

# *Facility Automation Management Engineering (FAME) Systems*

Friday, 1 January 2010

To All:

The text following this page is a draft response to a **Washington Post** on-line editorial, titled: “**The Worst Ideas of the Decade Vaccine scares**”, by contributing writer Clive Thompson ([clive@clivethompson.net](mailto:clive@clivethompson.net)), which this respondent downloaded on Monday, 21 December 2009 from: <http://www.washingtonpost.com/wp-srv/special/opinions/outlook/worst-ideas/vaccines-and-autism.html>.

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This formal response, titled:

“**The Worst Ideas of the Decade Vaccine scares’  
A Scientist’s Response**”,

begins on the next page.

## **Introductory Remarks**

First, to “*simplify*” this response, when portions of the article being reviewed are addressed in this response, the statements in this report will be quoted in a “Times New Roman” font.

Second, except for his introductory remarks, the remarks by this respondent, Paul G. King, PhD, are presented in indented text following the section of the article that is being reviewed.

In addition, this respondent’s remarks and suggested changes are in a “Georgia” font except, when he quotes: **a)** from or refers to any US or New Jersey statute or regulation, the text will be in a “Franklin Gothic Medium Cond” font or **b)** from other sources, the quotations will be in an “Arial Narrow” font.

When this respondent quotes from statements made in the article, this respondent 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 respondent so that he can improve his understanding of factual reality and revise his views and the final response.

Respectfully,



Paul G. King, PhD,  
*FAME Systems*, Founder

33A Hoffman Avenue  
Lake Hiawatha, NJ 07034-1922

Email: [drking@gti.net](mailto:drking@gti.net)

Tel. 1-973-997-1321, after 21:00 Eastern Time  
[To whom all inquiries should be directed]

## “The Worst Ideas of the Decade **Vaccine scares**” — A Scientist’s Reaction

### INTRODUCTION

As a research scientist with decades of accomplishment in many arenas (see <http://www.dr-king.com>) as well as a student of Newspeak and Doublespeak, this respondent was taken aback by Clive Thompson’s editorial on many levels.

First, given the writer’s title, this writer and/or his publisher apparently believes that “*Vaccine scares*”, a provocative phrase, are one of the worst ideas mankind has had during the period from 2000 through 2009 and that these “*scares*” are responsible for, in this writer’s view, all of the negative aspects of the current “swine flu” situation.

Second, it is obvious that this writer has no understanding of the processes by which, barring some catastrophic highly infectious contagious viral disease with an infectivity of at least 50% and a mortality rate of 10% or higher, vaccines are supposed to be tested for safety and effectiveness, proven to be safe and effective to all applicable standards, approved by the federal government, and then produced by, in this case, licensed vaccine producers who have obtained government approval.

That this respondent’s assessment is valid can be seen in this writer’s opening question and answer:

*“Why didn't the United States have enough vaccine to fight swine flu this fall? It's partly because federal health officials didn't mix adjuvants into the drug” with underlining added for emphasis)*

Factually, under the current good manufacturing practice (CGMP) regulations for finished pharmaceuticals (21 CFR Part 211 as well as, for vaccines, 21 CFR §§ 600 – 680), drugs, including vaccines, must be manufactured in facilities that operate in compliance with CGMP and the drug manufacturer must formulate and package the finished dosage units in compliance with the applicable CGMP regulations, which for vaccines, require that aseptic conditions be maintained throughout the manufacturing process.

Thus, “*federal health officials*” cannot legally mix adjuvants into a vaccine!

Given that this writer apparently has no understanding of vaccines or their lawful manufacture, the reader should be prepared to be continually misled and misdirected.

Turning to the article’s content, this respondent will assess each statement that this writer in the rest of this editorial makes in terms of its local context as well as, where appropriate, the underlying “vaccine” issues.

