Dangerous mRNA Vaccine Contaminants Were Just Discovered

A Discussion on Production Quality Control, Bacterial Evolution, Spike Proteins and Antibiotics

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The current mission of this Substack has been to expose fraud on the vaccine manufacturer's part. I believe this is the most persuasive point for sinking the entire COVID-19 vaccine program, as it gives those who blindly supported the narrative a way to save face if they change their point of view on the vaccines ("*it's not my fault, Pfizer lied to me*"), and because demonstrated fraud is the most likely thing to compel governments to act against the manufacturers.

If you consider the situation with Operation Warp Speed—using an untested technology to design a vaccine for an extraordinarily difficult pathogen, and produce that vaccine in a fraction of the time it takes to make a normal vaccine—it should be obvious that there was no reasonable way to accomplish those goals. Instead, the best that could be expected from this haphazard scheme would be taking lots of shortcuts on safety thereby resulting in an incomplete vaccine to be thrust hastily onto the market, hoping there would not be too many issues subsequently cropping up.

Since the manufacturer isn't supposed to cut corners during the pharmaceutical development process, the only option was to cover it up (also known as fraud). Interestingly, when I completed my review of what was seen by each whistleblower at Pfizer, I learned that the company has a long and documented history of sweeping things under the rug and altering or deleting incriminating documents.

With the COVID-19 vaccines, the most likely points of fraud were:

•Producing preclinical data (e.g., animal studies) that claimed that the vaccines were safe and effective.

•Altering the clinical trials to erroneously claim the vaccines were safe.

•Altering the clinical trials to erroneously claim the vaccines were effective.

•Failing to producing the claimed vaccine product (there were quite a few almost insurmountable production challenges for doing this).

In a recent article, I reviewed how this issue was systemic throughout the clinical trials (e.g., those severely injured by the vaccine were aggressively gaslighted by the study coordinators so that their adverse events could be dismissed from the final results). Similarly, I also recently reviewed some of the other indications that Pfizer submitted fraudulent data to regulators on the production quality of their final vaccine product.

Since the time that article was written, more signs have come out confirming that Pfizer (and likely the other manufacturers) are not accurately reporting what is contained in their vaccine. One of the most recent discoveries is particularly convincing because it helps to explain some of the observations I and colleagues have seen in our vaccinated patients.

Spike Protein Persistence

Many of us who have worked with vaccine-injured patients suspect that the COVID-19 vaccine can persist for an extremely long time in their bodies (which makes it quite challenging to treat them). One of the best points of evidence for this theory is autopsy studies of suspected vaccine-related deaths where spike proteins were found throughout the tissues months after their vaccination.

However, exactly why this happens is a bit more of a mystery. As far as we know, the half-life of the mRNA vaccines was never tested prior to their entering the market. Before the

recent citizen's investigation, I considered the following potential explanations for what was happening:

•Because the mRNA was modified to resist degradation in the body (so it could produce sufficient vaccine product), and the manner used to do this (pseudouridation) is quite haphazard, it is very likely that some of the vaccine mRNA persists for months inside the body. The only study that has ever looked at this issue found that mRNA was still present 60 days after vaccination, and did not look beyond that timeframe.

•The mRNA is changing the DNA of cells, and causing them to begin to permanently producing spike proteins. Research has now shown that mRNA alters the DNA of cells, but it is not clear if this change is enough to cause significant and sustained spike protein production throughout the body.

•Some vaccinated individuals (e.g., those who develop myocarditis) cannot form antibodies to the spike protein, and this causes the vaccine spike proteins to persist for a very long time within the body.

•The vaccine eliminates the body's ability to get rid of a COVID-19 infection, and as a result, a chronic low-grade COVID-19 infection develops, which continually manufactures spike proteins in the body.

mRNA Vaccine Quality Control

One of the major challenges with mass-producing the mRNA vaccines was the number of complex steps (prone to error) that had to be done correctly to create the finalized product. A few of these were:

•Producing the correct DNA plasmids (those that would result in spike protein mRNA being made).

•Giving the DNA plasmids to *E. coli* bacteria, which then began reproducing them, which were then harvested and transformed into DNA that could be used to make the spike protein-producing mRNA.

