

Facility Automation Management Engineering (FAME) Systems

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Wednesday, 5 November 2008

To All:

The text following this page is a draft response to an e-mailed copy of the New Jersey Department of Health and Senior Services position statement titled, “**The Position of the New Jersey Department of Health and Senior Services (NJ DHHS) on: The Pending New Jersey Conscientious Exemption Legislation**” received on 27 October 2008.

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**

This formal response, which is titled: “**A Draft Response To: ‘The Position of the New Jersey Department of Health and Senior Services (NJ DHHS) on: The Pending New Jersey Conscientious Exemption Legislation’**”, begins on the next page.

Introductory Remarks

First, *to simplify this review*, when portions of the report are addressed in the review, the statements in this report 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 part of the report that is being reviewed.

In addition, this reviewer's remarks and suggested changes will be in a **dark blue** “News Gothic MT” font except, when he quotes: **a)** from or refers to any federal statute or regulation, the text will be in a “Lydian” font or **b)** from other sources, the quotations will be in an “Arial Narrow” font.

When this reviewer quotes from statements made in the author's article, this reviewer will use an *italicized* “Times New Roman” font; suggested corrections, *if any*, will be made in **red**.

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

Respectfully,

<ds>

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A Draft Response To:

“The Position of the New Jersey Department of Health and Senior Services (NJ DHSS) on: The Pending New Jersey Conscientious Exemption Legislation”

INTRODUCTION

Lest any take this reviewer's responses as those of someone who is anti-vaccine, this reviewer again reiterates that, given the scientific information available, he currently supports national vaccination programs for those vaccines that have truly been proven to be both generally safe and, at least, societally cost-effective, provided the individual parent's, guardian's, or competent citizen's constitutional right to "due process of law" is neither abridged nor ignored.

Having made clear his position as an advocate for:

- a. Banning the use of mercury compounds in medicine to safen vaccines,
- b. Vaccine safety, and
- c. Medically cost-effective vaccines,

this reviewer will now assess the statements made in the position statement sent by the New Jersey Department of Health and Senior Services (NJ DHSS) to the New Jersey Coalition for Vaccination Choice (NJ CVC).

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>S1071 - Conscientious Exemption to Mandatory Immunizations

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>The New Jersey Department of Health and Senior Services is opposed to S1071, which provides for a conscientious exemption to mandatory immunizations.

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Obviously, the NJ DHSS has made it clear that it “*is opposed to S1071*” and A260, legislation to provide New Jersey citizens with a limited conscientious exemption to New Jersey's mandated vaccination programs.

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>Public health care and medical communities consider vaccinations one of the most important measures in improving the public's health over the past 100 years.

>

While there is no dispute that “(p)ublic health care and medical communities consider vaccinations one of the most important measures in improving the public's health over the past 100 years”, the facts are that, *in the industrialized world*, vaccines have been a <10% factor in the reduction of the common contagious diseases (where sanitation, hygiene, clean water, safe food, adequate housing account for 90-plus % of the decrease in childhood diseases before vaccines were mandated).

Moreover, *in less developed countries (e.g., India)*, repeated vaccination campaigns for diseases such as polio have failed to provide the reductions in polio cases and/or the “elimination” of polio seen in the USA and other industrialized nations).

At this time, the evidence in today's USA is: our current vaccination programs have succeeded in reducing the incidence of: **a)** several highly contagious, acute childhood diseases and **b)**, *increasingly*, some other diseases to a lesser extent – at the cost of creating epidemics of chronic disorders, syndromes and diseases that have a strong autoimmune/immune-system-disruption component (e.g., asthma, type 2 diabetes, childhood MS, neurodevelopmental disorders, and food allergies).

Yet most of those “(p)ublic health care and medical communities” continue to:

- Deny the preceding realities,
- Actively suppress the scientific research establishing these realities,
- Attack the character and credibility of those independent scientists who dare to publish the truth about these health realities, and
- Publish articles: **a)** which are based on "junk" science, **b)** which use knowingly "perverted" study designs, or **c)** which rely upon easily manipulated epidemiological reviews where independent access to the datasets used is blocked or the data sets are "lost" – preventing independent researchers from verifying the soundness of the:
 - Datasets evaluated,
 - Study designs used,
 - Results reported, and/or
 - Conclusions drawn from those findings.

>

>New Jersey has historically only permitted religious and medical exemptions to school entry vaccine requirements.

>

Here, the NJ DHSS states what has been the New Jersey history without addressing the reality that an exemption for a "sincerely held religious belief" is: **a)** in essence, a "conscientious" exemption for those who adhere to any religion and **b)**, *therefore*, an exemption that discriminates against those who are religiously agnostic or atheists – a probable violation of the equal protection guarantees for all Americans.

Were the State of New Jersey to enact this statute, which provides a general limited conscientious (philosophical) exemption, this statute would end this seemingly illegal form of discrimination.

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>Broad exemptions to mandatory vaccination weaken the entire compliance and enforcement structure mandating vaccines for school entry and continued attendance.

>

First, taking this statement at face value, the NJ DHSS is advocating for a position that borders on a health dictatorship where the "health police" and not the constitutions of the United States of America (USA) and the State of New Jersey control the lives of New Jersey citizens.

Thus, the NJ DHSS appears to be advocating for a society in which the rights to bodily integrity and informed consent are either non-existent or trampled under by the healthcare establishment for a "greater good" that essentially benefits the healthcare establishment and ignores the physical, financial, mental and spiritual health of the public that it claims to protect.

Given the wording used, "*weaken the entire compliance and enforcement structure*", the NJ DHSS is apparently more concerned about strengthening their control over our children than it is in strengthening the overall and individual health of our children.

Second, in other "democratic" nations (e.g., Canada, UK, and Japan), high rates of vaccination compliance have been attained and, *provided less-safe vaccines have not been knowingly supplied (e.g., the less expensive MMR vaccine the UK used even though it contained the dangerous Urabe strain of the mumps)*, these rates have been maintained without any need for general mandatory vaccination programs for their citizens.

