Dr. Meryl Nass: More Vaccine Deaths Reported to VAERS in the Last 20 Months Than All Vaccines in the Last 30 Years Combined

Jan Jekielek

“The FDA was instructed by a federal judge to revoke the license … because it had never been shown to be safe or effective,” says Dr. Meryl Nass, referring to regulation of the anthrax vaccine in the late 1990s.

Nass, a physician of internal medicine, began her research into pandemics 30 years ago, with a focus on anthrax vaccines and biological warfare. From the Rhodesian Civil War to the 2009 swine flu, she says she saw a profit-driven push for mass vaccination. In many cases, the public health establishment bypassed adequate testing, and modified or attempted to bury data, she says.

“WHO had changed the pandemic definitions a couple of months before the 2009 swine flu pandemic showed up … so, you didn’t need deaths anymore to trigger these contracts, it could just be a new virus,” says Nass.

Today, Nass is one of many doctors whose medical license is threatened for deviating from official COVID-19 guidelines during the pandemic.

“If all you’re good for is to give patients the government narrative … there’s not going to be any practice of medicine anymore,” says Dr. Nass.

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Jan Jekielek:

Dr. Meryl Nass, such a pleasure to have you on American Thought Leaders.

Dr. Meryl Nass:

Thank you for inviting me.

Mr. Jekielek:

Dr. Nass, you just finished—in fact, we live streamed it on The Epoch Times—a hearing where you were defending your right to keep your medical license, which has been suspended.

I want to talk about your background first, which is that you were someone who established many years ago that this anthrax outbreak that we’re all familiar with was actually a biological warfare attack.

Dr. Nass:

Yes. In Rhodesia, which is now called Zimbabwe, during its civil war.

Mr. Jekielek:

Why don't you give me a picture of your career up to present, and then we can build up from that.

Dr. Nass:

Sure. Sort of by chance, I wound up discovering that there was this very peculiar anthrax epidemic, which occurred from 1978 to 1980 at the end of the Rhodesian Civil War. I had decided to look at a bunch of anthrax epidemics that were happening over a 15 year period.

This one was completely different than all the others, so I spent a lot of time studying it. There were 10,000 cases, and there were just a few hundred deaths. No one had ever studied an epidemic and shown that it was actually due to biological warfare.

I thought it was important to do that as a preventive to show potential perpetrators, "Hey, we can actually use the science and show that you did it." Because the advantage of biological warfare is generally that people don't know it was actually perpetrated. They think it just happened.

So anyway, I did that. I published a paper 30 years ago. In the process, in the three years of research I did up to that time, I learned a lot about anthrax and anthrax vaccine. In the middle of it, the Gulf War broke out and suddenly anthrax and anthrax vaccine were a big deal.

So, I became a spokesperson for Physicians for Social Responsibility on biological warfare and anthrax. By 1998, the anthrax vaccine was suddenly being mandated on every service member in the military, two and a half million people.

I knew that it had been identified as a potential cause of Gulf War syndrome, and that had been talked about in a congressional hearing. It had never been resolved. To just give two-and-a-half million people a vaccine that might be causing Gulf War syndrome, you don't do that.

I wrote this very short paper in an afternoon laying out the evidence, which went to an infectious disease mailing list, and then all of a sudden it went viral. It was linked to the Lancet Journal and I was asked to write a review article on the vaccine. Lancet mentioned it, and all of a sudden loads of people started getting anthrax vaccine and getting sick.

Now I hadn't anticipated they would. I just thought it was possible. Anyway, hundreds and then thousands of people contacted me, including a number of military officers and some lawyers. Eventually, we formed a coalition and fought the anthrax vaccine mandate and the license of the vaccine.

We had a total of 13 congressional hearings that discussed the vaccine. This is between 1998 and 2002. The FDA was instructed by a federal judge to revoke the license and redo it, because it'd never been shown to be safe or effective. That was all very good. The Pentagon was probably about to end the whole program.

And then, the anthrax letters were sent in September and October of 2001. All of a sudden Tommy

Thompson, who was the secretary of HHS, said, “We’re going to relicense this factory. We’re going to get anthrax vaccine for everybody.” And the FDA relicensed the vaccine, and there we are. Soldiers are still getting this vaccine, although it’s been cleaned up a bit.

