preparedness and Response, or ASPR, and Public Health Emergency Medical

Countermeasures Enterprise, or PHEMCE); and the restructuring and repurposing of some agencies such as the Defense Advanced Research Projects Agency, or DARPA, the Federal Emergency Management Agency, or FEMA, and the National Security Agency, or NSA, all of whom played a major role during the COVID crisis. The Public Health Emergency Medical Countermeasures Enterprise (2006/2019), in particular (a sub-agency of the US Department of Health and Human Services (HSS)–sponsored Administration for Strategic Preparedness and Response, created in 2006) is of special interest here because it exemplifies the proliferation of the public/private partnership concept under executive branch government leadership in the wake of 9/11. It appropriates public funds to economically benefit private corporations, while blending the spheres of medicine, biowarfare, governance, and private interests. The main legal pillars of the frame that I have decided to focus on are four: (1) the above mentioned Public Health Service Act of 1983 (and its subsequent amendments); (2) the introduction of Expanded Access Use (EAU) and Emergency Use Authorization (EUA) legislation to enable the deployment of unapproved products, initiated in 1997; (3) the Public Readiness and Emergency Preparedness (PREP) Act of 2005; and (4) the OTA legislation of 2015.

Health Emergencies

Modern public health emergency legislation began to be installed in 1983 with an amendment to the Public Health Service Act of 1944 (codified as Public Law no. 98-49, 97 Stat. 245). Here a section 319a titled "Public health emergencies" is inserted (42 USC 247b), which already reserves new extraordinary powers to "the Secretary of Health and Human Services," to be further significantly amended in 2000 as the Public Health Threats and Emergencies Act (42 USC 201 note). This amendment reworked and expanded the aforementioned section 319 ("Public Health Emergencies" 42 USC 247d) of the 1983 Public Health Service Act, and established a working group on bioterrorism 'countermeasures' research and development. It was then again amended in 2002 in the wake of 9/11 as the Public Health Security and Bioterrorism Preparedness and Response Act (Public Law 107-188, 116 Stat. 594). The reason why it is important to situate the beginning of the construction of this grid in 1983, even though much of its current content was added or amended in the late 1990s and early 2000s, is because the 1980s timestamp coincides with crucial developments in virology, immunology, and genetics/genomics toward a promise of ever-increasing control over the human body, as well as over viral and microbial ecologies in which it exists. Beyond the capacity for genetic sequencing, two specific technologies have played a central role in the COVID crisis: the polymerase chain reaction (PCR) test (1985) and the cloning of RNA viruses by copying them onto cDNA plasmids (becoming common practice from the late 1970s on). The latter is crucial both for the weaponization of RNA viruses and for the production of biologic countermeasures. In close quarters with biological weapons development, genetically oriented biomedicine

(primarily in cancer- and AIDS-related research) begins to develop and implement ideas around humans as hackable organisms, and legal frameworks develop alongside these discourses of fear, control, and securitization. It is no coincidence that vaccines stand at the center of this operation. As a preventative technology, they are the quintessence of the promise of security, of securing the future from potential harm and exploiting future potential economically. They instantiate both the late capitalist stock market investment in "futures" (as projections of value rather than its present reality), and fear-based governance that paternalistically promises security.

In its essence, the creation of Public Health Emergency (PHE) and its juridical inscription in the act of the same name (in its definitive version of 2000) allows an authoritarian takeover of the executive branch from the legislative and judicial branches of government. The HHS Secretary has sole discretion to declare a PHE and to implement countermeasures (21 US Code 360bbb-3). This is arguably a form of coup d'état centered in the HHS Secretary.

Emergency Use Authorization

In 1997 the Food and Drug Administration Modernization Act was passed (Public Law 105-115, 111 Stat. 2296), which begins to pave the way toward EUA under PHE through so-called Expanded Access Use (EAU) to unapproved drugs, biologics, and devices (21 CFR 312.300). Ostensibly, this legislation was introduced to facilitate access to new experimental drugs, but such access was limited to scenarios where a patient with a serious or life-threatening disease, for which no alternative therapy is available, applies for EAU with their licensed physician, carefully calculating their individual risk-benefit profile. A permission granted under EAU assumes that the drug has already achieved Investigational New Drug (IND) status, meaning there are clinical trials being conducted, but that the applicant has no access to enroll in an existing clinical trial. The application also requires approval by an institutional review board, indicating further careful consideration and informed consent.

Reinterpretations subsequently took this law out of its original conservative contexts for individual patients with life-threatening illnesses, and enabled it to become EUA under PHE, allowing access to medical countermeasures outside regulatory law. It became one of the pillars of the regulatory quagmire of the COVID operation where medical countermeasures were universally applied to millions of healthy citizens on the sole discretion of the HHS Secretary without consideration of their medical history, lifestyle, age, or informed consent. An EUA under PHE does not require the product to have IND status, to be approved by an institutional review board, or to include the informed consent of the recipient. After PHE was declared in March 2020, the complex equivocations between EAU and EUA legislation could easily produce the impression in health professionals

and the general public that EAU requirements (IND status, clinical trials, informed consent) were applicable to the COVID countermeasures under EUA when they were not. This equivocation became the basis for the following:

- EUAs for over a hundred different commercial PCR tests were issued alone in the first five months since PHE was declared (Murrin, 2022). Many of them are now no longer in existence and it is near impossible to verify the primers used in them. This means we cannot know which exact proteins each of them tested for, opening a loophole for statistical fraud about infection rates.
- EUAs were issued for the use of experimental and highly problematic antivirals in hospital protocols. The primary example here is the drug Remdesivir, the history of which would warrant an entire investigation in its own right. Not unlike AZT in late 1980s AIDS politics, Remdesivir was a dangerous and failed drug, meaning it had never been successfully used for anything despite numerous attempts and had a poor safety record, yet remained under patent and provided the grounds for huge profits for Gilead Sciences, a corporation with a long history of tight government connections.
- An equivocal regulatory game became possible around EUA, EAU, and fully licensed product (FLP) concerning the transfection products (mRNA "vaccines") to be analyzed in greater detail below.

The Public Readiness and Emergency Preparedness (PREP) Act

The PREP Act constitutes a key piece of legislation for the implementation of the COVID policies. It presents a complex set of additions and amendments to the existing health emergency legislation. In brief, consider the following features:

- The act gives legal immunity to anyone involved in the production, distribution, transportation, and administration of COVID countermeasures. As such, it contradicts the legal standards set at the Nuremberg trials because it legalizes an "I just followed orders" defense.
- It centralizes decision-making power in the HHS Secretary who simply "makes a determination": "if the Secretary makes a determination that a disease or other health condition or other threat to health constitutes a public health emergency…" he or she may then order "the manufacture, testing, development, distribution, administration, or use of one or more covered countermeasures" (42 USC 247d-6d).
- Liability protection includes death, injury, disability, loss of property, and more, caused by the administered countermeasures, and liability standards are set at an unprecedented degree: "willful misconduct," which implies both proof of intention, and temporal proximity.
- In combination with the Homeland Security Act of 2002 (Public Law 107-296, 116 Stat. 2135), the PREP Act embeds public health within a growing network of federal agencies, coordinating action between the Department of Health

and Human Services, the Department of Defense, the Department of Homeland Security, the National Security Agency, the Federal Emergency Management Agency, and the Department of Justice (with several sub-agencies that function as links, such as the Biomedical Advanced Research and Development Authority, the Defense Advanced Research Projects Agency, the Defense Threat Reduction Agency, the Administration for Strategic Preparedness and Response, and Accelerating COVID-19 Therapeutic Interventions and Vaccines ("ACTIV"), formerly known as "Operation Warp Speed"), thus militarizing public health.