Moreover, the flexible Japanese approach to vaccines and vaccination programs has been so successful that the first-year infant mortality rate (IMR) in Japan (2.80 deaths per 1,000 “live births” [all values are CIA 2008 estimates]) is less than half the IMR in the USA (6.30 deaths per 1,000 live births [IMR_{UK} = 4.93; IMR_{Canada} = 6.08]), and significantly, chronic childhood disorders and diseases (e.g., childhood asthma, childhood type 2 diabetes, childhood obesity) are not at the epidemic levels seen in the USA.

In fact, *on average*, the Japanese life expectancy is 4 years longer than the average life expectancy in the USA and, *unlike the USA*, the life expectancy in Japan is not beginning to decline.

Finally, in the 18 states with a general conscientious/philosophical exemption to vaccination, there is no substantiation of the claim that having “(b)road exemptions to mandatory vaccination” has greatly reduced vaccine uptake rates or led to higher average background disease rates for those vaccines that are apparently safe and at least societally cost-effective in actuality.

>

>If vaccination requirements can be waived by a parent, one may argue that this dissolution sets precedent for other mandatory health screenings (e.g., hearing, lead, tuberculosis) or services to become optional.

>

In a democratic society that recognizes bodily integrity as a fundamental right, there should be no mandatory health screenings or services unless these is a compelling actual “communicable disease outbreak” reason for such and, *even in such instances* (e.g., a TB outbreak in a school), the parents should be given the choice of a non-invasive alternative (e.g., a chest x-ray for the TB example) or a definitive blood test (and, *in this example*, the cheap but problematic and, *for some*, medically dangerous TINE test should be banned).

Currently, the religious exemption already provides a means by which “*vaccination requirements can be waived by a parent*”.

Finally, since when is a person’s exercise of any granted legal option a “*dissolution*” of anything?

>

>No highly or densely populated states in the Eastern United States permit a philosophical exemption to school vaccination requirements.

>

First, the states with an children-of-all-ages conscientious (philosophical) exemption are (in alphabetical order): 1) Arizona, 2) Arkansas, 3) California, 4) Colorado, 5) Idaho, 6) Louisiana, 7) Maine, 8) Michigan, 9) Minnesota, 10) New Mexico, 11) North Dakota, 12) Ohio, 13) Oklahoma, 14) Texas, 15) Utah, 16) Vermont, 17) Washington State, and 18) Wisconsin.

In addition, Missouri and Nebraska have a conscientious/philosophical exemption for child care entry only.

Though only 5 states [Maine, Michigan, Ohio, Vermont and Wisconsin] of the 18 provide a full “*philosophical exemption*” in the Eastern United States, one could argue that one of them, Ohio [11.5 million], *which has a population one-third larger than New Jersey* [8.7 million], is a “*highly or densely populated state*”.

However, California, the most populous state [36.5 million], and Texas, the second most populous state [23.9 million], both have philosophical exemptions with no evidence of a significant excess of disease cases in children for those vaccines that are vaccines against a disease (e.g., measles, mumps, rubella, polio, hepatitis B) or for vaccines against bacterial toxoids and/or toxins (the diphtheria and tetanus toxoid components and the toxic substances in the acellular pertussis preparations) in the diphtheria, pertussis and tetanus combination vaccines (**see Table “1”** on the next page). [**Note:** The cases data was taken from the Florida Department of Health’s April 2008 “Task Force Requests to the Florida Department of Health” report to the Florida Governor’s Task Force on Autism Spectrum Disorders. The population numbers used are based on the published data at: http://en.wikipedia.org/wiki/List_of_U.S._states_by_population.]

In contrast, Florida, the fourth most populous state and one that has no philosophical exemption, shows some evidence that not having a philosophical exemption has led to more than expected cases of measles and rubella but a less than expected number of mumps and pertussis cases (two diseases not well-controlled by the vaccines [the MMR and DTaP/Tdap vaccines] containing components for these two diseases).

Thus, for those diseases well-controlled by their vaccines and for which low levels of cases are still being reported, it would seem that the states with “*philosophical exemptions*” have, on average, a lower disease incidence rate than: **a)** the overall average for the USA and **b)** the rate for Florida, the fourth most populous state.

Thus, the two most populous states as well as 16 other states have a conscientious/philosophical exemption and less than expected disease levels for those diseases that are well-controlled by vaccines.

Therefore, *based on the preceding realities*, every state should have a conscientious/philosophical exemption.

Moreover, like New Jersey, the citizens of New York, the third most populous state [19.3 million], are also seeking legislation providing this exemption to its citizens.

Based on all of the preceding realities, the evidence favors having a “philosophical exemption” in New Jersey, the eleventh most populous state [8.7 million].

>

>New Jersey has numerous characteristics that make it particularly vulnerable to vaccine-preventable disease, which include a high population density, past history of multiple vaccine-preventable disease outbreaks affecting children, a highly mobile population, high numbers of recently arrived immigrants, and its "corridor state" nature.

>

As long as there is good sanitation, hygiene (including personal hygiene and hot-water washing for soiled undergarments and bedding), clean air, clean water, and adequate nutrition and housing, none of the cited factors make New Jersey “*particularly vulnerable to vaccine-preventable disease*”.

When it comes to high population density, the much higher population density in Japan, a nation with less than half the infant mortality as the USA, clearly shows that this factor is not significant unless the aforementioned basics are compromised.

Since there is no post-vaccine-adoption history of any vaccine-preventable epidemic in New Jersey for any disease for which the current mandated vaccine is truly long-term protective, localized sporadic disease outbreaks are:

Table “1”: 2006 Comparison of Vaccine-Preventable Disease Cases, Among States with Philosophical Exemptions for Immunizations, Florida and U.S.