### THE DRAFT RESPONSE

“Adjuvants are substances that boost the immune system's response to a vaccine, so that less vaccine is needed per dose. Using them could have allowed us to create up to four times more H1N1 vaccine doses than we have. Most of Europe used adjuvants; so did Canada.”

First, this writer’s “*substances that boost the immune system's response to a vaccine*” is much too simplistic.

Factually, the adjuvants used in “swine flu” vaccines, the “Lipid A” and “oil-in water (squalene or squalene-derivative mixtures, typically with surfactants) adjuvants added to a vaccine formulation that is injected actually cause a strong reaction to be initiated in the circulating immune system that initiates a less-than-specific immune-system response that not only can induce the person’s immune system generate higher levels of the desired antibodies to the “vaccine’s active antigen” (the inactivated A-2009-like-H1N1 antigenic material) but also induces it to produce antibodies to the adjuvant components and other components in the vaccine’s formulation.

Since the substances in these adjuvants are the same as or similar to key biological components of the person’s systems, the unintended consequence of using an adjuvant of the types used in the “swine flu” vaccines is to greatly increase the risk that vaccination with these adjuvanted swine-flu vaccines will induce a strong and, for some, disabling and potentially lethal autoimmune reaction in the person receiving the vaccine.

For this reason, the military personnel and government officials in Germany were given a non-adjuvanted swine-flu vaccine while the German public was only offered the adjuvanted swine-flu vaccine – the politicians, bureaucrats, and military understood the risk for a debilitating autoimmune response and decided that the risk was too high for them but acceptable for the population at large.

With respect to the writer’s inaccurate “[m]ost of Europe used adjuvants; so did Canada”, this respondent first notes that the writer’s “logic” is counseling us to be “vaccine” lemmings and blindly follow what others have purportedly done.

Factually, for the vaccines in question, the drug regulators in several European countries approved inactivated swine-flu formulations that contained not only adjuvants but also Thimerosal as a preservative as well as non-adjuvanted vaccines.

Then, the governmental healthcare officials decided which of the vaccines approved in a given European country that they would offer to the general public in a mass vaccination program.

Based on the available information, including a milder-than-normal flu season in the Southern Hemisphere, principally, Australia and New Zealand, and the lack of proof of safety some of the Eastern European nations (e.g., Poland, Bulgaria, and Austria) and the Western European nations that were former Soviet republics (e.g., Lithuania, Estonia, Belorussia) decided not to undertake a mass swine-flu vaccination program.

Thus, only some European countries (e.g., Great Britain, France, Italy, and Germany) elected to initiate mass vaccination programs for the general public that used adjuvanted vaccines – while apparently reserving unadjuvanted vaccine doses for selected population segments as was the case openly in Germany but seemingly less transparently in other countries.

Turning to Canada, at least one of the adjuvanted batches of the swine-flu vaccine given to the public had a higher than acceptable incidence of severe adverse reactions causing its use to be suspended and the remainder of the lot to be recalled.

In contrast, in the United States, so far only the only lot-wide problem in inactivated vaccines has been a loss of potency in Sanofi’s “no Thimerosal” inactivated-swine-flu vaccine packaged in 0.25-mL syringes.

However, there have been no “swine flu” lot recalls for an unacceptable level of adverse reactions or, for that matter, widespread reports of serious adverse reactions.

Based on the differences in outcomes seen, it appears that, if any swine-flu vaccine formulations should have been approved, the FDA's decisions were more sound than those of the European and Canadian drug-safety regulators who elected to approve adjuvanted swine-flu vaccines for use in the general population even though no such vaccines had been approved previously for use in pregnant women, children and young adults, and the only approval previously had been for an adjuvanted seasonal inactivated-influenza vaccine for use in the elderly in Italy.

“Why didn't the feds?”

The primary reason that “*the feds*” did not use any adjuvanted inactivated-swine-flu vaccine is that the United States Food and Drug Administration (FDA), charged with ensuring that all drugs are safe and effective, did not approve any adjuvanted inactivated-swine-flu vaccines.

