Transcript
The End of COVID
Session 6 - The PCR Tests

SPEAKERS
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Notice to Viewers (00:00:00):

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The purpose of this presentation is to educate the public on everything there is to know about "the pandemic", and all the pandemics before it. That way, we can finally end this fictional show that's been on air since screens looked like this.

Mike Donio (00:00:30):

Today I am joined by Jerneja Tomsic and Kevin Corbett, both whom have extensive experience in P with P C R, although a bit divergent. But today they're gonna share their, their experiences with P C R. We're gonna talk about what it is, is it in any way, shape, or form valid to use it as a diagnostic test because PCR has been front and center as one of the primary tests for covid. And then we're also gonna talk about the kind of bigger picture ramifications of turning our health into a, the, the measurement of, of a test. Can we, can we use a test to make any sense of our health? Is that logical in any way? So that's kind of what we're gonna explore today. I want to just start off by really, you know, well, allowing you two to hopefully make the point that, you know, can a PCR test be used in any way to diagnose, you know, anything, especially a viral supposed viral disease?

Dr. Jerneja Tomsic (00:01:41):

If, if I may start I'm gonna say, so I've been working with PCR technology since 1995, so it's been some decades that I've been around the technology and what I can say, it's not diagnostic, it cannot be used as a diagnostic tool, that's for sure. And with Kevin, we will explain why. We can say that, right? But what I've used it for, so then people ask, so what were you using it for, if not for diagnosis? PCR is used to amplify a short region, a short sequence of DNA to then proceed with sequencing, to proceed with amplifying a specific gene that expresses a protein that we want to clone into what is called an expression plasmid, to create more of this protein that then we use in biochemistry testing. So it's a biotech tool that we use to do our things in a research lab.

(00:02:44):

So we've never used it. I mean, in my life, I've never used it to diagnose anything, and I was not really aware that PCR is used for diagnosis. Although now looking back, I think I remember hearing about HIV care Malis, how he was a conspiracy theorist back in the day, but I ignored the whole thing, and I just didn't look into it because it was, it was not, it didn't interest me. I mean, I just thought, okay, it doesn't really matter. So I was just using it for my purpose, but now it's actually clear what's going on, and they've been, they've abused it. So when I first heard Dr. Kaufman saying PCR is used to diagnose or to find these cases, the COVID cases, this was in, I believe, March, the end of March, 2020. That pretty much stopped me in my tracks. And at that point, I started researching. So definitely it's not for diagnosis.

Dr. Kevin Corbett (00:03:43):

I can certainly concur with that, agree with that. My experience of it has been in the clinical sphere in clinical practice. And I can tell you that when it came in, in the 1990s, had an amazing, amazingly significant impact in clinical care with HIV , and I would say a negative impact. It's a misapplication in the clinical sphere to use something like PCR because it's basically a meaningless result for a patient. And that may seem so counterintuitive, but the reality is that you are giving people a, a quantitative framework to reframe their perception of their body. And I don't think that that's morally, ethically, or scientifically correct, and it's created huge huge problem or problems certainly with HIV because with the individual, they're encouraged to look at the numbers and often look at their own conception of health, their own bodily intuition is thrown in the bin, and they become co-opted into a quantitative view of health chasing numbers, which very often are meaningless. I think it's a fraud, if that's the right word. It's certainly the creation of something that isn't there, a fiction, a chime. And I think that, that, that's basically what I've got to say about it. And that may not be a very positive thing, but I think there's things we can do about it as all these transhumanist type of techniques have come in we can move away from it and we can create descent.

Mike Donio (00:05:45):

Yeah, that's, that's great. So now we're gonna move into, both of you have brought some presentations to share that I think will provide a lot of context to what you've, what you've just mentioned. And I, I hope it'll become clear that P C r, while there are certain potentially valid uses for it in the lab, what it's been turned into via this test is something entirely different. So I think we're gonna start with Kevin and then Nia.

Dr. Kevin Corbett (00:06:16):

So of call my presentation, nature remade falsifying the polymerase chain reaction. The historical development of the PCR is a story about biotechnology and its relation to the field of molecular biology and historical perspective on the development for PCR and the associated reverse transcription. Q PCR can help us to understand the full basis of the claims that PCR can detect viral genetic material. PCR is just a set of genetic engineering techniques. These basis lies in the manipulation of genetic material now used worldwide and commercially manufactured test kits and PCR machines. Since the 1980s, conceptual and commercial development of PCR has enabled widespread administration claim and mistaken claims over virus identification or even isolation and disease staging, all of which are fraudulent fear inducing, and have proven to be devastating to both individuals bodily sovereignty and our own national economies.

(00:07:26):

The recent focus on the PCR without any critique of its controversial bio technological origin, has misled many people in the truth and freedom movement into a downstream discussion of, of how well or not the PCR detects its analytical specificity has become their, their downstream focus. This popular focus has virtually ignored the more important upstream debate over the origin or the provenance of that which the PCR detects since 2020. And the development of the R T Q PCR for SARS COV two, the alleged virus that's supposedly causing the alleged disease, COVID 19, the key issue is not how well the PCR works, but what is the origin or provenance of the applicant, the target sequence that it detects and amplifies from what is already known. The answer to this question is that it cannot be viral in origin.

(00:08:29):

In 1919, the Hungarian Carl REI invented the word biotechnology to describe technology based on converting elements of raw, natural materials into commercial products. Therefore, from its perception,

biotechnology was always defined in terms of manufacturing saleable products based on abstract abstractions from nature. Technology's core discipline is molecular biology, which started to eclipse the field of biochemistry in the 1930s as Warren Weaver, a mathematical physicist who directed the Rockefeller Foundation, colonized the field of biology with the highly reductive methods and techniques of physics and chemistry. The English sociologist Edward Yoon described how weaver transplanted into biology methods of experimental manipulation, quote, exact analytical, vigorously formulated reductive experimentation based on the methods of physics and chemistry, unquote, this enabled weaver to further extend the reductive paradigm through the Rockefeller grant system to create links between universities and industry, which favor the interests, the commercial interests of a highly reductive form of molecular biology.

(00:09:52):

The history of PCR is a history of genetic manipulation. 1953, Watson and Creek claimed to unravel the destruction of hypothesizing that one day it would be possible to copy genetic material. 1956 Kornberg claimed to identify and isolate DNA polymerase, an enzyme that replicates cells DNA In the sixties, Cara claimed to sympathize DNA oligo nucleotides, which are short bits of nucleic acids thought to be key for artificial gene synthesis. And in 71, that invented the founding principle for PCR by suggesting the bracketing of a d a targeted DNA sequence using a pair of primers, strands of nucleic acids, which serve as a starting point for DNA synthesis, and then copying the sequence using DNA polymerases. By 1977, the use of primers was claimed to be made easier with the development of techniques to sequence DNA by Fred Sanger at Cambridge University.

(00:10:57):

PCR is a biotechnology which forms the basis today's PCR test kits machines. This was originally defined back in the 1980s in Martin Kenney's analysis of the biotechnology industrial complex, where he defined biotechnology as new biological techniques that found commercial applications during the seventies and eighties. In 1996, Paul Anos critical analysis, the developed of PCR stated that biotechnology hallmark lies in its potential to get away from nature, to construct vast artificial conditions in which specific variables can be known in such a way that they can be manipulated. This knowledge then becomes the basis for remaking nature according to our, our norms. And that's the key thing here. This is about manipulation, remaking, and abstracting nature according to a set of norms. And the question is, whose norms? All of these definitions show that technologies like PCR produce outputs or products which are claimed to be pop copies of natural occurring phenomena, DNA and r n a.

