

# Facility Automation Management Engineering (FAME) Systems

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Sunday, 25 November 2007

## To All:

This article is a review of a November 11, 2007 article by Logan Molyneux. The article, titled, “**Parents, officials struggle over right to refuse vaccines,**” was located and then downloaded on 12 November 2007 from:

<http://www.heraldextra.com/content/view/243180/3/>

After some introductory remarks, the formal review, which is titled “**A Rebuttal to the Doublespeak in: ‘Parents, officials struggle over right to refuse vaccines,’**” begins on the next page.

## Introductory Remarks

First, *to simplify this review*, the statements in the article by Logan Molyneux will be quoted in a “Times New Roman” font.

Second, remarks by this reviewer, Paul G. King, PhD, will be presented in indented text following each of the writer’s quoted remarks.

In addition, this reviewer’s remarks will be in a dark blue “News Gothic MT” font except, when he quotes from, a federal statute or regulation, the text will be in a “Lydian” font and all other reviewer quotations will be in an “Arial” font.

When this reviewer quotes from statements made in the writer’s column, this reviewer will use an *italicized* “Times New Roman” font.

Finally, should anyone find any significant factual error for which they have published substantiating documents, please submit that information to this reviewer so that this reviewer can improve his understanding of factual reality and appropriately revise his views and the final review.

With these things in mind, this review of “**Parents, officials struggle over right to refuse vaccines,**” begins on the next page.

Respectfully,

<S>

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## A Rebuttal to the Doublespeak in: “Parents, officials struggle over right to refuse vaccines”

### “Parents, officials struggle over right to refuse vaccines

Logan Molyneux - DAILY HERALD

Marie Hansen of Spanish Fork says something changed the day she took her son Dylan to his 1-year-old doctor's appointment.

Until then, Dylan had been successfully overcoming developmental problems caused by his low birth weight. But, when he got his MMR and chicken pox immunization shots, he started crying uncontrollably and stopped breathing regularly. Doctors and nurses were eventually able to stabilize him, but Hansen says she never learned exactly what happened. She assumes it was a seizure, but all she really knows is that she soon realized something was wrong.

‘He just seemed really off the next week,’ Hansen said. ‘He didn't really run a fever or anything, he was just off. The best way I can describe it is that he kind of lost the spark in his eye. I can show you pictures and it's just night and day.’”

This reviewer finds that this anecdotal recounting of the severe harm to this child from the simultaneous administration of four live viruses (measles, mumps, rubella, and herpes varicella-zoster) in two Merck vaccines (MMR-II and Varivax) accurately portrays the harm a child may “rarely” experience after getting these two vaccines.

However, this recounting does not reflect the reality that vaccine administration can, and does, cause worse injuries and death to some who have been given this combination of vaccines at 12 months of age.

Since administering these two vaccines inoculates the child with “weakened” strains of live viruses for four diseases (measles, mumps, rubella and chicken pox [varicella]), the reader should not be surprised that an adverse outcome, such as the one reported, may occur.

“Hansen is among a small but growing number of parents who choose not to vaccinate their children, and, according to the medical community, consequently increase the population's risk of disease.”

The writer's “*Hansen is among a small but growing number of parents who choose not to vaccinate their children*” is an obvious misstatement of the facts since their child was apparently vaccinated up through the age of 12 months, provided the writer's previous account is factually accurate.

Perhaps the writer intended to say:

“Hansen is among a number of parents who choose to stop vaccinating their children after a given vaccination has resulted in significant harm to one or more of their children.”

While the writer's concluding remark:

“... *according to the medical community, consequently increase the population's risk of disease.*” captures the orthodoxy of those who religiously believe in vaccination, this reviewer notes that the writer fails to cite, or reference, any study that shows that stopping the

vaccination of children who have severe adverse reactions to vaccines increases the population's overall risk of disease.

Moreover, many of the proponents of vaccination who appear to hold this belief are the same conflicted pediatricians who derive half, *or more*, of their income from giving vaccines – certainly a group with an innate financial bias towards more vaccinations.

“Arguments against vaccines include the idea that large pharmaceutical companies that manufacture the vaccines are corrupt and lobby for vaccine laws just to make money.”

Here, *in part*, the writer is simply stating the obvious.

This is the case because all corporations, including “*large pharmaceutical companies that manufacture the vaccines,*” are, *as they admit*, driven by the imperative to “*make money.*”

Thus, *as all corporations currently do*, these firms have not only lobbied “*for vaccine laws*” but also, *given the laws shielding them from direct suit in vaccine injury cases* (see, for example, **42 U.S.C. Part 300aa**), have been successful in obtaining protections that allow them to make vaccines with little worry of direct litigation even when one or more of their vaccines are dangerous.

Moreover, to the extent that “*large pharmaceutical companies that manufacture the vaccines*” *knowingly* fail to comply with any applicable federal policy, law or statute governing the manufacture of drugs, *in general*, or vaccines, *in specific*, it is obvious that not only are they corrupt but, *when the federal officials collude with them to allow adulterated drugs* (e.g., vaccines containing a preservative, like Thimerosal, whose toxicological safety has not been proven to the applicable standard “**sufficiently nontoxic ...**” [**21 C.F.R. Sec. 610.15(a)**]) *to be marketed*, they are also apparently operating a “racket” and would seem to be violating the criminal RICO statutes (Racketeering, Influencing, and Corrupt Organizations) statutes set forth in **18 U.S.C.A Sec 1961 et seq.**

Moreover, the federal government “profits” from the current US\$ 0.75 tax on each covered vaccine disease dose (currently about US\$ 210 million annually and increasing) as long as the payout from the Vaccine Injury Compensation fund is, *as has been the case for more than a decade*, significantly less than the annual interest that accrues to this fund – thus, government officials also have financial incentives to: **a)** approve more vaccines and **b)** minimize the payout from the Vaccine Injury Compensation fund.

Yet, this reviewer is surprised that the writer presents: **a)** only some of the financial incentives for more vaccines and more doses without regard to the true medical cost-effectiveness of each vaccine and **b)** these financial incentives as “*Arguments*” rather than the factual realities that they so obviously are.

To see this reality, one need only look at the billions Merck is projecting for its newest vaccine, Gardasil, and Merck's direct and indirect efforts to widen the vaccine's indicated age range and to expand its indications to include males – all without any proof that vaccinating today will truly protect against cases of cervical cancer, a cancer that: **a)** is life-style related, **b)** will only develop in a small percentage of women, and **c)** will not develop for 25 to 50 years after the initial vaccination series.

“There has also been increased interest in natural health and the idea that you can be healthy without medicines.”

Here, the writer is only stating the obvious.

In spite of intense propaganda by the “healthcare” establishment, the reality remains that some groups and individuals manage to be healthy and live into their eighties and beyond, with little, or no, vaccinations as well as only minimal, or no, use of prescription drugs.

Perhaps, if more of us followed their examples, we would be as healthy, as a group, as they are.

Moreover, if, *as the writer should have done*, the rhetoric were restricted to vaccines, then there are large groups of people in the United States of America who: **a)** do not vaccinate and **b)** apparently have “no higher” infant, childhood, or lifetime mortality than those groups who vaccinate their children.

“But the biggest complaint is that vaccines are administered by force.”

This reviewer agrees with the writer to the extent that coercive state laws are used to increase vaccination and, *though medical, religious and, in some States, philosophical exemptions exist*, health, school and other officials continually discourage the public from exercising their Constitutional right to exempt themselves and their children.

“Laws in every state require school-aged children to receive a series of vaccine shots.”

Here, the writer again only speaks of the coercive aspects of the laws for “*school-aged children*,” when these laws extend to adults seeking to attend universities and those wishing to be employed in certain jobs.

In addition, the writer’s remark does not address the Constitutionally guaranteed right of exemption that, *in most states*, includes a religious exemption, *as it should in a nation where freedom of religion is guaranteed*, and, *in many states*, also includes a “philosophical” exemption.

“Because there is overwhelming medical evidence and opinion stating that vaccines are not only safe but the greatest triumph of public health in history,”

While this reviewer agrees that, in the healthcare establishment’s view, as stated by the writer here:

*“there is overwhelming medical evidence and opinion stating that vaccines are not only safe but the greatest triumph of public health in history,”*

the scientific reality is that, *for most vaccines*, there is:

- No proof of long-term safety,
- An increasing body of evidence that the long-term financial, societal and human costs of many vaccines outweigh their claimed benefits, and
- Increasing clarity that the “*greatest triumph of public health in history*” is the ability of the healthcare establishment’s propaganda to mislead the public concerning the true role of vaccines and vaccination in improving the overall health and the quality of life of the American public.

“... many who choose not to vaccinate do so quietly and don't speak out about it for fear of being seen as a bad parent.”

Here the writer is attempting to subtly portray those “*who choose not to vaccinate*” as being “*a bad parent*”

However, there are large groups (e.g., the Amish) who do not favor vaccination and who do not consider themselves bad parents.

Finally, as *this article and others show*, there are many good parents who do speak out about the harm that some vaccine has, or vaccines have, caused to one or more of their children.

“At 7 years old, Dylan is still non-verbal despite early intervention programs and thousands of dollars in therapy. Hansen said she never noticed any previous reaction to Dylan's or her other children's vaccinations.”

Here again, the writer returns to the “personal” story of “*Dylan*” but continues to depersonalize “*Marie Hansen*,” Dylan’s mother as “*Hansen*” rather than using “*Marie*” or “*Marie Hansen*.”

Again, the writer affirms that the Hansen children were vaccinated until the concomitant administration of the Merck MMR-II and Varivax vaccines to Dylan Hansen severely damaged him.

“Dylan probably would have experienced various delays no matter what, she said, but she can't shake the idea that something changed that day. The experience scared her so bad she says none of her children will receive another vaccine, if she can help it.”

Since the writer does not quote Marie Hansen, it is impossible for this reviewer to know what part of these statements is what the writer heard and what part is what Marie Hansen actually stated.

However, had the drug have been an antibiotic and the child experienced a severe anaphylactic reaction, this reviewer understands that no one would be writing about that child and/or his mother’s decision not to ever again allow that antibiotic to be given to that child or to his siblings.

### “**Growing numbers**”

Once home to one of the lowest vaccination rates in the nation, Utah has increased its rates in recent years, and now ranks 25th. But more parents are now signing exemption forms to avoid the required series of vaccine shots for their school-aged children. According to Dr. Joseph Miner, director of the Utah County Health Department, about 5 percent of Utah County children have vaccination exemptions with UCHD, a number that has been rising in recent years.”

Without more details as to the nature (e.g., medical, religious, or philosophical) and extent of the exemptions (e.g., specific vaccines, general exemption, or exemption following adverse events) and the rate (number divided by population) of the increase, neither this reviewer nor any other reader can understand the importance, *if any*, of the writer’s remarks here.

“‘Utah has a history of having some of the lowest immunization rates in the nation,’ Miner said. ‘We've been last, then next to last, then almost average, but we've never been above average.’”

All that this reviewer can gather from these statements is that the overall vaccination rate in State of Utah appears to be increasing in spite of the non-specific “*about 5 percent of Utah County children have vaccination exemptions*” reported by the writer here.

“Most other states have lower vaccine exemption rates, perhaps in part because Utah is among a minority of states that allow parents to cite medical, religious or philosophical objections to the immunizations. In other words, parents can opt out for any reason.”

Here, the writer has made contradictory statements.

First, the writer states that Utah allows “*parents to cite medical, religious or philosophical objections to the immunizations*” – three legal grounds for an exemption in Utah.

Then, the writer generalizes these specific exemptions into “*parents can opt out for any reason,*” misleading the reader to consider “*philosophical objections*” as “*any reason*” objections, even though they are not.

Finally, absent an ordered State list of the pertinent information on vaccine uptake percentage and vaccine exemptions by category, the reader cannot determine or estimate the extent to which the philosophical exemption affects Utah’s rank among the States.

“Most states only allow medical or religious exemptions (requiring parents to state that vaccinations are against their religious beliefs) and Mississippi and West Virginia allow children to miss vaccinations only for medical reasons.”

Here the writer is correct.

However, this reviewer notes that the laws of Mississippi and West Virginia appear to be at odds with the First Amendment to the Constitution of the United States of America, which seems to ban laws that prohibit the free exercise of religion.

“Immunization programs are becoming victims of their own success, Miner said, because as contagious diseases disappear, parents see less of a need to vaccinate their children.”

This reviewer must respectfully disagree with the writer’s statements here concerning Dr. Miner’s views.