2006	Measles* (incidence/ 100,000)	Mumps** (incidence/ 100,000)	Rubella* (incidence/ 100,000)	Tetanus* (incidence/ 100,000)	Pertussis* (incidence/ 100,000)	Hep B acute* (incidence/ 100,000)	Polio (paralytic)*	Diphtheria**
Arizona	0	40 (0.631)	0	1 (0.016)	508 (8.01)	unreported	0	0
Arkansas	0	8 (0.282)	0	1 (0.035)	112 (3.95)	87 (3.07)	0	0
California [12% of US pop.] % of US Total [% of 12%]	6 (0.016) 10.9 [90.9] ^{1,3}	31 (0.085) 0.471 [3.93] ^{1,3}	1 (0.003) 9.09 [75.8] ^{1,3}	11 (0.030) 26.8 [223] ^{2,3}	1,749 (4.78) 11.2 [93.3] ³	427 (1.17) 9.06 [75.5] ³	0	0
Colorado	1 (0.021)	51 (1.04)	0	0	710 (14.6)	34 (0.70)	0	0
Idaho	0	7 (0.47)	0	0	88 (5.87)	15 (1.0)	0	0
Louisiana	0	3 (0.07)	0	3 (0.07)	24 (0.56)	63 (1.47)	0	0
Maine	0	0	0	0	174 (13.2)	26 (1.97)	0	0
Michigan	1 (0.001)	84 (0.079)	1 (0.001)	3 (0.003)	632 (6.27)	141 (1.40)	0	0
Minnesota	1 (0.019)	180 (3.46)	0	0	320 (6.16)	32 (0.616)	0	0
New Mexico	0	3 (0.152)	0	0	147 (7.46)	24 (1.22)	0	0
North Dakota	0	14 (2.19)	0	1 (0.156)	43 (6.72)	1(0.156)	0	0
Ohio	0	45 (0.392)	0	3 (0.026)	644 (5.62)	123 (1.07)	0	0
Oklahoma	0	10 (0.276)	0	1 (0.028)	64 (1.77)	96 (2.65)	0	0
Texas [7.8% of US pop.] % of US total [% of 7.8%]	0 0.88 [11.4] ⁴	58 (0.243) 0.88 [11.4] ⁴	0 2.4 [31.2] ⁴	1 (0.004) 6.1 [79.2] ⁴	954 (3.99) 17.7 [230] ⁴	833 (3.48) 17.7 [230] ⁴	0	0
Utah	0	5 (0.189)	0	1 (0.038)	779 (29.4)	26 (0.98)	0	0
Vermont	0	0	0	0	110 (17.7)	4 (0.64)	0	0
Washington State	2 (0.031)	42 (0.649)	0	0	377 (5.83)	74 (1.14)	0	0
Wisconsin	0	842 (15.0)	0	0	221 (3.94)	33 (0.59)	0	0
Total of states above % of US Total [% of 36%] ⁵ [% of 42.5% est. pop % in 18 states]	11 (0.008) 20.0 [55.6] {47.1}	1,423 (1.09) 21.6 [60.0] {50.8}	2 (0.0015) 18.2 [50.5] {42.8}	26 (0.020) 63.1 [176] {148%}	7,656 (5.89) 49.0 [136] {115%}	2,039 (1.57) 43.3 [120] {102}	0	0
Florida [6% of US pop.] % of US Total [% of 6%]	4 (0.022) 7.3 [122] ⁶	15 (0.082) 0.23 [3.8] ⁶	1 (0.005) 9.1 [152] ⁶	2 (0.011) 4.9 [81.7] ⁶	228 (1.25) 1.5 [25.0] ⁶	420 (2.30) 8.9 [148] ⁶	0	0
U.S. Total	55 (0.180)	6,584 (2.15)	11 (0.004)	41 (0.013)	15,632 (5.11)	4,713 (1.54)	0	0

* Confirmed Cases **Confirmed and Probable Cases

¹ Since the vaccine given is the MMR vaccine, the average of the percentages should show effect of philosophical exemption if and only if the MMR average is > 100% of the expected level based on the population. For MMR, the average percentage is 90.9% of the expected % based on California's total population.

² For the DTaP vaccine, taking Diphtheria as "0" and excluding Pertussis, that average is 46.7% of the expected level – indicating that California's "exemption effect is, if anything to REDUCE disease incidence over expected. [Note: Pertussis excluded because vaccine is not truly effective.]

³ Moreover, for California, the most populous state, excluding Tetanus and Hepatitis B cases because most cases in California occurred in adults and Pertussis because the vaccine is not in-use effective, the average level for the other 3 diseases, where cases were reported in the USA in 2006, is less than 57% of the expected percents.

⁴ For Texas, the second most populous state, excluding Pertussis and Hepatitis B cases because most cases occur in adults, the average level for the other 4 diseases, where cases were reported in the USA in 2006, is less than 11% of the expected percents.

⁵ Presuming that, on average, the 18 states have a total population that is about the same % of the U.S total population as the 18 states are of the 50 states, then the data indicate that the philosophical exemption's only significant effect on cases observed is seen with the DTaP and the Hep B vaccines. Since no cases are seen for diphtheria, the effect for the DTaP vaccine again indicates that this vaccine may not provide adequate long-term protection for the tetanus (most cases in the elderly) and overall protection for the pertussis component. For Hep B, one could argue that philosophical exemption may have contributed to an apparent "20%" excess in disease cases; however, this is probably an artifact because most cases of acute hepatitis B are found in adults and not in Hep-B vaccinated children.

⁶ For Florida, with the 4th highest population and no philosophical exemption, excluding Pertussis and Hepatitis B cases because most cases occur in adults, the average level for the other 4 diseases, where cases were reported in the USA in 2006, is less than 90% of the expected percents.

- A red herring or
- A clear indication that the available vaccines are not in-use effective in some instances.

Since:

- There are other states, including California and Texas (the two most populous states) that have a “philosophical exemption” and “*a highly mobile population*” and a “*high numbers of recently arrived immigrants*” (including much larger numbers of illegal immigrants),
- Three of these 18 states, Arizona, California, and Texas, are also conscientious/philosophical exemption states that are also corridor states for the majority of illegal immigrants entering the USA, and
- None of these states have overall disease rate averages (for those diseases that are truly vaccine-preventable diseases) that are significantly higher than the overall rates for the USA,

all of these factors are “red herrings” in today’s USA.

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>Particularly in light of New Jersey's special traits, the highest number of children possible must receive vaccines to protect them and others.

>

Given the data for the states that have conscientious/philosophical exemption and special factors similar to those raised in this NJ DHSS statement, the data do not:

- Support the NJ DHSS’ assertion that “*the highest number of children possible must receive vaccines*”, or
- Provide evidence that the mandated vaccines “*protect*” the implicit children who receive these vaccines or the unidentified “*others*”.