•Eliminating everything except the intended mRNA from that mixture so that it could then be packaged into the lipid nanoparticles for the final vaccine product.

Although there have been many signs that the final mRNA product was not what Pfizer and Moderna advertised it to be, to my knowledge, no one has directly tested the genetic sequences present. Fortunately, the technology to do so is widely available, and recently an anonymous Substack did just that. One of its most interesting discoveries was that the DNA plasmids were still present at a much higher concentration than the arbitrary threshold set by drug regulators. This has a lot of very important implications which we will discuss after a brief interlude.

Thoughts on Antibiotics

Antibiotics are one of the modern-day miracles of medicine, and their ability to save lives has fundamentally improved our modern lifestyle to the degree that most have difficulty even comprehending today. Conversely, since antibiotics were first discovered, practitioners from many different medical systems have noticed that they seem to cause a variety of issues that can outweigh the benefits of the therapy. Most of these issues are encapsulated under the belief that antibiotic therapy trades an acute disease for a chronic one. In general, the issues tend to fall under one of the following:

•Antibiotics are toxic to the batteries of our cells, the mitochondria (mitochondria evolved from bacteria and share many similarities to them).

•Individuals can have allergic reactions to the antibiotic (although this is the most obvious issue, it typically has the most minimal long-term consequences for a patient).

•Antibiotics have a high degree of general toxicity which typically results in them being pulled from the market once safer options are made available (sadly this can often take years).

•Antibiotics pathologically disrupt the gut microbiome (leading to digestive problems) and pathologic bacterial evolution.

Unfortunately, in conventional medical practice, most of these issues are not recognized, and doctors typically focus on determining which drug the bacteria are least likely to have

antibiotic resistance towards (as this is what medical training primes you to focus on). This bias frequently results in dangerous and not necessarily needed antibiotics being prescribed, because "allergies" and antibiotic availability are typically the only contraindictions considered. In short, there are a lot of issues that arise from antibiotics being given out like candy.

Although I try to minimize my usage of pharmaceutical—there are a variety of effective non-pharmaceutical therapies for infections—antibiotics are nonetheless sometimes needed. From having looked at the above question in detail, I believe that when you must prescribe antibiotics, the safest ones are as follows:

•Ceftriaxone (Rochephin)

•Doxycycline

•Azithromycin (the Z-Pack)

•Cefalexin (Keflex)

For those curious, the first antibiotic is a first-line therapy for many infections for which patients require hospital care (so I always keep some in my cabinet). The first three treat many complex conditions caused by chronic infections (e.g., Lyme disease or Garth Nicolson's mycoplasmas—which happen to respond to the two oral antibiotics that also helped with COVID-19), and the last two treat many common infectious illnesses.

Additionally, there are a few other antibiotics (Ciprofloxacin is the best example) that are dangerous but sometimes are nonetheless needed to treat life-threatening infections. Unfortunately, those drugs (Ciprofloxacin again being the best example) are also regularly given out for much more minor infections that can be treated with other antibiotics (e.g., a urinary tract infection), due to the medical community being unwilling to acknowledge their dangers.

Medical Models

For the institution of science to progress, it needs to have a standardized way to teach the discipline to future members. In turn, one of the major challenges with science is the

immense complexity of nature; the complexity present will often exceed whatever can be taught within a standardized model. When you add in the human ego, this often leads to "science," becoming anti-science (opposed to the scientific process of inquiry) because those who invested themselves in the standardized paradigm taught to them are frequently unwilling to consider a more complex universe that calls into question the simplistic paradigm they were taught.

Due to the immense complexity of the human body, mind, and spirit, this issue is particularly apparent within medicine. To address this complexity, every medical system has taken a similar approach: create a simplified model of the human body which allows one to identify key areas that can be focused upon to create a positive effect for the patient.

The perspective of healthcare practitioners radically changes once they begin to employ multiple models, rather than simply the one on which they were trained. Assuming one is open-minded, the person normally realizes:

•Certain models come much closer than others to encompassing the wide range of medical needs of each human being.

•For each medical issue, there are normally multiple models which have a viable means to address it.