(00:12:11):

They're therefore reflections, artifacts, or products fashioned by corporate intentions using genetic engineering techniques, which by definition cannot be natural, but nature remade and remade. According to the norms of viral contagion theory by the 20th century Molecular barge and its spinoff, biotechnology startup companies have begun to link across academia, venture capital, and multinational corporations. This has been critically researched since the 1970s by scholars like Lily E k Martin Kenney, Robert Coer, Paul Au, Edward Oxon, and many others. Harry Mullis was personally credited for the PCR invention by shared Nobel Prize, but it was his employer, the CERs Corporation, which oversaw the strategic direction of the P C R, the aim of the CS corporation with the technical development and commercialization of new methods for diagnosing disease at the nuclear acid level without the need for culturing what what they thought were often dangerous microorganisms.

(00:13:22):

And this is a quote from the CSS Corporation annual report, 1982, where you can see that they were developing or wanted to develop something that would diagnose easier at the nucleic glass acid level. So

the intention was always, always to reduce diagnosis and isolation of microorganisms to the nucleic acid level. Further diminishing am bastardizing the classical definitions of diagnosis and isolation by profitable and u ubiquitous entry onto the commercial markets of quicker and cheaper techniques exemplified by the PCR and the R T Q PCR PCR is a concept and a technique based on manipulation. Polymerase is naturally occurring enzyme, a biological macromolecule or polymer, which catalyzes the formation and repair of DNA and r n a chain reaction is an exponentially repetitive process whereby PCR amplifies a segment of DNA to target the alicon.

(00:14:26):

PCR is very sensitive. Given the presence of a designated target, it will almost invariably detect it. The PCR process is cycling three step involving denaturation primer, kneeling an extension of the DNA in the first step. Double DNA is denatured into single strands by heating to 95 degrees centigrade in the second step. Short, DNA fragments called primers are manipulated through heating and cooling and kneeled to these DNA strands at 35 to 40 degrees Centigrade in the third step. Primers are extended by DNA DNA polymerase at 72 degrees C by adding complementary nucleotides to the three prime end and three dash prime end of the primers. Starting from a single target DNA or ribo nucleic acid sequence, theoretically, more than 1 billion product sequences can routinely be synthesized by PCR in just one run.

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The PCR process is modified in reverse transcriptase qualitative PCR in order to detect single stranded R N a 'cause PCR can only amplify DNA . What is this process? The starting material to be amplified the applicant is amplified a millionfold. The process is useful to molecular biology because it eliminates the need for extraction of large amounts of alleged genetic material for molecular studies. Understanding how the stated intention of the SEEDS corporation that PCR was part of their development of new methods of diagnosing at the molecular level may help us to partly explain why there have been forced claims made that PCR can identify genetic material representing viral isolation, which is an incorrect understanding, even to claim the p c i amplifies viral material means that a viral origin for the applicant would need to have been scientifically proven by means of it being derived from a real person chemical isolation and purification morphological characterization, electron microscopy and photography, and then whole novel structure would need to be genetically sequenced at the very outset.

(00:16:51):

Prior to subsequent use PCR amplification technique to detect it, Harry Moler spoke about the generative power of the PCR saying that beginning with a single molecule, PCR can generate a hundred billion similar, similar molecules in an afternoon. This amplification process is exponential in terms of the amount of the outcome product. A loss of mileage has been made about this rather like the way Henry Ford could produce most cars, where quickly whereby previous techniques were more laborious. But what is it that the PCR E amplifies and how do we know what it is from a virus or a human? That's the key question. From the 1980s onwards, the Perth group of biomedical showed the proven sequence for so-called HIV was never scientifically proven to be viral in origin. The work of the Perth group was unique in falsifying the original claims over HIV isolation by showing how there was no scientific proof of either the existence of a unique exogenously acquired retrovirus called HIV, or the alleged HIV genome, r n a or DNA that ever originating in a unique exogenously acquired infectious retroviral particle.

(00:18:23):

Of course, that is not the same as saying it doesn't exist, only that it's not been proven to exist. The essence of the Perth group analysis has been extrapolated to many and all allegedly human disease causing viruses such as so-called SARS COV two. This provenance factor issue excludes any normative discussion of base theorem applied to the PCR as a medical diagnostic test. That is, we can't talk about

how well it performs in terms of force and true positives 'cause the underlying origin provenance of the target Applicant has not been scientifically proven to be viral. And given that the alleged viral etiology of what is alleged to be covid is unproven. Thus irrespective of the prior strategic intentions of the biotechnology sector and its industrial complex, the PCR cannot be used as a diagnostic test for disease. Contemporaneous ignorance about the Perth group's work coincided with scientists signifying fatal problems with the emergent fashion of conflating genetic identification with both tissue isolation and purification of microorganisms, including alleged viruses.

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For example, in 1996, Fredericks and Realman highlighted the lack of proof for viral disease by Kosh postulates stating sequence based approaches to microbial identification and disease causation share some problems with more traditional approaches, but also generation additional problems. Perhaps the most, the most obvious and perplexing issue raised by sequence based approaches is the absence of a viable or even intact microorganism, which, which to reproduce disease strict adherence to the principle behind cautious dirt. Oculars poses a major difficulty for the evaluation of microorganisms that have not yet been purified or propagated in the laboratory in relation to the 1990s UK public health promotion of HIV testing for pregnant women. It was stated by Harrison and Corbert that p c is a technique that amplifies small amounts of DNA or r n a, but the same fundamental problem exists unless you can isolate the virus free of cellular contamination.

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You cannot be certain that the DNA or r n a fragments of viral and not cellular. This statement published in 1999 highlights the key upstream issue over the provenance of what is detected by P C R. And it echoed what Fredericks and Realman was saying earlier, a couple of years earlier. However, the, our key point was completely ignored by a plethora of virologists and associated public health outlets who went downstream to protect their PCRs falsely accused us of trying to bring the UK HIV testing program into disrepute. Two years later in 2001 was the further acknowledgement from within the mainstream of the problems of trying to reduce diagnosis down to the nucleic acid level. In a discussion on how new technologies create new problems, Kal stated quite clearly, detection of viral nucleic acid is not equivalent to isolating a virus.

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This statement in a 2001 paper by Kaher represented the consensus view of 14 members of the American Committee on arthropod born viruses. It succinctly encapsulates the essential problem of conflating detection of nucleic acid with viral isolation, which previously had entered the literature by the Perth Group and others like Harrison and Corver. The clinical use of PCR technology has been shown in 2009 to undermine bodily sovereignty In a 2009 paper on the inconsistencies of patient and provider experiences of the P C R, it was shown how PCR viral load is not a test for HIV or diagnosing anything. Despite documenting that P C's license as an aid for identification, not diagnosis of HIV, it is used as a diagnostic even though readings translating to vastly contradictory medical diagnosis of positive, indeterminate and negative. You've got it. You may have it, you haven't got it.

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The mainstream claim to use it to show undetectable levels of HIV, which is the, the statistical epidemiological is wrong. Patient's experiences is setting up unobtainable goals and devaluing the hu the human immune response. It shows that the fundamental basis of PCR viral load is false, yet its use creates dependency on more and more quantitative readings to chase the holy grail of undetectable. So devaluing people's intrinsic trust in their own bodily wellbeing by 2020. The European, the first R T Q PCR for the alleged SARS COV two virus admitted in their paper in the journal Euro surveillance that no

SARS COV two existed, and that the R TQ PCR was developed using artificially generated primers and in in silico genetic sequence. This was the historical end result of using manufactured techniques of gene manipulation, reductive methods to reorient biology away from nature and towards artificial manipulation of abstracted elements.

(00:24:22):

Its nature remade to conform to the virtual construct of the virus. It's a misapplication of the PCR Corman. Roston admitted that a viral genome sequence was released for immediate public health support via the community online resorts biological.org on the 10th of January Wuhan, h u one gene back session number MN 9 0 8 9 4 7, followed by four other genomes. These were not vial isolates or samples from infected patients 'cause none had become available. The PCR therefore was designed in absence of the available isolates or original patient samples. So basically this test was created through computer software on without real live sample, without the isolated virus. Basically, that's what they're saying in this language. And here was the here's a slide of the the primers and probes. This has been backtracked quite established quite well through investigative journalists like Eric Pelino in the United States, that the, the basis for this was, was, I wouldn't say fake, but the basis was not material in terms of from real biological samples.