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>Vaccines not only protect the child being vaccinated but also the general community and the most vulnerable individuals within the community, including those too young to be vaccinated, the elderly, the immunocompromised, and those who have medical contraindications to vaccination – this fact is well-documented in scientific literature.

>

The NJ DHSS’ unsupported assertion that “*(v)accines not only protect the child being vaccinated but also the general community and the most vulnerable individuals within the community*”, is at odds with the reality that inoculation of children with the currently recommended live-virus vaccine components (measles, mumps, rubella, herpes varicella zoster, 3 bioengineered strains of human influenza, and 5 strains of human-cow hybridized rotavirus or a human rotavirus) puts all of the uninoculated and unprotected individuals with whom these recent inoculees have contact at risk of contacting these viral diseases that those inoculated shed after they are inoculated.

For example, *although the CDC asserts that all children become “immune” to the human rotavirus by the time they are five years of age*, the studies on the human-bovine hybrid rotavirus reported that up to one-third of “supposedly rotavirus-immune” adults who come into contact with a child recently inoculated with this rotavirus vaccine (Merck’s RotaTeq®) may contract a case of rotavirus – a possibility that some parents have reported experiencing as an all-too-real actuality.

Moreover, the use of vaccines that clearly do not protect the children inoculated (the influenza vaccines that offer no real protection to children under 2 years of age and

marginal protection to children under 5 years of age) based on a claim that this practice will protect the elderly is not only not supported by the published science on the epidemiology of human influenza but also, *if it were true*, it would still be a peculiar policy where, to “protect” the health of the elderly:

- Children are knowingly put at risk (see the influenza-vaccine-related adverse events, *including death*, seen for all influenza vaccine formulations, that are reported in the Vaccine Adverse Events Reporting System (VAERS) database) and
- The healthcare establishment supports the knowing mercury poisoning of children, which clearly occurs when Thimerosal-preserved influenza vaccines are given to children, pregnant women and nursing mothers and probably occurs when any Thimerosal-containing influenza vaccine is given to pregnant women and/or children because, *though the safe dose for Thimerosal in any vaccine has never been established*:
 - Mercury poisoning has been established in young children who have been given toxic doses of Thimerosal-preserved serums and/or vaccines, indirectly (in the womb) and directly (in early childhood), and have subsequently been diagnosed with a neurodevelopmental disorder in the autism spectrum¹ where the mercury bolus doses from the serums and vaccines represent *not less than 50%* of the mercury dose received by an effected child from conception to age 3, and
 - Persistent Thimerosal-derived mercury toxicity has been seen in monkeys^{2,3b,3d} (and other mercury-sensitive animals³) given just the doses of Thimerosal or one of its ethylmercury metabolites that, *in some instances*, mimicked the Thimerosal doses that children given Thimerosal-preserved vaccines at 2, 4 and 6 months would receive under the vaccination schedules recommended in the USA from 1999 through 2001.

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- ¹ a. Geier DA, Kern JK, Garver CR, Adams JB, Audhya T, Nataf R, Geier MR. Biomarkers of environmental toxicity and susceptibility in autism. *J Neurol Sci.* 2008 Sep 24. [Epub ahead of print]
b. Geier DA, Mumper E, Gladfelter B, Coleman L, Geier MR. Neurodevelopmental disorders, maternal Rh-negativity, and Rho(D) immune globulins: a multi-center assessment. *Neuro Endocrinol Lett.* 2008 Apr; **29**(2): 272-280.
c. Nataf R, et al. Porphyrinuria in childhood autistic disorder: implications for environmental toxicity. *Toxicol Appl Pharmacol.* 2006; **214**: 99-108.
d. Geier DA, Geier MR. A prospective assessment of porphyrins in autistic disorders: a potential marker for heavy metal exposure *Neurotox Res.* 2006; **10**: 57-64.
e. Young HA, Geier DA, Geier MR. Thimerosal exposure in infants and neurodevelopmental disorders: an assessment of computerized medical records in the Vaccine Safety Datalink. *J Neurol Sci.* 2008 Aug 15; **271**(1-2): 110-118. Epub 2008 May 15.
- ² Burbacher TM, et al. Comparison of blood and brain mercury levels in infant monkeys exposed to methylmercury or vaccines containing Thimerosal. *Environ Health Persp.* 2005; **113**(8): 1015-1021.
- ³ a. Laurente J, Remuzgo F, Ávalos B, Chiquinta J, Ponce B, Avendaño R, Maya L. [Neurotoxic effects of thimerosal at vaccines doses on the encephalon and development in 7 days-old hamsters.] *An Fac Med Lima* 2007; **68**(3): 222-237.
b. Shiraki H, Nagashima K. Essential Neuropathology of Alkylmercury Intoxication In Humans from the Acute to the Chronic Stage with Special Reference to Experimental Whole Body Autoradiographic Study Using Labeled Mercury Compounds. *Neurotoxicology* 1977; **1**: 241-260.
c. Tryphonas L, Nielsen NO. Pathology of chronic alkylmercurial poisoning in swine," *Am J Veter. Res.* 1973; **34**(3): 379-392.
d. Takahashi T, Kimura T, Sato Y, Shiraki H, Ukita T. Time-Dependent Distribution of ²⁰³Hg-Mercury Compounds in Rat and Monkey as studied by Whole Body Autoradiography. *Eisei Kagaku [Japanese: J Hygienic Chem.]* 1971; **17**(2): 93-107.

Finally, for influenza, the epidemiological evidence is that human influenza viruses are neither highly contagious⁴ nor, as *discussed in the same reference*, easily transmitted from those infected to those who are well – even in close communal groups, including families.

>

>As an example, in a Journal of the American Medical Association study published in 2000, investigators found that children who did not receive measles and pertussis vaccines for philosophical or religious reasons were 22 times more likely to contract measles and 6 times more likely to get pertussis; also, schools with higher numbers of exempted children were associated with more outbreaks that had community wide-implications.

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First, the referenced, but not cited, article's text appears to be more self-serving propaganda than it is important information because the locations, time periods, and diseases chosen seem to have been knowingly selected to result in the preordained outcomes that the study was "designed" to find.