Other Transaction Authority (OTA)

The final cornerstone of the edifice snapped in place with the 2015 OTA legislation applicable to DoD contracting. The use of OTA for medical countermeasures first emerged in 2015 at the kick-off event for the public/private Medical CBRN (chemical-biological-radiological-nuclear) Defense Consortium (MCDC). The MCDC is the national equivalent of the global Coalition for Epidemic Preparedness and Innovation. As the MCDC webpage states, "the usage of an OTA allows government to partner with the MCDC to leverage cutting edge R&D and develop prototypes for commercial sources. This gives MCS [Medical Countermeasures Systems] an agile and flexible way to develop medical countermeasures using new and innovative technology" (n.d.). This "flexibility" is achieved because an OTA procurement arrangement is not a contract, or grant, or other form of legally regulated tool. Under OTA, the DoD can order and pay for medical countermeasures without needing to adhere to good clinical practices or current good manufacturing practices (CGMP). This means that such countermeasures, legally named "prototype" (a term normally reserved for weapon systems), exist outside of the regulatory framework overseen by the FDA for pharmaceutical products. The July 2020 base contract between DoD and the MCDC, which legally establishes Operation Warp Speed, is explicitly framed under OTA. "The U.S. Army Contracting Command-New Jersey (ACC-NJ) is entering into a Section 815 Prototype Other Transaction Agreement (OTA) with the Medical CBRN Defense Consortium (MCDC)," and the product to be financed for $10 billion is referred to as a "prototype" (U.S. Army 2016/2020). In other words, the COVID transfection prototypes that were the result of this OTA (referred to as June and July 2020 attachments seven and eight to the 2016 base contract), and were injected into the majority of the US population, are not legally pharmaceutical products, while the FDA engaged in theatrics to convince the population that it was being given (and mandated) pharmaceutical products that were being regulated. Thus, the label "safe and effective," reserved for FDA-approved and -regulated products, was arguably used illegally. Its use under OTA amounts to government deceit. CGMP, a central aspect of regulatory law, which guarantees quality control, consistency, and efficacy and safety of all pharmaceutical products, including biologics, was obliterated through OTA.

What essentially this four-pillared frame of PHE offers is a military/civil and public/private joint venture to bypass the Constitution, existing health and contracting regulations, and shift power away from Congress and the courts to the unelected sector of the executive branch and its corporate partners. Unlike a declaration of war, for example, which has to be authorized by vote in Congress, this legislation transfers power exclusively to the HHS Secretary without validation by representatives of the voting public. As such, it replaces constitutional rights of citizens with a permissions-based management of populations. Pivotal for this arrogation of power is 21 USC 360bbb-3, Authorization for medical products for use in emergencies.[3] Both the determination to declare a public health emergency, and the issuance of an EUA for products that diagnose, treat, or prevent such an emergency, are here put in the hands of a single person, who may base this determination on "scientific evidence…*if available*" (emphasis added).[4] What if it isn't? What if, say, scientific evidence were simply "out-of-scope" as is the case for a prototype under OTA? Well, then the Secretary makes a determination anyway, based on the sole power invested in him or her by Congress through 360bbb-3. Pfizer and Moderna may not even be the manufacturers of BTN162b2 and Spikevax, respectively, just as Pfizer does not conduct its own clinical trials. The OTA for COVID prototype medical countermeasures, signed between the US DoD and the public/private MCDC, involves hundreds of defense subcontractors, and offers no such certainties. Like Coke and Pepsi, like Camel and Marlboro, Pfizer and Moderna may simply be recognizable branding tools utilized in the production of Preciado's synthetic-molecular pharmacopornographic subjectivities. Are you a Pfizer dude? A Moderna kid? Just as the hormone-industrial complex decoupled gender from nature in Preciado's analysis, the mRNA subject is the current endpoint of a carefully orchestrated production of the human immune system as necessarily augmentable. The innate and adaptive evolutionary immune systems have been superseded, upgraded, trans-humanized. There is to be no alternative to the transfection-based Pfizer and Moderna subjects. Is that the real reason why the control group was unblinded and eliminated in the theatrical Pfizer clinical trials in 2020? Is there to be no well-controlled scientific evidence as to whether the prototypes work (better than evolutionary nature) and what their dangers are? For those radical old-timers who, despite best propagandistic efforts, still remember the concept of natural immunity after infection, we offer "hybrid immunity" as a semi-synthetic compromise. Pharmacopornographic biotech strives to replace nature in every biological context with a commercial synthetic product for everyone: lab meat, synthetic breastmilk, injectable hormones, industrial neurotransmitters, transfected immunity. Nevertheless, transfection, like most political phenomena in the US, comes in two fake flavors: beef or chicken? Republican or Democrat? Pfizer or Moderna? And we are encouraged to fight it out. Freedom in permissions-based authoritarian capitalism is all about the illusion of choice, *if available*.

Jackson v. Ventavia: It's an OTA, Stupid[5]

Brook Jackson is a pharmaceutical whistleblower who worked as a clinical trials supervisor for Ventavia Research Group, a company subcontracted by Pfizer to conduct some of its phase three clinical trials for its mRNA shots. Jackson reported significant irregularities in the trials (including violations of clinical trial regulations and safety standards, and data fraud) first to her employer, who ignored her, then to the FDA on September 25, 2020. She was fired from her position at Ventavia on the same day for not being "a good fit" (Thacker 2021). After her report to the FDA, Jackson received a phone call from an FDA inspector, informing her that no further information could be given. On December 10, 2020, Pfizer submitted its application for EUA for the mRNA product, without a mention of the occurrences that Jackson had reported, and the very next day, the FDA granted EUA. On January 8, 2021, Jackson filed a False Claims Act complaint with the US District Court for the Eastern District of Texas against Ventavia and Pfizer. On April 22, 2022, Pfizer filed a motion to dismiss. On March 31, 2023, Judge Michael Truncale granted Pfizer's motion to dismiss. Of greater interest than Jackson's allegations and her detailed documentation of fraud committed by Pfizer/Ventavia, however, is what this case has brought to light about the pandemic response in a broader sense. Pfizer's motion to dismiss has brought the paperwork between the DoD and its contractors (among them Pfizer) into public focus, and for many citizens that alone is still news altogether, assuming as many did that the mRNA vaccines were ordinary pharmaceutical products, manufactured by the pharmaceutical industry and regulated by the government's agencies. In granting Pfizer's motion, and dismissing Jackson's complaint, Judge Truncale's ruling puts a significant dent in the public pandemic response narrative, despite defeating Jackson's cause against Pfizer. Truncale's disturbingly cynical self-positioning and his equivocal legal argumentation destroy the legal and ethical basis on which the complaint was built. By annihilating this basis, it simultaneously eviscerates assumptions held by most of the general public concerning the mRNA vaccines and the rule of law.