Subsequently, I was asked to testify regarding bioterrorism and Gulf War syndrome to congressional committees. In the meantime, I had learned about other vaccines. In the beginning, I only knew about anthrax vaccine. But having spoken at conventions and meetings, I had also listened to the other speakers and learned, “Oh, there might be problems with other vaccines.”

I started studying the other adult vaccines, and then developed some expertise on that. Subsequently, I spoke to many state legislatures on the issue of vaccine mandates. While all that was happening, I watched the CDC go through an unscientific process of attempting to get rid of vaccine exemptions.

The CDC began to deny that people could get sick from vaccines, and that there was any reason to not get a vaccine. Over the last five to 10 years it has been tightening up its guidelines on what it takes to get a vaccine exemption, and then over the last few years, encouraging the states to remove the licenses of doctors who give out vaccine exemptions.

It has been an interesting process. I did not know this was all happening because COVID was going to be coming. But in hindsight, I realize somebody wanted very solid culture, rules, and regulations that would try to herd everybody into the COVID vaccine corral. And that’s where we are now.

Mr. Jekielek:

Okay. That’s very interesting what you’re saying, because I’ve heard this said by a number of people that I’ve spoken to, even on this program, that there was this interest in what some people describe as a biosecurity state or biosecurity apparatus, and there’s folks who are just waiting for the opportunity to implement it. Then, COVID presented this opportunity.

Dr. Nass:

Well, yes. There were laws being passed in the United States regarding bioterrorism. There was a huge industry developed after the anthrax letters worth about, that we know of, about $7 billion a year ever since to develop products for potential bioterrorism.

There were new structures instigated. The Emergency Use Authorization was developed as the result of the Bioshield Act of 2004, and the PREP Act of 2005, that would for the first time allow unapproved vaccines and medicines to be used on a mass scale in the United States with minimal testing, and potentially without any human testing.

There was also an international plan set up under which countries—this was brought together through the WHO—were basically making all the same contract with vaccine manufacturers, so that in the event of a dangerous flu pandemic, a bird flu pandemic or bioterrorism, the manufacturers would agree to produce vaccines for that purpose.

At the time, nobody knew what those vaccines would look like. The countries had agreed they would pay for

a certain number of vaccines ahead of time. So, these contracts that I'm aware of began at least around 2004 and were used.

One of the reasons there was a lot of controversy about the WHO declaring a pandemic in 2009 was that it triggered these contracts and obligated countries to buy tens of billions of dollars worth of vaccines that had not yet been developed. And in that case, some of them caused narcolepsy.

Mr. Jekielek:

Just to be clear, which pandemic are we talking about here?

Dr. Nass:

This was the 2009 swine flu pandemic. These contracts were triggered then. They were preexisting before 2009, and they still are in play.

Mr. Jekielek:

Were these same contracts triggered with the COVID pandemic as well?

Dr. Nass:

Probably.

Mr. Jekielek:

Okay. But we don't know.

Dr. Nass:

Right. Exactly. The WHO had changed the pandemic definitions a couple of months before the 2009 swine flu pandemic showed up. The definition had been loosened, and they had taken away deaths. You didn't need deaths anymore to trigger these contracts. It could just be a new virus, and it could be a cold.

As long as it was a new virus that nobody had seen before, if it was declared by the Director General of the WHO, all these countries would be obligated to buy vaccines. So, there was a big investigation after 2009. There was no media about what was going on in that regard with COVID.

Mr. Jekielek:

I keep thinking about something that Thomas Sowell writes about in Basic Economics is to always look at incentive structures.

Before we continue, I also want you to tell me about your training and your background, because you didn't just randomly become interested in anthrax outbreaks and potential biowarfare attacks.

Dr. Nass:

I went to MIT and I got a degree in biology. This was during the Vietnam War, and I was very concerned about the war. I dropped out. I hitchhiked with my boyfriend all across Africa and India, and I wanted to know what to do with my life. When I was in Africa, I thought, "Well, these people really do need doctors."

So, I went home, I finished college, and traveled some more. I said, “Okay, time to go to medical school and get this done. And I did, but I always had a goal to help people in underdeveloped countries with their medical problems. But fortunately or unfortunately, I got married in the middle of medical school and had a kid by the time I graduated.