First, the locations in which the researchers at the Centers for Disease Control and Prevention (CDC) chose to do this study (in some counties in Colorado) were areas with relatively small populations as compared to the population of the USA (some percentage of Colorado's population that overall is only about 1% of the population of the USA) that were/are not representative of the population of the USA or the U.S. population's overall risks of contracting "*vaccine-preventable*" diseases.

Though the NJ DHSS fails to cite the study mentioned, based on a search of "PubMed" (<http://www.ncbi.nlm.nih.gov/sites/entrez>), the abstract of the study apparently referenced states (with underlining added for emphasis):

"1: JAMA. 2000 Dec 27;284(24):3145-50. Links

Comment in:

JAMA. 2000 Dec 27;284(24):3171-3.

JAMA. 2001 Mar 28;285(12):1573-4.

JAMA. 2001 Mar 28;285(12):1573; author reply 1574.

Individual and community risks of measles and pertussis associated with personal exemptions to immunization. Feikin DR, Lezotte DC, Hamman RF, Salmon DA, Chen RT, Hoffman RE. Respiratory Diseases Branch, Centers for Disease Control and Prevention, 1600 Clifton Rd, MS-C23, Atlanta, GA 30333, USA. drf0@cdc.gov

CONTEXT: The risk of vaccine-preventable diseases among children who have philosophical and religious exemptions from immunization has been understudied.

OBJECTIVES: To evaluate whether personal exemption from immunization is associated with risk of measles and pertussis at individual and community levels.

DESIGN, SETTING, AND PARTICIPANTS: Population-based, retrospective cohort study using data collected on standardized forms regarding all reported measles and pertussis cases among children aged 3 to 18 years in Colorado during 1987-1998.

MAIN OUTCOME MEASURES: Relative risk of measles and pertussis among exemptors and vaccinated children; association between incidence rates among vaccinated children and frequency of exemptors in Colorado counties; association between school outbreaks and frequency of exemptors in schools; and risk associated with exposure to an exemptor in measles outbreaks.

RESULTS: Exemptors were 22.2 times (95% confidence interval [CI], 15.9-31.1) more likely to ac-

⁴ Cannell JJ, Zaslloff M, Garland CF, Scragg R, Giovannucci E. On the epidemiology of influenza. *Virology*. 2008 Feb 25; **5**: 29. [Among the issues this paper addresses, this recent electronically published review article reports the lack of high sick-to-well infectivity for human influenza.]

quire measles and 5.9 times (95% CI, 4.2-8.2) more likely to acquire pertussis than vaccinated children. After adjusting for confounders, the frequency of exemptors in a county was associated with the incidence rate of measles (relative risk [RR], 1.6; 95% CI, 1.0-2.4) and pertussis (RR, 1.9; 95% CI, 1.7-2.1) in vaccinated children. Schools with pertussis outbreaks had more exemptors (mean, 4.3% of students) than schools without outbreaks (1.5% of students; P =.001). At least 11% of vaccinated children in measles outbreaks acquired infection through contact with an exemptor.

CONCLUSIONS: The risk of measles and pertussis is elevated in personal exemptors. Public health personnel should recognize the potential effect of exemptors in outbreaks in their communities, and parents should be made aware of the risks involved in not vaccinating their children.”

Apparently, *since none were reported*, there were no severe adverse outcomes in any group of children based on the reported 2006 data.

In addition, though this study did report these relative risks for disease as:

“Exemptors were 22.2 times (95% confidence interval [CI], 15.9-31.1) more likely to acquire measles and 5.9 times (95% CI, 4.2-8.2) more likely to acquire pertussis than vaccinated children.”

it also reported:

“After adjusting for confounders, the frequency of exemptors in a county was associated with the incidence rate of measles (relative risk [RR], 1.6; 95% CI, 1.0-2.4) and pertussis (RR, 1.9; 95% CI, 1.7-2.1) in vaccinated children”,

indicating that, *after the confounding factors were removed*, neither of these relative risks was statistically significant (requiring a RR of 2.0 or larger) and, *because no other diseases were mentioned*, there was no “exemption” effect for the other diseases covered by the MMR vaccine (mumps and rubella) or the DTaP vaccine (diphtheria and tetanus).

Though not mentioned by the NJ DHSS here, the most important fact in this article was:

“At least 11% of vaccinated children in measles outbreaks acquired infection through contact with an exemptor” –

indicating that, *unlike having the measles once*, the MMR vaccine is not effective in protecting all those given the MMR vaccine from subsequently contracting measles when exposed to the measles virus.

In the final analysis, there was/is really no statistically significant risk associated with exemptors (religious and medical) and, *apparently*, the CDC had/has no interest in conducting such studies in the more populous, densely populated, highly mobile, “corridor” states like New Jersey.

>

>All vaccines currently licensed in the United States are safe and effective.

>

First, the NJ DHSS neither provides nor cites any studies that establish the validity of the preceding statement.

Second, *as cited in previous reviews*⁵, there is a large and growing body of evidence that some of the current FDA-licensed vaccines are neither truly population safe nor, *in some cases*, in-use effective even when the effectiveness criterion is loosened to only require that the vaccine be societally cost-effective.

⁵ These reviews are freely available for download from the “Documents” web page of the CoMeD Internet website: <http://www.mercury-freedrugs.org/>. For example, the most recent 2-part review, “**A Draft Review of: 'Florida Governor' Task Force on Autism Spectrum Disorders- Task Force Requests to the Florida DoH', Part 1** (17 October 2008; 68 pages)” and “**A Draft Review of: 'Florida Governor' Task Force on Autism Spectrum**

Examples of national vaccination programs with these problems include:

The Current Recommended National Human Influenza Vaccination Program

Published studies have clearly established that the influenza vaccination program is not in-use effective in children, adults and the elderly for a variety of reasons.

Moreover, the majority (greater than 75 %) of the available doses contain a level of Thimerosal that has not been proven safe to administer to either children or adults.

Therefore:

- New Jersey's mandate for vaccination of young children should be rescinded,
- The current recommended national program for influenza should be abandoned,
- The human influenza vaccines should be removed from the list of vaccines covered by the National Vaccine Injury Compensation Program (NVICP), and
- All petitions filed with the NVICP from the time the influenza vaccines were added to the list of compensable vaccines until 3 years after the vaccine was recognized to be not effective and removed from the national vaccination program should be *automatically* paid, with the government assessing the manufacturer of the putative causal human influenza vaccine for the costs of that compensation because the human influenza vaccines are not effective drugs.