Factually, the FDA-approved one no-adjuvant live-virus mist swine-influenza vaccine and four (4) no-adjuvant inactivated-virus swine-influenza vaccines.

Moreover, these vaccines were approved under the presumption of safety because they were made like the corresponding approved seasonal influenza vaccines, which are not adjuvanted — though most of the doses of the inactivated-seasonal-influenza vaccine doses were Thimerosal-preserved doses.

Since no adjuvanted swine-flu vaccines were considered safe enough to approve, the only vaccines “*the feds*” could legally use in a mass vaccination campaign were the FDA-approved non-adjuvanted swine-flu vaccines.

“They were too worried about spooking anti-vaccine activists, many of whom claim adjuvants contribute to autism. This almost certainly isn't true: Adjuvants have been widely used for years, with no reputable study suggesting a link between them and autism. But federal officials feared people would avoid the H1N1 vaccine if it included adjuvants.”

This writer's first statement here is an obvious, but typical, fabrication by someone who is, or is posing as, a vaccine apologist who feels compelled to blame some anti-vaccine group, “*anti-vaccine activists*” in this instance, for the actions of “*the feds*” when the factual record clearly shows that “*the feds*” acted, for the most part, as the vaccine makers and their pro-vaccine acolytes directed.

In addition, this writer's second statement is an excellent example of the use of the English language to create a complex but false tapestry of linked “sound bites” designed to misdirect the reader.

As one dissects this statement, as written, “*This most certainly isn't true*”, logically refers to the theme of the previous sentence, “*They were too worried about spooking anti-vaccine activists*”, and not to the modifying clause, “*many of whom claim adjuvants contribute to autism*”.

Further, the attached assertion, “*Adjuvants have been widely used for years*” is a non-specific assertion that conceals the realities that: **a)** though polymeric hydroxy-aluminum compounds have been widely used for years as adjuvants in some FDA-approved vaccines, these adjuvants have not been used in FDA-approved influenza vaccines and **b)** the type of “oil in water” adjuvant systems that some influenza vaccine makers used in the “swine flu” vaccines approved in some countries for use

in the 2009-2010 “swine flu” pandemic had, prior to or in 2009, not been approved for use in any FDA-licensed vaccine.

Thus, the writer’s second statement here is, at best, overly broad and misleading.

In addition, the writer’s mischaracterizes the genuine safety concerns of “*the feds*” and the public about all of the “swine flu” vaccines, not just the “adjuvanted” vaccines, as if these concerns were limited to concerns about the links between vaccines and autism when the safety concerns were much broader.

There were safety concerns for these “swine flu” vaccines because: **a)** the scientifically sound saline-placebo-controlled studies demonstrating that any of these vaccines are safe were missing; **b)** the antibody titer estimates of efficacy did not show efficacy much above 50%; **c)** there were no completed effectiveness trials to show these vaccine were effective in preventing those inoculated from contracting the disease; **d)** the adjuvant systems being used or proposed for use in the “swine flu” vaccines have not been approved for use in any FDA-approved vaccine; and/or **e)** the requisite toxicity studies that the preservative and/or adjuvants used in, or proposed for use in, these “swine flu” vaccines met the legal standards for safety as set forth in 21 CFR § 610.15(a) were not available.

Further, since this writer cites no references, this respondent must presume that this writer’s “*with no reputable study suggesting a link between them and autism*” admits that there are published peer-reviewed studies that suggest a link between adjuvants and “*autism*” as well as possible other seriously adverse outcomes.

Finally, given that no adjuvanted swine-flu vaccines were approved and the majority of the public is avoiding the swine-flu vaccination programs in spite of the on-going massive propaganda, advertising, public service, and other disinformation campaigns and articles, like this one, that are pushing these vaccines, this writer’s “*federal officials feared people would avoid the H1N1 vaccine if it included adjuvants*” is simply nonsense because the public’s safety concerns caused the majority to shun the vaccines without the adjuvants.