•For each of those issues, there is typically one model that is dramatically better than the others (e.g., there are a few conditions that I believe should always be treated with Traditional Chinese Medicine).

The above also is true within the medical system. Specialists from the same medical specialty will default to treating many patients they see nearly identically, but when those patients sees specialists from another specialty, they will often be given a completely different regimented treatment approach. For example, this is commonly observed by patients with a chronic debilitating illness like Lyme disease or chronic fatigue syndrome, when they see cookie-cutter rheumatologists and neurologists.

Similarly, within the integrative field, one can commonly observe integrative physicians become very committed to a specific approach or holistic model and treats everyone within their box. Each of these boxes works for some (but by no means all) patients.

It is thus very difficult to find physicians who use a wide range of therapeutic models and are willing to creatively discern which box fits best for their patient's needs. Similarly, colleagues who run integrative clinics have told me one of the greatest challenges they face is finding physicians they can hire who will go outside the constraints of their specific box, and do not need formulaic protocols to follow. Because of all of this, it is common for patients with a complex illness have to see dozens of providers before they are lucky enough to stumble upon one who can think outside their box to address the patient's particular medical needs.

Bacterial Homeostasis

A very common box which integrative medicine practitioners utilize is focusing on the gut microbiome, since "good" bacteria produce a variety of essential biomolecules, while "bad" bacteria produce a variety of toxins that can dysregulate the entire body. Books could be written on all the approaches available for addressing the gut microbiome, but most of them essentially boil down to lab tests to determine if your microbiome is abnormal, using agents to eliminate bad bacteria, probiotics, and prebiotics, and dietary changes to support healthy gut flora. It should also be noted that there are many other important microbiomes in the body besides that within the gut, which can also become dysregulated and create significant issues when they do (e.g., on the skin, in the urinary tract, in the vagina, in the eyes, in the sinuses etc.).

One of the general beliefs within this discipline is that "bad" bacteria tend to have a much greater antibiotic resistance than "good" bacteria, so when you utilize an antibiotic for something like an ear infection, it also kills off the good bacteria that previously kept the bad bacteria in balance, allowing the bad ones proliferate and take over the gut flora. While this is true, I believe there is also an entirely separate mechanism that explains why this pathologic transformation occurs.

Note: The next two parts of this article will likely be highly controversial—please look past them if you feel this way.

When you attempt to observe what goes on inside the blood or in tissues with microscopes, two major issues always arise for observing bacterial organisms.

•Light physics makes it nearly impossible for an optical light microscope to resolve (clearly distinguish) specimens smaller than 150-200 nanometers (μm). While this is sufficient to see most common bacteria, many microorganisms are much smaller than this (e.g., mycoplasma, the smallest bacteria, are 1–2 μm long and 0.1–0.2 μm wide, while SARS-CoV-2 is a sphere just 0.07 μm to 0.09 μm in diameter). The alternative, electron microscopy, requires everything observed to be fixed and killed, so it is not possible for living processes to be observed under the electron microscope, and many of these smaller components often become distorted by the fixation process.

•There is an immense degree of variability in the forms of bacteria of the same species, many of which can appear to the untrained eye to be something else (e.g., irrelevant cellular debris).

One of the major (but mostly forgotten) debates within medicine regards the morphology (shape) of bacteria. One of the schools of thought (the conventional one) believes that they maintain a relatively constant morphology (except for times when they do things like forming spores). A different school of thought, the pleomorphic one, believes that their morphology can significantly vary, and this variation is often heavily influenced by the surrounding environment of the body (this is where terrain theory comes from).

I believe the still unresolved disagreement between these two schools of thought (which has persisted for over 150 years) exists for three reasons:

•The technological limitations of optical microscopy (as many of the pleomorphic [varying] bacterial forms are too small to see with conventional microscopy).

•The existence of pleomorphism adds an overwhelming degree of complexity to understanding microbiology. It is hence much easier to come up with reasons to dismiss signs of the pleomorphic nature of bacteria (and certain other microorganisms like fungi) than it is to seriously study them.

•The monomorphic paradigm is much more amenable to pharmaceutical management (and in many cases, it works).