The plaintiff's allegations, articulated under the False Claims Act, assumed that Pfizer defrauded the US government by breaking the regulatory rules set forth for pharmaceutical products. More fundamentally, it assumed that vaccine safety and efficacy was material to the government's interests. Truncale, in turn, shows that the government was at no point defrauded, citing several different reasons. Analyzing the OTA between the DoD and its contractors, he points out that Pfizer was under no obligation to even conduct clinical trials because the product in question was a "prototype": "Such prototype agreements are executed under the DoD's 'Other Transaction Authority' and, as a statutory matter, are not subject to FAR [Federal Acquisition Requirements]"[6] Truncale equally confirms Pfizer's claim that "the Government did not condition payment on compliance with FAR

requirements or FDA regulations"[7], only to deliver a specified number of "prototype" injections by an agreed upon date, which they did. He concludes that to litigate against a contractor for fulfilling its legal obligations is "unavailing"[8] (40).

Truncale's text painfully reveals that Jackson's main conceptual mistake was not to have understood the legal construct of the OTA and to have assumed, like much of the general public, that the Pfizer "vaccine" was a pharmaceutical product, and that therefore regulatory law applied, and that the breaches of regulatory law that she documented should have been material. The judge never takes issue with any of her allegations, and in fact calls them "well-pleaded facts" throughout.[9] In a breathtaking dismissal of the relevance, or materiality, of such facts Truncale simply states, "Continued payment by the federal government after it learns of the alleged fraud substantially increases the burden on the relator in establishing materiality…The well-pleaded facts in Ms. Jackson's Amended Complaint cannot plausibly shoulder that burden."[10] In other words, the facts concerning pharmaceutical regulations don't matter. What matters is that Pfizer and the government agree, which they clearly do because the government paid and keeps paying, and there is nothing more to it. The government ordered a prototype. It received a prototype. It paid. End of story.

The district judge leaves no doubt, either, about his own positioning vis-à-vis the government: "The United States itself has taken the unusual step of filing a Statement of Interest Supporting Dismissal of the Amended Complaint."[11] In other words, Truncale is doing as told, as a judge in an authoritarian system would. Is this not leaving a clear record of the chain of command in a system in which the judiciary branch has no independence? One wonders, furthermore, who exactly "the United States" is. He rounds off this implicit analysis of his own role when he affirms: "Ms. Jackson is in effect asking this Court to overrule the DoD's decision to exercise Other Transaction Authority to purchase Pfizer's vaccine…This Court will not veto the DoD's judgment concerning mission effectiveness during a national emergency"[12] In line with the perception of his own role, he lectures Jackson that she must not "second guess decisions made by those empowered through the democratic process to shape public policy."[13] The invocation of the "democratic process" adds a facetiously dissonant tone to the judge's opinion, particularly in view of the fact that none of the decision-makers in question are elected members of the government, let alone that the very "democratic process" actually depends on the public "second guessing" those that are "empowered."[14]

Perhaps against his own intentions, Truncale's refutation of the whistleblower's naively optimistic belief that regulatory law is material and should trump raw power reveals many of the more caustic aspects of the COVID operation. Not only does it open the door to future, more on-target, legal strategies, the judge's ruling

and the case's focus on official documents actually opens a window on the truth of the "autoimmune disease" that has befallen the body politic that, to the date of his "Order and Opinion," could not easily be found in a more striking form in the public record.

There is another major reveal from Truncale's gob smacking text. Truncale's own argumentative structure performatively mimics the duplicitous legal structure that the government has put in place surrounding the "vaccine," duplicitous here to be understood as both "deceitful" and "twofold." In a mind-boggling twist of logic, the judge (basically just following government narrative) plays the FDA against the DoD, asserting that Jackson doesn't understand that the two are not the same. She complained to the FDA in September 2020, but the FDA didn't purchase the prototype (and didn't have an OTA with Pfizer, the DoD did), and so the DoD is entitled to claim that it didn't know of her report to the FDA about the fraud until February 2022. Jackson then points out that the OTA contains a clause that the product needs to achieve FDA authorization. However, the judge counters that suing the FDA for false claims isn't an option because it is the DoD that is Pfizer's OTA partner, not the FDA. And the whole problem is that Jackson sued Pfizer for defrauding the government, which, according to Truncale, it never did. Pfizer followed orders and complied with the OTA it had signed with the DoD. Separately, it achieved EUA with the FDA, based on (allegedly fraudulent) clinical trial data, but the OTA has no care for how the EUA is achieved, as long as it is achieved, because it is technically "out-of-scope." No regulations apply. Here another equivocation plays out: EUA under PHE is not the same as EAU, which requires IND status, clinical trials, informed consent, and internal review board supervision.

In her evident lack of comprehension of the duplicitous structure set up by the government, Jackson alleges that the FDA, as well, has been defrauded by Pfizer. To this, the judge responds that the FDA had full knowledge of all her "well-pleaded facts" since September 2020, but then proceeded with three EUA's from December 2020 on, and has to this day never revoked its approval of Pfizer's product. EUA, unlike EAU, does not require clinical trials. Jackson's fraud reports about the theatrical clinical trials are immaterial. "The Government's unbroken chain of authorization and payments in the face of Ms. Jackson's allegations does not support an inference that the alleged misrepresentations were material."[15] Clinical trial related facts just don't matter. In other words, if the "government" (the DoD? the FDA?) thought something was wrong with the product as far as their goals with it, they would have acted upon the knowledge she gave them, but they didn't. The fact that they didn't means that Jackson's facts were "immaterial." The prototype did exactly what the government intended. Needless to say, what that intention is remains in the shadows, but clearly it is not an intention based on valid and legal clinical trials, which are the preconditions of a safe and effective pharmaceutical product. There was never an investigation. The

facts were ignored, along with the many who died of, or were maimed by, the prototype, no matter whether they reported to the government's surveillance systems, no matter in how many Senate hearings they (or their survivors) testified.

Why then not simply waive the FDA regulatory stipulations altogether? Why bother with discussions and votes on the FDA's vaccine advisory board? Why did the DoD lawyers write those requirements into the OTA in such a duplicitous manner where they seem to matter and they don't? As the discussion of an additional lawsuit currently under way will demonstrate, this equivocation played a crucial, and allegedly deadly, role in the COVID countermeasures rollout.