The Current Recommended National Herpes Varicella Zoster Vaccination Program

Since:

- The recommendations for a national varicella vaccination program were based on an unfulfilled promise of marginal societal cost-effectiveness provided: **a)** one dose would produce lifetime protection, **b)** the vaccine was assumed to cause no serious side effects, and **c)** the vaccination program would not increase shingles cases,
- The CDC is now recommending 2 doses because one dose has failed to control "wild" chickenpox cases,
- Shingles cases in both children and adults have increased and
- The vaccine has not only the highest level of VAERS-reported adverse side effects of any single-component vaccine but has also been shown to cause serious conditions in some who are vaccinated,

it is obvious that the chickenpox vaccination program is not societally cost effective.

Thus,

- The recommendation for inclusion of "varicella" (chickenpox) in the national vaccination program should be rescinded,
- New Jersey should remove it from its list of mandated vaccines for children,
- Varicella should be removed from the list of NVICP-covered vaccines, and
- All petitions filed with the NVICP from the time the varicella vaccine was added

Disorders- Task Force Requests to the Florida DoH', Part 2 (17 October 2008; 77 pages)" [along with the report that was reviewed, "**Florida's Governor's Task Force on Autism Spectrum Disorders - Task Force Requests to the Florida DoH** (16 Sept. 2008; 49 pages)"], contains a detailed analysis of the current childhood vaccination programs that *dispassionately* assesses the in-use medical cost-effectiveness of the current vaccines and their associated vaccination programs.

to the list of compensable vaccines until 3 years after the vaccine was recognized to be not societally cost-effective and removed from the national vaccination program should be *automatically* paid, with the government assessing the manufacturer of the varicella vaccines for the costs of that compensation because, *though all drugs, including vaccines, are required to be by U.S. law to be both safe and effective*, the varicella vaccines are not effective.

The Current Recommended National Rotavirus Vaccination Program

Because:

- The current rotavirus vaccination programs have not significantly reduced the risk of severe adverse effects (intussusception, Kawasaki's, and pneumonia) in the inoculees as compared to the unvaccinated,
- The vaccines are live virus vaccines that not only infect those inoculated but also, *at a high rate*, those who come into contact with recent inoculees or their fecal waste, and
- The costs of the vaccine and its administration greatly exceed the societal cost-effectiveness level established in the 1990s even after correcting for inflation,

it is obvious that the rotavirus vaccination programs are not societally cost-effective in the USA.

Thus,

- The recommendation for inclusion of rotavirus in the national vaccination program should be rescinded and rotavirus removed from the list of NVICP-covered vaccines,
- New Jersey should not add rotavirus to its list of mandated vaccines, and
- All petitions filed with the NVICP from the time the rotavirus vaccine was added to the list of compensable vaccines until 3 years after the vaccine was recognized to be not societally cost-effective and removed from the national vaccination program should be *automatically* paid, with the government assessing the manufacturer of the offending rotavirus for the costs of that compensation because, *though required by law to be both safe and effective*, the rotavirus vaccines are *clearly not* in-use effective.

At best, all that the rotavirus vaccines do is give clinical cases of the rotavirus strains in the vaccines to those inoculated with no significant reduction in either the number or severity of cases of rotavirus compared to the unvaccinated population, even in the carefully contrived clinical trials where the lack of reduction in life-threatening outcomes in the vaccine arm over the unvaccinated arm was *perversely* turned into positive because, *although some of those inoculated had these life-threatening side effects*, the elevation in their level was not statistically significant.

Thus, the licensing and approval of the human-bovine rotavirus vaccine rests on a knowing perversion of the reality that, *to be effective*, the vaccine should have produced a statistically significant reduction in the level of cases for these life-threatening adverse effects.

However, *like the previous vaccine*, Wyeth's RotaShield®, the current live-virus rotavirus vaccines, Merck's RotaTeq® and GlaxoSmithKline's Rotarix® did not significantly reduce the incidence of the following life-threatening adverse outcomes:

- Intussusception (for either of these vaccines).

- Kawasaki's⁶ (for the RotaTeq vaccine), or
- Pneumonia (for the Rotarix vaccine,

even though the test populations for the Phase 3 clinical trials were selected to be in areas where the background rate of disease was significant to mask the level of harm caused by vaccination so that it would not produce a statistically significant increase in life-threatening outcomes.

The Current Recommended National Vaccination Programs For Other Vaccines

For discussions of other vaccines, the reader should study the prior applicable posts on the CoMeD Internet website: <http://www.mercury-freedrugs.org/>.

>

>The Department only mandates vaccines licensed by the FDA and recommended for universal use by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices, American Academy of Pediatrics, and other government and professional organizations.

>

While the preceding states what the NJ DHSS is doing vis-à-vis setting vaccination mandates, one should note that these actions are seemingly at odds with the NJ DHSS' constitutional duty to only support the use of preventive medicines, *including vaccines*, that are proven to be effective in protecting the health of New Jersey citizens – a duty that the NJ DHSS and elected state officials, *including the governor*, have obviously failed to discharge in those instances where vaccines, *which have been proven to be in-use ineffective*, are being mandated for New Jersey's children.

>

>The Department, medical experts and practitioners believe that using available vaccines is highly preferable to control individual cases and outbreaks of vaccine-preventable diseases.

>

Here, it is unambiguous that the "*Department, medical experts and practitioners believe*" in what they are doing.

Unfortunately, public health policy should not be based on what the NJ DHSS, "*medical experts and practitioners believe*".

Public health policy should only be based on proof that the mandated vaccines are safe and in-use cost-effective when all the costs (including the costs of the adverse events associated with the vaccination program for them) are accurately assessed and included.

Thus, the NJ DHSS should:

- Abandon its unsupported belief-based policies, which have elevated vaccination to quasi-religious prominence, and
- Return to mandating only those vaccines that, *based on in-use outcomes that include the costs of the adverse reactions to a given vaccine or vaccine component and the need for "boosters" and their risks*, are proven safe and at least in-use societally cost-effective for New Jersey's children.