Advocates of Pleomorphism

There are a few well-known figures who advanced this model. Two, Gaston Naessens (1924-2018) and Royal Rife (1888-1971) developed optical microscopes with clever designs that could bypass the optical magnification limit. Using those microscopes, they observed a complex biological cycle of pleomorphic organisms (e.g., this one), which appeared to be influenced by the internal environment of the body (its terrain).

Although pleomorphism is quite controversial, I am inclined to support it. This is because both scientists demonstrated immense integrity throughout their lifetimes, and both utilized their microscopic observations to develop remarkable (but mostly forgotten) therapies, which I have repeatedly observed to work in clinical practice. Simultaneously, however, I do not believe the cycles they mapped out were completely accurate, as they resemble, but do not match what later researchers using modern techniques found, which is completely understandable given that Naessens and Rife were simply researchers working alone on an immensely complex topic.

The most recent well-known advocate of pleomorphism was Lida Mattman, who in 2006 published, Cell Wall Deficient Forms: Stealth Pathogens. It is a compilation of dedicated researchers using modern microbiology techniques (e.g., antibody staining, chemical analysis, a variety of culturing techniques, careful electron microscopy, etc.) whose data demonstrates the pleomorphic morphology of bacteria, and the behaviors of those forms. It should be noted that these researchers also identified pleomorphic fungi, and that bacteria could sometimes adopt a fungal-like morphology (which some bacteria are also conventionally recognized as doing), but for length considerations, those fungi will not be focused upon here.

One of the best theories I have seen to explain all of the contradictory observations about cancer, is that the cancer process is an ancient survival response of cells. In this model, when stressed by an environment the cell cannot survive in, some of the cells, rather than dying, revert to a more primitive evolutionary stage. One of the things that characterize increasing evolutionary development is cells becoming able to work in harmony with each other for the sake of a greater whole, and conversely when the opposite occurs, the cells focus on their own benefit at the expense of the surrounding organism. As a result, once cells become cancerous, if allowed to, they will grow out of control and destroy the surrounding organism with which they should be in harmony.

A similar thing appears to occur with bacteria (and some fungi—e.g., *Candida* has been observed changing its morphology depending on what carbohydrates are available to it). When these organisms are stressed by environmental factors, while many of the organisms die, others are incompletely killed and instead revert to a more primitive form.

Frequently, for example, the bacteria lose their cell walls and become mycoplasma-like cell-wall-deficient organisms (CWD or L-form bacteria) with similar but not identical characteristics to the original organism. A variety of stressors can trigger this transformation, but antibiotics that target the cell wall of a bacteria (e.g., penicillin) are the most effective for inducing this transformation.

Once the transformation occurs, the CWD bacteria become much harder to detect (most conventional microbiology techniques cannot culture them, and like viruses, they pass through most bacterial filters). Eventually, once a sufficient number of them are present (which requires a safer environment without the previous stressor), they will revert to their classical form.

As a result, numerous infections that follow a chronic relapsing pattern, or where it is difficult to determine if one is or is not infected with them, can often be observed to have CWD bacteria present when the infection is in "remission" and not conventionally detectable (e.g., with skip cultures). Similarly, when CWD bacteria are still detected, this can often accurately predict the occurrence of a relapse. It should also be noted that both CWD and classical bacteria are typically both present, and frequently each inhibits the growth of the other (presumably to ensure the appropriate balance of each).

CWD organisms often end up residing within cells (as they are better suited to surviving that environment). Because they reside within cells, they often provoke an autoimmune response to the cells they inhabit (which is essentially a less severe version of what is now being seen in autopsies of vaccine victims where the immune system attacks cells containing spike proteins). In a variety of different autoimmune diseases that have no known "cause," such as scleroderma, sarcoidosis, lupus, a variety of kidney diseases, uveitis, "non-infectious" ulcers, arthritis, ulcerative colitis, Crohn's disease, and multiple sclerosis, cell-wall-deficient bacteria have been identified by researchers, often directly within the cells of the affected tissues. In some cases, a very specific CWD organism is tied to the condition, while in others, multiple species are found are found.