Watts v. Austin: Getting on Target[16]

George Watts Jr. was a twenty-four-year old college student who submitted to the Pfizer transfection to satisfy a college mandate. The second injection made him very ill, and five and a half weeks later he died. Unlike many other comparable cases, against prevailing Centers for Disease Control and Prevention (CDC) recommendations, his family had an autopsy performed. The autopsy report concludes "to a reasonable degree of medical certainty" that "the 'Primary Cause' of death is 'Covid-19 vaccine-related myocarditis.'"[17] A nasopharyngeal postmortem test further ascertained that Watts was not infected with COVID-19. Watts was healthy, young, and had no pre-existing medical conditions. His case is so unambiguous, and therefore free of any possible alternative interpretations, that it makes for an irrefutable model court case. After exhausting the legal remedy provided by the HHS's Countermeasure Injury Compensation Program and being ignored within the legal response period, on May 31, 2023, his parents proceeded to file for damages with U.S. District Court of the District of Columbia. The location of this litigation is significant because this court ruled two decades earlier in *Doe #1 v. Rumsfeld* against the DoD's violation of service members' informed consent when the DoD strong-armed soldiers into submitting to an experimental anthrax vaccine. *Watts v. Austin* has, as of this writing, not been adjudicated.

What I wish to emphasize in my discussion here is that this is most likely the first instance of litigation concerning the COVID-19 countermeasures operation that aims at the right target, the United States Department of Defense. As mentioned earlier, the whistleblower case against Pfizer was ill-construed in targeting Pfizer. In the wake of its dismissal, the plaintiff of *Watts v. Austin* savvily addresses both the OTA contractual nature of the military prototypes deployed, and the PREP Act, which indemnifies any and all participants in COVID countermeasures. Jackson's case was doomed from the beginning, misunderstanding the entire legal framework that I traced above, and counting on the naive assumption that the government would want to learn about safety and regulatory breaches. *Watts*

v. Austin states outright that it is known that the government is fully aware of the unprecedented number of severe adverse events and that it is monitoring them through detailed data collection. Jackson's misguided assumption was the government was being defrauded by Pfizer and did not know the facts she was revealing. Furthermore, the Watts' complaint is unambiguous from the outset on the role of the bureaucratic cluster of security agencies that came together in Operation Warp Speed under DoD leadership, and then hones in on the one possible limit to the liability shield provided by the PREP Act: willful misconduct.

The construction of a legal argument around willful misconduct, allegedly committed by the DoD, focuses, among other things, on one more instance of what I have called duplicitousness in discussing Jackson's case above. Two things were deployed while it was made to look like one and vice versa. In arguing that the DoD committed willful misconduct when luring George Watts Jr. into accepting a fatal experimental injection, the plaintiff demonstrates that the DoD did so by means of a deceitful maneuver. The Pfizer prototype was distributed, and continued to circulate throughout 2021 and most of 2022 until it was replaced with the "bivalent booster," as an unapproved EUA experimental vaccine (BTN162b2), while also being introduced as an FLP on August 23, 2021 ("Comirnaty"). The trickery consists in that Comirnaty—what a strange corruption of the word "community"—was never available in the US. Public campaigns championed the "Pfizer vaccine" as "fully approved," making people believe that they were receiving a product that had gone through rigorous testing, and had therefore earned the legal label "safe and effective," while what they really received was the unapproved experimental prototype BTN162b2. The government had deceived Watts by means of this bait-and-switch strategy. He waited until after August 23, 2021, to receive the FLP, but received the EUA prototype with fatal outcome, so the plaintiff contends. The complaint argues in detail, by documenting various public appearances of DoD leaders, how the term "safe and effective" was deployed "in massive, deliberate deception and exaggeration…making the majority of the country (including Mr. Watts) unknowing participants in its mass human experiment."[18] In calling attention to the BTN162b2/Comirnaty equivocation, the case lifts the veil on a duplicitousness that cuts in both directions: the two products are both one (and the same) and two (separate entities). Propagandistically it allowed the government to "borrow" the label of "safe and effective" for the EUA prototype by claiming both were essentially the same, while it protected itself by maintaining a legal difference between the two products. In this context, the equivocation between EUA and EAU was exploited as well. The original conservative EAU legislation prohibits the coexistence of EAU for an IND and full licensing of a product (FLP). EUA under PHE does not. By making Comirnaty unavailable, no arm was ever injected with anything but the experimental military prototype. Whether, as the complaint claims, the FDA-approved product Comirnaty is actually really "safe and effective" is immaterial because, for all we know, it is a legal chimera.

The complaint then contextualizes the subject matter of involuntary human experimentation both in the anthrax vaccine precedent *Doe #1 v. Rumsfeld* and the Nuremberg judgments against Nazi medical experimentation. In *Doe #1 v. Rumsfeld* (2003), the U.S. District Court of the District of Columbia had struck down the DoD vaccine mandate of an experimental (i.e., unapproved) vaccine for service members. *Watts v. Austin* claims that both the COVID-19 vaccination campaign and the anthrax vaccine mandate "eviscerate[ed] informed consent," which this Court has found constitutes a violation of federal law.[19] *Doe #1 v. Rumsfeld*, which is cited here, actually went so far as to pronounce that "the United States cannot demand that members of the armed forces also serve as guinea pigs for experimental drugs" (Doe v. Rumsfeld 2003, section 81). In *Watts v. Austin*'s argumentation, the violation of informed consent as a foundational ethical principle in the practice of medicine is grounded in the Nuremberg code. Having recourse to a Supreme Court ruling on *United States v. Stanley* (1987), which refers to the Nuremberg code in the context of a case about the DoD's LSD experimentation on a soldier and categorically declares that "experimentation with unknowing human subjects is morally and legally unacceptable" as a "first principle" (section 687),[20] *Watts v. Austin* suggests that the "DoD's mass experiment" may constitute "a crime against humanity."[21]

Unlike Jackson's suit, *Watts v. Austin* does not assume that the US government is the unwitting victim of corporate fraud. Quite the opposite: Pfizer, as evinced by the OTA, is merely a contractor in Operation Warp Speed under DoD leadership, fulfilling its legal obligations, which are clearly "out-of-scope" of regulatory pharmaceutical law. In autoimmunitary times, the simple notion of regulatory capture has been superseded by something much more insidious. The high stakes set by the only opening within the PREP Act that makes legal action possible, "willful misconduct," necessitate that any potentially successful legal strategy must aim high. As spelled out by the law, willful misconduct implies an "act or omission that is taken…intentionally to achieve wrongful purpose" and, furthermore, "in disregard of a known and obvious risk that is so great as to make it highly probable that the harm will outweigh the benefit."[22] For this reason, the complaint had to outline in great detail that the government has meticulously collected data on severe adverse events since the rollout began, and continued with its "mass experimentation" despite the immediate evidence that the prototype it had deployed constituted a "known and obvious risk." *Watts v. Austin* aims much higher than did *United States v. Pfizer*, whether or not it has any chance of succeeding in court. Its potential success lies in the legal precedents that have documented, and punished, the history of reckless DoD experimentation on service members. The difference is one of scale. From anthrax to COVID, military "guinea pigs" were replaced by civilian lab rats, reminiscent of Neocleous's discussion of violence against non-combatant targets in modern warfare (2022, 312).