“As Anne Schuchat of the Centers for Disease Control and Prevention said in congressional testimony last month, ‘The public’s confidence in our vaccine system and in vaccines in this country [is] very, very fragile.’”

First, this respondent accepts that this writer’s paraphrasing of Schuchat’s “*congressional testimony*” accurately portrays her views and apparently those of this writer.

However, this respondent rejects the statements that follow as both simplistic and an attempt to pervert the problematic historical factual record in the USA concerning the recommended vaccination programs (this writer’s “*our vaccine system*”) and the FDA-approved vaccines.

Factually, from the 1950s onwards, the public’s confidence in vaccination has been driven by one of the largest, most pervasive, and incessant propaganda campaigns designed to distort the performance of our vaccination programs and to cover up the shortcomings in and lack of cost-effectiveness of almost all of the mass-vaccination programs, including those which were such obvious failures that even this massive propaganda campaign could not cover up (e.g., first rotavirus [RotaShield] vaccination program that was recommended by the CDC before the

FDA even approved the vaccine as well as the horrific Lyme-disease vaccination program, to name two).

Since “*our vaccine system*” is supported by puffery more than by substantiated fact and sound science, this respondent understands that, like any other similar baseless mass-marketing campaign, the public’s confidence is “*very, very fragile*” because it must be continually reinforced by the vacuous propaganda systems that have created it.

“The movement blaming vaccines for causing autism emerged in the early 2000s, and it was one of the most catastrophically horrible ideas of the decade. Not just because it's misguided: Sure, study after study has found no solid link between autism and many alleged vaccine-based culprits, ranging from adjuvants to thimerosal [sic; Thimerosal], a mercury-based preservative. The bigger problem is how uniquely powerful the anti-vaccine contingent has become - and how it has begun to deform both public policy and everyday behavior.”

Here, this writer starts by spinning his view of an obviously alternate universe in which there exists a “*movement*” solely “*blaming vaccines for causing autism*” that “*emerged in the early 2000s*”.

Fundamentally, this writer’s initial assertion ignores the following facts:

- ◆ Studies reviewing the toxicity of Thimerosal (also known as Merthiolate or, in Europe, Thiomersal) published from the late 1930s have repeatedly recommended that Thimerosal should not be used or, in products in which it was used, that it be replaced with safer and more effective compounds;
- ◆ Infant deaths, reported in the 1970s, which were proven mercury-poisoning deaths caused by the topical application of marketed Thimerosal-based antiseptic products underscored the lack of toxicological proof of safety for the use of Thimerosal in medicine;
- ◆ In the early 1980s, based on toxicity studies, including multi-generational reproductive toxicity studies, of injected Thimerosal in rats and other animals, the then Soviet Union stopped using Thimerosal in vaccines and other drugs;
- ◆ In the 1990s, Denmark, Sweden, and Norway, based on their review of toxicity data, stopped using Thimerosal-preserved childhood vaccines; and
- ◆ In 1998, finally acting on an internal toxicity review report issued in 1982, the US FDA banned the use of Thimerosal in all topical antiseptics and vaginal contraceptives.

This writer’s assertion also ignores the factual reality that, in 1999, the United States Public Health Service (USPHS) and the American Academy of Pediatrics (AAP), among others, called for the removal of Thimerosal from vaccines as soon as possible because of their evidence-based concern that the Thimerosal (49.55% by weight mercury) used as a preservative in some vaccines was mercury poisoning some of the babies to the point that some exhibited the documented neurological impairments and other symptoms of subacute mercury poisoning.