I couldn’t go off to Africa at that point. When I was 38, just a few years after I’d finished my residency, I wound up being asked to look at these contracts for anthrax vaccine that were with a professor at UMass and the Biological Defense Program of DOD, as a member of Physicians for Social Responsibility.

I knew nothing about anthrax or vaccines, but I was asked to do it, so I did it. I found out that the title of the contract had nothing to do with the body of the contract. The title was “Studies to Develop a Better Anthrax Vaccine.” The actual contract was about a primitive form of genetic engineering of anthrax.

I said, “Why is DOD doing this? Why are they hiding it?” I happened to know somebody who was very high up in Quaker movement, and the Quakers were interested in this also. They hired a fellow who had just graduated from Brown University, and he got lots of documents together.

I started going through them. At that time, 30-plus years ago, you could read everything that had been published on anthrax. And I did. I went to the Harvard Library and I had crumbling journals from the 1830s describing anthrax cases. When I was done, I knew a lot about anthrax.

Mr. Jekielek:

Then, you basically smelled a rat in this particular scenario, and you decided to do the definitive research. Fascinating. So now, the COVID pandemic is upon us. What are you doing now?

Dr. Nass:

I do a lot of things, because now I have a pretty strong background in pandemics and in biological warfare and in the FDA regulation of vaccines. I have been commenting about the public health response to COVID from the very beginning.

I pointed out in late March of 2020 that this was likely to be a lab release, rather than a natural epidemic. Subsequent to that I pointed out that it could be a lab release, and it could be a deliberate spread.

We don’t know which it is. But now that more information has come out, we know it was definitely made in a lab. There’s really little question about that.

Mr. Jekielek:

Yes. It would be incredibly unlikely. Yes. Not impossible, but…

Dr. Nass:

One in a billion. Yes.

Mr. Jekielek:

Incredibly unlikely. So, the pandemic hits January, February, March, 2020 and you’re in medical practice.

Dr. Nass:

Yes.

Mr. Jekielek:

How did you respond to that?

Dr. Nass:

I believed the public health response, and the government response. I looked to see what can we find out about this agent? How does it spread? What are the concerns? I wrote long articles telling people what to do; wash your fruits and vegetables in a bleach solution. Take your shoes off before you enter the house.

All these methods one might call paranoid, because at this point we didn't know how deadly the virus was. At that point, we were seeing the movies from China with people dropping dead on the street. In the beginning I told people, "Don't go in elevators. Walk up the stairwell, because you don't want to be in closed spaces breathing someone else's air."

However, within a few months, information kept leaking out that things really weren't that bad. And the virus, although transmitted airborne—which by the way, the government didn't admit until about August 2021—we didn't have to be that careful.

And then, I started exploring other avenues. I knew of and had even met some of the people who were involved in the coverup of COVID having a lab origin. When papers were published in February and March from who I would now call coverup scientists and doctors, I read them and I immediately recognized them as coverups.

I'm referring to something called a correspondence in the Lancet in late February, which was ghost written by Peter Daszak, but a lot of other people had a hand in it. It was signed by 27 people, I think. Then, in March, in Nature Medicine, there was another correspondence by five scientists, which attempted to claim that there was no way COVID could have come from a lab, because of certain reasons.

The reasons didn't make sense. Then, we found out that Tony Fauci actually had that article written. He and Jeremy Farrar from the Wellcome Trust, and Francis Collins, head of NIH, had convened a meeting at which they decided to create this article as a cover up.

Anyway, I didn't know Fauci was involved. I didn't know who was involved besides the five authors. I wrote in March of 2020 that I don't understand how these people could have written this. This doesn't make any sense. These are supposed to be credible scientists.

When I was interviewed for Mikki Willis's Plandemic 2 movie, I said, "I don't think they wrote it. Somebody made them write it, or it was ghost written." I turned out to be right about that.

Mr. Jekielek:

You've gotten deeply involved in the actual early treatment of the disease as well.

Dr. Nass:

Right. I'm a doctor. I had a private practice and my son got sick with COVID in March of 2020. I always try to use what I know, however it may be useful to others. I had a finger in a lot of different pots with respect to COVID, because I had enough background to be able to do that.