In this reviewer’s view, immunization programs have become victims to greed-driven additions:

- Of vaccines for non-contagious (e.g., hepatitis B and HPV), relative benign (e.g., chickenpox) and non-population-wide (e.g., rotavirus, which is mostly confined to the demographically poor) diseases, where the vaccination programs are not medically cost-effective
- Where, in spite of efficacy claims, the vaccines are not truly effective in preventing the disease (e.g., human influenza), and
- Where the vaccine does not provide any protection against one or more of the prevalent virulent strains (serogroups) of the disease (e.g., the current vaccines for *Neisseria meningitidis*).

Since the long-term safety of most vaccines has not been proven, in deciding whether or not to deploy a vaccine for which short-term safety and true effectiveness has been

established, the decision should be based on medical cost-effectiveness considering the worst-case costs of the harm that the vaccine is known to, or may, cause.

Today, “societal costs,” as determined by studies influenced by those who benefit from the vaccine’s being deployed, are used to justify vaccine approval and, *in some cases* (e.g., rotavirus), the lack of even “societal cost-effectiveness” is ignored and the vaccine is licensed and approved for universal use.

Finally, “ill-conceived” vaccines (e.g., the now-withdrawn Lyme disease vaccine) are licensed, approved, deployed and quietly withdrawn without the public’s being told the truth about their failure to protect and/or the long-term harm these vaccines caused to those inoculated.

Together these factors (and not the “success” of the polio, DTaP, and MMR-II vaccines) are increasingly pushing parents to question and reject the claims about vaccine safety (e.g., “the safest of medicines”) and vaccine effectiveness (e.g., protects “all” those vaccinated from getting the disease) spread by those who profit from increasing the vaccination programs.

“A recent Associated Press study found a rise in religious exemptions in states that don't allow philosophical exemptions. Some parents admitted their real concerns were about the safety of the vaccines, not their religious beliefs.”

Here, this writer is simply reporting the reality that the parents’ real concern is the real safety of certain vaccines and/or vaccine additives (e.g., Thimerosal, aluminum salts, and gelatin), where they have been told that vaccines are supposedly “the safest of medicines” but their experience or that of their friends and relatives has found that this “the safest of medicines” claim has not been supported by the outcomes observed.

“The increasing exemptions are a problem for everyone, because vaccines are only effective to the extent that everyone gets them.”

If vaccines truly protected all those vaccinated from contracting a disease, then the only people at risk would be those who were not vaccinated.

However, accepting the validity of the writer’s statement here, it is clear that vaccination does not even protect all those vaccinated from getting the disease the vaccine is supposed to prevent.

Moreover, as the ever-increasing need for one or more subsequent booster doses indicates, the protection from contagious childhood diseases provided by most vaccines for them does not last as long as the protection from disease afforded by having the childhood disease and recovering from it.

As the recent measles outbreak demonstrated, when exposed to measles, some of those who had not had measles but who were “fully” vaccinated still contracted measles – most at ages well-beyond the childhood period, when, *for children with a healthy immune system and adequate stores and/or intakes of vitamin A and D from Cod-liver oil and vitamin C from fruits and vegetables*, the disease is almost always very mild.

In contrast, those who have no immunity and contract an early childhood disease much later in life have a much more severe case of the disease.

Thus, at best, vaccines are generally protective for some (unknown) period of time for most of those who are vaccinated – regardless of the percentage vaccinated – as the reported outcomes from disease exposure by outside carriers entering the vaccinated population clearly indicate.

“Dr. Russell J. Osguthorpe, a pediatric infectious disease specialist at Utah Valley Regional Medical Center in Provo, likens it to requiring everyone to drive the speed limit so everyone has a safe ride.”

Dr. Osguthorpe’s example is appropriate because, as we all know, almost everyone does not drive the speed limit and, *for most of us*, the ride is still safe.

"We don't immunize just for fun, or because we can," Osguthorpe said. "It's because children die from preventable diseases."

While this reviewer agrees that we “*don't immunize just for fun*” and that some “*children die from preventable diseases*,” the unspoken reality is that some children die from being vaccinated and that some more are severely harmed by being vaccinated.

Yet, this reviewer does not hear Dr. Osguthorpe or others of his ilk forthrightly addressing this reality.

For example, addressing the hepatitis-B vaccine issues, Dr. Jane Orient, director of The Association of American Physicians and Surgeons, wrote:

“In 1996, only 54 cases of the disease were reported to the Centers for Disease Control and Prevention (CDC) in the 0 to 1 age group. There were 3.9 million births that year, so the observed incidence of hepatitis B in the 0 to 1 age group was just 0.001 [actually 0.0014] percent. In the Vaccine Adverse Event Reporting System (VAERS) there were 1,080 total reports of adverse reactions from hepatitis B vaccine in 1996 alone in the 0 to 1 age group [raw incidence of 0.028 %], with 47 deaths reported [raw incidence of 0.0012 %].

For most children, the risk of a serious vaccine reaction may be 100 times greater than the risk of hepatitis B. Overall, the incidence of hepatitis B in the U.S. is currently about 4 per 100,000. The risk for most young children is far less; hepatitis B is heavily concentrated in groups at high risk due to occupation, sexual promiscuity, or drug abuse.”

Thus, in 1996, for a hepatitis B rate to 0.0014 % (54 cases) “in the 0 to 1 age group,” at least 47 children in this age group were reported to have died and 1,033 more were reported to VAERS to have an adverse reaction from being vaccinated with the hepatitis vaccine.

Thus, the U.S. national hepatitis-B vaccination program appears to be a very poor risk tradeoff especially since most of the reported 54 cases of hepatitis B in infants under 1-year old did not kill the infected infant.

In addition, a recent paper<sup>1</sup>, discussing the abuse of evidence-based medicine (EBM) reported the obvious increase in multiple sclerosis (MS) in children that occurred at such an increased rate that, 4 years after hepatitis-B vaccination program for French middle-school children was implemented, the number of cases of MS had increased by about 60% (see the quoted text and **Figure 1** on the following page):

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<sup>1</sup> Girard M. When evidence-based medicine (EBM) fuels confusion: multiple sclerosis after hepatitis B vaccine as a case in point Medical Veritas 2007; 4: 1436-1451.

“The incidence of severe MS cases (according to the data from the national health insurance system) and the sales of hepatitis B vaccine doses are depicted in Figure 1, which shows a significant displaced correlation between the two factors.

**Figure 1.** Sales of hepatitis B vaccine in France as compared to the frequency of severe multiple sclerosis, 1982-2000 (Data from the French health-insurance system)”

This increase was so notable that the government of France canceled that national vaccination program for hepatitis B in children as the drop of sales of hepatitis B units after this hepatitis-B program was terminated.

Finally, this increased risk had already been noted in a previous U.S. study of the U.S. Vaccine Adverse Event Reporting System (VAERS) that examined the statistical correlation between administered hepatitis-B vaccine and autoimmune disease, including MS.<sup>2</sup>

“A 2000 study of Colorado children found that those who filed religious or philosophical exemptions were 22 times more likely to acquire measles and six times more likely to acquire pertussis (whooping cough) than vaccinated children.”

First, this reviewer wonders why no data is reported for those who have medical exemptions.

Second this reviewer notes that no incidence/prevalence rates were reported for either disease so that neither the incidence/prevalence rates for “*vaccinated children*” could be assessed nor could the import of the increased rates among those with these exemptions be assessed for measles and whooping cough.

Third, this reviewer notes that there are no outcomes data to assess whether or not the harm caused by the disease to the children in the “exempt” cases was significantly more than the harm in the “*vaccinated children*” who still contracted the disease.

“Two years ago, Utah Valley saw an outbreak of whooping cough -- the county health department

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<sup>2</sup> Geier D, Geier M. A case-control study of serious autoimmune adverse events following hepatitis B immunization. *Autoimmunity* 2005; **38**: 295-301.

recorded more than seven times the normal amount of cases. Those sick kids can spread disease even to vaccinated children.”

From the writer’s statements here it seems as if those cases (“*sick kids*”) were unvaccinated children who “*can spread disease even to vaccinated children,*” but, *from the wording used here*, apparently did not actually do so

“‘Vaccines are between 95 and 99 percent effective,’ Miner said. ‘You’ve got anywhere from 1 to 5 percent of kids who for some reason have lost immunity or haven’t developed it. That’s a small percentage, but if you have 25 percent of other kids not immunized, then illness can spread through the whole population.’”

First, this reviewer would challenge Dr. Miner’s blanket, unqualified, effectiveness numbers for vaccines in general, as this reviewer does not know of any effectiveness (not efficacy) studies that have proven the effectiveness of vaccines in general.

For example, his blanket assertion concerning vaccine effectiveness seems to be at odds with the claims made by Sanofi-Aventis for its Menactra meningococcal vaccine, where for the four covered strains, the short-term (3-year) efficacy, not effectiveness, claims are 85% or less and the vaccine has no efficacy or effectiveness for the “B” strain that is the identified strain in up to 50% of the early childhood cases of this disease and up to 25% of the cases in older children.

However, accepting the writer’s “*from 1 to 5 percent of kids who for some reason have lost immunity or haven’t developed it*” assertion as valid for measles and pertussis, and taking his “*25 percent of other kids not immunized*” assertion to mean those children with “*filed religious or philosophical exemptions,*” the subject of this paragraph, this reviewer finds that, at best, these two well-controlled illnesses can only spread through no more than about 5% of the whole population and, *with appropriate quarantine and other healthcare interventions*, should spread through no more than 1% of the population who has not already had, or been vaccinated against, these diseases.

“That’s why Miner says deciding not to immunize your children puts them and their peers at risk.”

Again, the statement made here is obviously at odds with reality since, *when most are vaccinated and the vaccines are truly long-term effective*, the only children put “at risk” are your and everybody else’s non-immunized children and a small percentage of those children who have been vaccinated.

However, for everybody’s unvaccinated children there is no risk of the known adverse outcomes including death and severe injury associated with the administration of these vaccines.

Since, *as the doctor admits*, vaccination does not guarantee immunity, those making the choice not to vaccinate are accepting the theoretical (theoretical since, absent disease exposure, there is no disease risk) risk of disease and the harm it may cause while rejecting the known risks associated with vaccination, including death and severe injury, and accepting the admitted reality that vaccination may not protect their child from contracting these two diseases.

Section 1 of Amendment XIV, ratified July 9, 1868, to the U.S. Constitution states:

“All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens

of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.”

Therefore, it is clear that the right to choose or refuse vaccination is a right protected by the constitution of the United States of America and that, *if anything*, given the rise in State laws and regulations mandating vaccines for diseases other than those that are immediately life-threatening to the whole population, the laws should be changed to “opt-in” for all such vaccines – where the person, parent or guardian must give their affirmative consent before any of these vaccines may be administered to themselves, their children or their wards.

“With 95 percent of the population in Utah Valley immune, there is little risk of an epidemic. But if that percentage continues growing, the risk would increase, and Miner said the state would have to disallow exemptions to protect the population.”

Here this reviewer notes that the writer is obviously confusing immunity with vaccination since no data has been presented concerning the present-day immunity of the entire population of “Utah Valley” or, *more importantly*, the breakdown between “natural” and “vaccination acquired” immunity and the “immunity” tests that proves, *contrary to reality*, that both types of immunity are truly protective of all known strains of each disease.

Further, given MRSA and the emerging incidence of variant virulent strains of viruses where the vaccine does not cover all strains, this reviewer wonders why there is no mention of the risk of creating more virulent strains when the virus strains in the live-virus vaccines interact with the “wild”/“natural” disease strains.

Moreover, this reviewer is struck by the writer’s failure to state, *much less address*, the biggest risk factor: exposure of the population to a recent non-indigenous immigrants or other travelers, who enter the local population while actively shedding either the measles virus or pertussis.

For we all know that, absent exposures to these disease organisms (unlike some other diseases), there is no disease risk for either pertussis or measles.

Thus, Dr. Miner’s “*the state would have to disallow exemptions to protect the population*” advocates violation of our fundamental Constitutional rights based on a claim that “*the risk would increase*” while ignoring the real disease risk drivers (e.g., illegal immigration, poor hygiene, contaminated water, poor nutrition, and substandard housing) that far outweigh the increased risk from fewer vaccinations and the reality that nationwide vaccination, *for the newer (approved after 1987) vaccines*, is, at best:

- Not medically cost-effective,
- Only marginally cost-effective on a societal basis for some vaccines, or
- For a few of these newer vaccines, not cost-effective even when the projected societal costs are considered and the costs of the harm caused by the vaccines are excluded.