Further, the writer’s assertion ignores the findings of a 2003 Congressional report titled “Mercury in Medicine – Taking Unnecessary Risks” that reported the

data the Congressional staff had examined over a period of more than three years clearly indicated mercury toxicity from Thimerosal-preserved vaccines, the failure of the vaccine makers to: **a)** prove (21 CFR § 610.15(a)) the Thimerosal was safe in the manners required by law and **b)** submit (21 CFR § 601.2(a)) that proof to the FDA in their biologics license application (BLA) as well as the FDA's failure to comply with the laws governing its conduct which require the manufacture prove safety to all of the required safety standards, including for preserved and adjuvanted biological drug products, the applicable safety standards set forth in 21 CFR § 610.15(a), before the FDA can approve a vaccine (21 CFR § 601.4(a)).

Thus, the initial impetus for connecting the adverse outcomes seen in developing children to certain vaccines came from the scientists studying the toxicity of Thimerosal in developing animals and the actions demanded or taken by various governments throughout the world (in the 1980s and 1990s) and, in the USA, the FDA (in 1998), and the USPHS and the AAP (in 1999).

Moreover, the incessant reductive miscasting of the concerns about vaccines and serious adverse outcomes linked to a specific vaccine, more than one vaccine, a specific vaccine component, or specific vaccine components as only a vaccine-autism connection (as this writer's "*blaming vaccines for causing autism*" does) is not only a false portrayal of the concerns but also misleading and, when knowingly asserted, duplicitous.

Turning to this writer's "*and it was one of the most catastrophically horrible ideas of the decade*", this respondent simply notes that, because governmental agencies around the world and medical societies in the USA were the source of the connection between Thimerosal and mercury poisoning (the symptoms of which include those that are used to diagnose autism), this writer should credit these groups, and not his undefined "*movement*", as the source for what he thinks is a "*catastrophically horrible*" idea.

With respect to this writer's:

*"Sure, study after study has found no solid link between autism and many alleged vaccine-based culprits, ranging from adjuvants to thimoserol [sic; Thimerosal], a mercury-based preservative",*

this respondent applauds this writer for his clever use of words to assert the lack of a "*solid link*" between a "*causeless*" symptom-based diagnostic label ("*autism*") and "*many alleged vaccine-based culprits*".

However, this respondent does note that many studies have found solid links between the level of mercury exposure (from Thimerosal in vaccines and serums) and the risk of neurodevelopmental and other developmental impairments in children as well as between the risk of immune/autoimmune-dysfunction-mediated diseases (e.g., childhood MS, childhood diabetes, and childhood asthma and COPD) and the level of mercury an/or adjuvant exposure.

Furthermore, several studies have established a statistically significant link between a given vaccination program or its timing and the relative risk of a severe adverse outcome (e.g., the link between the rotavirus vaccination program and the increased risk of intussusception in those vaccinated as compared to those who are not vaccinated for rotavirus; the links between hepatitis B vaccination and the risk of developmental delay as compared to those for whom vaccination was delayed or not done; and the link between initiation of a DTP vaccination program at 2 months

and the increased risk of asthma as compared to delayed initiation of that DTP vaccination program, to name a few).

Worse, this writer demonstrates his fundamental lack of knowledge concerning Thimerosal by not only parroting an oft-used vaccine-apologist's misrepresentation, "*thimoserol* [sic; Thimerosal], *a mercury-based preservative*" but also misspelling Thimerosal.

Factually, Thimerosal (49.55% by weight mercury) is not a preservative – it has been, and still is being used as a preservative in some vaccines and other biological drug product systems as well as a preservative component in some other drugs.

Further, Thimerosal, a highly toxic, very water-soluble compound, is a bioaccumulative mercury toxin and a human teratogen, mutagen, carcinogen and immune-system disruptor, even at levels below 1 part-per-million, as well as an established California Proposition 65 human reproductive toxin.