PART II

SARS-CoV-2 and mRNA "Vaccines": Autoimmune Logic

Before I proceed with the second, more biomedically centered, section of this article, a clarification is in order that I write without formal training in medicine, biology, or chemistry. In medical contexts, the right to speak at all seems increasingly reserved for disciplinary "experts" who offer "settled" truths presented as "consensus," a form of consensus that has ousted scores of censored, discredited, and smeared dissidents of distinguished expertise. Cursed with a temperament that has always favored dissidence and "biodefection,"[23] my ambition is to raise questions and doubts, and to make connections that have not been made in the mainstream. The "vaccine question" has been especially vexed and polarizing ever since the antibody-industrial complex took hold of medicine and obliterated robust discussion, not just of technical details, but of larger philosophical frames.

While this section is about some of the specific aspects of the novel transfection methodology purportedly utilized for immunization purposes, I do see the COVID "vaccines" emerging from a line of traditional vaccines that are in themselves not unproblematic. Autoimmune disease as an adverse result of vaccination has been known for decades.[24] It was largely the autoimmune Guillain-Barré syndrome that caused the recall of the swine flu vaccine during the 2009 pandemic, a recall for what now seem to be surprisingly low numbers of adverse events. More broadly even, only dissidents seem to address the question why the industry standard for vaccines against respiratory viruses, foremost influenza before COVID, is an intramuscular injection where the body encounters the antigen at a highly counterintuitive location, and arguably with ineffective and unsafe consequences. Intramuscular vaccination arguably confuses the immune system by forcing it to encounter antigens in a place where it is set up to deal with mutations and malignancy, not infection. Effective immunity to respiratory viruses is primarily mucosal, not humoral. The immune system, in general, encounters foreign antigens at the body's three major epithelial boundaries with the outside world: the skin, the respiratory system including nasal mucosa, and the digestive tract. Who started the intramuscular injection trend and why isn't the mainstream questioning it on basic immunological knowledge of the immune system? As I understand it, the IgG antibodies produced by intramuscular injection are too large to cross the blood/lung barrier, and cannot be where the action would be needed. In immunology, it is understood that it was the innate immune system (especially dendritic cells) in connection with T-cells that provide immunity, and B-cell derived antibodies "mop up" the debris after infection is defeated. Is it that the convenience of measuring seropositivity for immunoglobulins has come to stand in for "immunity" most obviously for commercial reasons and to further the

"politics of immunity" (Neocleous 2022)? Is it because the antibody market has one of the largest, most lucrative shares of the pharmaceutical pie?

However, the precipitous introduction of transfection through mRNA and adenovirus vector technologies in 2020 also ushered in a fundamental change to the definition of "vaccine" and "immunization" on the CDC's webpage. Before September 2021, the CDC defined a vaccine as a product that "stimulates a person's immune system to *produce immunity* to a specific disease" (Jones 2022, emphasis added). After September 2021—which is to say at the moment where the official narrative that the transfections would prevent infection and transmission began to fall apart—the definition of "vaccine" reads as follows: "A preparation that is used to *stimulate the body's immune response* against diseases" (CDC 2021, emphasis added). The move away from immunity as the central purpose of vaccination is obviously the most striking shift, but at the same time the epidemiological bar is significantly lowered here in general. Many substances "stimulate immune responses," such as vitamins, hormones, medications, or the consumption of alcohol or sugar. Are they all to be understood as vaccines now? At the same time, a stronger emphasis is placed on "protection" in the post-September 2021 definition, a term that is arguably bolstering the paternalism of the corporate and bureaucratic institutions that market these experimental EUA products. The more precise scientific term *immunity* (untenable as a claim for the products as of mid-2021) is replaced with an emotional one: immunization is defined as a "process by which a *person becomes protected* against a disease" and vaccination "produce[s] *protection*" instead of immunity (CDC 2021, emphasis added). Along the lines of Neocleous's thinking, immunity and its long metaphorical connection to warfare is replaced with "protection" perhaps because such a substitution "replicates a broader liberal position which is happy to critique war and its tropes but less comfortable with a *critique of security*" (2022, 42). What could be a better way to disguise the security state's violence than to dress it up as protection?

There are several aspects of the mRNA COVID injections that participate in autoimmune logic where, as Neocleous defined it so succinctly, "the body…is threatened, damaged, and ultimately destroyed from within by its own immunity-security" (2022, 27). It would be interesting to speculate why public health eschewed the technically precise term *transfection* when referring to their prototype. By suggesting an "autoimmune logic" inherent to transfection, I am casting a wider net than strictly the causation of autoimmune diseases in a narrow sense, and am referring to a more general immune dysregulation that includes inflammation syndromes (such as myocarditis);[25] immune suppression including undesirable IgG4-based immune tolerance leading to infection, reactivation of latent viruses, and cancers; as well as immune-system-induced blood clotting and resulting heart attacks and strokes. Some of these phenomena are already built into certain features of the human response to the spike protein of the SARS-2

virus itself,[26] others appear to be linked to the gene-therapy-based technologies themselves (although we will see that it is also the specific combination of mRNA and synthetic spike that has produced specific damage). Early on in the pandemic, the scientific literature was replete with studies and evidence of the inflammatory nature of the spike antigen (see, e.g., Khan et al. 2021; Simon et al. 2021). There are now also studies emerging that contradict CDC statements that the spike protein that is expressed after injection with mRNA products is "harmless," or that "our cells break down the mRNA and remove it" (in what time frame?) (CDC, n.d.). This is a statement that would be true for natural mRNA, but the synthetic mRNA employed in the COVID products is codon-optimized, and natural pyrimidine nucleoside uridine has been replaced with pseudo-uridine. Both technologies stabilize the molecule and prevent it from being broken down by the innate immune system, a fact that was known already much before the massive transfection rollout (see Karikó et al. 2005).

In contrast to the CDC publication, a seminal 2022 study finds "vaccine mRNA and spike antigen up to 8 weeks postvaccination in some cases" (Röltgen et al. 2022, 1025); that is, they do not remain at the injection site, and are not simply "broken down and removed." Palmer and Bhakdi (2021), who analyzed a Japanese document on one of Pfizer's pre-clinical pharmacokinetics experiments on rats, also show both the extraordinary ubiquity of the synthetic mRNA throughout the rats' bodies, and the accumulation of it in specific organs. This analysis provides understanding for some of the human adverse events reported in the wake of the rollout. In addition, there are other hyperinflammatory ingredients in the mRNA products, such as the lipid nanoparticles that are used to transport the mRNA into cells. This technology is also novel in medicine, and there is no long-term data available (Ndeupen 2021).