If, as alleged in this article, “*there is little risk of an epidemic*” in Utah Valley, perhaps this would be an ideal area to assess the true costs of vaccination and non-vaccination.

**“A matter of public policy**

Robert Johnston, an associate professor of history at the University of Illinois-Chicago, has studied the anti-vaccination movement for 20 years and said most of the resistance revolves around the freedom of making an informed choice.”

While this reviewer agrees that the “*freedom of making an informed choice*” is a major issue concerning vaccines and vaccination programs, this reviewer finds that other major issues are:

- The rigid intransigence on, and propagandization of, the almost religious “savior of mankind” view of vaccines by the healthcare establishment and health officials, and
- The failure of the government and the vaccine makers to provide full and complete scientifically sound and unbiased information:
  - Concerning the theoretical benefits from each vaccine, the apparent efficacy rates and efficacy duration period, and the probable adverse effects, including death and their incidence rates for healthy children who may contract the disease(s) covered by the vaccine,
  - The real immediate adverse-reaction risks and risk incidences associated with each vaccine or vaccine combination, and
  - The long-term (> 1 year) adverse event risks and their incidence rates for those vaccinated with each vaccine or vaccine combination.

“‘This is really the only area of American medical life that they're not allowed to offer a truly free consent,’ Johnston said. ‘Some of them may even vaccinate, but they may speak out for the right to choose. They're willing to hear that vaccines are safe, but they want to make that freedom of choice.’”

Here, this reviewer agrees with Johnston’s view of reality and suggests that the public needs to have the laws governing vaccination rewritten to make them “opt in” laws instead of the current “opt out” laws that are in place today.

If this were to be done, then this major stumbling block would be removed and, *like most of the other elective aspects of medicine*, “affirmative consent” would be required from each person, parent or guardian before any vaccine could be given.

In this America, vaccination status would no longer be tied to either school attendance or job qualification.

“Interestingly, mandatory vaccination is one of the rare laws in society that citizens can choose not to follow.”

Here the writer begins by making a misleading statement.

Because, *to comply with the Constitutional mandates regarding “free exercise of religion” and the right to bodily integrity*, the State vaccine laws and regulations provide exemptions that any person may elect.

When the citizen elects to seek an exemption, be that exemption medical, religious, or philosophical, then the citizen is following the law.

Therefore it is disingenuous for any person to even attempt to cast:

- The laws and regulations governing vaccination as “*mandatory vaccination*” laws or regulations, or,

- *As the writer does subsequently, citizens choosing a legally provided exemption as law breakers.*

As with any permissive laws and/or regulations, the vaccination laws and regulations provide options that a person may *legally* elect.

Thus, *contrary to the writer's distortion of the facts*, the Utah vaccination laws and regulations are not *"rare laws in society that citizens can choose not to follow."*

"No one can declare themselves exempt from the speed limit, for example. So it's a push for freedom of choice in an area of public policy where adherence is already optional."

Again, the writer makes irrelevant and illogical statements here.

First, persons can and do legally declare themselves exempt from the posted speed limits when, *for example*, they decide that the weather conditions do not permit them to operate their vehicle safely at the posted speed limit and slow down.

For example, when it is raining hard and the posted speed limit is 70 mph, some drivers choose to limit their speed to about 50 mph because they think driving at higher speeds is not safe.

Thus, the writer's:

*"So it's a push for freedom of choice in an area of public policy where adherence is already optional."*

is a blatant attempt to mislead the reader and portray laws enacted by the legally elected representatives of the people according to the will of the governed as "*public policy*," a term that is usually used for policies decreed by unelected administrative officials without obtaining the affirmative consent of the electorate or their elected representatives.

Hopefully, the citizens of Utah will recognize this attempt to subvert the will of the people and demand that their elected officials purge the State of all appointed health officials who hold the opinion that their obviously less-than-objective views should supersede the will of the people of Utah.

"Why make a law and then allow people to break it?"

Again, the writer begins by making a knowingly false statement concerning the Utah laws governing vaccination.

In reality, the reasons for the conditional vaccination rules enacted by the Utah government currently reflect the "will of the people."

Increasingly, the need for these options is being supported by the reality that the newer vaccines are apparently not only less than safe and/or less than effective but also, *in several instances*, not cost-effective.

"First, because here in the U.S., people value personal freedoms and rights so highly. Also, Brigham Young University public policy specialist Sven Wilson said the law sets an expectation of society, and even if it is optional, it encourages people to follow a particular path. Even an optional law has a greater influence than guidelines."

What this reviewer finds sad is that the United States of America, which gave Japan its democratic government – a government that does not mandate vaccines as a

general condition for school attendance – continues to deny the same democratic freedom of choice concerning vaccines to American citizens.

At a minimum, it is clear that this writer, the Utah health officials in this article, and U.S. health officials, *in general*, do not value the personal freedoms and rights of the American public when it comes to the right to choose (freedom of choice) and the right to know all the facts before being asked to choose (informed consent) concerning any aspect of vaccination.

The Japan example is particularly instructive because, *without a mandatory vaccination program*, Japan has a strong vaccination program that has produced an infant mortality rate that is about half of the infant mortality rate in the U.S. today.

Otherwise, this reviewer agrees that laws and regulations on vaccination, *which recommend a given course of action but provide optional choices*, have “*greater influence than guidelines*” because, *in general*, they are *currently* written in a coercive manner or, *when not so written*, are rendered coercive by the administrative practices adopted by State and local “health” officials.

“But vaccine skeptics say parents should do their homework before taking their children down the shot path.

‘When you make a decision that involves a risk, you want to be the best parent and have the best information possible,’ said Barbara Loe Fisher, president of the National Vaccine Information Center, a leading vaccine skeptic group. ‘Vaccines should not be separated from the informed consent ethic in medicine. We recommend that parents do their homework and talk to one or more health professionals and get all the information they can.’”

First, this reviewer finds it unprincipled to cast those who recommend, “*parents do their homework and talk to one or more health professionals and get all the information they can*” about vaccines as “*vaccine skeptics*.”

Moreover, this reviewer finds that it is a slander on the good name of the “*National Vaccine Information Center*” (NVIC) to refer to it as “*a leading vaccine skeptic group*” simply because the NVIC: **a)** tries to provide people with as much information as they can concerning vaccines and **b)** focuses on the scientific information that the healthcare establishment and health officials do not routinely provide to the public.

Otherwise, this reviewer agrees that parents should do what Fisher’s group suggests.

“Because following immunization law in Utah is optional given the exemptions, public officials are looking for other ways to encourage parents to immunize their children.”

This reviewer is bemused not only by the plainly belief-driven views of the health officials concerning vaccines but also by their “*looking for other ways to encourage parents to immunize their children*.”

If vaccines truly were: **a)** “the safest of medicines,” **b)** “safe and effective,” and **c)** “able to immunize almost all those vaccinated” as the healthcare establishment and health officials claim, then why is there any need to “*encourage*” (by obviously coercive means) parents to vaccinate their children or, as *the writer does here*, to use the word “*to immunize*”<sup>3</sup> when “to vaccinate” or “to inoculate” are the verb that should have been used.

In a free market, vaccines that are truly safe and protective need no coercive measures to “*encourage parents*” to accept them for use on their children or themselves.

Thus, the clear message that attempts to “*encourage parents to*” vaccinate their children is sending and, *if these measures are increased*, will increasingly send, *whether or not they should*, is that: **a)** vaccines are not safe and effective and **b)** people should take whatever actions they can, including demanding, *on pain of non-reelection*, that their elected State officials repeal the current “opt out” vaccination laws and regulations and replace them with laws that clearly state that all vaccines are optional and cannot be required as a precondition for access to any school, social program, or job.

“In Utah County, the Women, Infants and Children program has considered a plan to tie WIC food vouchers to vaccine records. Under the proposed plan, a parent whose child is up on his or her immunizations could receive three months of vouchers at a time, while parents of children who are not caught up would have to return to the WIC office each month. WIC officials support the plan, but the cost of keeping a nurse on hand to verify immunization records has been deemed prohibitive.”

Again, this reviewer finds that this plan is particularly offensive because it obviously targets the poor (those who receive “*WIC food vouchers*”) and, *as stated*, it appears to be illegal because it does not treat those with exemptions the same as those “*whose child is up on his or her immunizations*.”

This reviewer is also sad to read that these “*WIC officials support the plan*” but glad that the cost was deemed to be prohibitive.

“It's precisely the overwhelming medical and public support for vaccines that vaccine skeptic Fisher says drives some parents to hide their choice.”

Here the writer is obviously attempting to prejudice Fisher's remarks by explicitly casting her as a “*vaccine skeptic*” and to misrepresent the propaganda and “must vaccinate” pressure by health officials and the Establishment to which, as Fisher reports, parents are continually subjected.

“‘You have people telling you you're unpatriotic and selfish when you're just trying to protect your child,’ Fisher said. ‘Parents who do not vaccinate their children are seen as selfish, and they're talked about as a danger to public health. And when they use a religious exemption to get out of it, they're called liars. So the problem is that when parents talk about this they can then be targeted by their communities.’”

Here, this reviewer finds that Fisher's remarks accurately reflect the view of reality that most parents see.

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<sup>3</sup> Given the admitted reality that vaccination does not even provide short-term immunity to some who are vaccinated, it is clear that the use of the verb “*to immunize*” here is, *at best*, inappropriate.]

“Driving those who choose not to vaccinate underground is not the goal of public health officials like Utah County's Dr. Miner. He said his work is a constant effort to educate.”

Contrary to the writers remarks, if the goals of Utah public health officials were truly not to drive “those who choose not to vaccinate underground,” then they would not be “looking for other ways to encourage parents to immunize their children” as this writer has previously stated in this article that they are.

If, as this writer states, Dr. Miner’s work were “a constant effort to educate,” then he would be:

- Actively publishing on-line all of the available peer-reviewed published data on each vaccine so that all might see what all of the benefits and risks are for each vaccine,
- Opposing vaccine administration whenever a child is ill and/or on any drug treatment regimen for an acute infection,
- Working towards a flexible vaccination schedule where developmental age, immune-system state, and other factors, like breastfeeding, should be used to determine when a child should be vaccinated and not the current rigid schedule that considers none of these,
- Opposing a statewide vaccination program for any new vaccine where the medical cost-effectiveness has not been established, and
- Supporting the removal of any vaccine that is not cost-effective in terms of its costs to society (medical and other) from the Utah list of recommended vaccinations.

However, from the remarks that Dr. Miner has made and makes here, it is clear that none of these are a part of his “educational” priorities

““You have to constantly educate people about what it used to be like with infant mortality and preventable diseases,” Miner said. ‘But unfortunately it takes an outbreak of whooping cough to remind people that this is what our grandparents were talking about when you used to have six or 10 kids in order to raise four of them to adulthood. Now we take it for granted that we'll raise all of them to adulthood, but that's not the way it used to be.’”

**Infant Mortality in Deaths per 1000 Live Births & Other Information**

<b>Year</b>	<b>United States</b>	<b>Approx. annual decrease in U.S.</b>	<b>Japan</b>	<b>Approx. annual decrease in Japan</b>	<b>Other Information</b>
1920	86	-----	-----	-----	
1930	65	2.1	-----	-----	
1940	47	1.8	-----	-----	Second World War 1942 – 1945 utterly devastated Japan
1950	29.2	1.78	60.1	-----	Salk vaccine in US mid 1950s
1960	26.0	0.32	30.7	2.94	
1965	-----		18.5	2.50	
1970	20.0	0.60	13.1	1.28	
1980	12.6	0.74	7.5	0.56	
1985	10.6	0.40	5.5	0.40	
1990	9.2	0.28	4.6	0.19	
1995	7.6	0.32	4.3	0.06	
2000	7.0	0.12	3.2	0.22	

2005	~ 6.43	~ 0.11	~ 3.24	~ 0	Life expectancy: US 78.0; Japan 81.4 years
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Using the infant mortality rates for Japan and the U.S. as a guide to what it used to be like with infant mortality and preventable diseases in two democratic countries, the first with a non-coercive cost-effectiveness-driven vaccination program and the second with a coercive vaccine-centric vaccination program, it seems clear that we should be adopting a program similar to Japan's and abandoning the U.S. approach because it obviously has a higher infant mortality in American children than the Japanese program, and has done so since the early 1960s (as shown in the preceding comparative 'infant Mortality' table).

Moreover, the overall additional 3-plus years of life expectancy seems to confirm that these vaccine-program differences contribute to today's overall longer life expectancy in Japan.