At the same time I was challenging the origin, I was also looking into treatment. I was aware that the Chinese had told us in February that the chloroquine drugs were their best option. They had about 20 different treatment trials of chloroquine and hydroxychloroquine going very early on.

I didn't know then, but I soon found out that the reason they were using chloroquine is because these articles had been published in Europe and the United States showing that chloroquine had killed SARS-1 in tissue culture, in vitro. Starting in 2004 those articles had been published.

SARS-1 had been a huge problem for China. It only affected 8,000 people, but it had a 10 per cent mortality rate, and it seemed to originate in China. They and most other countries were very concerned about this agent SARS-1, the original SARS.

It came out of nowhere in 2002, and died out in 2003. But it was considered by all nations to be a potential biological warfare agent. It was put on a list by the CDC called the Select Agents and Toxins List. These microorganisms cannot be sold or transferred without permission from the CDC.

It turned out that NIAID and Fauci had spent up to $50 million a year researching SARS. And then, another deadly Coronavirus popped up around 2012 in the Arabian Peninsula, Middle East Respiratory Syndrome (MERS), a cousin. It had a 30 per cent mortality. DOD money that had gone to Fauci was being used to look at responses to these viruses.

In 2004, 2005, and 2014, papers were published by the CDC, by Fauci's NIAID and by two groups of European scientists showing all sorts of already licensed drugs killed these viruses in vitro, in tissue culture. The 2014 paper by Fauci's group listed over 60 different drugs that killed MERS or SARS, which included hydroxychloroquine and chloroquine. It didn't include Ivermectin.

The federal agencies were aware before COVID ever appeared that the chloroquine drugs were very likely to be effective. This was reinforced by the Chinese. And what did they do? When Trump got word of it and said it publicly, they suppressed the use of those drugs immediately, and they're still being suppressed.

Mr. Jekielek:

Why do you think that happened?

Dr. Nass:

At the time, I only knew that it happened. I didn't know why it happened. With hindsight, we can see that the purpose was to prolong the pandemic. It was done, because under the guise of pandemics, under using emergency legislation that only can be brought into play during a designated medical emergency, you can do a lot of things.

You can increase surveillance. You can centralize controls that the federal and state governments would not be able to do otherwise. Now, we see things are changing. We see central bank digital currencies coming in.

We see food shortages. There was a fertilizer shortage, and the Union Pacific Railroad refused to carry a lot of fertilizer in its trains this past spring.

I don't know the full dimensions of this, but had the pandemic not been designated, had people not been confined to their homes, had we had business as usual, societal changes could not have been implemented nearly as quickly or effectively. I knew that the chloroquine drugs were being used in China.

I had used them on my son already. He was my first patient, but the public didn't know there was a drug that might be useful for COVID. They had been told there is nothing to be done. "Stay home and take Tylenol." Once Trump started saying it in public, then people wanted it. That was when the suppression became necessary, apparently.

Mr. Jekielek:

Here we are today, and you're fighting for your medical license. Please give me the story on that.

Dr. Nass:

I have been treating people with Ivermectin and hydroxychloroquine and other medications and supplements and vitamins for COVID reasonably effectively. Very few doctors have been willing to do that, because they felt their licenses were threatened, or they felt these drugs couldn't possibly be effective, because how could it be that the public health establishment would speak so strongly against them?

In my case, I had already used hydroxychloroquine a lot in Lyme disease patients, and in some lupus and rheumatoid arthritis patients. I had taken the drug myself. So, I knew that it was safe. I didn't know that about Ivermectin. And I documented many forms of suppression.

I started writing an article in May, June of 2020. I completed it about a year later. I documented over 50 different ways the federal government, state governments, foreign governments, as well as manufacturers, drug store companies, and others were suppressing the use of the chloroquine drugs.

Basically, by the middle of 2020, I knew there was a major suppression in play. Others had already identified that in the UK, a clinical trial of hydroxychloroquine used too high a dose, a dangerous dose that could potentially kill people. And I thought, "Wow, if that's going on in the UK, might it be going on anywhere else?"

And I found several other clinical trials where the same thing was happening, including one in over 30 countries that the WHO was running using the same dangerous dose.