>

>For many of these diseases, effective therapies are not available to treat sick individuals or are ineffective when given at the time of diagnosis.

>

⁶ Geier DA, King PG, Sykes LK, Geier MR. RotaTeq vaccine adverse events and policy considerations. *Med Sci Monit.* 2008 Mar; **14**(3): PH9-PH16.

Since the mandated childhood vaccines are supposedly intended to “protect against” “native” diseases by giving the children:

- “Weakened” strains of the disease (e.g., the live-virus measles, mumps, rubella, varicella, rotavirus and influenza vaccines),
- Inactivated strains of the disease (e.g., the inactivated-virus polio and influenza vaccines),
- Manufactured components derived from superficial components of the disease organisms (e.g., the hepatitis B, hepatitis A, meningococcal, pneumococcal, and HPV vaccines), or
- The modified toxins (“toxoids”) or toxic components produced by the disease organisms (e.g., the diphtheria, tetanus, and pertussis vaccines),

the NJ DHSS’ broad “(f)or many diseases” generalization here is, at best, problematic.

Moreover, for those diseases for which the available preventive vaccines have not been shown to be truly in-use cost-effective, it is wrong to waste public health dollars vaccinating our children because, *at best*, the vaccine only postpones the age at which our children contract the disease – a move that, *for some of the contagious viral childhood diseases*, only increases the probable severity of the disease as well as the costs to treat that disease in those instances where our children finally contract that disease.

In addition, the NJ DHSS’ statement ignores:

- The potential long-harm to our children’s developing immune system that injecting them with vaccines containing not only the disease-related components but also other immune-system-reactive components may cause in some of those injected, and
- The long-term immune-system imbalance that occurs when our developing children are abnormally exposed to disease components by injection rather than by the “natural” exposure routes.

Furthermore, though it is clear that aluminum-based adjuvants may over-stimulate the macrophagic branch of the immune system and, *for some*, lead to autoimmune disorders and increased susceptibility to some chronic medical conditions, vaccine formulations containing such aluminum-based adjuvants (or other adjuvants that are known to be capable of causing immune-system dysfunction) continue to be approved when, *by increasing the level of the disease-related antigens or making other formulation changes*, it is, *or should be*, possible to make an effective vaccine without adding any adjuvant.

Finally, even though the vaccine makers have, *as the U.S. Food and Drug Administration (FDA) and the vaccine makers have repeatedly admitted*⁷, failed to prove that the Thimerosal in Thimerosal-preserved vaccines is safe to the explicit “sufficiently nontoxic ...” standard required by law in 21 C.F.R. § 610.15(a) and such Thimerosal-preserved drugs are “**deemed adulterated**” drugs under 21 U.S.C. § 351(a)(2)(B), the FDA and the vaccine makers have colluded to continue to approve and market these adulterated vaccines to the American public.

⁷ Subcommittee on Human Rights and Wellness, Committee on Government Reform of the House of Representatives, “Mercury in Medicine Report – Taking Unnecessary Risks,” Washington, DC, as published in the ***Congressional Record***, pgs. E1011-E1030, May 21, 2003.

Thus, the NJ DHSS' decision to be an active party to the preceding collusive actions that expose our children to adulterated vaccines is particularly egregious in the case of the inactivated influenza vaccines given to our children, where:

- Several publications, including: Geier DA, King PG, Geier MR. Influenza Vaccine: Review of Effectiveness of the U.S. Immunization Program, and Policy Considerations, *Journal of American Physicians and Surgeons*, 2006 Fall; **11**: 69-74, have established that the influenza vaccines are not in-use effective,
- Several studies have clearly established that Thimerosal is not an effective preservative in any vaccine formulations that contains proteins or other sulfur-containing compounds,
- More than a dozen recent studies have established that injection of Thimerosal-preserved vaccines mercury poisons all of those injected to varying degrees,
- Most of the available doses of these inactivated influenza vaccines are still unnecessarily preserved with Thimerosal or contain a lower level of Thimerosal that has been proven to be toxic to our children, and, worse,
- Studies have shown that daily supplementation with vitamin D-3⁸ apparently protects almost all adults who take daily 2000-IU vitamin D-3 supplements during the influenza season against most all strains of influenza while, *at best*, the current influenza vaccines only provide limited protection:
 - For a few of the probable circulating influenza virus strains,
 - To only some of those inoculated with them.

Thus:

- IF the NJ DHSS were truly interested in preventing cases of influenza, as this statement asserts,
- THEN the NJ DHSS would be mandating that all children and the elderly be: **a)** appropriately tested for their level of vitamin D-3 and **b)**, *based on the test results*, given an appropriate added daily dose of vitamin D-3 during the “flu” season, which the NJ DHSS would then supply for each child whose family could not afford the cost.

>

>Though diseases still occur among the vaccinated, many more vaccine-preventable illnesses would occur if fewer persons were vaccinated.

>

Here, the NJ DHSS' statement is a classic example of Orwellian doublespeak – a statement that begins with a muted truth, “*diseases still occur among the vaccinated*” – which embodies the reality that even multiple doses of the current vaccines do not provide either short-term or long-protection to all those who have been vaccinated against contracting these diseases when those fully (multiply) vaccinated with them are exposed to

⁸ Preventive dietary supplementation with vitamin D-3 (1,000 to 5,000 IU per day depending on the child's or adult's size, skin color, age, sun exposure, and overall health) has been proven to protect against contracting all strains of human influenza (while the vaccines, at best, only protect against a few strains of influenza) as well as to have other health benefits. [Note: The short-duration administration of high-doses of vitamin D-3 (ca. 50,000 IU per day) has also been shown to be effective in treating influenza cases. References: a. Cannell JJ, Hollis BW. Use of vitamin D in clinical practice. *Altern Med Rev*. 2008 Mar; **13**(1): 6-20. b. Cannell JJ, Vieth R, Umhau JC, Holick MF, Grant WB, Madronich S, Garland CF, Giovannucci E. Epidemic influenza and vitamin D. *Epidemiol Infect*. 2006 Dec; **134**(6): 1129-1140.]

the actual disease – and connects that truth to an unclear statement, “*many more vaccine-preventable illnesses would occur if fewer persons were vaccinated*”, that falsely speaks of “*more vaccine-preventable illnesses*”.