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It's computer generate. It's design and validation were enabled by the use of synthetic primers. Synthetic nucleic acid technology was used, and the word key into there is synthetic. This fact of no quantified virus isolates being used was picked up by the C D C in 2020. We stated that since no quantified viral isolates are currently available. Assets designed for detection of the 2019 NCO R N A were tested with characterized stocks of in vitro transcribed full length R N A of known titer spiked into a dilutant consisting suspension of human, A 5 4 9 cells and viral transport medium to mimic clinical specimen. And the key thing here is this MN 9 0 8 9 4 7. The provenance of this was not viral, was not established as viral. This something that existed in a gene bank, it wasn't derived from real patients, and there's no backtracking of it to the clinical sphere.

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This was, this fact was also picked up by the UK Pub Health Agency Public Health England in April, May, 2020. The UK National Public Health leader in charge of testing was Professor Maria Zambon Imperial College and the UK Public Health England zambon admitted that the R T PCR tests had no gold standard that involves viral isolation and the PCR tests to the alleged virus. SARS COV two were developed using synthetic transcripts. ZAMBON was one of the co-authors of the European surveillance paper, launching the R T Q PCR for SARS COV two. There was simply no gold standard of viral isolation for it. What it detected was assumed to be viral in origin, but it was never proven to be such. No study since has scientifically proven the applicant detected and amplified to be viral in origin. So its provenance is unknown and therefore the test technically has an unknown specificity and sensitivity.

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By November, 2020, the Corman Roston test was critically reviewed and the journal you found was asked to withdraw the Corman Roston paper. The 22 critical reviewers found as many as 15 FA fatal shortcomings in the PCR first and major. One is that the novel coronavirus is based on in silica theoretical sequences supplied viral of in China because at the time, neither control material of infectious life or an activated so-called virus nor isolated genomic r n a of the virus was available to the authors. To date, no validation has been performed based on isolated SARS COV two viruses or full-length R n a there are in 2023. Several co-authors of the PCR retraction paper led by or RICO KA, claimed they had overcome the shortcomings of the original PCR fabricated by Corman and Roston. They

published this in the Journal, international Journal of Vaccine Theory Practice and Research claiming that all sorts of things, and I'll briefly go through that before finishing the claim, is to fabricated a new highly sensitive and specific PCR for the alleged SARS COV two virus.

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As you can see, their claims are contradictory. If you read the paper, some of the statements support claims in the original traction paper about the fallibility of our DI diagnostics. Yet other statements implied that the PCR can be used to identify viral material in the absence of prior isolation purification and EM morphological analysis claim to have fabricated a better test actually rests on their use of part of Target five dash slash U utr, a consensus region of that target as which they claim is specific and sensitive over and above anything else. They say it's a unique consensus region based on what they claim is the inter-individual genomic heterogeneity of the alleged SARS COV strains, alpha, beta, gamma, and delta. Now the issue, this is, this is the basis of their claim for creating the perfect PCR for SARS CO two. However, researchers have falsified the idea of consensus regions from genomics representing anything materially real in nature.

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And likewise what are called different strains only represent artifacts from PCR and genomics. Therefore, the same question needs to be asked of this paper by camerara etal. How do they know that the consensus sequence embodied within five dash slash UTR is viral in origin? How do they know this? This is not stated in their paper. And therefore the answer to this question is unknown. That's the question we need to ask. So to wrap this up then PCR cannot be used to detect a virus unless what is detected is first. What is detected is first proven to be viral in origin and detection of viral nucleic acid is not equivalent to isolating a virus. PCR can only be used to amplify specific known nucleotide sequences, and it has to be known in advance. So you'll had to isolate, purify, morphologically, characterize, et cetera, and genetic sequence it before you can then detect it.

(00:31:38):

PCR cannot determine the origin, the provenance of significance of any nucleotide sequence. Thus, what is detected and amplified cannot be VAR unless number one is proven. And PCR anana analytical sensitivity and specificity isn't equivalent to diagnostic specificity for a clinical condition. So until you've done number one here in the conclusions, you cannot go on and apply it to populations and calculate sensitivity and specificity using a normal, standard based theorem that you use for any medical test. It cannot be applied to populations in that way. And that's basically what's happened and what ha shouldn't have happened since the 1990s. And it's happened because of the overreach of technology, because of the phenomenal performative value of PCR in terms of its amplification and its, its overreach beyond the laboratory into the clinical sphere when it should have been kept as a laboratory tool only, not as a clinical diagnostic. That's the end.

Mike Donio (00:32:50):

All right, great. Thank you, Kevin. That was, that was really great. There are, there's a lot of really good and critical information in there, you know, I would suggest even that people go through that a second time because you, you make some, some really important points and, and distinctions about PCR and its use. So thank you. Let's now move on to Renee's presentation if you're ready.

Dr. Jerneja Tomsic (00:33:20):

So thank you, Kevin for the amazing introduction on history. Let's say I'm focusing right right now because history to me of PCR was Kerry Malice was driving up and down the Pacific Coast Highway,

which is the famous highway in California. And in the middle of the night sometime he came up with this idea of how to use an enzyme to amplify these molecules, right? So this was the story that I was told back in 1995, and I bought without even questioning. So there was this one guy who was really smart, and he created a tool that now in molecular biology labs and biochemistry labs we were using. But Kevin went into the history of who he was working for. All of those other people that actually were describing back in the day what they wanted to do. They wanted to be figuring out how to use DNA to do what we are doing now.

(00:34:27):

So it's been a long time plan, but we were just not aware of it. So I will really go more into how PCR works as I've been working with it in the lab, and I've designed my own primers and all of that. So, and I've been digging deep into trying to understand how it really works. And this was even before C Ovid 19 thing started. So as I said, in March, 2020, my, my world turned a little bit, started turning a little bit upside down when I realized that PCR is used for di for diagnosis of, of diseases, let's call it flu. And then it's HIV and then it was SARS COV two, the C ovid 19. So I became curious and I said, let me go and look into the virology textbook. And this was the interesting box 1.1 that I found in these principles of virology book. Mike, can I ask you to please read?

Mike Donio (00:35:37):

Yeah, sure. Although Koch's postulates provided a framework to identify a pathogen unambiguously as an agent of a particular disease, some infectious agents, including viruses cause disease, but do not adhere to all of the postulates. In fact, it has been argued that the rigid application of these criteria to viral agents may have impeded early progress in the field of virology. Koch himself became aware of the limitations of his postulates upon discovery that Vibrio cray, the agent of cholera could be isolated from both sick and healthy individuals.

Dr. Jerneja Tomsic (00:36:22):

Thank you, Mike. I just wish that people would seed with this few sentences and really take them in and really start seeing what's going on here. So it's clear that rigid application of Cox postulates may have impeded early progress of virology. Wait a minute. So what they are telling us, Hmm, let's throw Cox postulates out because we can proceed with this new technology that we have now in nineties, 2000. So we can go on and again, create a story of what is causing diseases, of what is causing people to have certain symptoms, right? So, and this is the, the new technology that was pushed forward, more sensitive technologies, which is including DNA sequencing. And PCR goes with it have triggered reconsideration of co postulate. So before standard techniques were used which I'm not saying that they are perfect and that they work and that they do what we were told they do, but they just went and tossed all of that out, like growing bacteria and viruses in cell cultures.

(00:37:47):

Now they just went and detect some sequence that somebody claimed belongs to a viral genome. Here is a plot that a person that works in the lab that is working on the real time P C r they, this is the result of their PCR reaction. So when we are told you need to swab your nostril and put the, whatever's not in the tube and send it to the research lab, this is what you do, you swab and then you send it to the lab, which will add some chemicals in it. And the polymerase, I'll talk about it in, in a bit. And then they run, they put this tube in A PCR thermocycler, and, and this is what you get. So you get on the I axis, you get PCR product is increasing, which is actually shown is measured as an increasing fluorescence.