Mr. Jekielek:

You're telling me that based on historical precedent and papers that were published, the trials that were being run were being run at dosages that were potentially toxic.

Dr. Nass:

Dosages that had never been clinically used before. Dosages that are not appropriate, using the chloroquine drugs, which can cause dangerous arrhythmias if given at too high a dose. These are old drugs. These are

drugs that have been on the market more than 60 years.

They're very well known. In fact, they were over the counter in France until the very beginning of the pandemic. They're over the counter in most of the developing world, Ivermectin also. Both of these drugs have a very well established safety profile. You just have to look in a textbook to find out what the proper dose is.

There was no reason to believe you needed a higher dose for COVID. There were some post hoc justifications why we had to give this high dose, but they don't hold water. I've written about this in my long article on suppression. Again, to see that there were five clinical trials using excess doses, there had to be a reason for that.

Doctors don't come up with this on their own. "Oh, it's COVID, let's give a deadly dose." So, there is something behind this, although I don't know what it is. I've been treating people since early in 2020.

Starting in October, November of last year, two strangers who didn't know me or any of my patients reported to the medical board that they'd seen an interview I did on the internet, and they didn't like it, and that I was spreading this information. One said I was spreading this information in tweets. So, the board told me to defend myself.

I said, "You haven't told me what I've done wrong. Could you specify one thing I said that was incorrect and that was misinformation?" They never did. "Could you define misinformation for me?" They never did, but they decided to open an investigation.

Then, I spoke at a pharmacy board meeting in November, probably before the second complaint. They had issued a guidance document that was not really a policy, it wasn't a rule or regulation. They had told pharmacists to check that Ivermectin prescriptions were being used for legitimate purposes, and implied that they should not be used for COVID.

They had earlier initiated a similar document about hydroxychloroquine and chloroquine, which interestingly was taken back in January. So, most of the pharmacies, over 90 per cent, would not fill the Ivermectin or hydroxychloroquine prescriptions for COVID. Well over 90 per cent of the doctors would not write such prescriptions.

I wound up having a large number of patients call them for me. And none of them complained, not one, to the board. Then the board found a doctor and a midwife who both complained that with patients that we had jointly cared for, I had given an Ivermectin prescription to one, and a hydroxychloroquine prescription to the other.

So, that was two more complaints, not that I'd harmed the patients, just that I had used horse dewormer on them, or I had given them hydroxychloroquine. The midwife didn't even know it's approved in pregnancy. And then there was a fifth complaint, which was very interesting. This is the complaint that I made myself.

I had emailed the board of medicine last fall and I said, "Look, you people have forced me to lie to a pharmacist. I had to provide misinformation to a pharmacist—because you've suppressed the use of hydroxychloroquine, and the pharmacist would not dispense it, even though it's a legal drug and I'm legally

able to prescribe it—because of your whisper campaign, and you need to change that policy."

They said, "Oh great, we finally have a real complaint. Dr. Nass complained that she lied to a pharmacist, and we're going to get her on that one." The executive director of the board told me this was a very serious crime I had committed. And so, they wrote all this up, "Misinformation. Ivermectin, hydroxychloroquine, lied to a pharmacist."

They had a meeting of the board, and they decided that this crime was at least equal to rape or murder, and that my license needed to be immediately suspended that same day by the board, because I was a risk to the people of Maine. That's what happened in January.

My hearing just began on Tuesday, and will continue in another couple of weeks on October 25th. Then, the same people who voted unanimously to strip me of my license will vote again on whether they think my license should continue to be suspended. We shall see what happens.

Mr. Jekielek:

We actually live streamed your hearing, because we see this of interest to society in general, these sorts of activities. What was your impression of their reaction?

Dr. Nass:

Most of the board members had what we call in medicine, masked faces. They looked angry, they looked unhappy. Two of the board members' faces became very mobile towards the end, and they looked very upset. I think that their view of COVID medicine was being challenged.

I challenged them. I told them that they had participated in a crime against humanity. I told them that they had destroyed my reputation with no grounds, which was true. I told them that there's no laws against misinformation except for one. It's called the First Amendment, freedom of speech.

A couple of them were shocked to realize that we actually did have a law guaranteeing my freedom of speech. Two weeks before the hearing, the board attorneys dropped most of the charges. They just disappeared, because they realized they couldn't possibly defend them.