Since the toxicity of the spike protein was well established in the literature soon after the emergence of SARS-CoV-2, one wonders why the manufacturers of all the COVID vaccines, not only the mRNA varieties, would have not only focused so narrowly on the spike protein as the only antigen around which to construct the products, but why even to have focused on it at all. CDC guidance is, once again, not helpful: "Spike proteins are ideal targets for vaccines" (CDC, n.d.). Why? The spike protein represents the most cytotoxic antigen of the coronavirus, and also the most unstable one. In addition to safety concerns, this also affects efficacy. It means that a vaccine focused on the spike protein rather than the much more stable nucleocapsid protein, for example, which remains conserved across not only different SARS-CoV-2 variants but most coronaviruses, will always already be outdated (Wang et al. 2023). Coupled with another, traditional, immunization platform (i.e., the direct delivery of the antigen plus adjuvant) the focus on spike may have been a risky one, but it would have introduced the negative in known and manageable doses. The mRNA platform, in turn, introduces an altogether new logic, which coupled with the known toxicity of spike, redoubles its dangers.

As it stands, it is completely unknown in which quantities the lipid nanoparticles, the mRNA, and the spike antigen remain in the body of transfected patients (Trougakos et al. 2022). Fascinating new research is also beginning to draw connections between spike, mRNA, and the gut microbiome (Hazan et al. 2022). The concern then arises that microbiota may also be transfected and produce spike protein.

More specifically, one central argument about an autoimmune logic in the mRNA prototypes focuses on transfection as a technology itself. In the medical dissident discussions of the last years, a major rift has opened between those who reject the entire mRNA platform as incompatible with human health, and those who consider the problem to be the choice of the spike protein for which the transfections code. The latter camp leaves the door open for future "better protein choices," and fails to question the technology itself. Many, if not all, vaccines (and other platforms) in the immediate future are scheduled to be changed to transfection, connecting the technology to massive economic interests. A series of litigations throughout the 2010s culminating in the *Amgen v. Sanofi*[27] Supreme Court decision in 2023 on current antibody patents has thrown traditional biologics-related patent law into crisis to the point where transfection may offer an attractive legal bypass and continuation of economic growth. In other words, what is at stake is much broader than the topic of mRNA-based COVID prototypes, which may have been launched as an unprecedentedly massive involuntary experimentation to establish the previously unsuccessful transfection technology. The critics of the spike protein choice implicitly accept what the antibody industrial complex is currently celebrating as a revolution, and which is clearly one of the main reasons behind the dogged insistence on pushing this experimental technology onto the majority of the world's population at "warp speed."

Another faction, however, sees the main problem with transfection technology itself. My argument concerning an autoimmune logic in transfection is based on this critique, and is fundamentally very simple: transfection makes human cells express a foreign protein.[28] The expression of a foreign protein by a human cell unleashes an autoimmune cascade of events that has been explained by Palmer and Bhakdi (2021) in their call to discontinue the mass experiment. They illustrate the effect of immune surveillance on the transfected cells: "an immune response will be mounted against that [foreign] protein and against the cells that produce it. This response is mediated by cytotoxic T-lymphocytes (CTLs, T-killer cells)" (2021, 3). They explain the occurrence of blood clotting not simply as a consequence of the spike protein's cytotoxicity, but of the cytotoxic effects of the immune response to transfection itself: "If the vaccine is expressed in the cells that line the blood vessels—the endothelial cells—the vascular lesion caused by the immune attack will again set off blood clotting" (3). Although censored and

punished after the rollout of the mRNA injections, this insight into the genesis of autoimmune dynamics in reaction to tissue damage is not novel or groundbreaking. In fact, as Vanderlugt and Miller showed already in 2002, "tissue damage during an immune response can lead to the priming of self-reactive T and/or B lymphocytes, regardless of the specificity of the initial insult" (85). Why were these well-known, and also common-sensical, facts about immune function buried with such overwhelming force at the rollout of the transfection platform?

Another particularly troubling aspect of immune dysfunction produced by the mRNA products, IgG4-based immune tolerance, has been described by Irrgang et al. (2022) and Seneff et al. (2023). The switch to IgG4 is basically what in lay parlance is called "desensitization." Irrgang et al. found that "IgG4 antibodies among all spike-specific IgG antibodies rose, on average, from 0.04% shortly after the second vaccination to 19.27% late after the third vaccination" (2022, 1). The logical conclusion is that repeated transfection within a short time frame such as recommended by public health officials, and required to achieve seropositivity, eventually leads to desensitization to the antigen. Seneff et al. explain that this development, replacing IgG3 antibodies with IgG4 after repeated COVID transfection "is immune suppressive. IgG4 plays a pathological role in many different diseases, including cancer, autoimmune diseases, allergies, and helminth infection" (2023).[29] Furthermore, in an analysis of the data available on the CDC's own Vaccine Adverse Events Reporting System (VAERS), Seneff et al. raise the troubling observations that "COVID-19 vaccines accounted for 96% of all cases in VAERS in 2021 where 'lymphoma' was listed as a symptom. Since 2021, a total of 50 cases of pancreatic carcinoma have been reported in VAERS, all of which were associated with COVID-19 vaccines" (2023).

Immune suppression as a result of IgG4 expression may perhaps also account for findings from a recent Cleveland Clinic study with nearly fifty thousand participants that showed negative efficacy for the very COVID-19 disease against which the transfections are supposed to protect. The study concludes that "being 'up-to-date' on COVID-19 vaccination by the CDC definition was not associated with a lower risk of COVID-19 than not being 'up-to-date'." (Shrestha et al. 2023, 8).

"Autoimmune" Political Attacks on Regulation and Quality Control

Returning to the irregular legal contracts for the production of the transfection products through OTA, EUA, and the PREP Act (and equivalents in several other countries), I will point to a few specific biological data points that link to my previous discussion of the legal framework that undergirds the COVID operations. This time, my observations hinge primarily on the question of CGMP, a regulatory framework bypassed by OTA and EUA. In my discussion of some of the aspects of the biology of the transfection products above, the foundational assumption is

still that we know what the products contain—that is, that the publication of contents and mechanisms of action by the presumed manufacturers are accurate and complete, or that the manufacturers are even able to characterize their products with precision. Very few independent analyses of the products have been conducted, and the few that have, are small scale. Keep in mind that, in the US these products are owned by the DoD from the moment of production until they have been injected into arms. The few independent instances of analysis have revealed astonishing surprises. One of them is a recent analysis by the molecular biologist and genetic sequencing expert Kevin McKernan, who found DNA contamination in vials (consistent with the likely use of cDNA plasmid-based cloning of RNA in the production process) with far-reaching implications for the safety of the products.[30] Two of the main risks of bacterial DNA contamination are carcinogenicity, as well as the long-denied integration into the human genome.[31]