CWD bacteria are also found in certain autoimmune conditions after the infection is assumed to have passed (e.g., Group A strep is known to cause rheumatic fever, and CWD strep can be found in the affected heart valves of someone with rheumatic fever). CWD bacteria have also been found in certain cancers, blood clots, kidney stones, and atherosclerotic plaques. In some of the diseases listed, it is only the CWD form that creates disease (e.g., in rats *Streptococcus fecalis* was innocuous when injected into rabbit ileum [part of the small intestine], whereas the CWD variant caused granulomas).

This is an immensely interesting subject, and I would highly recommend anyone who wants to learn more to read Mattman's book (it contains all of the references for the above section and much, much, more such as the pleomorphic nature of the bacteria which causes Lyme disease). I also felt that one of Mattman's statements summed up the entire phenomena quite succinctly:

> While many points remain obscure, cell wall deficiency and variation are clarified when one views classical growth as perfect cooperation between wall autolysis and replacement. Aberrant forms result whenever there is imperfect balance between construction and destruction.

One of the most well-known scientists who advanced the pleomorphic model was Günther Enderlein (1872-1968), who did not yet have access to advanced microscopic technologies and instead had to make do with a lot of observation, intuitive explorations, and careful deliberation. In 1925, he published a summary of his work outlining a pleomorphic cycle of some organisms he had observed traces of within the blood. Enderlein essentially argued that when these organisms were in a healthy environment, they had a symbiotic relationship with the body, whereas when they were in an unhealthy environment, they created disease.

The existence of microorganisms in the blood is a hotly debated subject since blood is conventionally considered to be sterile (whereas I believe hard-to-detect CWD bacteria are often present). One of the better cases I've seen against the sterility of the blood was mentioned within one of the classic texts every ICU doctor learns from:

> The organisms involved in CRBI [Catheter-related bloodstream infection] are (in order of prevalence) coagulase-negative staphylococci, Gram-negative aerobic bacilli (Pseudomonas aeruginosa, Klebsiella pneumoniae, E. coli, etc), enterococci,

> Staphylococcus aureus and Candida species (40). Coagulase-negative staphylococci (mostly Staphylococcus epidermidis) are responsible for about one-third of infections, while Gram-negative bacilli **and other organisms that inhabit the bowel** (enterococci and Candida species) **are involved in about half the infections**. This microbial spectrum is important to consider when selecting empiric antimicrobial therapy.

This quote demonstrates that microbes from the bowel can colonize the catheter, and therefore must be present to some degree in the blood.

Enderlein came up with a very creative approach to addressing pathologic regulations of the pleomorphic cycle which completely diverges from the allopathic mindset (conventional medicine). First, he would try to fix the terrain of the body. Secondly, he would culture the pleomorphic organisms when they were in a healthy state, create a dilute extract of them (which became the Sanum isopathic remedies), and then expose those organisms in an unhealthy state to that extract, at which point they would transform to the healthy state.

Enderlein's approach appeared to work, so it has maintained a devoted group of adherents (including a few readers here) for almost a century. I personally believe that their full program of optimizing one's internal terrain is not practical for most patients, but some of the isopathic remedies by themselves (when correctly administered) are remarkably effective for treating certain otherwise difficult-to-treat conditions (although in many cases, alone they are **not** sufficient to treat the condition). Some of those conditions include:

•Systemic Lupus Erythematosus

•Gut and urinary microbiome dysregulation following the administration of certain antibiotics such as fluoroquinolones or Flagyl.

•Mastitis and prostatitis.

•Many types of cancers.

As I discussed in the previous series on zeta potential, I believe that one of the primary causes of blood clumping and poor zeta potential is pleomorphic dysregulation, and in some cases, you cannot address the coagulation issue unless the underlying microbial issue

is also addressed. Many of the above authors have likewise made this observation (e.g., Naessens found that the non-pathologic form of his pleomorphic cycle was distinctively negatively charged, Mattman's work details pleomorphic organisms found within thrombi and that when one bacteria became CWD, it could cause kidney stones, the formation of which is heavily influenced by zeta potential).