In spite of:

- ◆ The 1999 "agreement" to remove Thimerosal from vaccines in the USA as soon as possible and
- ◆ Oft-published claims that it was "removed from ... vaccines in ...",

Thimerosal is still used:

- ◆ As an in-process sterilant in the manufacture of some FDA-approved vaccines:
  - Sanofi Pasteur's Tripedia® DTAP, Trihibit® DTaP-Hib, DT, and Decavac® TD vaccines;
  - MassBiologics' Td vaccine; and
  - GlaxoSmithKline Biologicals' Twinrix® HepA/HepB vaccine), and
- ◆ Without the required proof of safety to the minimum required by law, "Any preservative used shall be sufficiently nontoxic so that the amount present in the recommended dose of the product will not be toxic to the recipient", for preservatives in biological drug products (as set forth in 21 CFR § 610.15(a)), as a preservative in all of the "FDA-approved" inactivated-influenza vaccine formulations that are packaged in multi-dose vials:
  - Sanofi Pasteur, Inc.'s Fluzone®,
  - Novartis Vaccines and Diagnostics, Ltd' Fluvirin®,
  - CSL Ltd.'s Afluria®,
  - ID Biomedical Corporation of Quebec's FluLaval®, and
  - All of the FDA-licensed multi-dose 2009-A-H1N1 vaccines [produced by Sanofi Pasteur, Inc, Novartis Vaccines and Diagnostics, Ltd, CSL Ltd, and ID Biomedical Corporation of Quebec, a GlaxoSmithKline subsidiary)

as well as in some other FDA-approved multi-dose vaccines:

- Sanofi Pasteur, Inc.'s multi-dose Menomune®,
- Sanofi Pasteur, Ltd.'s DT,
- The Japanese encephalitis (JE-VAX®) marketed in the USA by Sanofi Pasteur, Inc. and
- Sanofi Pasteur, Inc.'s TT.

Finally, this writer closes this paragraph by stating:

*“The bigger problem is how uniquely powerful the anti-vaccine contingent has become - and how it has begun to deform both public policy and everyday behavior”*,

which begins with a clever misrepresentation *“how uniquely powerful the anti-vaccine contingent has become”* cast as *“[t]he bigger problem”*.

While this respondent admits that there is an *“anti-vaccine contingent”*, he notes that this *“contingent”* has little or no political or economic power, and almost no mainstream media access.

Moreover, this contingent seems to be far from unified and is continually portrayed by the mainstream media as a fringe element of less-than-rational parents – and, to date, has had little, if any, effect on *“public policy”*.

Further, the groups of people who have truly begun to affect *“public policy and everyday behavior”* are the independent researchers, scientists, doctors, clergy, teachers and other educated professionals who, like this respondent, have studied our vaccination programs, found them problematic in one or more aspects, and are stridently demanding that the documented missing proofs of safety, effectiveness and/or cost-effectiveness must be provided or:

- ◆ When a given mass vaccination program fails to provide:
  - Adequate safety,
  - Effective long-term protection (> 50 years) for almost all who are vaccinated and
  - Overall cost-effectiveness when all costs, including the costs generated by the serious adverse reactions that some have, are included,that mass vaccination program must be abandoned and the licenses for those vaccines that are neither adequately safe nor long-term effective should be revoked
- ◆ When a given mass vaccination program provides adequate, effective long-term protection but is not overall cost-effective, when all costs, including the costs generated by the serious adverse reactions that some have, are included, then:
  - Either the number of vaccine doses must be reduced and their timing altered so that the mass vaccination program remains long-term effective and becomes overall cost effective.
  - Or the mass vaccination must be stopped and the vaccine provided only to those individuals for whom their parents or guardians have a medically sound basis for administering those vaccines,
- ◆ When a given vaccine is not truly population effective in preventing more than 90% of those inoculated from contracting a disease if exposed to any strain of that disease, then that vaccine should not be used in any mass vaccination campaign but rather reserved, where appropriate, for outbreak situations where the strains covered by the vaccine are identified as being present.
- ◆ When a given vaccine is adequately safe but population ineffective and not cost-effective and the disease does not have a high morbidity, the FDA licenses for such diseases should be revoked

For these groups, who seek to maintain any and all safe, effective, and cost-effective mass-vaccination programs, the monies saved by stopping all of those deficient mass-vaccination programs for which the deficiencies cannot be corrected should be spent in maintaining and/or improving sanitation, hygiene, clean non-fluoridated water, safe and healthy foods, healthy diet, adequate housing and a cleaner environment.