All the misinformation charges, and the charges of writing prescriptions off-label. They said, "We don't want to talk about the vaccine either. Let's drop the vaccine." Yet, having dropped all those charges, the board voted unanimously at the start of the hearing that my license should remain suspended.

Mr. Jekielek:

What have you been doing for those 10 months that you haven't been able to practice?

Dr. Nass:

I'm doing more of what I was doing before, which is trying to understand the pandemic, trying to understand what's behind it, trying to work on finding the best medical treatments, methods of care, and making the public aware of them.

I'm on Children's Health Defense TV every week, and I do a lot of writing and trying to figure out what has

happened to society, and what has happened to the world? How do we understand it? How do we get over it? How do we build a better society? I feel that my life has probably never had as much meaning as it has had this past year.

Mr. Jekielek:

One of the most recent articles you've written is about negative vaccine efficacy. Please explain what that is, because it's still very hard to conceive.

We also have industry people confirming that this is a reality now, and this was the subject of a recent paper you wrote. Please tell me about that.

Dr. Nass:

Let me start that discussion by saying that in the United States, a measles vaccine was licensed in the early 1960s that people received. If they were exposed to measles and had been vaccinated, they developed a much more severe form of illness. It wasn't measles anymore, it was something worse.

So, that vaccine was taken off the market. Then later, there was respiratory syncytial virus (RSV). It's a disease of young babies, very, very common. There was an experimental RSV vaccine given to babies, and it killed some babies when they got exposed to respiratory syncytial virus.

In animals, there have been animal vaccines that we know of that have caused worse illness in the animals if they've been vaccinated. There are different mechanisms that can do that. I don't want to call it just antibody-dependent enhancement or antigenic sin, because we don't know for sure what the mechanisms are with respect to COVID.

With negative efficacy in a vaccinated person, they become either more susceptible to the disease that they were vaccinated against, or they get a worse case of the disease when they're vaccinated. We actually saw this recently, and this is a kind of a scandal. Dengue.

Dengue is a viral illness. A new dengue vaccine from Sanofi was actually licensed in the Philippines, although it hadn't gone through full trials, and it was given to lots of kids. When kids got dengue, there were many deaths. This was just in the last four years. That vaccine has now been licensed in the United States for kids.

We now have a little bit of dengue in Hawaii and Florida, in Puerto Rico, in the Virgin Islands, and a tiny bit in Texas. The restriction on that dengue vaccine, Dengvaxia is the name of the vaccine, is that the child should have already had dengue, so that they're much less likely to have this life threatening result.

There are bad vaccines out there, and the FDA licensed this one in the United States right before the pandemic started, actually. What has happened now with the mRNA vaccines is that when you get vaccinated, for a couple of weeks immediately afterwards, your immune system has been suppressed, and you're more susceptible to COVID and to other viral infections, including viruses that may already be in your body.

And then, after two weeks, you get some enhancement of immunity against COVID for weeks to months.

Depending on the age group and depending on the vaccine, a few months later the immunity slowly wears off. Instead of going to zero, which is what you would logically expect, it goes below zero.

It becomes negative and you become more susceptible to getting COVID in the United States. CDC data shows this, data from New York State shows this, and now data from Kaiser Permanente shows the same thing. After several months in children, and after about six to seven months in adults, after your last shot, you are more susceptible to getting COVID.

There is some very limited data from the UK—most of the data is not being shared with the public—that suggests you are probably more likely to die if you've been vaccinated. After a period of six, seven months after vaccination, you're at higher risk of death from COVID or from everything. But those data are limited.

So, I'm not going to stand by that at this point in time. But it's a huge concern. This is probably one reason why the FDA, CDC and the White House want people to get frequent boosters, because they don't want them to get to that six to seven month mark where they become more susceptible, and may become more susceptible to mortality.

But that's not going to work either, because the more shots you get, the more other problems develop. I'm not going to go into all that, but you can only boost for a time. Right now everybody's kicking the can down the road in the U.S. public health system.

Mr. Jekielek:

Fascinating. Basically, you're saying there's this signal that should probably be researched extensively.

Dr. Nass:

And it has been, but that information is mostly suppressed.