Similarly, one of the remedies Enderlein developed targeted a pleomorphic organism he believed was responsible for blood clotting, and in practice, this one often helps conditions characterized by poor circulation and increased blood viscosity. One of the interesting things we have discovered from working with COVID-19 and vaccine injuries is that this isopathic remedy is also often very helpful for improving the circulatory issues observed following a spike protein injury. This and other observations have led us to believe that one of the issues with the spike protein vaccines is that they disrupt the homeostatic regulation of the pleomorphic microbiome.

Note: One of the frequent misunderstandings I see from advocates of terrain theory who attack germ theory and the existence of viruses on Substack, is failing to recognize the two theories are not mutually exclusive. A dysregulation in one's terrain can cause illness, and the introduction of a pathogenic microbe can also cause illness.

Spike Proteins and the Microbiome

Viruses (besides bacteriophages) do not typically infect bacteria. One of the many odd characteristics of COVID-19, however, is that it does (I first learned about it from this post which discussed an Italian study that demonstrated how it happens). This is important, since a sustained infection of the gut microbiome with SARS-CoV-2 can transmit the virus into your stools and sustain its presence within the body.

The researcher who to my knowledge has studied this phenomenon the most is Dr. Sabine Hazan M.D. a gastroenterologist and researcher who has built her career around researching the gut microbiome. Throughout the pandemic, Hazan has observed that unhealthy changes in the gut microbiome predisposed one to a severe COVID-19 infection and that SARS-CoV-2 infects the gut microbiome (many of her studies are published here).

More importantly, Hazan has also observed that COVID-19 vaccination pathologically alters the gut microbiome so that the bacteria she had found that would typically prevent a severe COVID-19 infection (and many other conditions) instead disappear and no longer serve their protective function. As far as I know, however, she has not put forward a definitive explanation of why this happens (the best guess I have heard from Hazan was that the spike protein produced by the vaccines is a toxin that kills the good bacteria).

One of the things that are not appreciated about bacteria is how incredibly well-suited they are to adaptation, and developing the complex enzymes that make life possible. Bacteria rapidly reproduce in large numbers, allowing them to have an almost infinite number of opportunities to make the needed evolution, and then once they do, they share that DNA with the surrounding bacteria (via plasmids), making it possible for a bacteria colony to rapidly adapt to its environment. This, likewise, is why it is often so hard to deal with bacteria simply by targeting them with lethal agents.

When I examined Enderlein's isopathic remedies (the ones extracted from healthy microorganisms and then given to pathogenic ones to positively transform them), I concluded that their active ingredient was most likely plasmids. Thus, when these plasmids were taken up by the pathogenic organisms, they would not only transform the pathogenic ones to a healthy state but also, before long, cause the bacteria to reproduce and have the healthy plasmid be produced throughout the body.

Like Hazan, until I saw the recent citizen's investigation, it had not occurred to me that the vaccines might just be directly transfecting the gut microbiome with a spike protein plasmid (and essentially giving the equivalent of a toxic isopathic remedy).

Other Plasmid Modifications

In addition to the spike protein, it was also noted that the plasmids found contained the gene for the SV40 virus promoter (I am still unsure of the implications of this) and resistance to kanamycin and neomycin (interestingly, these are some of the antibiotics CWD bacteria are the most susceptible to). Inserting this antiobiotic resistance in addition to the target modification is done as a method of ensuring that bacteria that ultimately reproduce contain the desired genetic modification (as the other bacteria are purged by those antibiotics). This approach, however, is advised against since it creates the potential