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So how does this work? Increasing fluorescence. So at every cycle, which again, I will explain later on, at every cycle this third primer is releasing fluorescence. So when PCR is synthesizing new strands, fluorescent tag is being released. So every, every cycle you get a higher and higher number, so higher and higher fluorescent amount. And pretty much what happens is we have a threshold, which is an, in an arbitrary level of fluorescence that is chosen on the basis of the, of the baseline variability. So it's actually a signal detected above the threshold. And it's considered a real signal that can be used to define the threshold cycle. So everything that's down here, you wouldn't consider as anything you wouldn't consider as positive, you wouldn't consider as the signal, but everything that's above here you consider as real. So in this case, let's say in this sample you call 15 cycles.

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This is where your curve crosses the PCR threshold. It's at 15 cycles, and in this case it's in at 19 cycles. And pretty much this is what you would get back from the lab. Usually some people were getting the numbers, some people were getting just, it was positive. And that's it. And what we need to always keep in mind, we always run. So when you start a PCR machine, the thermocycler, it always, you set up how many cycles you wanna run the reaction for. So you set 40, 45. So it always goes all the way through to the end. And a camera that's attached to the, to the cover of the machine is actually picking up the fluorescence. So in real time, that's why it's called real time p c r. In real time you are seeing the increase in fluorescence, right?

(00:40:55):

So you set the number of cycles at the beginning and, and you, when you look at the results, you see, okay, this one was 15, this one was 19, right? So, so this is the polymerase chain reaction, which is a chemical reaction. Kevin already mentioned a few things about it. I'm just gonna repeat briefly. So we have the nucleotides that are building blocks of DNA , right? We have G A T C, G is s pairing with c, a is sparing with T. And here we have an example. Let's say on one strand you would have G A T C, and of course on the other trend you would have in the other order because C pairs with G pairs with a, you would have in the other order, G A T C or C T A G. And polymerase is the bricklayer.

(00:41:46):

So polymerase is actually the the enzyme that would be adding nucleotides to the three prime end of the primer. So you need, so these are primers are short sequences of DNA 18 to 22 nucleotides usually. And you you pick a pair of primers that is in the, in the area that you want to amplify. So let's say I want to amplify my whatever gene. In SARS COV two, they were amplifying a few different areas, a few different genes that somehow they found in the silicone sequencing. So you pretty much create these primers and you put everything in and you run this thermocycler, and the cycles mean it's cycles of temperature change. So you are actually starting with 95 degrees opening of DNA . Then you have, this is for a certain number of seconds, and then you have another cycle, which is binding of primers to complementary sequence.

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So usually it's based on the sequence of the primer, which temperature is fitting for the primers. And usually if the sequences are very far apart as the GC content I won't go into explaining that, but for people that understand P C r, they will know what I'm talking about. So if one primer is optimal temperature is at let's say 56, and for the other primer, it's let's say 64 PCR reaction most probably will not work properly. So you will have to redesign primers and play with it and, and repeat it probably several times and maybe redesign them. And then there is the, the final step, which is usually going for like a minute, it's a 72 degrees which is really when the polymerase adds nucleotides to build this new

double strand. So this is how the reaction looks like you have at the beginning your long molecule, which whichever length molecule of DNA and of course we shouldn't forget.

(00:44:02):

So here we're talking about its DNA amplification, as Kevin already mentioned. Polymerase chain reaction, PCR only works on strands of DNA . So you first need to reverse transcribe r n a. And again, we won't be going into it right now at this point, it doesn't really matter. But what I want to point out is when you purify r n a from your, from your sample, from, from the snot, from wherever the sample is coming from or from the cell line that was inoculated with the snot previously. So wherever you purify this r n a from you need to understand that in all the papers that I I've come across, it says R n A was purified using viral r n a purification kit. So just because it says viral r n a purification kit, just because there is that word viral is it doesn't mean that it'll pull viral r n a out of the mix.

(00:45:06):

So viral r n A is no different chemical information or chemical facts of viral r n a are exactly the same as of human R n a or a a planned r n a or any r n a. So it'll not separate one r n a from the other. So we know that we have a mix of RNAs when we go down the down when we proceed with C DNA synthesis. So this is then the PCR when we have this molecule maturation, you open up the double helix and then you ane the two primers. So one is complementary, one strand on one end, and the other one is complementary to the other strand on the other end. And then polymerase extends and polymerase just keeps going at the first at the first run. So then you do the second cycle again, and you open these molecules, right?

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And you, again, a neo forward. So one is called forward, one, it's called the reverse primer, and you just extend again the molecule and make new molecules until you get to the point where many, many, many of these molecules are created. So these molecules are actually of a specific size. They begin with the forward sequence of the primer and, and with the end of the reverse sequence of the primer. So then you can actually see, you have many, and I will show later on what this many means, although Kevin already mentioned at every cycle you do two to the cycle number. So you do two to the two, it's four, I guess, right? Two to the three is eight. So every cycle you amplify, you exponentially amplify your molecules. Here I just pulled out one thing that it's important to mention.

(00:47:04):

Again this is a cartoon of what polymerase does in the, in the reaction tube. So it's, it has never been really shown that this is how it works. It's just a cartoon based on models what they think, but it's very convincing. I mean, the, the whole thing, what they're usually showing in cartoons, everything is very convincing, right? So, but I don't want people to confuse with something that you can really see like an apple hanging on the tree or whatever in your fruit basket compared to this. So nobody has ever seen this, right? So, but I want to point out the DNA polymerase fidelity. So actually I had to go and refresh my memory because I forgot what is the fidelity of DNA polymerase. So when polymerase is adding these building blocks, these nucleotides during the PCR reaction, it actually makes mistakes.

(00:48:05):

So the error rate of polymerase is one in 3,500 nucleotides. So if we think about it, let's say if you have a strand of, if you're trying to amplify an amplicon of 350 nucleotides only, you only need to amplify, make 10 molecules when there is a chance that one nucleotide will be wrong, right? Because it'll be at that point you would have 3,500 nucleotides, right? If you 10 times 350. So, and if, if the mistake happens relatively early in the cycles, you just keep amplifying the mistake. So then you sequence something that is not even close to what you started with. And this is the thing. So then of course there are polymerases

that are used in research labs that are, that have way higher, like lower error rate, so way higher fidelity, but they are much more expensive. So you really just use it for specific things.

(00:49:15):

And definitely they are not used in this, let's call them diagnostic tests again, quote unquote, because they shouldn't be used for that. So this was, this is just to point out that what is being done is actually creating of molecules that are not even the same sequence as what the original molecule was that you started amplifying. So just to go back to what we are amplifying when we run PCR cycles. So let's say if you start with 10 molecules at the beginning, so the dark blue after 10 cycles, you have 10,000 molecules, and with 50 you have 50,000, right? If you keep going with cycles, you actually see that let's say if your T c R threshold, what I said before, which is the, the threshold when below it, it's kind of the baseline and above it, the result can be taken as the real result.

(00:50:20):

So for 50 molecules, you actually get over the PCR threshold at 17 cycles. So this would be your ct when you start with 50 molecules and for 10 molecules, you only get over the PCR threshold with 20 cycles. So this would be the difference between, as I showed at the beginning. Another thing that I want to point out is in this test, in these diagnostic tests, there never is a reference gene. And this is what people that work with quantitative PCR are never thinking about, are never mentioning, are pretty much always ignoring. So this is the experiment. This is kind of a result of the experiment that we, when we use real-time PCR to do gene expression. So when we are looking at an expression of of a gene in a cell after we treat the cell, let's say one is treated with a drug and the other one is not treated, and we want to see if the target gene that we are interested in, if the expression increases or decreases.

(00:51:30):

So what is important is always to have so-called reference gene, which usually it's g dh or there are some other genes which are genes that which expression doesn't change when you treat cells with different things. This is just what, what we see. So the expression of those doesn't change. So it helps us. So tracing this gene, it actually helps us to see if when you, we see differences in argene expression, we can understand if it's due to different amount of R n a being in the tube between one sample and the other, or if it's really the difference in gene expression, how much gene is expressed in, in one sample or the other, right? And in for all these diagnostic tests, this is never done. So we actually don't know how much starting material we, we even had, and then we are just amplifying something that we don't even know what we're dealing with.