Mr. Jekielek:

Fascinating. And so is it suppressed, or is the data not available?

Dr. Nass:

It's complicated. The CDC collects data from about a dozen different databases, including Medicare, Medicaid, the VA, the Defense Department, and a group of HMOs. The CDC pays the HMOs for their data on 12 million Americans. They have all these different databases. They're only showing us a small fraction of them.

The FDA has a group of different databases that it pays for, which includes data from over 100 million Americans. They're not showing us that either. What they're showing us is the VAERS, (Vaccine Adverse Event Reporting System), which is a voluntary database where people can report if they choose to, or doctors can report. They're supposed to report, most of them.

This database is being denigrated by the FDA and CDC, because of the issue of voluntary reporting, and not knowing what the reporting rate is. Is one in 10 cases of death being reported, or one in 100? We don't know. But that database is critically important, because by law it has to be shared with the public.

We get to see it, and we get to see the whole thing. It turns out there have been more deaths related to a COVID vaccine in the last two years, they started in December of 2020, than all the deaths for all other the vaccines in the 30-plus years since this database started.

I'll repeat that. All reports of all deaths for all vaccines added together for 30 years are not as high as the number of deaths related to COVID vaccines that have been reported to this system in the last 20 months.

Mr. Jekielek:

Just to be clear, these aren't necessarily causal things.

Dr. Nass:

No.

Mr. Jekielek:

This is something that a medical professional or a non-medical professional saw that was sufficiently close in proximity, or they believed for some reason might have been related.

Dr. Nass:

Exactly. What you're supposed to do is to use that database to figure out what the red flags are, and then use these 20 other databases that the FDA and CDC have, many of which are active surveillance.

For example, like the VSD (Vaccine Safety Datalink) with 12 million Americans total medical records on it and the date of every vaccine. Use those databases to find out which of these red flags actually turn out to show a causal effect. This is not what they're doing. They're hiding that information from us.

Mr. Jekielek:

Or maybe they're doing it, but we don't know.

Dr. Nass:

Yes, in the bowels of the FDA and CDC, these are easy things to do searches on. Everything is electronic. The DOD alone can do these studies, and the states can do them.

In some cases, the states have their own Medicaid databases, because that is a federal-state program. But so far, the vast majority of the data has not been made public.

Mr. Jekielek:

There is one state that has been looking at its data pretty carefully. Surgeon General Joseph Ladapo of Florida has released some pretty shocking data, and now has guidance not recommending these genetic vaccines for males below age 39, because of substantially increased myocarditis risk.

Dr. Nass:

And deaths.

Mr. Jekielek:

And deaths. Right, exactly. Deaths. Here's the question I have. Am I to understand that you're actually an advocate of a radical transparency of all of this data that should all be made available to the public, so that people can kind of sift through it?

Dr. Nass:

What do you mean by radical transparency? These are not classified documents. What normally happens in medical research is that you anonymize data, you don't have patients names, addresses, or towns. You don't provide data that can be identified with individual people.

But public health is based on databases of public health records. All that should happen is that the databases that the taxpayers are already paying for—these federal agencies are paying to record this data, and they have loads of scientists who are being paid salaries to analyze the data, and it's not classified—should all be in the public domain.

Mr. Jekielek:

Then, amateurs could try their hand at analyzing it, as well as professionals, much like the Surgeon General in Florida did.

Dr. Nass:

Exactly. That is what is supposed to be done with data that is published in papers in the medical literature. The scientists who do these studies are supposed to make their databases available to other scientists to independently verify that their conclusions are correct. Why should the federal agencies do anything less?

Mr. Jekielek:

How far away are we from that?

Dr. Nass:

We're very far away, because when people like myself and many others who are much more adept at studying these data look into it, we find that the CDC has changed definitions. They have made many adjustments to data, and made it impossible for anyone to follow what they're doing.

I've worked on two studies where we've requested data from CDC scientists, and they won't share it. We've asked them what their methodology was, and they won't share it. I have studied how the definitions of a case of COVID have changed. The definition of what a positive PCR test is has varied from time to time.

For instance, here's another good one. On May 1st of 2021, the CDC said, "Okay, we don't want the states to report breakthrough COVID cases anymore, unless the patient dies or is hospitalized and has had a positive COVID test with a cycle threshold of 28 or below."