“Osguthorpe said his work has introduced him to many cases of children afflicted with one of the 27 vaccine-preventable diseases. He speaks of them as tragedies, but tragedies that could have been averted with a timely vaccination.”

Since not all are protected by “*a timely vaccination*,” how does Osguthorpe know that all or, *for that matter*, any of the unidentified number of children about whom he is speaking could have avoided the “*tragedies*” as this writer reports them?

Also, why is there no mention of the children, like Dylan Hansen, who are tragically damaged by the vaccines that they have been given?

“‘I'm confused by people who don't vaccinate their kids,’ Osguthorpe said. ‘They're playing dice with their kid, if you look at the chances. As I see cases of preventable diseases, and I talk with the moms and dads, when I tell them that it was preventable, they're just so sad and wish it could be so different. I'd like to see people avoid some of the heartache that is avoidable.’”

This reviewer understands this vaccinologist's point of view and shares his concerns for all those children who are not vaccinated and contract a disease that vaccination may have prevented.

However, this reviewer's concerns are less myopic and extend to those who, *although fully vaccinated for a given disease*, still contract that disease and, *equally importantly*, to those who have been seriously injured by a vaccine or combination of vaccines as well as to the families of those children where vaccination has killed their child.

Rather than make blanket statements like the ones this doctor makes, this reviewer finds it would be more constructive to limit such comments to those vaccines whose diseases carry a significant risk of death or severe injury at a rate significantly higher than the risk of death or significant permanent injury from the vaccine's being given to otherwise health children.

Unfortunately, most vaccinologists seem unable or unwilling to even admit that many vaccines carry some non-zero risk of death and/or severe permanent damage for some who are vaccinated, much less to determine and rationally present the true risks and their true risk incidence rates.

Moreover, this reviewer seeks to help parents avoid some of the unnecessary risks borne by young children from vaccines that provide little or no protection against diseases they are likely to contract before they are adults.

Thus, this reviewer suggests that the facts clearly support the reality that many of today's childhood vaccines, including the vaccines for hepatitis B, haemophilus influenzae type b (hib), pneumococcal infections in the ear and nasal cavities, herpes varicella-zoster (chickenpox), rotavirus, Neisseria meningitidis, HPV and human influenza, should be reevaluated for continued inclusion in the national vaccination schedule for children and, unless they are proven to be *medically* cost effective and *truly* safe long-term, their FDA approvals for use in American children under the age of 6 years should be restricted to children who will be traveling into foreign countries where these diseases are presently endemic.

### **“Reaction risks**

Yes, vaccines have risks -- no medical treatment is 100 percent safe. Osguthorpe points out that, for all the good they do, vaccines aren't risk free.”

In general, this reviewer agrees with the statements made here

“In recent years, the number of reports to the CDC's national adverse event reporting system, which was created to catch problems with vaccines, has exceeded the reports of childhood diseases that are preventable by vaccines, with the exception of chickenpox, according to the Centers for Disease Control and Prevention's Manual for the Surveillance of Vaccine-Preventable Diseases printed in 2002.”

While this reviewer agrees with the facts being reported here, this reviewer notes that the writer failed to report the reality that many more “adverse events” occur than are reported.

For example, in 1999, JA Singleton et al from the VAERS Working Group published that the reporting efficiency<sup>4</sup> for selected vaccine-associated adverse events in VAERS ranged from a minimum of <1% to a maximum of 68%.<sup>5</sup>

Moreover, *given the reality that most all children have been and are being vaccinated for chickenpox*, the continued excess of reports of cases of chickenpox over chickenpox-vaccine-related adverse reports to VAERS clearly indicates to this reviewer that the national chickenpox vaccination program should be suspended until its safety and effectiveness can be independently established.

This is the case because, *among other things*:

- It is clear that the current chickenpox vaccination program, *justified originally only on societal cost-effectiveness based on a single dose's providing long-term protection*, does not protect children from getting chickenpox, and
- This program has increased the number of childhood cases of shingles (a much more difficult to treat disease caused by the same herpes varicella-zoster virus that causes chickenpox) from rare events to common occurrences.

Thus, this is an instance where it is clear that the national “chickenpox” vaccination program has clearly worsened the overall disease outcomes observed in children.

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<sup>4</sup> The term “reporting efficiency” is defined as the reported number of instances for a specific adverse event divided by the number of adverse events expected for that specific adverse event.

<sup>5</sup> Singleton JA, Lloyd JC, Mootrey GT, Salive ME, Chen RT. An overview of the vaccine adverse event reporting system (VAERS) as a surveillance system. *VAERS Working Group. Vaccine* 1999; **17**: 2908-2917.

“The manual concludes that ‘in the absence of disease, benefits of vaccination may be overshadowed by reports of vaccine adverse events,’ which could result in the resurgence of diseases that can be prevented by vaccines.”

While this reviewer does not question the accuracy of the text quoted, he notes that it would take a significant decline in vaccination rates for some period of time before the risk of the contagious diseases for which there should be a vaccine would translate into a significant resurgence of these contagious diseases.

Moreover, this reviewer notes that these concerns seem to be misplaced.

This is the case because we have and use other effective means (e.g., hygiene, sanitation, vector eradication, quarantine, and anti-infective drugs) to reduce the risk of the spread of diseases that are truly contagious.

For example, though there are FDA-licensed vaccines for “typhoid fever” (Sanofi Pasteur, SA’s Typhim Vi and Berna Biotech, Ltd’s Vivotif), federal health officials do not recommend that the general public be vaccinated because the general population risk on America is so low that a national vaccination program is not needed.

This is the case because today’s American hygiene and sanitation practices provide more than adequate barriers to the propagation of this disease in the population.

Thus, the only diseases for which there should be a concern of resurgence are those that are highly contagious and have a high risk of seriously harming the child (e.g., measles) or those whose endemic prevalence results in a significant risk of contracting that disease when exposed (e.g., tetanus).

Unfortunately, health officials and the healthcare establishment have misapplied, and are currently attempting to misapply, these valid disease-specific risk concerns to all of the diseases for which there is a recommended nationwide vaccination program.

“The National Immunization Program lists 27 diseases that are preventable by vaccines. Information from the CDC says nearly all those vaccines can lead to swelling or redness at the injection site and anything from mild to severe allergic reactions.

This reviewer does not disagree with what the writer states here.

However, this reviewer would suggest that this writer should have mentioned that more than causing “*severe allergic reactions*,” vaccines can be and, *in some cases*, are lethal to the recipient and/or permanently damage their health and quality of life.

“But medical evidence shows the more severe reactions to vaccines to be very rare.”

Here, this reviewer finds that this writer is basically repeating the somewhat disingenuous statements made by other vaccine apologists without citing any supporting studies or even defining what the term “*very rare*” means.

For, example, a recent first-providers smallpox immunization program was rolled out with claims that the risk of death was less than one in a million (perhaps, “*very rare*”?) and the risk of a severe adverse reaction was less than 1 in 10,000 (perhaps, “*rare*”?).

After less than 40,000 had been inoculated, more than a thousand had a severe reaction, and three (3) had died, a not “*very rare*” less-than-1-in-12,000 raw incidence rate, the first responders refused to continue participating (being inoculated).

Based on the fact that first providers are informed health-knowledgeable citizens who understand what an acceptable risk is, then vaccines that carry a severe adverse effect risk greater than 1 in 12,000 appear to be unacceptable to this informed public.

Thus, *based on this well-monitored program*, it is clear that a claimed risk of dying of “less than 1 in a million” translated into an actual “in use” death-rate of about 1 in 12,000 – a risk about 84 times higher than claimed and one that was unacceptable to the first providers.

Since the childhood vaccination programs are not well monitored and rely on voluntary reporting of adverse events, this reviewer finds that the public would do well to mentally multiply the claimed risk rates for a given adverse outcome by a factor of 10, *for less than fatal events*, and, *to be safe*, by a factor of 100 for death.

These recommendations are based on both the outcomes observed in the well-monitored smallpox vaccination program for first providers, and the rates of voluntary reporting to VAERS, which, *for less than life-threatening adverse events*, are typically no more than 10 % of the actual occurrence rates for most adverse events.

These recommendations are also based on:

- The reality that the health officials, healthcare establishment, and the vaccine makers who profit from, and are championing, vaccination programs are also the sources for the rates for adverse events, and
- The fact that the current adverse-effect studies:
  - Only last for a few days so that long-term adverse effects are usually neither observed nor reported by these studies,
  - Routinely exclude adverse events, like SIDS (sudden infant death syndrome), that are not “expected” to be vaccine related, and
  - Do not study the interactions with all of the other vaccines that may be injected at the same time.

“The CDC's site says seizures (jerking or staring) like the one that may have affected Dylan Hansen of Spanish Fork occur in 1 out of every 3,000 doses. But long-term problems like Dylan's mom describes, such as lowered consciousness and brain damage, occur in less than 1 out of a million cases.”

While this reviewer does not dispute that this is what the “*CDC's site says*,” this reviewer does question the accuracy of the rates the CDC, *also charged with promoting vaccination*, publishes.

Using:

- This reviewer’s suggested factors and
- The fact that the MMR and chickenpox vaccines were given at the same time and are live-virus vaccines,

the probable incidence rates for a “seizure” in children, such as Dylan Hansen, whose developmental age lags behind their physical age, is closer to 1 out of every 300 doses than to “*1 out of every 3,000 doses*” and the long-term severe adverse events risks are closer to less than 1 in 10,000 than to “*less than 1 out of a million*” that the writer reports here.

Moreover, IF the CDC, the FDA, the healthcare establishment, vaccine makers, and health officials were *truly* interested in knowing the true incidence rates or all adverse events, then, *contrary to the current voluntary reporting*, THEN:

- The reporting of adverse events to VAERS would be mandatory, and
- The penalties for failure to report any adverse event would be significant.

In addition, the VAERS system was established by legislation (and not by voluntary efforts on the part of the parties involved in vaccination programs) to track the adverse events and their rates.

Furthermore, the National Vaccine Injury Compensation Program (Title 42, Chapter 6A, Subchapter XIX, Part 2; 42 U.S.C. Sec 300aa-11 et seq.) includes the types of neurological injuries reported for Dylan in Sec. 300aa-14. Vaccine Injury Table as recognized reactions to the MMR and other vaccines (e.g., DPT) that occur close to the time of vaccination.

*Given the preceding realities*, this reviewer finds that the lack of scientifically sound adverse-event incidence rates for each vaccine and vaccine combination is, *in general*, undermining the credibility of all of the vaccination programs.

Finally, the other scientifically unsound practices being allowed by federal officials in the pre-approval safety studies for the more recent vaccines (such as allowing another approved or, *in some cases*, experimental vaccine to be used as the placebo rather than mandating sterile saline be used as the placebo) are also undermining the credibility of any vaccine pronouncement.

Finally, the practice of making a licensed vaccine as nationally recommended vaccine shortly after or at the same time is undermining the credibility of all of the vaccination programs because vaccines are being approved for general use without any significant in-use safety experience and, *in some cases*, in spite of the known adverse risks for doing so.

“From an entire population point of view, the risk is so small that it is far, far outweighed by the benefits,” Osguthorpe said. ‘But if you have had a bad reaction, even if it was one in a million, it was your child.’”

Allowing that Osguthorpe has accepted the CDC’s pronouncements as being valid and that he is speaking here about a “*less than 1 out of a million cases*” adverse event, this reviewer finds that the quote:

“*But if you have had a bad reaction, even if it was one in a million, it was your child*” seems to be confused since it speaks of “*if you have had a bad reaction*” as if this “*you*” were the person given the vaccine and not “*your*” child.

Moreover, choosing to utter the words, “*it was your child*,” Osguthorpe appears to be considering Dylan Harman as an “*it*” and, *by speaking in the past tense*, implies that, *after the severe adverse reactions experienced by Dylan Hansen*, he is now less than human or should be considered as if he had died (“*was your child*”).

Overall, these remarks, *reportedly quotes*, apparently indicate that Osguthorpe does not really care about the children damaged by the current national vaccination programs – in today’s world, they are simply “collateral damage.”

“The CDC estimates that more than 1 in 10,000 people die each year from causes related to influenza, which is preventable by a vaccine.”

Here, the writer’s statement is, at best, misleading.

Based on a recent (2006) published review<sup>6</sup> of the actual government-reported U.S. population experience for the period from 1979 through 2001:

- On average, about 0.050 (0.023 – 0.103) in 10,000 “*people die each year from causes related to influenza,*” and
- Based on a lack of an inverse correlation between vaccine doses administered, influenza cases, hospitalizations or deaths, the current influenza vaccines do not prevent influenza.