Along with Brook Jackson's whistleblower complaints in September 2020 with subsequent legal complaint in early 2021, one of the other first official reports about major irregularities concerning Pfizer's BTN162b2 came from a data leak at the European Medicines Agency (EMA, the European equivalent of the FDA in the US) in January 2021 shortly after the FDA had issued the first EUA for Pfizer's product. The EMA server was hacked and several emails between regulatory officials and Pfizer executives were anonymously shared with journalists, among them the *British Medical Journal* (*BMJ*). Under discussion was the fact that the nucleic acid content of the product was far below the declared specifications, and an unknown amount of uncharacterized truncated and modified mRNA was found in the products. Interestingly, the exclusive area of concern addressed in the *BMJ* article that discusses the debacle is efficacy. (Tinari 2021) Even though truncated species of RNA are well known to be dangerous and implicated in carcinogenicity and other disease processes,[32] vaccine safety concerns in 2020 and 2021 remained so taboo that they could apparently not be addressed: "'The complete, intact mRNA molecule is essential to its potency as a vaccine,' professor of biopharmaceutics Daan J.A. Crommelin and colleagues wrote in a review article in *The Journal of Pharmaceutical Sciences* late last year. 'Even a minor degradation reaction, anywhere along an mRNA strand, can severely slow or stop proper translation performance of that strand and thus result in the incomplete expression of the target antigen'" (Tinari 2021). All the agencies contacted by Tinari for the *BMJ* stonewalled the investigation: "In subsequent correspondence, FDA, EMA, and Canadian government department Health Canada all stated that specific information related to the acceptability criteria is confidential" (Tinari 2021). As expected, Pfizer also blocked all scrutiny, and Moderna "declined to respond to any of the BMJ's questions" (Tinari 2021). What emerged in the leaked documents is also that regulators across the various countries were under considerable pressure to issue EUAs (and legal equivalents) in short order. As documents obtained through freedom of information act requests from the Medicines and Healthcare products Regulatory Agency (the British FDA)

demonstrate, the regulatory process was by-passed in the UK in similar ways to how it happened in the US through OTA contracting and emergency legislation, which concentrates the power exclusively in the HHS Secretary. "All the Covid vaccines and therapeutics authorisation decisions were taken by the Licensing Minister and were not delegated" (MHRA Customer Services 2023). This means the MHRA's concerns as regulatory agency, similar to the ones the EMA had expressed internally, were immaterial to the rollout of the product, and the minister of health, Matt Hancock, alone decided to go forward with the rollout.

Ultimately, the EMA settled for lower purity in negotiations with Pfizer than the one originally specified. The question of impurities, specifications, and manufacturing standards, however, seems uncontrollable with a product that is legally exempt from pharmaceutical regulation through EUA and OTA, is a military prototype owned by the DoD, and is produced at a scale and speed that are considered by pharma insiders to be impossible to be handled according to CGMP. There are several "nitty-gritty" details revealed by pharmacologist Luz Maria Gutschi in her recent sworn testimony before the Canadian National Citizens Inquiry (Gutschi 2023). Gutschi, who is an expert in regulatory law and production standards, speaks about the extreme fragility of RNA, and the sheer impossibility to scale-up production safely. She mentions many "pedestrian" details that make such a large-scale operation practically unfeasible, such as the fact that lipid nanoparticles conglomerate through various freeze and thaw cycles in the distribution chain, and shaking will disintegrate them. The purification process with magnetic beads that extracts RNA from the cDNA plasmids in which it was generated is extremely difficult to perform in large quantities, which possibly accounts for the DNA contamination discussed above.

Gutschi further analyzes the data leak of early 2021, and draws attention to the discrepancy that EMA regulators noticed in late 2020 between the Pfizer product that had been used in clinical trials and the commercial product BTN162b2 that was about to be rolled out. She makes two important points. First, when the impurities were noted, under normal regulatory circumstances, and since Pfizer was unable to clarify the discrepancy in a satisfactory manner, new clinical trials would be ordered, which did not happen. Second, BTN162b2 falls into the category of a pro-drug, meaning that what is injected into recipients is not the active agent (spike protein) but a substance that produces it (mRNA). In pro-drug regulation, the manufacturer needs to characterize carefully what exactly the pro-drug produces in the body, where it does so, and how much of it in a given time frame. None of those data points were ever delivered by the manufacturers, and in fact the spike protein for which the mRNA presumably codes was never fully characterized.

Although it has not been peer reviewed, a study by Veenstra et al. (2022) addresses this astounding regulatory disaster, over a year after billions of doses

had been injected into arms. As the authors write, there has been "extensive research around mRNA vaccines and their proposed utility…but none describe the characteristics of the full-length protein obtained from the modified/synthetic mRNA that is part of the Moderna and Pfizer-BioNTech vaccines. In this paper, we provide the first data characterizing the actual proteins produced…" (2022, 2). Perhaps more astoundingly even, they state, "In communications with Moderna and Pfizer-BioNTech regarding the proteins expressed by their synthetic mRNA vaccines, each company's medical information group disclosed that they had not examined the protein dynamics more than 48 hours post-transfection in cell culture" (Veenstra et al. 2022, 8).

A study by Banoun (2023) examines the regulatory limbo into which mRNA transfections were thrown by classifying them as "vaccines," even though their mode of action "should classify them as gene therapy products (GTPs)." (2023, 1) The author proposes that "the wide and persistent biodistribution of mRNAs and their protein products," which would have had to be studied had the products been classified as GTPs, "raises safety issues" (2023, 1). All of these unknowns, failures to characterize, and derelictions in comprehensive study, ultimately underscore the factual nature of the "conspiracy theory" statement that no one knows what is in the vials, and explain partially the wide and uneven scattering of severe adverse events (SAE) across batches and sometimes even individual doses.

A recent Danish study by Schmeling, Manniche, and Hansen (2023) found an unprecedented variability of SAEs in correlation with specific batches of the Pfizer transfection product. This study, published in the *European Journal of Clinical Investigation*, once again confirms, and puts into mainframe scientific discussion, data that had previously been vilified as "conspiracy theory" ("How Bad," n.d.). Schmeling et al. found that some batches had nearly no associated adverse events at all. This is a finding that, in a recent evaluation of Schmeling et al., the German organic chemistry professor Gerald Dyker summarized as "maybe in fact something like placebos" (Dyker and Matysik 2023). Other batches, however, are associated with unprecedented rates in the magnitude of 8,000 SAEs per 80,000 doses, or one in every ten. SAEs refer to deaths and permanent or long-term maiming, which seems to have occurred in 10 percent of all recipients of specific batches. What the study fails to consider, however, is that some batches were likely applied to different age and comorbidity demographics, such as in nursing homes. Much more detailed investigations based on all-cause mortality, which bypass the inherent bias in studies based on diagnoses, are needed. In the meantime, such unexplained variability speaks to the complete absence of quality control and regulation. No pharmaceutical product has ever been allowed to stay on the market with such a safety profile. For the sake of this associative statistical analysis, it is irrelevant whether those SAEs have been proven to be causative. The point is simply that the variability in outcomes is unheard of for a regulated

product. One batch of aspirin would never cause one thousand times the number of reported SAEs than another without regulatory intervention.