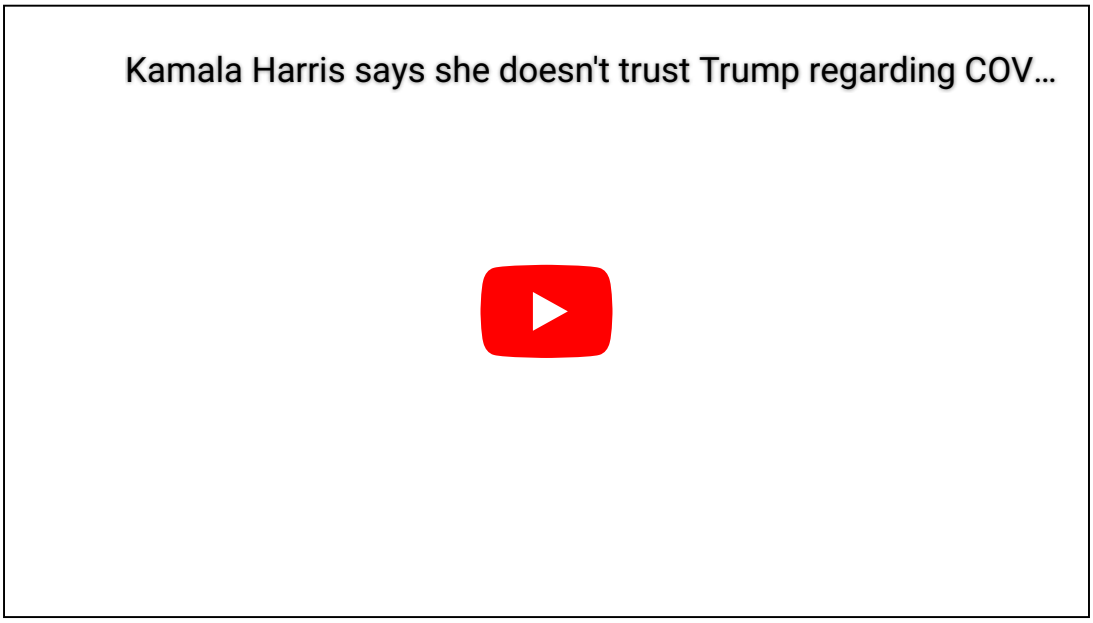
for widespread antibiotic resistance (a major issue in infectious disease control) because those genes can eventually make it out of the lab into the global bacterial population(there are also many other issues with this approach).

Conversely, however, an additional issue emerges here; if an individual who has spike protein-producing bacteria within their microbiome is now exposed to these (and potentially similar) antibiotics, it will rapidly select for their microbiome to only have those (toxic) bacteria. There are, in turn, some reports on VAERS of adverse reactions in vaccinated individuals following the administration of these antibiotics.

If you have the time, I would highly recommend reviewing this investigation and Jessica Rose's follow up to it, both of which have a much greater focus on the technicalities of what was found within the vaccines and additional points of evidence implicating fraud by the vaccine manufacturers.

Conclusion

One of my great disappointments is the many Democrats who vocally spoke out against all the potential safety issues with vaccines produced within the timeline Operation Warp Speed was operating under who completely changed their tune once Biden was elected and they decided to push it on America.



It is still difficult for me to believe that we were all told to "trust the experts" on the vaccine, but we were never permitted to directly evaluate its data or evaluate what was actually in the vaccines, especially since there were a variety of extremely valid concerns regarding what could potentially be in them. Instead, we just were left hanging and left to deal with the inevitable problems that emerged.
Note: East Palestine, Ohio is essentially dealing with an identical situation now to this with the train derailment that had large amounts of toxic chemicals be "safely" burned in their vicinity while the residents have been left to wait and see what complications they will develop.

Since the start of the rollout, many people were seriously concerned about the potential quality control issues with the vaccines, and from almost the start of the vaccine rollout, it has been abundantly clear there are serious issues which are leading to a high variability over what ends up in each vaccine. Typically within the pharmaceutical industry, this is absolutely inexcusable. However, as you all know the exact opposite has happened and people aren't even allowed to independently examine the products.

Since there are so many things that could have gone awry, despite a lot of research on the subject, I genuinely admit I had not even considered this possibility there could be plasmid contamination adversely transforming our entire microbiome. However, as I hope this article has shown, in hindsight, it makes a great deal of sense. All of this should illustrate just how many serious issues can happen when an experimental vaccine is rushed to market and critical steps (such as sufficiently removing the bacterial plasmid from the final product) are skipped—**especially with a gene therapy**.

As you might guess, these quality control issues were particularly apparent within my "favorite" pharmaceutical company:

> While the Moderna vaccines are meeting this specification [the maximum allowable plasmid contaminant level originally proposed by regulators], **the Pfizer [vaccines] are 10-fold higher in contamination** with 1 DNA molecule per 350 mRNAs. This is 1 replication competent plasmid per 350 mRNA molecules and equates to billions of antibiotic resistant plasmids injected per person per shot.