(00:52:35):

So I would say that there are several problems with P C R, which is what I mentioned. The polymerase makes mistakes which is during C DNA synthesis and PCR amplification. Very often I've seen, and again, some people say that I'm not able to design primers, but that's not the case. Even when primers are designed with what's called, I think primer three is one of the softwares. Very often it can happen that you get a specific amplification. So maybe it's something in your, in your water, maybe it's something so you need to change water. But sometimes even when you, when you open a new bottle of water that should be DNA R N A free, you still get amplification. So there are things that go on in those tubes that nobody really knows what's going on.

(00:53:26):

In a research lab, we never run more than four amplification cycles. So we always say, we always say that something that's above 35 is not, when we do gene expression is not to be taken as a result of there being amplification. And I've heard that these diagnostic tests are often run with 45 or more cycles. So that is definitely a big problem. And as I pointed out, what we are looking at is a fluorescent signal, and

this fluorescent signal does not even mean that the target and sequence was amplified. So if we really want to know what we have in the tube at the end is we would need to take the tube and submit the tube for Sanger sequencing. So we would really see what is the product, if the product is what we were looking for at the beginning, or the product is something else just gave the signal, but it has nothing to do with, with the original amplicon we are looking at.

(00:54:27):

So I just want to, Kevin went into the, the mentioning this Corman roston paper that is the one that where the whole thing actually started. I mean, we started with being able to find cases, quote unquote cases of c ovid 19 sars COV two carriers when they designed these primers based on in silico sequence. And what Kevin pointed out was that they tested these primers on in the lab synthesized sequence. So what they had was they sequenced a piece of DNA that contained what they wanted to amplify in, let's call it a viral genome. They sequenced it and they saw if these primers were working on that sequence. But again, that has no meaning, that is really just checking if PCR reaction on its own is able to amplify something. But the question, it is, what is that something?

(00:55:33):

And one thing that we need to notice here is the ridiculous, completely ridiculous concentrations of time. So I don't know what other people do in the labs. I mean, I've seen stuff done in the labs that I just hold my head and I'm like, wow. 800 ano molar is at least four times over, let's say here at least four times over the concentration that is usually recommended. So usually concentration should be between 102 hundred nanomolar. It doesn't really matter again, what it means in oles. And so people that don't really understand chemistry that goes behind it, it doesn't really matter. But what happens is when you throw a higher amount of primer into the reaction, you will actually amplify stuff that, hmm, I'm not even sure if it's, if it exists in there. And again, we are not even sure it really amplifies something because as I said, when you see the fluorescent signal, it doesn't mean that you amplified what you were trying to amplify.

(00:56:45):

So this is just one of the shortcomings in that, in this paper. And it was pretty much, it was torn apart by the Corman Roston review that Kevin is also the co-author of. And they found those other several points that are the problem. And definitely here in the sequence, I mean, this is something which you usually don't put inside a primer sequence, R means, so GT c A are the nucleotides. R means that in this place you can have a G or an A. So they're already giving it some sort of okay, it, it can amplify this, but it can amplify also something else. So they give it, they make them less stringent, and this is not how things are usually done. So, so this is one thing, and then I looked briefly at this latest paper. It's interesting how only four of the people on this paper, or only four out of the 22 that published the Corman Roston review paper, which Kevin is also co-author on, are part of this new paper.

(00:57:58):

And they actually pulled in a couple of new people, Sonia Kova from Czech Republic, and I'm not even trying to pronounce his name, it doesn't matter. And they're all PhDs and they all probably hold like high positions somewhere in biotech and so on and so forth. So I didn't even have to read the whole paper again. I usually start at something that I find, I mean, in that virology book was was box 1.1. Here is actually box one, no diagnostic value of R T PCR for the proof of an an infectious virus. So they already say there is no diagnostic proof, there is no diagnostic value of R T P C R. So of utmost importance and irrespective of any protocol design, R T PCR solely detects, detects the reverse transcribed and amplified R N A targets selected by applied primers, and therefore can by no means prove that replication competent infectious virus is actually present in a given sample.

(00:59:04):

So they say again, and this Kevin pointed out, we don't even have proof that there is any such thing as an infectious virus and so on and so forth, but clearly they know themselves that what R T PCR is doing is actually not able to really say that it's amplifying something that belongs to the sequence, to the complete sequence to the complete viral genome sequence. And of note, due to the high sensitivity of R T PCR reju residual not infectious, viral, R N a remains de detectable even in the absence of infectious viruses. So you can actually have degraded pieces of something, something sequences that belongs that come from who knows where that you would amplify with this R T P C R. So definitely what they are describing then because they found the five prime U T R that can be used because using that region, they overcome some shortcomings of the first W H O recommended R T PCR test.

(01:00:17):

But again, they are just showing us how good they are at designing primers and tweaking PCR reaction to amplify something that can be sequenced and so on and so forth. But again, it's all just an illusion because what it's doing, it's amplifying something that nobody has ever proven belongs to the full length viral genome because again, it's everything based on assumption on the in silico sequence, which is an assumption that what the computer tossed out as the result is something that is really there. So I really have a little bit of a problem with when people see things that are the problem, but they don't want to go all the way and are kind of backtracking what they may be said at some point. So, and with this I will stop. Thank you.

Mike Donio (01:01:16):

Thank you very much, AYA, that that was great, really, really good overview of what PCR is and some of the, the potential limitations sources of air, we could spend an awful lot of time <laugh> discussing. You know, both you and I have, have used this technique extensively, primarily for its intended purpose, but you know, clearly it's been sort of hijacked into this other really weird usage as, as a diagnostic. I just wanna, you know, make it really clear for the viewer, especially if they're, they're not familiar with this. So, you know, one of the biggest takeaways, obviously, especially with respect to the current PCR tests and the the sort of origins of that being, the, the, the work that was published by the, the corpsman and dross group, the fact that they didn't even have any source material, any viral isolate or material, that there was no established providence of the, the sequence, the nucleic acid sequence that they used to design their primers.

(01:02:32):

That's a huge issue. How do you, I mean, that means that there was no appropriate gold standard reference to, to test that that assay and any test really that was derived from that, that's been put into use to quote unquote diagnose people. But let's just say for a second that you did have that material. There still are considerable potential sources of air and issues with PCR as you, as you just showed, AYA, what, in your experience and, and in your opinion would be some of the, the biggest, like to highlight for people that could, that could really be create confounding issues or you know, false positives, let's say, or you know, where a lot of people might think that these are very sensitive and, and you know, a very sensitive and accurate tool, especially real-time p c r. Like how is it possible that you can get a positive result, but yet it not actually be positive?

Dr. Jerneja Tomsic (01:03:34):

Yeah, as, as I pointed out right there is you can get a positive even without anything in your tube, like just with water, right? So there is one thing that can happen because of primer dimers, other things, especially when you throw in these huge amounts of primers, huge amounts of primers do all sorts of

tricks. So that's, that's definitely one thing. Another problem that they're kind of fooling people with is when Corman roast and they said, we need to amplify. I didn't point out, but in that table, they were showing three pairs of primers targeting three different regions, right? So and they kind of said, so I think that the test was at one point amplifying all three, but then they said, even if just two are amplified that it's still okay, if two are positive, then you are still positive and so on and so forth.

(01:04:32):

But it's, again, you are amplifying something that is, if you look on the, in the, on the viral genome, if you look at the, in silica, a sequence in the viral genome, those regions are separated by several thousand nucleotides. So even if, let's say that viral genome exists not just in silico, but even if it exists, nobody's telling you that those regions are connected with each other. When you swab the nostril and then send the sample to sample it, can everything be degraded? It can be fragments. So nobody knows what's going on. But again, they just sell it as, oh, if you have, if three are positive, then it means it's the complete, the full length viral genome, and so on and so forth. So I mean, that, I'm really having a hard time to just pinpoint one thing. And I'm sure by now, I mean, people have seen how the sequencing was done, right? Because it, it was explained in, in previous webinars. So it's clear if maybe now you go and watch that again, it, some things might become even more clear.