No Conclusion

Most of the quoted accredited experts who are beginning to come forward within mainstream professional and academic venues, and are diagnosing the various failures of regulatory law and have begun raising the alarm about irregularities that occurred as early as late 2020 in the interactions between regulatory agencies and manufacturers, seem to be unaware of the OTA set up and military nature of the operation. Most of them speak as if the products in question were pharmaceuticals. Most of them analyze and publish data as if, as Judge Truncale stated so cynically in *United States v. Pfizer*, they were "material." What is strikingly absent in all of this important analysis is the bigger "autoimmune" picture of the global security formations that I have tried to put into the frame.

There is no final conclusion to this article because the processes of investigation into what has happened since the COVID pandemic was announced in 2020 have not concluded, and indeed on an almost daily basis, new facts and understandings emerge, and I expect them to continue. However, what has not changed since I began to work on this material is the fundamental insight into what I call the autoimmune turn within the security apparatuses of the state and its public-private structures, particularly in relation to the antibody-industrial complex that began to be weaponized in the 1980s. The Cold War seems to have turned inward targeting the body politic, and it has chosen to do so molecularly. The duplicitousness that I have diagnosed at various junctures of the COVID operations is perhaps of the same ilk as the one Neocleous finds at work in the politics of immunity when he points out, "So: we live in an age of noncombatant immunity designed to provide civilians with some semblance of security, that is also an age of collateral damage in which civilians appear to lack any meaningful security…How is it possible that immunity is a human right ascribed to noncombatants, codified in international law and adhered to by liberal democratic states, and yet so many noncombatants are being killed by those same states?" (2022, 312). Indeed, how is it possible?

Notes

[1] Hatfill is a physician and bioweapons expert, and later came to play an advisory role on COVID matters in Trump's White House.

[2] Doe #1 v. Rumsfeld, 297 F.Supp.2d 119, 135 (D.D.C. 2003).

[3] Authorization for Medical Products for Use in Emergencies , 21 U.S.C.S. §360bbb-3 (2004).

[4] 21 U.S.C.S §360bbb-3(c)(2).

[5] I am using this abbreviated reference to the court case, whose full citation is United States ex rel. Jackson v. Ventavia Rsch. Grp., LLC, 667 F. Supp. 3d 332 (E.D. Tex. 2023).

[6] Id. at 351.

[7] Id.

[8] Id. at 362.

[9] Id. at 351.

[10] Id. at 363.

[11] Id. at 362.

[12] Id. at 352.

[13] Id. at 362.

[14] Id.

[15] Id. at 361.

[16] I am using this abbreviated reference to the complaint, whose full citation is Watts v. Austin, Sec'y, Dep't of Def. (May 31, 2023) (1:2023cv01544). The text of the compliant can be found at https://www.documentcloud.org/documents/23831826-watts-v-dod (Accessed November 10, 2023.

[17] Id. at 2.

[18] Id. at 18.

[19] Id. at 17.

[20] United States v. Stanley, 483 U.S. 669, 687.

[21] Watts v. Austin at 19.

[22] 42 U.S.C. 247d-6d(c)(1)(A)(iii).

[23] I make reference here to Ruha Benjamin's (2016) attractive concept of the "biodefector" who practices "informed refusal" at a historical moment where the foundational principle of informed consent is being eviscerated in medical contexts.

[24] See, for example, Ian R. Mackay's historical discussion of vaccine-induced autoimmune encephalomyelitis (2010, A253).

[25] Consider a 2022 Israeli study that demonstrates that it is not SARS-CoV-2 infection itself that causes myocarditis (as CDC officials have claimed), but most definitively the mRNA injections (Tuvali et al. 2022).

[26] An interesting study to consider here is David Simon et al. (2021), which studies patients with hyperinflammatory autoimmune diseases such as rheumatoid arthritis and inflammatory bowel disease who are on biologic cytokine inhibitor drugs. When infected with SARS-CoV-2, these patients appeared to be protected from severe illness because the biologic agents appear to mitigate the hyperinflammatory response to the virus. In this sense, COVID-19 acts similarly to a hyperinflammatory or autoimmune disease. However, as the seminal study by Röltgen et al. demonstrated, "histological analysis of draining LN [lymph node] shows…in severe COVID-19 compared with mRNA vaccination, higher quantities, and persistence of spike antigen accumulated in the GCs [germinal centers] of mRNA vaccinees and detectable vaccine RNA in GCs for up to two months post-second dose" (2022). In other words, presumably safe transfection produces even higher amounts of spike antigen than severe COVID-19.

[27] Amgen Inc. v. Sanofi 143 S. Ct. 1242 (2023).

[28] This is true as well for the cells of pets and livestock, since the rollout of mRNA technology is already progressing rapidly in veterinary practice (see, e.g., Merck's Animal Health platform, "Sequivity RNA Particle Technology," 2018, https://www.merck-animal-health-usa.com/offload-downloads/merck-sequivity-white-paper).

[29] In an earlier, pathbreaking study Seneff et al. (2022) found "evidence that [mRNA] vaccination induces a profound impairment in type I interferon signaling," which could potentially present causal links to cancer, neurodegenerative disease, and a host of other human health problems.

[30] McKernan (2023) writes, "8/8 monovalent vaccines sourced from a single case from a single lot of Pfizer monovalent vaccines all fail the EMA specification of 3030:1 RNA:DNA (330ng/mg DNA/RNA). They are over the limit by an order of magnitude (18-70 fold). The DNA contamination is very consistent and the vial to

vial ratio of RNA:DNA is very consistent within the same lot of monovalent vaccines."

[31] There is evidence as well from an older Swedish in-vitro study that mRNA from Pfizer's product is, despite the CDC's denials—without any clinical evidence, the CDC claims that "they [mRNA COVID-19 vaccines] do not affect or interact with our DNA" (CDC 2022)—reverse transcribed into human DNA in the liver within as little as six hours after exposure to the transfection products, and that liver cells then show changes in gene expression of long interspersed nuclear element-1, a protein associated with aging and tumor suppression (Aldén et al. 2022). Another study that addresses the risk of reverse translation and integration into the human genome is Beaudoin et al. 2022.

[32] See, for example, Romano et al.: "Small non-coding RNAs, in particular, have been the focus of many studies in the last 20 years and their fundamental role in many human diseases is currently well established. Inter alia, their role in cancer development and progression, as well as in drug resistance, is being increasingly investigated" (2017, 485).

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