Given that the actual influenza-related population experience has been published, it is clear that the “CDC estimates” are a 10- to 40- fold inflation of the real values and that the influenza vaccines do not prevent those vaccinated from getting influenza.

“The CDC also estimates that more than 1 in 10,000 people each year will get whooping cough, also preventable by vaccination.”

While this reviewer lacks data to contest the CDC’s admitted “estimate” (a “guesstimate” based on some unstated model) for whooping cough reported here, this reviewer notes that, *in the recent outbreaks of whooping cough where pertussis was the confirmed cause*, many of those who contracted the disease were fully vaccinated.

“It’s not inconceivable that a vaccine could result in a severe reaction that causes the death of the patient, but such cases are so rare that a causal link is difficult to establish.”

Given the outcomes observed in the recent fully monitored smallpox “first providers” inoculation program and federal officials allowing pre-approval vaccine safety studies to:

- Subjectively exclude certain deaths from being possibly vaccine-related (e.g., SIDS),
- Be conducted for only short periods of time,
- Use non-saline injections as the “placebo,” and
- Limit the time period of the study to from a few days to, typically, no more than a month or two,

this reviewer understands that, *on some level, conscious or otherwise*, both severe reactions and their incidence are being significantly underascertained and there is a not-so-subtle institutional pressure to underestimate both adverse events and their incidence rates.

Consequently, the preceding practices and the lack of a strong desire to establish the cause of any serious adverse event combine to make “*such cases are so rare that a causal link is difficult to establish.*”

Thus, the innate biases, preconceptions, beliefs and conflicts of interest of “health” officials in the federal and state agencies, the healthcare establishment, academia and the vaccine manufacturing firms are the drivers that limit the determination of the causal links between a given vaccine, or a given vaccine combination, and “rare” adverse events.

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<sup>6</sup> Geier D, Geier M. A case-control study of serious autoimmune adverse events following hepatitis B immunization. *Autoimmunity* 2005; **38**: 295-301.

“A rotavirus vaccine was taken off the market in 1999 because it raised some red flags in the adverse event reporting system. It was linked to an increased risk for intussusception, a type of bowel obstruction, in young infants.”

While the writer’s remarks are generally accurate, they are technically incorrect because the license for the initial rotavirus, RotaShield, was only suspended on July 16, 1999 (10.5 months after it was licensed on 31 August 1998) – not revoked.

Moreover, these statements fail to reflect that, *in spite of the fact that the limited pre-licensing safety studies had found a possibly significant increased risk for intussusception that was linked to the vaccine*, the federal government elected to license this vaccine when it should have postponed any such decision and demanded that additional trials be conducted to determine the magnitude of the increased intussusception risk.

This should have been the case because

- Rotavirus infection is not, and was not, in 1998, a population-endemic disease in the U.S.,
- The data from the monitoring of rotavirus cases was clearly indicating that the incidence of this disease was already naturally declining, and
- Most U.S. children develop natural immunity to the “native” viruses that cause this disease by age five without having a clinical case of rotavirus.

However, *instead of erring on the side of safety*, the FDA and CDC elected to place other interests, *including those of the vaccine maker*, ahead of the safety of U.S. children and, *because this vaccine is a communicable live-virus vaccine*, the safety of all those adults who will have contact with the live viruses shed by those who are inoculated with this vaccine and, *similar to the case for the now-abandoned (in the U.S.) live-virus polio vaccine*, infect some of these exposed adults with a severe case of rotavirus at infection rates that are greater than the current adult disease rates for the “natural” or “wild” rotaviruses.

“As soon as the cases showed up, Osguthorpe said, the vaccine was pulled and reviewed. It was later replaced by a more effective vaccine.”

Again, the implication of the writer’s “*the vaccine was pulled*” is that all unused doses were recalled from the market, which was not the case.

With regard to the statement:

*“It was later replaced by a more effective vaccine,”*

this reviewer, *having examined the some of the data generated in the pre-approval process and the post-licensing data from VAERS*, finds that this new vaccine, Merck’s RotaTeq (a mixture of bioengineered human-bovine hybridized artificial strains, licensed on February 3, 2006, and approved for nationwide use in August of 2006) is not only no more “effective” than the previous vaccine but also apparently has about the same risk<sup>7</sup> of causing intussusception as the previous rotavirus vaccine as well as other vaccine safety issues at least as important as the previous issues.

However, rather than “pulling” RotaTeq off the market after more than 100 adverse

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<sup>7</sup> In its first 10 months post-licensing, the previous rotavirus generated about 120 intussusception reports in VAERS (about 12 per month). Similarly, in its first 15 months post-licensing, RotaTeq has generated about 165 intussusception reports to VAERS (about 11 per month with an increasing trend from 2006 into 2007).

event reports in the first year of approval because it is not safe, based on VAERS reports (where, for the 3 years prior to RotaTeq licensing [2003 – 2005], the yearly rate for intussusception case reports was less than 5), the federal officials have elected to:

- Ignore:
  - These safety concerns,
  - The fact that RotaTeq is clearly not preventing intussusception and
  - RotaTeq appears to simply be giving many of those inoculated an active clinical case of rotavirus when, *before the vaccine*, a much lower percentage of children had a clinical case of rotavirus (many with obviously sub-clinical cases), and
- Allow this vaccine to remain on the market.

All that they did do was to require the RotaTeq package insert to be updated to more accurately reflect the adverse events being reported.

To this reviewer, this is just another in the increasingly sell-serving and arrogant actions of those with vested interests in promoting vaccination with little, or no, true regard for their safety for our children or, *for that matter*, ourselves.

“Doctors should report cases like Hansen's, but they may not always link the problem to the vaccine because they are so rare.”

Here, the writer's “*should report cases*” is a tacit admission that doctors do not always report the adverse reactions to vaccines, as they “*should*.”

However, the writer's “*they may not always link the problem to the vaccine because they are so rare,*” at best, hard to believe because, *at a minimum*, the “seizure” that Dylan had happens in at least 1 in every 3,000 doses of vaccine and, *given the reported underreporting for adverse events in VAERS*, the true incidence for a “seizure” may be closer to 1 in 300 doses.<sup>8</sup>

Moreover, given that the purpose of VAERS is to collect all adverse events that could be linked to any vaccination of any individual, all vaccine providers should report all adverse events to VAERS unless unequivocally proven not to be vaccine related.

Thus, vaccine providers should be required to report any possible vaccination-related event to VAERS.

Given the reality that VAERS gathers adverse event reports and follows up on them, the job of winnowing the reports submitted should be that of those who study the reports submitted.

Moreover, given the reality that most adverse events are significantly underreported, it appears obvious that many vaccine providers are derelict in reporting even the known vaccine-related adverse events to VAERS.

“Osguthorpe said if there were any kind of trend developing, as was the case with intussusception, it would certainly be noticed and corrected.”

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<sup>8</sup> In a population of about 8 million children being given a dose of the MMR vaccine annually, a “1 on 3,000 doses” risk translates into about 2,700 “seizures” annually while a “1 in 300 doses” risk translates into about 27,000 “seizures” annually.

Based on this reviewer's understanding of the current situation with intussusception and RotaTeq, all that this reviewer can agree is that developing trends are noticed.

However, this reviewer does not find that simply updating the package insert to reflect the reported adverse events has addressed the root cause of the "problem" (unnecessary harm to the inoculated children) much less corrected that problem.

### **"Autism accusation**

Like Hansen, Springville resident Sondra Hurst says her child, Sara, was harmed by a vaccine. Within hours of the shot, Sara came down with a high fever and wouldn't eat or drink regularly. She quit walking and talking and was soon diagnosed with autism."

This reviewer accepts the factuality of the information the writer reports here.

"Despite medical evidence to the contrary, Hurst doesn't doubt the vaccination contributed to her child's problems."

Since the writer does not cite any specific credible medical evidence here that proves that no vaccine contributed to Sara Hurst's diagnosis of autism, this reviewer must accept that Sondra Hurst's views are valid.

"'I felt strongly that it was night and day,' Hurst said. 'She was a healthy child, we had no reason to be worried, and within a matter of 24 to 48 hours, she was having all these problems. So for me there was no question.'

Sara's older brother also has autism. Hurst said there is probably a genetic disposition for the condition in her family, but believes the vaccine could have triggered the problem."

Again, this reviewer accepts that the writer has fairly reported Sondra Hurst's views.

"As more study as been done on the condition, autism can now be diagnosed in early childhood, and Osguthorpe said that timing could coincide with a child's vaccination."

Since the general "autism" disorder has been being diagnosed for decades, perhaps the writer meant to address "regressive autism," a condition in which, after some period of normal development, a child begins to regress and lose many, if not all, of abilities that he or she had developed.

If the writer did mean "regressive autism," then, the ability of parents to accurately diagnose the onset of the symptoms of "regressive autism" in early childhood has been confirmed for several years.

Further in cases where the regression is gradual, then it may be that an issue if the onset's coinciding with a particular "*child's vaccination.*"

However, when, as reported here, the child is healthy and within 24 to 48 hours, as this writer quotes the mother:

*"Within hours of the shot, Sara came down with a high fever and wouldn't eat or drink regularly. She quit walking and talking and was soon diagnosed with autism."*

this reviewer finds it is very probable that the unnamed vaccine triggered the events that led to Sara's subsequently being diagnosed with autism.

"Even though the two events can happen around the same time, there's no evidence that vaccines

cause autism.”

*Contrary to this writer’s statement*, there is a large and growing body of toxicological and epidemiological evidence that vaccines can cause the set of clinical symptoms used to diagnose “autism” and/or a related “autism spectrum disorder (ASD).” [See: [http://www.mercury-free-drugs.org/docs/070824\\_CoMeDCitizenPetitionPart2.pdf](http://www.mercury-free-drugs.org/docs/070824_CoMeDCitizenPetitionPart2.pdf).]

Thus, contrary to the writer’s statement here, there has been and is a large and ever-growing body of evidence that vaccines can cause the set of symptoms used to diagnose an autism spectrum order.

“Another oft-cited safety concern is the use of mercury-containing thimerosal as a preservative in vaccines.”

Actually, the actual “*oft-cited safety concern is the use of*” Thimerosal, 49.55% mercury by weight, as a preservative in vaccines without proving its safety to the applicable legally binding current good manufacturing practice<sup>9</sup> (CGMP) minimum<sup>10</sup> that the vaccine formulation in which it is used is “sufficiently nontoxic so that the amount present in the recommended dose of the product will not be toxic to the recipient, ...” (see: 21 C.F.R. 610.15(a)).

“Despite studies showing thimerosal had no adverse side effects, the preservative hasn’t been used in any vaccines for six years.”

Here, the writer makes a provably false assertion.

First, toxicology studies are required to show that Thimerosal has “no adverse side effects,” and, as far as this reviewer can ascertain, *after studying dozens of the published studies*, all of the published toxicological studies on Thimerosal have shown that Thimerosal has adverse side effects in living systems at levels more than ten thousand times lower than the level of Thimerosal (0.01%; 100 parts-per-million [ppm]) found in the typical Thimerosal-preserved vaccine.

In addition, the writer’s “*hasn’t been used in any vaccines for six years*” is a blatant falsehood, as any review of the U.S. FDA CBER’s “**Thimerosal in Vaccines**” web page (see: <http://www.fda.gov/cber/vaccine/thimerosal.htm>, last visited on 14 November 2007) clearly shows.

Factually, as that site’s Table 3, “Thimerosal and Expanded List of Vaccines - (updated 9/6/2007) — Thimerosal Content in Currently Manufactured U.S. Licensed Vaccines,” and the extracted updated listing on this page show, several U.S.-licensed vaccines still contain a preservative level of Thimerosal and some others still contain a lower level of Thimerosal.

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<sup>9</sup> 21 U.S.C. “Sec. 351. Adulterated drugs and devices

A drug or device shall be deemed to be adulterated -

(a) Poisonous, insanitary, etc., ingredients; adequate controls in manufacture

(1) ...; or

(2) (A) ... ; or

(B) if it is a drug and the methods used in, or the facilities or controls used for, its manufacture, processing, packing, or holding do not conform to or are not operated or administered in conformity with current good manufacturing practice to assure that such drug meets the requirements of this chapter as to safety and has the identity and strength, and meets the quality and purity characteristics, which it purports or is represented to possess;”

<sup>10</sup> See 21 C.F.R. “§ 210.1 Status of current good manufacturing practice regulations” and 21 C.F.R. “§ 211.1 Scope.”