Mike Donio (01:05:48):

Yeah. Thank you. Do you have anything to, to add to that, Kevin?

Dr. Kevin Corbett (01:05:53):

Yes. I think the issue here is that it's so difficult, I think for people to understand this, because what happens is people go into, it's like a rabbit hole. You go into the black box of the P C R, and everybody's done this in the last three years. You know, we knew this 30 years ago that, that unless there's a purification and a morphological characterization and sequencing and absolute proof that this thing is viral, and, and for the to be viral, you've got to replicated the so-called disease it's supposed to represent. So you've got to have a model to, it's got to fulfill those co postulates. You cannot get around that. And that just hasn't done, they haven't been able, the system, the system haven't been able to do that. The techniques haven't been able to do that. So they've attenuated these definitions, these co postulates into other postulate, other, you know definitions to, to show that they have something that's viral when they haven't.

(01:07:10):

And this is what happened with HIV, they changed the definition of a retrovirus from the 1970s to the 1980s. So what Gallo Montier showed in the lab could be shown to be retroviral, but it wasn't. It's this phenomenon, this manipulation of material that I mentioned earlier. That's all that's happening. It is like a, a sort of 20th century, 21st century alchemy in a way. And maybe that's unfair. And I don't mean to diminish what people are doing in the labs on a day-to-day basis and the work that Janine is doing, but what's happened with this is it was never a diagnostic. Well, that's wrong actually. The nucleic acid di identification was always seen as to become diagnostic. That's what CITAs Corporation said in 1982. They wanted to develop diagnostics based at the nucleic acid level. They don't want dispense with all these wet labs and expensive people in white coats and all the rest of it.

(01:08:14):

They want genetic engineering to identify disease. And that's where we are today for, you know, 40 years later with after the the development of this, you know, we're, we're into this virtual identification of disease. Diagnosis of disease. Yes, it shouldn't be used as a diagnostic. Everybody says that every data

sheet that you pull out on PCR says it can't be used as a diagnostic yet. That's exactly what it's used for. It's exactly used for just that. So it can't be kept in the lab. It's translated into this clinical sphere but without any checks and balances. And this is what's happened. It's a jack in the box that's un un unregulated, really, no matter what standard operating procedure you use, it's all a mess. You are amplifying rubbish, you are amplifying noise. You don't even know what target is really that you're doing.

(01:09:18):

And I hate to say this, but it's technology rip what run wild, really. And no matter how sophisticated it looks or how quantitative it looks or how normative it is, it's actually a very, very dangerous technology. And when I've seen it translated into the clinical sphere, and it becomes the goal for people, the quantitation becomes the goal for their lives. And I've seen this 30 years ago with HIV patients that end up chasing a chimera, you know, a a false horizon of undetectable with HIV. And their lives are gone and they spend the rest of their lives on drugs trying to do this. And this is what I think we need to, to tell people is that the, you know, no matter how well you do a technique like this in the lab, that's one thing, but actually it's translatability into the clinical sphere is what's wrong.

(01:10:24):

Keep it in the lab, keep it as an identification, an amplification mechanism. That's all it is amplifying. That's all it is. It's for amplification. And you know, one thing I would say about Carrie Mulli is that scientists who get Nobel prizes invent all sorts of, just so stories post hoc after the event. And I don't wish any harm or any malice on Karen Malice, but really he was part of a bigger wheel, a bigger machinery, which is the SEATS corporation. And all these bio technologies have come out of venture capitalism and pharma working together with the academics and with the agencies like the F D A and the C D C and over here, the Public Health Labor Service, the UK H SS a. And this is the nexus. This is the infrastructure. It's come outta and it serves those purposes for profit making, et cetera. It's got nothing to do with health and health gain and wellness and sickness. Very little to do with that. It's about product development and market placement. And you can see that in the last three years. It's incredible. I'm sure your labs genega full of PCR machines and, and the rest of it does it cost a huge amount of money.

Dr. Jerneja Tomsic (01:11:52):

May I add something because Yeah, please. I mean, you, you described everything perfectly. So what I can add is when you realize, so I went into biology, I wanted to solve this, solve that, and then I went into cancer research as a molecular biologist. I'm like, yeah, I'm gonna help people, and so on and so forth. And then 2020 comes and you sit at the table and you tell to your husband who's also a PhD in molecular biology, and you say, do you realize that we've been tools in the hands of people, corporations, whoever that really doesn't wish us well as humanity? So it was that realization. I'm like, wow, interesting. And again, we didn't do it knowingly, right? I mean, you just, you do your thing. You see the positive of everything. When I was as an undergrad we were working, it was more like biochemistry in bacteria and stuff.

(01:12:58):

Oh, we gonna find antibiotics, you know, we will improve people's lives. And again, that's another thing. Do we need antibiotics to improve people's lives? That's, again, an upside down story. So we won't go into that today. Right? But just saying slowly, slowly, you just, you just keep only seeing the positive of everything, of technology, everything that you're using. And you can get very much sucked in by the new technology that they're bringing into the labs. So right now, it's all these single cell analysis. It's all these fancy, I mean, it's a lot of fancy technology that what happens is you as a wet lab person, you, you

create, you, you make single cell out of tissue, and then you send for sequencing, you do all these different treatments, and then results get into the, into hands of, in bioinformaticians, I mean, you call them bioinformaticians, but nothing to do with bio.

(01:14:03):

They've never seen a patient, they've never seen they never studied any biology. So they just, oh, so what question can we answer with this data that we have? And it's so much data that they themselves don't even know what to do with it. Like all these sequencing things and stuff. And it's, I pretty much compare it to the sandbox and, you know, all of those little, little tools that kids are using. I mean, it's just a little bit different form of a sandbox. And the tools are a little different. It's not whatever kids use, right? So <laugh>, I mean, it's, you just give all of these toys to people that have PhD, md I mean, that are so smart and everything, and they get lost down the wrong path. And to bring them back is very hard, very hard, close to impossible, because I mean, they don't wanna see it.

(01:15:01):

They definitely don't wanna see it. You, you need to have some sort of a connection still with reality to realize, wait a minute, something is off. Something is off. And c Ovid 19 shook several of us. I know. I mean, two are sitting here, right? It's Mike and myself. Like we've been, yeah, I'm still in the lab because I think I still need to be there to, when time comes, I think I will need to help people. Because right now they're slowly, slowly realizing that something is off, but they're still not ready to accept. When I point out you've been, you are jabbed, you got all these vaccines and you keep being sick. And I've not had anything in the last three years. Oh, yeah, yeah, yeah, yeah. They just dismiss me. So time will come when I will need to explain to them, listen, let's sit down. Let's have coffee, tea, whatever. But yeah, going down using these shiny objects that are powerful computers and stuff.

Dr. Kevin Corbett (01:16:09):

Can I just say something Mike, about the Coleman Roston review report, the key issue with that paper, which is called the retraction paper, the key issue was the in silico sequencing. This was the key critique, the major issue that the 22 life scientists had with the Corman Roston charity test. And it's interesting because all the rest of Corman Roston review report was about the technical, the primers, the probes. But the, the provenance issue was this, in silico sequencing, this in silico approach, this virtual approach. So you can conjure up a test, a medical test, without any patient material, without any, any life sample, without any purified isolated. You can conjure it up outta thin air, basically with, you know, the computer modeling, with the genetic sequences online. You can whisk it up out of nothing really outta nothing material, outta nothing really biological in a medical clinical sense.