However, for “*vaccine-preventable illnesses*”, the truth is:

- There could only be more cases of the illnesses that are claimed to be “*vaccine-preventable*” – not more “*illnesses*” (diseases) and
- The evidence is clear that the current USA recommended vaccination programs are, *for whatever reasons*, major causal factors for the current epidemics of chronic childhood medical conditions (e.g., asthma, severe food allergies and intolerances, type 2 diabetes, MS, certain leukemias, idiopathic dilated cardiomyopathy (IDCM), obesity, and neurodevelopmental and behavioral disorders) that were either rare or non-existent in our children before 1980.

>

>The return and resurgence of vaccine-preventable diseases translates to significant economic and human costs related to time lost from work, medical care, and public health interventions.

>

Since, *except for smallpox*, the diseases of which the NJ DHSS speaks have not been reduced to laboratory specimens in every nation on the Earth, it is false to speak of the “*return and resurgence of vaccine-preventable diseases*” when all that is happening in the USA today, for those diseases where the vaccines seemingly provide effective “long-term” protection, are sporadic isolated outbreaks.

Moreover, *except for the disease cases caused by herpes varicella zoster*, most of these outbreaks in the USA are being triggered by exposure to recently infected carriers coming from countries where, *for whatever reason*,

- The native disease is still endemic, or
- A recent live-virus-vaccine inoculee was shedding the vaccine’s live viral components and infected the carrier just before their return to the USA, and
- Those exposed to these returning outbreak initiators:
 - Were not vaccinated or,
 - *If vaccinated*, were not adequately protected from contracting the disease by the vaccinations they received.

Second, the actual data for those diseases that the federal government and the NJ DHSS have labeled “*vaccine-preventable diseases*” fails to show any nationwide disease resurgence for those few diseases for which the vaccines apparently are at least in-use societally cost-effective.

Third, the “*economic and human costs*” from the chronic illnesses that the USA’s current vaccination programs have engendered are orders of magnitude greater than the short-term “*economic and human costs*” for the current levels of these acute childhood diseases (e.g., measles, mumps, rubella, diphtheria, tetanus, pertussis [whooping cough], rotavirus and pneumonia).

>

>The more exemptions we allow, the more difficult it will be to prevent vaccine-preventable diseases from affecting our communities.

>

The data presented by the Florida Department of Health along with the added information provided to address incidence levels and relative disease levels to address the “philosophical exemptions” issue (**see Table “1”**) does not support the

NJ DHSS' assertion that the "*more exemptions we allow, the more difficult it will be to prevent vaccine-preventable diseases ...*" in today's America in the 18 states, including the two most populous states, California and Texas, that have a "conscientious/philosophical exemption" option.

Hopefully, after reviewing this response and the referenced and cited publications, the NJ DHSS will not only drop its opposition to S1071 (and A260) and support the passage of this legislation, but also immediately revoke its mandates for influenza vaccination and, *after reviewing the in-use effectiveness data for each of the currently mandated vaccine components*, adjust the vaccination mandates to eliminate those other vaccines that are not in-use cost effective, starting with the current vaccines for herpes varicella zoster and rotavirus.

Finally, after reviewing this response and all of the cited publications, if the NJ DHSS ignores any of the factual realities set forth in this review, then the people of the state of New Jersey should, *in mass*, rise up and demand that the New Jersey State Legislature pass and the Governor of the State of New Jersey sign into law a statute that:

- ❑ Repeals all vaccination mandates, and
- ❑ Simply states that:
 - ❖ All vaccination programs shall be voluntary, and
 - ❖ *For those vaccines that are truly provably cost-effective:*
 - The state will provide the vaccine doses for all of its residents,
 - All medical insurance programs will only cover the overhead medical costs for those vaccination programs where vaccination is provably societally cost-effective by truly independent investigators, and
 - The NJ DHSS will initiate and support programs for all of the alternative disease-preventive measures, including:
 - Better hygiene and sanitation,
 - Dietary supplementation and healthy diets, which have been proven to reduce the risk of the initiation and spread of communicable-disease outbreaks,
 - Setting the state's recommendation for daily intake of vitamin D-3 to *no less than* 1,000 IU (25 micrograms), and
 - Requiring:
 - All school-related health-screening blood tests include an assessment of serum 25-hydroxy-vitamin D levels, and
 - The healthcare provider to furnish or prescribe appropriate vitamin D-3 supplement levels when the measured level is below 45 ng per milliliter (mL) of serum with appropriate follow-ups to ensure that the child's serum 25-hydroxy-vitamin D levels exceed 45 ng per mL.

Concluding Remarks

As a supporter of vaccines and vaccination programs that are reasonably safe and at least societally cost-effective, the author understands that the current New Jersey

mandated vaccination programs have severe problems, which the NJ DHHS should immediately address.

Moreover, the NJ DHSS should address the problems with its vaccination program mandates in a manner that is:

- Truly public-health cost-effective and
- Free of the pernicious influence of those who directly and/or indirectly profit from:
 - More vaccines and/or
 - Expanding mandated vaccination programs that are intentionally blind to the rise in, *and the costs of*, the chronic childhood diseases, which the affected children and their families must bear for the rest of their lives.

If the NJ DHSS fails to act in the responsible manner being recommended, then the NJ DHSS should be prepared to be the proverbial “last straw” that will trigger a movement to repudiate all vaccination mandates because it will be knowingly ignoring the actual fiscal and physical harm that its scientifically indefensible vaccination mandates have caused, are causing and will cause.

Finally, in conjunction with this response, the NJ DHSS should carefully study the in-depth two-part review of the September 2008 report issued by the Florida Department of Health, and the report itself, as posted in the “**Documents**” section on the CoMeD Internet website: <http://www.mercury-freedrugs.org> (**see footnote 5**).

About the Reviewer:

Information about this reviewer, Paul G. King, PhD, can be found on the Internet at: <http://www.dr-king.com/>.

This reviewer received no compensation for this review; and, other than his advocacies, has no conflicts of interest.