### Current FDA-Listed Vaccines That Contain Thimerosal

Vaccine	Trade Name	Manufacturer	Thimerosal Concentration <sup>1</sup>
DTaP	Tripedia	Sanofi Pasteur, Inc	≤ 0.00012%
DT	No Trade Name	Sanofi Pasteur, Inc	< 0.00012% (single dose)
		Sanofi Pasteur, Ltd	<b>0.01%</b>
Td	No Trade Name	Mass Public Health	<b>0.0033%</b>
	Decavac	Sanofi Pasteur, Inc	≤ 0.00012%
TT	No Trade Name	Sanofi Pasteur, Inc	<b>0.01%</b>
Hepatitis B	Engerix-B Pediatric/adolescent Adult	GlaxoSmithKline Biologicals	< 0.0002 % < 0.0002 %
HepA/HepB	Twinrix	GlaxoSmithKline Biologicals	< 0.0002 %
Influenza	Fluzone	Sanofi Pasteur, Inc	<b>0.01%</b>
	Fluvirin	Novartis Vaccines and Diagnostics Ltd	<b>0.01%</b>
	Fluvirin (Preservative Free)	Novartis Vaccines and Diagnostics Ltd	< 0.0004 %
	Fluarix	GlaxoSmithKline Biologicals	< 0.0004 %
	FluLaval	ID Biomedical Corporation of Quebec	<b>0.01%</b>
	Afluria	CSL Ltd, (Approved 28 Sept. 2007) <sup>2</sup>	<b>0.01%</b>
Japanese Encephalitis	JE-VAX	Research Foundation for Microbial Diseases of Osaka University	<b>0.007%</b>
Meningococcal	Menomune A, C, AC and A/C/Y/W-135	Sanofi Pasteur, Inc	<b>0.01%</b> (multidose)

<sup>1</sup> The values in bold are levels of Thimerosal that are considered to be preservative levels.  
<sup>2</sup> Added by this reviewer since it was licensed after the FDA last updated Table 3 on 6 Sept. 2007.

Specifically, nine (9) for the vaccines listed contain a preservative level (nominally, 0.001 % [10 ppm] to 0.01 % [100 ppm]) of Thimerosal and eight (8) contain a lower level (< 0.00012% [< 1.2 ppm] to < 0.0004 % [< 4 ppm]) of Thimerosal.

Thus, it is clear that, *contrary to the writer's assertion here*, U.S.-licensed vaccines still contain Thimerosal.

“To deal with claims of vaccine injury or death, the Vaccine Immunization Compensation Program was established in 1988. A group of attorneys judge complaints and have decided to award settlements in only about 2,300 cases since the program's inception. Hansen said she has not filed a claim because she didn't feel like fighting for a settlement.”

In general, this reviewer accepts that the writer's statements here are essentially accurate.

However, the reader should note that the writer's minimalistic “*only about 2,300 cases*” translates into a cost of almost two billion (US\$ 2,000,000,000.00) taxpayer dollars.

“Claims filed with the program have increased since 2001, coinciding with a rise in diagnoses of autism. Many parents link the disorder to a vaccination their child received, despite overwhelming medical evidence showing no link between vaccines and neurological disorders, including autism and many others.”

This reviewer again finds that the writer is *knowingly* misrepresenting reality concerning the evidence (toxicological, epidemiological and case-study) that has clearly proven a causal link between certain “*vaccines and neurological disorders, including autism and many others*” in children from injecting Thimerosal-containing vaccines that causes sub-acute mercury poisoning.

*In some cases, this sub-acute mercury poisoning by vaccines containing Thimerosal manifests as the clinical neurological symptoms that are used to diagnose various neurodevelopmental disorders, including autism and the other autism spectrum disorders.*

Hopefully, after reviewing the toxicological, epidemiological and case-study evidence provided in the text portion of the FDA citizen petition assigned FDA Docket # 2007P-0331<sup>11</sup>, this writer and all who read this citizen petition and check the published studies referenced therein will understand that at least one causal linkage between some “*vaccines and neurological disorders*” has been proven.

Moreover, studies<sup>12</sup> published after this FDA citizen petition was filed on 24 August 2007 have strengthened the causal link between Thimerosal (49.55% mercury by weight, mercury poisoning and childhood neurodevelopmental disorders.

### “Other complaints

Besides the risks associated with vaccines, some parents complain that there are just too many shots. The complete schedule of childhood immunizations recommended by the National Immunization Program requires 15 vaccine doses. Some of the doses can be combined and given in a single shot, but others can only be given separately and still others require ‘boosters’ later in life. It could add up to a dozen or more needle pokes.”

First of all, the writer’s “*National Immunization Program requires 15 vaccine doses*” grossly understates the number of vaccine doses in the current (2007) program<sup>13</sup>, which recommends 36-38 (or, *for certain risk groups*, more) vaccine doses (when the recommended 3-dose rotavirus and annual-plus influenza vaccines are included) be administered to children from birth through 6 years of age.

From age 7 to 18, *for females*, six more vaccine doses (including the 3-dose HPV vaccine) and, *for males*, only three vaccine doses (one each of a Tdap, an MCV4 and an MPSV4 vaccine).

Thus, since:

- The 2007 schedule has been available in its current form since March of 2007 and, even in the first “seven” months, a child fully vaccinated under this schedule would receive 19 to 21 vaccines, and

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<sup>11</sup> This FDA citizen petition, titled “Citizen Petition to Ban Use of Mercury in Medicine, UNLESS Proven Toxicologically Safe to the CGMP Standard ‘Sufficiently Nontoxic ...’” by the FDA, was filed by CoMeD, Coalition for Mercury-free Drugs, with the FDA Division of Dockets Management on 24 August 2007 and, on that day, was assigned FDA Docket # 2007P-0331 by the FDA.

(see: [http://www.mercury-free-drugs.org/docs/070824\\_CoMeDCitizenPetitionPart2.pdf](http://www.mercury-free-drugs.org/docs/070824_CoMeDCitizenPetitionPart2.pdf)).

<sup>12</sup> a. Geier DA, Geier MR. A case series of children with apparent mercury toxic encephalopathies manifesting with clinical symptoms of regressive autistic disorders. *J Toxicol Environ Health A* 2007; **70**: 837-851.

b. DeSoto MC, Hitlan RT. Blood Levels of Mercury Are Related to Diagnosis of Autism: A Reanalysis of an Important Data Set. *J Child Neuro* 2007 November; **22**(11): 1308-1311.

<sup>13</sup> <http://www.cdc.gov/vaccines/recs/schedules/child-schedule.htm#printable>

- As the tables' titles reflect, the national program only recommends vaccines – neither it nor the laws and regulations of Utah require giving these vaccines, this reviewer does not understand how this writer can justify the “requires 15 vaccine doses” language used unless this writer was actually speaking about some program other than the current recommended U.S. national program.

“I'm not totally against vaccinations,” Hurst said. ‘But I think the way they have them scheduled is too much. There should be an option to split them up. I just think it's safer that way.’”

This reviewer agrees with, and finds that the scientific evidence clearly supports, Sondra Hurst's views.

Moreover, this reviewer supports a program that allows the parents to choose both when they vaccinate and which vaccines they allow to be given to their children.

“The schedule is there for a reason, Osguthorpe said. First, as a public health program, it was developed for everyone, not for individuals. Second, it was developed based on the times children are vulnerable to each disease.”

This reviewer has difficulty accepting that any journalist who has done any study of

### Example 2005 Japanese Vaccination Schedule

Vaccine	Vaccination period (after receiving the vaccination coupon)	Child's age (Born:)	Delivery of vaccination coupon
BCG	Any day prior to the child's 6th month	From Dec 16th 2004 to Dec 15th 2005	3 to 4 months old
Polio		July to November/2004	May/2005
		December/2004 to March/2005	August/2005
DPT (1st term: 3 doses + 1)	Any day before the child reaches 7,5 years of age	December/2004 to November/2005	After 4 months of age
DT (1st term: 2 doses + 1)		If your child had contracted whooping cough (pertussis) in the past do not need to receive the DPT vaccination.	Contact the <a href="#">Infectious Disease Prevention Division</a> to apply for the DT vaccination
Measles	Any day before the child reaches 7,5 years of age	Born from March, 16th 2004 to March, 15th 2005	12 to 13 months old
Rubella		Born from March/2004 to February/2005	13 months old
Japanese Encephalitis (1st term: 2 dosis + 1)		Born from March/2002 to February/2003	At the following month of child's 3rd birthday
Japanese Encephalitis (2nd term: 1 dosis)	Any day prior to the child's 13th birthday	Elementary school: 4th grade students	May/2005
DT (2nd term: 1 dosis)	Any day prior to the child's 13th birthday	Students of 6th grade of Elementary school (born from April/1994 to February/)	May/2005 (at the following month of child's 11th birthday)
Japanese Encephalitis (3rd term: 1 dosis)	Any day prior to the child's 16th birthday	Elementary school: 3rd grade students	June/2005

the vaccination programs would believe that the current “Recommended” vaccination schedules in the U.S. have been developed for reasons other than the convenience of the vaccinators and the vaccine manufacturers.

Returning to the example set by Japan, a democratic nation that has a vaccination program that also “*was developed for everyone,*” this reviewer offers an example 2005 vaccination schedule, *shown on the next page*, to demonstrate how a vaccination program that was developed for everyone can be designed to provide sufficient flexibility for individuals.

Moreover, *unlike the U.S. program*, the Japan’s program uses “carrots,” *coupons for free vaccines*, instead of “sticks,” *regulations and laws pressuring people to vaccinate in order to obtain public services and jobs*, to encourage its citizens to vaccinate their children.

With respect to the second “reason”:

*“Second, it was developed based on the times children are vulnerable to each disease.”*

does this writer think that anyone will believe that, *for example*, the U.S. childhood hepatitis B vaccination program “*was developed based on the times children are vulnerable to*” contracting hepatitis B, a “lifestyle” disease, whose exposure risk is confined to those who are intravenous-drug users and those who engage in high-risk sexual practices with multiple partners?

Moreover, *if the writer’s assertion were true*, then the vaccination program would delay the vaccination of all nursing babies until after nursing stopped because human breast milk continually transfers protective immune factors from the mother to the nursing child.

“‘The reason we immunize babies is that's when they need to become immune,’ Osguthorpe said.”

First, this reviewer notes that Dr. Osguthorpe’s statement here is, *at best*, misleading, because inoculating a child with a vaccine for a given disease only “vaccinates” that child, it does not, *as earlier statements in this article clearly admit*, necessarily “immunize babies” against that disease.

Moreover, were Osguthorpe being honest, he would have said something like:

“The reason we vaccinate children when we do is: it is convenient for us to do so.”

“‘You and I don't die from pertussis but babies do. And we don't give the measles, mumps and rubella vaccine to children under 1 year because those diseases don't affect younger children.’”

This reviewer simply notes that these statements are feeble attempts to justify a U.S. recommended vaccination schedule that, *for most vaccines*, is actually more about convenience than it is about the “*for everyone*” and the “*times children are vulnerable to each disease*” reasons that the writer declares.

“Still, Hansen is with Hurst in believing that there shouldn't be a single vaccine schedule. She believes her child's pre-existing condition should have elicited special care.”

This reviewer agrees with and accepts the validity of the views expressed here.

“‘Doctors really, I feel, need to wake up to the point that all kids are different,’ Hansen said. ‘It shouldn't be a cookie-cutter approach. I think they need to look at the children and their health

issues. Obviously I don't have any research to back it up, but in my opinion, there's a reason some kids are having problems with the vaccines.”

As someone who works with other researchers, physicians, parents, and healthcare providers, this reviewer not only agrees with Marie Hansen but also has the research to back up at least one of the reasons “*some kids are having problems with the vaccines.*”

Based on a careful review of the published toxicological, epidemiological, and, most importantly, case studies, this reviewer understands that the neurodevelopmental and many other childhood disorders and syndromes have been, and are still being, caused by sub-acute mercury poisoning from the injected vaccine-derived Thimerosal (49.55% mercury by weight) as well as Thimerosal in some other medicines routinely given to children and, *to a lesser extent*, mercury from Thimerosal and other organic compounds added to other drugs as well as from *in utero* mercury exposures.

In addition, based on the proper interpretation<sup>14</sup> of the Danish epidemiological data for the introduction of the MMR vaccine and its delayed acceptance by the Danes, it is clear that, *in some cases*, the MMR vaccine is a causal factor in some cases where the child is diagnosed with a neurodevelopmental disorder.