(01:17:32):

And I think this is the key essence here of these technologies like PCR when they're translated into the medical sphere, that they construct something that looks real out of unreality. And I think this is the danger of it. This is the absolute evil essence of it. And I use the word evil because I think it is evil. I've been on the other end of this in the clinical sphere with patients being given results, being given test results, their lives are being gridded, their lives are being undergirded forever with these technologies that become the Bible for their living. And it's just plainly wrong. It's just so incorrect translation of science. If PCR is science, and I don't think PCR is science, I think it's all technique. It's manipulative engineering, it's technique. It's what <inaudible>, the philosopher, the French philosopher said, is technique, performative technique done to the nth degree of efficiency.

(01:18:46):

And I think it's, that's nothing like a diagnostic test. A medical diagnostic happens within the differential diagnosis, which those of us who've been involved in caring for people in clinical settings, the differential diagnosis is a spectrum that you move across. And it depends on clinical examination history, taking the testing that the medical lab testing is less than 5% of that, the not over 95% of a medical diagnosis. A clinical diagnosis for a patient is to do history, physical examination. That's the real nub of it. Not just a a wham bang test. We send things off to be tested in a lab. It's not definitive. And the differential diagnosis is a way of formulating a diagnosis from all the available evidence. And what these technologies do, like PCR is that they dispense with the human aspects of the diagnosis, the human aspects of the differential, which is history taking and clinical examination.

(01:20:08):

And that's why with HIV and with p with all the rest of it, that's happened since HIV up to sars COV two, you've had these asymptomatic concepts, these concepts of asymptomatic infection, which is, is not it's total contradiction in terms, it's an absolute contradiction in terms. And that I think is the evil nature of it. You can tell people completely well with no symptoms, that they're unwell. You can convince them that they're sick when they're not. And I think that that's pathological in itself. And I think this is the, the flip side of these technologies. They look wonderful in the lab. You know, everything works perfectly. You can set your thresholds or whatever, you know, you can do, you can, this is the problem with it. It's so malleable, PCR and as we've seen in the last three years some countries were running over 50 cycles so that we guarantee positive results based on what, based on nothing.

(01:21:17):

And I think at the end of the day, it's meaningless. This, it doesn't have a meaning, and it's been ascribed and attributed a meaning that's gone beyond any of the science, any of the technique. And I think this is so important that people try to realize this, and that we actually throw a spanner in the works of this technology and destroy it, destroy people's faith in it. Because unless we do that, this will just continue again and again and again. And you see the, the ramifications of this where people are using other tests like lateral flow to, to, to say that they're unwell when they've got no symptoms or when they've got a cold, they've got cold symptoms to say they've got something called covid absolutely spurious and so wrong. I, I can't, I can't stress that enough, really.

Mike Donio (01:22:16):

Yeah, that's, that's such a critical point to see how this stuff is being used and to, to, to the ends that it's been taken from something a, a tool in the lab that's really a manufacturing process technique where now as you said, we can create a test that supposedly detects something that's never even been proven to exist like they did with these in silico sequences. In fact, you know, we talk, we talked a little bit about sequencing, and I believe, if I'm not mistaken, the session on sequencing directly proceeded this one. So hopefully the viewer will be a little bit up to speed on sequencing. But I just wanna, so sequencing there, when, when the human genome was sequenced, there were multiple groups that were doing it. And one of the groups was, was led by a man named Craig Venner. And immediately after, so the technique that he used was similar to the technique that is being used to sequence all these supposed sars cov two genomes, this high throughput, mass tandem sequencing.

(01:23:32):

Well, he went out and after he completed the human genome and sequenced the air, the oceans, and claimed to have found all these new organisms because he identified sequences that weren't found in various databases and things. And people said, well, how do you know if you've never seen them, if you only have the sequence? And so thankfully they kind of called them out on it. But it's the same thing here where we've, we've, so as <inaudible> said, this technology has been put at a level, and it's so, I

don't even know it, it's just so captivating to scientists, especially the younger ones, to use this, that the information that comes out of it, we're, we're accepting it at a level where there's basically no burden of proof anymore. Just because we can find a sequence that we can claim through some kind of reasoning is viral in origin, then we can derive a test from that.

(01:24:34):

And now we've taken a process from the lab that has certain potentially usable capabilities, hold it out of a lab. Kevin said, we've packaged it nicely, it's established further credibility in it and commercialized it. And now everybody's using these things. And what has that done to, to health? It's, it's flipped it on its head, right? So let's, let's kind of wrap up, talk a little bit about that, like how this is completely inverted the way we really should be thinking about health. It's created this technocracy and yeah, I mean, so, so comment a little bit on, on that because that's really what I think, you know, where we're going with this here. We can talk about the techniques and all this stuff. It's the big picture ram, long-term ramifications of using this and what people have done with it now that it's been commercialized and is so available.

Dr. Jerneja Tomsic (01:25:32):

Can I just briefly, because I'm just gonna be brief because I'm so done with this <laugh>. I mean, so what I really hoped for in 2020 as I started seeing what's going on, wait a minute. Mm, something's off. I was hoping that people that have known me, that people I've interacted with work colleagues or you know, other people that I interacted in my volunteering mission, whatever life, so that they would kind of listen when I reached out to them and said, look, we need to look at this PCR thing because so, so, so, right. So to people that have worked with p C Army and my husband reached out and said, look, this is not to be taken as gospel because something is off here, right? I mean, you hear this asymptomatic patients and all of that stuff, and then asymptomatic infection.

(01:26:36):

And we were completely dismissed and ridiculed. So I'm like, wow, that's, that's weird. That's weird. I mean, people didn't want to understand. They didn't want to think at all what it means. If we start going down the testing for all of these new, let's call them new viruses, SARS COV two, and then would be a new birth flu virus and this, and they didn't even want to see what it would imply if we keep going. And I mean, people that went for testing when one woman I remember, she goes, oh yeah, I have a headache. So I decided to go and get tested to see if it's covid. I mean, people have been completely bamboozled into this whole thing because didn't you have a headache before at some point, maybe in 2015 and maybe in 2019? I mean, a headache is a relatively common thing that happens to people, right?

(01:27:39):

I mean, it's not something so to run out and go get a test, I mean, I couldn't say anything. I just looked at her and okay, because I tried before. Right? So it's, it's, and it's really inversion of reality, and it's creating this fake false reality that's completely upside down. Completely upside down. And all of these terms, I mean, isolation doesn't mean to remove everything from everything else, but means mixing this with that. I mean, it's like, it's completely upside down. And when people don't wanna see it, it's really nothing that we can do to make them see they need to come to their own. They need to kind of awaken at their own timing and decide, okay, let me look at what these guys are talking about, because maybe they are right.

Dr. Kevin Corbett (01:28:35):

Yeah, I'd certainly concur with that. I think it's important to have a historical perspective on these technologies that goes right back. And when you go back to see the context within which they were manufactured, they were created. They were conceived, yes. You've got the just so story, the, you know, the transformative idea that Carey Mullis had in the desert and all that. I don't, I don't diminish that in any way, but that was set, that's really a, a bit of a sort of narrative that came after the event. The event happened within the context of capital capitalism within the context of venture capitalism and corporate profit making. And this is what, what you see is it was always envisaged a technology like PCR to be more than just identification amplification. It was envisaged to be a diagnostic that would be based at the nucleic acid level to take diagnosis down from wet labs and cultures and all, all the traditional microbiological virological contexts that we've had in the last a hundred years to the, in silico level to take it down to the computer level.

(01:29:53):

So you could do it at home, online at distance. You don't need to be in a lab and you don't need to have anything to do with real people, real patients. You're extracted from the reality of the clinical situation. So you can do things to people at distance and this is what it is. And if camera etal in their 2023 paper that Sia had up and I mentioned, think that they've got a super duper PCR that has high sensitivity and high specificity and overcomes the shortcomings of the Corman roston test, they're very wrong. Because the key thing about their paper is they don't answer the question, what's the origin of the consensus region within the five dashen utr? They don't answer that question 'cause they just assume it's viral and it's not. You could do the same analysis that the Perth group did 30 years ago with HIV genome to show that it doesn't exist.