To be a breakthrough case, you needed a much, much higher, tighter COVID virus in you, than a case when you could have a cycle threshold of 40 or in some cases 45, which are not normally considered to be accurate numbers for diagnosing any infection.

Mr. Jekielek:

Just for the benefit of our viewers, the more cycle thresholds there are, the more likelier to see a positive response.

Dr. Nass:

Right. Exactly. So, with cycle thresholds even above 35 to 37 for COVID, in an interview with Vince Racaniello of Columbia, Tony Fauci said, "You can't believe those cycle thresholds." And yet, the CDCs instructed laboratories to use cycle thresholds of 40 to 45.

That's why I say you cannot rely on data the CDC provides us. Independent scientists or improved federal agencies need to start looking at raw data again, and figuring out what they really show.

Mr. Jekielek:

Presumably, you've got a lot of FOIA requests out.

Dr. Nass:

Yes. I'm working with Children's Health Defense, and we have been sending a lot of FOIAs. Recently, I've also started working with another organization sending FOIAs. Aaron Siri has probably had the best luck sending FOIAs, because once a vaccine or a drug is fully licensed by FDA, all the data package that was used in the licensure process is supposed to be made public.

As you know, FDA tried to stop the data on the Pfizer vaccine from being public first for 55 years, and then for 75 years, and he won that court case. So now, that data is being made available to the public, and we need more of that.

Mr. Jekielek:

What do you make of this new California law that was just signed into law by the governor? Please explain it to me.

Dr. Nass:

A new law was rapidly passed by both houses of the California legislature and signed into law by Gavin Newsom and goes into effect next month or this month. It criminalizes doctors who say anything about COVID to their patients that is outside of consensus.

Of course, a law doesn't know what consensus is, but everybody really knows what it is. It means you're not allowed to say anything outside the government narrative on COVID in California if you're a medical professional, because you can lose your license. That means you can't criticize the vaccines.

You can't have the discussion I just had about databases being hidden. You cannot recommend drugs for COVID if the government is not recommending them. This also means that you can't actually tell your patients the truth. You cannot tell a patient what is in the label of a drug or what isn't in a label.

For example, if the government wants me to give somebody monoclonal antibodies, I'm not sure that I'm allowed to tell the patient there's a black box warning on the label, and that monoclonal antibodies, if given to a hospitalized patient, can cause a worsening of their COVID condition according to the label.

But this California law would shut me up. I have to just go with the narrative. It means doctors are being told they can't practice medicine, but particularly that they cannot provide informed consent to their patients.

Mr. Jekielek:

Isn't informed consent a foundational principle of medicine?

Dr. Nass:

We thought it was. Even the law under which Emergency Use Authorization products are authorized requires that you tell patients the risks and benefits of the EUA product, but this California law is saying you can't do that. The California law thinks it's going to supersede federal law.

Mr. Jekielek:

What do you expect is going to happen?

Dr. Nass:

Doctors in California are already talking about leaving the state. They've been told they can't practice medicine. They're supposed to turn into computers. What I've said is that the reason you need a doctor is to assess your own individual risks and benefits, and to determine the best treatment for you in consultation, balancing many things.

If everybody is going to be told the same thing and be given the same drug, you don't need a doctor. You just need a computer. Spit your lab test into the computer, and it will release a prescription. If all you are good for is to give patients the government narrative, there's not going to be any practice of medicine anymore, so say goodbye. Maybe some of them are waking up to that.

Mr. Jekielek:

Any final thoughts?

Dr. Nass:

It's a very dangerous time. The patients should be even more upset than the doctors. The life expectancy in the United States has crashed. It's gone down three years in the first two years of the pandemic. A Cuban now lives three years longer on average than an American.

This is what's happened to the practice of medicine in the United States. Doctors have to stand up, but there's only a million doctors. There's 334 million people in the United States, and they have to say, "No more."

Mr. Jekielek:

Dr. Meryl Nass, it's such a pleasure to have you on the show.

Dr. Nass:

Thank you for giving me a chance to say what matters to me.

Mr. Jekielek:

Thank you all for joining Dr. Meryl Nass and me on this episode of American Thought Leaders. I'm your host, Jan Jan Jekielek.

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