Thus, in 2007, science has established two vaccine-related causal factors, mercury poisoning from Thimerosal in some vaccines and other sources, and, to a lesser extent, the MMR vaccine, as reasons that “*some kids are having problems with the vaccines.*”

“Margie Golden, director of school nursing at the UCHD, said many times parents who file exemptions end up vaccinating their children later, either because colleges require them (most don't accept exemptions), for travel or to serve a mission for the LDS Church. Though the children are eventually immunized, Golden says they were at unnecessary risk for years.”

While this reviewer does not dispute the fact pattern that Margie Golden states or that many of the children in question are eventually vaccinated, the reviewer again notes that Margie Golden, *as many do*, uses the word “*immunized*” as if it were medically synonymous with the word “*vaccinated*,” when it is not.

This is an error that vaccinologists have made so frequently that the public and most Thesauri have accepted this less-than-accurate juxtaposition of terms.

Furthermore, this reviewer notes that:

- Children who have a clinical case of a given communicable childhood disease (e.g., measles, mumps, rubella, chickenpox, whooping cough) once, *generally, except for chickenpox*, develop an immunity to that disease that lasts much longer than the immunity provided to only some percentage, *hopefully, greater than 80%*, of those who are fully vaccinated and
- Some of those who are fully vaccinated against a given disease subsequently may contract that disease when exposed to it because the vaccine provided them with incomplete, little, or no immunity to the disease.

However, this reviewer does not understand why Golden apparently believes that her views are more valid than those of the parents who have considered:

- The disease risks of not getting a vaccine as the U.S. schedule recommends,

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<sup>14</sup> Goldman GS, Yazbak FE. An Investigation of the Association Between MMR Vaccination and Autism in Denmark. *J Am Physicians and Surgeons* 2002 Fall; 9(3): 70-75.

- The risks of harm from getting a vaccine as the U.S. schedule recommends,
- How they are raising their children and the environment in which those children are being raised, and
- Their understanding that, for healthy children, the childhood diseases are usually not life threatening and, for the “lifestyle” diseases, their children have almost no risk of exposure, and

decided that exempting their children from the rigid recommended vaccination program for some period of time was, *on balance*, safer for their children than following this program.

Therefore, though these children have theoretically been “*at unnecessary risk for years*” of contracting a disease, these children have most certainly avoided all of the known risks of harm, including death, that come with vaccination according to the recommended national vaccination schedule – real risks that Golden does not even mention.

Finally, this reviewer notes that Golden fails to address the reality that vaccination does not necessarily provide immunity or to mention the reality that some vaccines do not provide complete disease immunity for anyone who is vaccinated (e.g., the vaccines for *Neisseria meningitidis*, Sanofi-Pasteur’s Menomune and Menactra, which provide no immunity for the “B strain” [serogroup B] of this disease that causes anywhere from about 50 % [in very young children] to roughly 20% – 25 % [in pre-teens, teens and young adults] of the identified cases of this disease).

“The diseases hit the younger kids too, and maybe more so, so immunizing the younger kids is important too,” Golden said.”

In a healthy natural society, where most all children are breastfed (by their mothers or a “wet nurse”) for two to three years, we know that human breast milk provides the antibodies and other immune factors necessary to maintain the children’s immunity to endemic diseases.

In addition, we understand that, during the period from birth to natural weaning, each infant’s immune systems are rapidly developing.

Given these two realities, it is obvious that there is no disease-related need to vaccinate a child that is being breastfed and, *if possible*, all vaccinations should generally be postponed until after the child is two years of age.

This is the case because “beyond two years” is the time, at which, naturally raised children’s immune systems would “begin” to fight disease on their own (without the immune factors continually provided by the human breast milk they ingest).

Thus, this reviewer must oppose early vaccination because it is obvious that there is a significant risk that early vaccination will do more harm than good to the child’s developing immune systems.

Likewise, this reviewer is opposed to any vaccination while a child is being breastfed, advocates for breastfeeding for a minimum of two years, and recommends, as long as the risk of disease is low, no child should be vaccinated before reaching two years of age.

The preceding recommendations are based on this reviewer’s current science-based understanding of the development of the human immune system.

Accordingly, this reviewer finds it unconscionable that anyone would recommend vaccinating children at birth for hepatitis B, *a lifestyle disease with near zero risk at birth*, or, *for that matter*, any other disease unless the disease is endemic in the population, highly contagious, there is proof that the human breast milk available for feeding the neonate provides no immunity for that disease, and the available vaccine has been proven to be safe and provide immunity – not just to produce antibodies.

Hopefully, all who read these remarks will understand the realities presented and adopt a similar stance toward what health officials should be doing to promote post-partum health and a rational vaccination program designed to minimize the risks of damage to the children’s developing immune systems – something that today’s recommended vaccination programs obviously ignore.

Returning to Golden’s words, this reviewer finds that her obtuse “*diseases hit the younger kids too, and maybe more so*” remark seems to imply that, in general, childhood diseases are more severe in younger children than they are in older children and adults – when, *for most childhood diseases*, the reality is these diseases are less severe in younger kids than they are in older children and adults.

For example, when a child has mumps as a pre-schooler the disease is usually very mild and recovery rapid; however, when that male does not have mumps until after puberty, the disease is much more severe and renders some infected males sterile.

When pre-schoolers first have chickenpox the disease is also mild and, *in many*, there are few, if any pox, and recovery is rapid; for children older than ten, chickenpox becomes an increasingly more virulent disease (wide spread pox and severe itching) and recovery times are more protracted.

Thus, based on this reviewer’s understanding of medical reality, this reviewer finds that Golden’s remarks would have been more accurate if she had said something like: “The diseases infect the younger kids too, though, except for the very young, the younger kids general have milder cases and recover faster, ...”.

In addition if truly Golden thinks “*immunizing the younger kids is important*,” then, *since having a childhood disease provides a higher level of and, generally, a longer immunity period than vaccination*, Margie Golden should be opposing vaccination for any of the communicable childhood diseases.

"We encourage parents to keep their kids up to date from birth on. I do hate to hear of cases of pertussis or other diseases that are preventable with a vaccine."

While this reviewer accepts that these are Margie’s views, this reviewer is driven by other imperatives.

This reviewer is opposed to vaccines that:

- Are not really effective (e.g., the human influenza vaccines),
- Are not cost-effective (e.g., the rotavirus vaccines),
- Provide a false sense of protection (e.g., the meningococcal vaccines),
- Cause more long-term harm (e.g., the now-withdrawn Lyme-disease vaccine),
- Create more disease overall than “immunity” (e.g., the varicella vaccine),
- Lead to worsening of the prevailing disease (pneumococcal-conjugate vaccine),
- Introduce new diseases into humans (e.g., the polio vaccines, which have introduced, *among other viruses*, SV-40 and RSV into humans, and the new

rotavirus vaccine, which has introduced bioengineered human-bovine hybrid viruses into humans [and the environment] without any long-term proof of safety), or

- Contain Thimerosal (49.55% mercury by weight), any other added or residual mercury compound, or any other bioaccumulative poison at any level.

Unfortunately none of the vaccine apologists quoted here or the writer of this article seem to share these concerns.

Finally, *even for "safe" vaccines that do provide protection for the majority who are vaccinated and do not contain bioaccumulative poisons*, this reviewer understands that the decision to vaccinate, or not to vaccinate, is one that parents and guardians should *carefully* consider and *affirmatively* make because, *as even the writer of the original article reports, no vaccine is completely free of adverse-event risks.*

### **“A history of resistance**

This is not the first time in Utah's history that there has been resistance to vaccines. An outbreak of smallpox in the late 1890s triggered a statewide vaccine controversy that lasted many years.

At the time, it had been more than 100 years since Edward Jenner first discovered a smallpox vaccine, but vaccination was not required in Utah. More than three years before the turn of the century, Utah saw 3,000 cases of smallpox and 26 deaths from the disease. Neighboring states, which by then had much success with the smallpox vaccine, complained that Utah was spreading the disease to the rest of the Intermountain West.

The state health commissioner, Theodore B. Beatty, enacted a mandatory vaccination ordinance. Even in the face of an epidemic, there was immediate, statewide opposition to the measure. The state Legislature passed a bill to repeal the mandatory vaccination requirement, and the governor quickly vetoed it. The Legislature just as swiftly overturned his veto and vaccination wasn't required in Utah until many years later.

Some of the backlash can be explained by a prevailing sentiment that The Church of Jesus Christ of Latter-day Saints was opposed to vaccinations. This was not the case, as is demonstrated by a May 1900 statement from church president Lorenzo Snow urging members to get vaccinated.

But an editor at the church-owned Deseret News frequently spoke out against vaccines, saying they were worse than the disease itself. Despite the president's statement, anti-vaccine sentiment held a firm position in Utah for decades.

By the 1930s, smallpox cases in Utah had significantly decreased, but there were still more cases than elsewhere. States that had mandatory vaccination laws in place weren't seeing any cases at all. Now the disease has been all but eradicated.”

Though this reviewer has a slightly different view of the history of smallpox and the recent “first providers” smallpox vaccination program obviously proves there are and were people with no immunity to the vaccine’s viruses, this reviewer accepts that, *absent widespread exposure to a smallpox virus, the smallpox “disease has been all but eradicated.”*

“The same goes for polio -- there have been no cases of the crippling ailment in the United States since 1979.”

Here, this reviewer finds that the writer’s statement is significantly distorting history.

Factually, the “last case of wild (naturally occurring) polio in the U.S. was reported in 1979.”<sup>15</sup>

However, because the U.S. used a live-virus vaccine to inoculate people with live polio viruses from the early 1960s until 2000, many people inoculated as well as some of those who came into contact with these children, or another adult shedding polio virus, have been infected with a vaccine or vaccine-related strain of polio.

By 1979, this practice had displaced the prevailing wild polio viruses and replaced them with vaccine strains and vaccine-related strains.

However, since, *in humans*, the polio virus typically rarely causes persistent long-term (lasting 30 days or longer) paralysis, the revised [in 1956] definition of clinical polio,<sup>16</sup> the reported U.S. annual risk for clinical polio was reduced to “on the order of one in 2.4 million”<sup>15</sup> or, for a U.S. population of 200 to 300 million citizens, about clinical polio cases per year.

Accepting that paralytic polio “occurs in about one in 200 infections,”<sup>15</sup> this means that about 2,000 people a year would be infected and experience some polio symptoms.

In 2000, “the use of the oral vaccine in the U.S. was discontinued in 2000, and all vaccination is now done with the injected inactivated virus.”<sup>15</sup>

However, in 2005, 4 non-paralytic polio cases were reported in Minnesota.

All were non-paralytic polio cases from an oral-live-vaccine-related strain.

The first case, the first reported case nationally since 2001, was found in an infant who had been diagnosed with immune system problems, and the other cases were three children in another family that had had contact with the infant.

The source of the infection was reported to be a person “who recently received an oral form of the vaccine containing live attenuated virus.”<sup>15</sup>

Thus, the last reported cases of polio clearly occurred in 2005.

These polio cases underscored the reality that some of the persons entering the U.S. from countries where the oral live virus is still being administered are introducing mutated strains of the vaccine strain they have received into America.