(01:31:01):

It doesn't exist as something exogenous that invades the cell and hijacks cellular mechanism to replicate. That's the definition of a virus. And it's just not there. So again, there's this chimera built up, this mirage of something real and something solid. And when you look at it, it actually starts disappearing. And people can do this themselves. You don't need to be a molecular biologist to do this, but you need to have a critical thought, a critical thinking mentality about what's being proposed here, what's being put out. And it's definitely a technocratic order where quantitation quantitation eclipses your own intuitive feelings and your bodily responses, your sense sensation of the self is totally eclipsed by the knowledge of these technologies. Once you've had the tests, you can't go back and not have them. Once that knowledge is there, it hangs over you like a black cloud, an HIV test or any of these, these tests, any PCR for any disease, once you've had it, you can't unha it.

(01:32:20):

And the knowledge will go everywhere. There's no such thing as confidentiality. And people will know, and you'll be gridded. Your life will become, if you believe in it, your life will become geared to the whole quantitative mechanism of this. And that's why people during the last three years, they've been going out shopping and they come back and they take a lateral flow test to see if they've caught covid. This is, this is the way these products have been marketed and have been hung in the public sphere. And I think that this is what actually needs to stop and needs to, we need to come away from this. And it's so hard for people to do it because the underlying contagion theory is out there in the culture, and it's very strong. And sometimes no matter what you do to say this is wrong, and you show people that, that the science of it is all technique and there's nothing really behind it.

(01:33:23):

They still can't believe you. They think you're crazy because it's so legitimated everywhere. People in white coats tell you it's okay. The public health authorities tell you it's fine. It's in the shops. When you

go to buy anything, you can buy these tests. It's all legitimating a fraud. That's a chimera. It's a house of cars built on sand. It doesn't have any substance to it. But unfortunately, this is what's been created in society. We've been doing it in our culture since before the second World War. We've created stories about things that have never been never happened through the, these, the intelligence services as a huge literature here that we can, we can parallel in other fields in the intelligence services where these things have been created in the public sphere. And there's been stories about them, and actually they're, they're fake. They don't have never existed.

(01:34:25):

This is exactly the same thing, same thing. But with it, it's couched in terms of molecular biology and virology. So it's got some credibility in the public eye when actually it's incredible and it's, it's actually outrageous and it's total utter fraud. And I, I'm afraid that if I knew this 30 years ago, I probably wouldn't have had the career that I'd had, and I would've done something completely different if I knew it in the way that I know it now. And, you know it takes you a long time, I think, to come to realization of this. But Mike, you, you've had had experience of this where you come away from a career direction because you find out that it's based on a fiction, it's based on fraud, and you can't actually do it anymore. And that's what what happened to me with the HIV area, because I was, had a career in it, and I knew I was well known, quite well known, and I had a, a career ahead of me.

(01:35:27):

But as soon as I did some in-depth research into it, I realized that I couldn't you know, go along that career track because it was unethical. It was immoral to package something that as real, when it's unreal, it doesn't exist, was not proven to exist. And I think that that's the great evil that's been perpetrated on, on the culture, really across the whole culture. Not just populations, but culture as a whole. It's in the literature, it's in the entertainment industry, it's everywhere. This whole idea of infection and infectivity and contagion and there might be a basis to say that there's, that, that certain emotional states can be taken up from one person to the other. But in terms of biological entities, there isn't any evidence. There is no proof. There's supposition and there's, you know, nothing real there to, to say that this can happen.

(01:36:34):

And unfortunately, the more we go into it and the more we tell people about it, I think sometimes the more dissent is created and you create the opportunities people to think critically about it. You're giving them tools so they can make decisions in their own life or not. People will go away from it. They will go towards it or go away from it, depending on all sorts of social factors. You see, and this is the other thing I'd like to say, maybe before finishing, is concentrating on the science of this is only part of it. I think it's, there's a more profound context here that we need to factor in that. 'cause It's legitimated everywhere, and Mike talked about this, you know, the tests are there and the shops and what have you. It's very hard for people to hear the message that it's all wrong because it looks all right, it looks fine. And that's, that's how beguiling this is really, and how difficult it is for us to get the message across because we're working uphill against all sorts of media and all sorts of legitimation and authorities, regulatory authorities, health authorities, that telling telling people that this is all right and this is the way forward when actually it's not.

Mike Donio (01:38:02):

Yeah, absolutely. The, the companies, the governments, the media, they've all done, you know, quite frankly, an incredible job of selling this to the public and packaging it up and, and presenting it in a way that you know, for, for maximum consumption. And it's it's been unfortunately and sadly quite effective because a lot of people have, you know, have believed it. But as you said, in what I've seen through,

through my career, mostly in biotech and pharma, you know, it, it really comes down largely to profiting. And this is just like anything else that's come out of that industry. It's, it's an innovation. It's a, it's a hot technique. And they've figured out a way to really sell it to the public and drive a tremendous amount of profits while turning, you know, the paradigm of how we think about health on its head. I think, and I hope that what people have taken from this is that there's, there's a lot that we can think about with respect to PCR and, and these tests. But at the end of the day, there's no way that you can use these things to tell us whether we're sick or, you know, something about our health. It, it's just not what they're supposed to be used for, and they, it, it can't be done.

Dr. Kevin Corbett (01:39:30):

I think there's a parallel here, Mike Jana. Yeah. And Janaia with all the other technologies. You think about the way a pregnant mother, a pregnant woman rather, is encouraged to have ultrasound sonograms again and again and again. They start forming a relationship with the embryo that's technological, it's technically mediated. And there may be reasons for that. There may be very valid reasons for that. I don't dispute that. But what I'm saying is the way PCRs being used to so-called diagnose and stage diseases like HIV, it's very similar to what's happened in, in the care of, in obstetrics, where women have been encouraged to perceive their bodies and their, their, their embryos through technical media, through the medium of, you know, the technology. And so they start forming a relationship with it through the technology, the way people hand around these sonograms, these ultrasound scans of the baby, rather than feeling themselves or knowing how their body changes naturally.

(01:40:41):

And as a result of being pregnant. And I think this is, this is all part of it, you know, it, it, it, the last 50 years of maybe longer, a hundred years of the development of these technologies has been around shifting us from the real, which is the material physical, biological presence to the unreal, to the virtual, to the numbers, to the quantitation, to the, the chimera of the number, you know, it's taken over. So this is quite interesting how it's happened. We've seen it in mid midwifery, in mid midwifery, obstetric nursing mid midwifery practice a long time ago here in this country, in the uk where the technology was becoming the guiding principle rather than the, the reality of the pregnancy, the, the, the pregnant body. And I, I find that that's, those parallels are everywhere when you look at modern technology and the technocracy, the technocratic order that's being created and put in place.

(01:41:48):

And indeed, PCR is just, just one part of this, really a small parts, it perhaps, and maybe an important part of it, where these technologies have performative value. They seem to perform really well, easily and cheekly. And so they become ubiquitous, they become everywhere, and yet their, their impact is profoundly evil in many respects. I would argue, and I'd use that word, evil, because the impact is negative. The impact is negative, especially when what's being created isn't there to begin with or unproven in terms of viruses unproven. So it's a very, very I would say a very, very ambiguous tool, really, that's brought profit of billions and yet delivered what, in terms of health gain, I'd say zero. Really Absolutely zero.

Mike Donio (01:42:51):

Yeah, absolutely. Absolutely. No, that, that's, that's a great point. I wanna thank you both for taking the time today for sharing your, your wonderful and informative presentations. Just a wealth, a wealth of information that I think will have a, a lot of value to people watching this. I would encourage people watch it more than once. There's, there's a lot to take in here, but it's really important. And in fact, you

know, a a an approach, like a drip, drip drip approach is, can be really good with information like this where it can get a little technical and heady at times, but it's, it's really important and this is great information that I think will be very helpful to people. So I wanna really thank you both for doing this and for everything that you're doing to bring awareness to this, to this and, and, and even, you know, the broader understanding not just PCR, but even beyond you know, thank you both so much a debt of gratitude to you both, and I really appreciate it. And we all at the, the end of Covid Summit appreciate it.