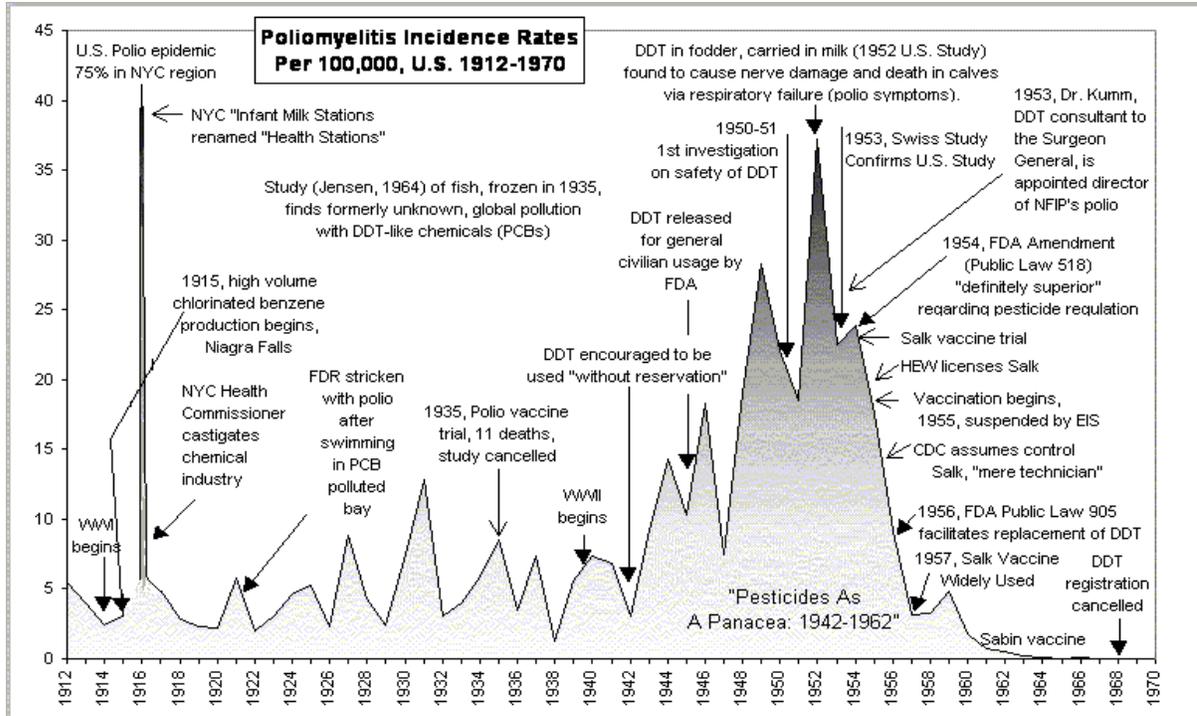
Moreover, *as the following figure shows*, the reality of paralytic polio is much more complex than the information provided in this article portrayed it and, *as is the case currently with Thimerosal and neurodevelopmental and other developmental disorders in children*, man-made environmental factors, chlorinated chemicals (labeled as “DDT-like chemicals,” and “DDT” in the figure), appear to have been significant causal cofactors in the rise (1912 – 1953) and fall (1953 – 1970) of “Poliomyelitis” in the U.S.<sup>17</sup>

### **Poliomyelitis: “Graphic Timeline: U.S. 1912-1970”**

<sup>15</sup> <http://www.medpagetoday.com/PublicHealthPolicy/PublicHealth/tb1/1935> last visited 14 November 2007

<sup>16</sup> Miller NZ. The polio vaccine: a critical assessment of its arcane history, efficacy, and long-term health-related consequences. *Medical Veritas* 2004; **1** (2): 239–251.

<sup>17</sup> [http://www.geocities.com/harpub/pol\\_all.htm](http://www.geocities.com/harpub/pol_all.htm) last accessed 24 November 2007.



Thus, this reviewer finds that, *among other factors* (like the change in the definition of polio in 1956), the introduction and use of chlorinated chemicals appear to have been significant cofactors in the incidence of clinical cases of "Poliomyelitis" in the U.S. from the 1912 through 1970.

“The success of these vaccines is huge,” Osguthorpe said. “They’re one of the greatest success stories of our time.”

If the preceding examples are the basis for Osguthorpe’s statements, it is clear that reality is very different than he and other vaccine apologists have painted it.

Furthermore, the “*success stories*” (repeatedly used as the “poster children” for the current national vaccination programs) are for vaccines where everyone is, or was, inoculated with a disease or a disease related to the disease of interest and contracted that disease – with, *based on the stated views of the vaccine apologists*, less-than-very-rare (< 1 in a million) deadly consequences, unlike the recent actual experience of those who participated in the recent “first providers” smallpox inoculation program, where about 1 in 12,000 died.

Based on the facts (not the claims made by the writer) and the increasing incidence of immune and autoimmune diseases, and the increasing incidence of allergies in our children today, the reality is that the current recommended national vaccination programs are apparently one of the greatest successes for programs that seem to be designed by the healthcare establishment and the drug providers to:

- Significantly increase their customer base and
- Increase the number of customers requiring long-term treatments for chronic conditions for which the healthcare providers and the drug firms could charge increasingly higher prices with little, or no regard, for the long-term health and welfare of the public.

“How vaccines work When a virus invades your body, the immune system figures out how to kill it with a combination of antibodies. But that process usually takes longer than it does for the disease to infect and damage the body, so you experience symptoms of the disease until it is killed. Once your immune system fights off the disease, your body creates a ‘memory’ of how to defeat the virus in the future, and you become immune to that disease. If the virus comes around a second time, it is quickly recognized and snuffed out before causing any problems. The AIDS virus is so devastating because it ruins this memory system, leaving the body susceptible to mass infection. Vaccines introduce a weakened version of a virus to your immune system, so it has a chance to create a memory without having to fight off the real disease at the same time. If the real virus does show up, it's easily recognized and killed. Patients rarely experience mild symptoms of the disease from the weakened virus, but generally the needle poke is the worst part of the experience.

Since the explanation provided here does not address pathogens other than viruses and fails to even address the separate immune systems within the human body, much less the current understanding of how the various immune systems in the human body function and communicate, all that this reviewer can do is recommend that this writer refrain from writing about matters that this writer not only clearly does not understand<sup>18</sup> but also about which he is apparently not willing to do even rudimentary research or, *if this portion of the text was provided by someone else*, simple fact checking.

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<sup>18</sup> Reviewer's general view of the fundamentals of the immune system and immunity:

The Immune System is the name of a collection of molecules, cells, and organs whose complex interactions form an efficient system that is usually able to protect an individual from both outside invaders and its own altered internal cells, which can, if not dealt with, lead to cancer.

The immune system is comprised of the lymphoid tissues and organs of the body. Lymphoid tissues are widely distributed. They are concentrated in bone marrow, lymph nodes, spleen, liver, thymus, and Peyer's patches scattered in the linings of the GI tract. The lymphoid system is encompassed by the system of mononuclear phagocytes (equivalent to a reticuloendothelial system [RES]) Lymphocytes are the predominant cells, but macrophages and plasma cells are present also. Lymphocytes are cells, which are continually circulating, alternating between the circulatory blood stream and the body's lymphatic channels.

The immune system can also be split into two components, non-specific (a/k/a innate immunity or non-adaptive immunity) and specific (a/k/a acquired or adaptive immunity). The breakdown of the immune system into non-specific and specific components is only valid for classification purposes because there is constant and complex interaction, coordination and communication between all parts of the immune system. The non-specific components provide the majority of the body's immune resistance to outside invaders and altered internal cells.

The first lines of defense are the physical barriers (e.g., the skin, mucosal membrane, tears, ciliary elevators, and urine) and the chemical barriers (e.g., sebum, sweat, stomach acid, mucosal secretions, metalothionens, and lysozymes).

The second lines of defense include the macrophage system, complement, fever, interferon and inflammation. The macrophage system attacks and consumes pathogens by engulfing them, a process known as phagocytosis. Complement cooperates with macrophages by attaching to foreign cells and initiating the ingestion of the cells in phagocytosis. Interferons are a class of proteins; activated by fever that prevent viral replication in surrounding cells and also inhibit the growth of cancer cells. Fever is a powerful part of the immune system, as it interferes with pathogen growth, inactivates many pathogen toxins, and facilitates a more intense immune system response.

Whether caused by bacteria, viruses, or physical means, when any tissue injury occurs, the injured tissues respond by releasing “inflammatory” substances such as bradykinins, complement, and histamines. This process is called inflammation and it strongly activates the macrophage system to remove damaged cell tissue. Inflammation is a vital part of the healing and repair process of the immune system and, when it is delayed or inhibited, healing and repair is incomplete.

Third lines of defense are the specific system also known as acquired or adaptive immunity. The specific system consists of B cells (humoral), and T cells (cell-mediated). These cells have mechanisms for selecting

**Reviewer's Concluding Remarks:**

Lest anyone attempt to paint this reviewer as “anti-vaccine,” a label often used by those who are fervent proponents of the current national vaccination programs, this reviewer reminds the readers that those who attempt to attack the credibility of the messenger (instead of defending their positions with scientifically sound published studies that support their positions and undermine those of this reviewer) should simply be ignored.

Factually, *as this reviewer has repeatedly stated*, this reviewer is not “anti-vaccine.”

If an animal that might be rabid bit this reviewer, he would immediately seek to be vaccinated with the rabies vaccine.

In addition, when this reviewer was raising a child in the 1970s, he did not oppose that child's being given the DPT, polio and MMR vaccines.

However, if this reviewer were to be facing parenthood today, he would oppose giving that child the hepatitis B, pneumococcal, hib, rotavirus, influenza, hepatitis A, chickenpox, meningitis, and HPV vaccines, because these vaccines have more real short-term and/or long-term risks than they may, *if there is an exposure*, provide protection against these diseases in today's America.

Also, this reviewer would, *as he did then*, support the child's mother in breastfeeding the child until natural weaning and in appropriately supplementing her lactation diet with added magnesium, potassium, selenium, silicates, and vitamins (e.g., A, the Bs, C and D-3), and see to it that the child received appropriate supplementary foods (home-purèed fresh and steamed vegetables and most fruits, and, in limited amounts, meats) after the child's first teeth began to erupt.

As a scientist, this reviewer understands that we should follow natural practices whenever we can and only add medicines when the natural practices and natural remedies truly fail to rapidly “cure” the child's discomfort.

Hopefully, after reading this review, all will carefully consider and verify the validity of the reviewer's statements, and, *to the extent you all can*, appropriately incorporate the reviewer's substantiated information into their views.

Since Logan Molyneux did not provide his credentials, this reviewer would encourage the readers to visit <http://loganmolyneux.com/> and read the applicable information provided there.

Similarly, this reviewer would encourage the readers to visit <http://www.dr-king.com> and read the applicable information that this website provides.

Further, *in addition to being sent to various others*, this review was emailed to Logan Molyneux at his website's contact address ([logan@loganmolyneux.com](mailto:logan@loganmolyneux.com)).

Also, this reviewer understands that the major problems with the current vaccines and vaccination programs have been self-inflicted by those who are the proponents of

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a precisely defined target and for developing memory to the antigen, so that the immune response will be a more efficient and effective response subsequent exposures will result in.

Every standard definition of immunity involves the overall competence of both the non-specific and specific components of the immune system to recognize, isolate and eliminate foreign pathogens. This competence also involves the ability of the immune system to distinguish between self and non-self. Thus, immunity is the body's ability to establish and maintain its molecular identity. Therefore, there is a huge difference between true immunity and the absence of symptoms of disease.

these and, unless these problems are openly and honestly addressed, these proponents are risking the complete loss of the confidence of the American people not only in the information that these proponents publish but also in any national vaccination program.

Moreover, the current realities (long case delays and miserly awards) for the U.S. National Vaccine Injury Compensation Program (NVIC) are also undermining the U.S. vaccination programs.

Furthermore, the unintended consequences of the National Vaccine Injury Compensation Program, which was created to: **a)** protect the vaccine makers and providers from being sued for the “rare” harm caused, **b)** provide rapid compensation for the families whose children who were harmed, **c)** require accurate records, **d)** track adverse events that could be vaccine linked, and **e)** mandate safer vaccines, this reviewer finds:

- ❑ Though the vaccine makers are being protected, the families with vaccine-injured children are not being:
  - ❖ Rapidly heard (cases can take 10 years to resolve and some types of cases have been repeatedly delayed from being heard by the government) or
  - ❖ Fairly compensated (the original 1987 cost-of-living-adjustment (COLA) provisions were repealed in 1998), and
- ❑ Based on an ever-increasing body of evidence, the federal government and the vaccine makers have:
  - ❖ Ignored and are ignoring the mandate to make vaccines safer and
  - ❖ Instead, elected to:
    - Market ever riskier vaccines and
    - Ignore the statutes and laws that mandate:
      - Proof of safety for vaccines to the applicable biological-drug standard “sufficiently nontoxic ...,”
      - Proof of effectiveness (not efficacy), and
      - The safening of all vaccines.

Finally, the greatest example of the Establishment’s “vaccine” hubris is the broken 1999 promise that Thimerosal would be **removed** from all vaccines that could be given to children, including implicitly vaccines given to pregnant women.

Though this writer and all vaccine apologists write as if this promise to the American people has been kept, they are *knowingly* lying to the American people.

Hopefully, **Americans who read this review will**, at a minimum, **continually** (at least weekly) **call the offices of their elected federal officials** (and the campaigns of all those running for federal office) **until: a)** this 1999 promise is kept, **b)** all unexpired Thimerosal-containing vaccines and other drugs containing any added mercury compound are recalled and destroyed, **c)** the use of Thimerosal or any other mercury compound is *permanently* banned from medicine, and **d)**, *after appropriate investigations*, the appropriate legal actions are taken against those firms and individuals who were or are responsible for illegally using, or permitting the illegal use of, Thimerosal and other mercury compounds in medicine without the required proofs of safety.