After all, history tells us all that improvements in sanitation, hygiene, access to clean water, safer foods, housing and our environment in the 1800s and early 1900s accounted for more than 95% of the decrease in all of the highly infectious diseases prevalent in that time frame.

In addition, the judicious use of antibiotic drugs and, more recently, increased supplementation with vitamins and minerals to maintain optimal levels (rather than the minimum levels needed for normal function upon which most dietary intake values are based) and thus potentiate the human body's natural disease-fighting processes have been shown to be effective in combating most bacterial infections as well as reducing the severity of viral infections.

Finally, when it comes to “deforming”/“distorting” today's “*public policy and everyday behavior*”, this respondent and most independent readers know that, when it comes to vaccines and vaccination programs, this writer and other vaccine/vaccination apologists with mainstream media access and support are the ones who are actually distorting “*both public policy and everyday behavior*”.

“Immunization used to be regarded as one of modern society's greatest achievements; before smallpox vaccines, the disease routinely accounted for 10 percent of all deaths in Europe. But amazingly, we're now moving back to the dark ages.”

Here, this respondent agrees with this writer's initial thought: “*Immunization used to be regarded as one of modern society's greatest achievements*”.

However, this respondent notes that, with the knowledge that our current mass vaccination programs fail to provide all of those who are vaccinated with lifetime protection from disease, many of the researchers who have truly studied the literature now know that “artificial immunization” through vaccination is a false “god” – one that today often does not often serve the interests of the people but instead usually serves the interests of those who profit from the revenue and control that its vaccination programs provide.

As to this writer's assertion, “*before smallpox vaccines, the disease routinely accounted for 10 percent of all deaths in Europe*”, this respondent notes that, absent any vaccine, hygiene and sanitation were more crucial in reducing smallpox infection than the cowpox (vaccinia) vaccines, which only provide long-term immunity from smallpox to those who survive inoculation and the subsequent infection it produces.

Moreover, based on the mortality induced by cowpox vaccination, it seems as though mass cowpox vaccination programs were, on some level, mass genetic weeding exercises.

In these exercises, those who were susceptible to dying from the smallpox disease were given, and died from, the adverse effects of infection by cowpox similar to some of those who died in the recent “first responders” program.

Ironically, with the advent of the live-virus vaccinia (cowpox) vaccines, the vaccinators' needles became the vectors that spread cowpox throughout the world

and through successive mass campaigns not only infected and, in many cases, re-infected almost every human with cowpox but also weeded out, among others, those whose health and immune systems were unable to fight off cowpox.

Thus, the cowpox vaccination program touted as a success because it “wiped out” smallpox did so by wiping out those whose health and immune system’s failed to protect them from dying from the disease – essentially, the worldwide mass cowpox vaccination programs were successful human genetic selection and viral displacement (the smallpox vaccine was brought to near extinction by infecting “everyone” with cowpox) programs.

Given:

- ◆ The realities behind the “*smallpox vaccines*”;
- ◆ Lesser successes for the attempted vaccine-based “eradication” of many other “contagious” diseases (e.g., polio, measles, mumps, rubella, and pertussis); and
- ◆ The virtual extinction of “scarlet fever”, for which there was no effective vaccine, through improved sanitation, hygiene, cleaner water, better food and improved housing,

this respondent finds that the facts are the claim of “immunization” through vaccination appears to be one of modern American society’s greatest healthcare propaganda stories.

Thus, this writer’s closing remark:

*“But amazingly, we’re now moving back to the dark ages”,*  
only serves to show how out of touch with reality that this writer’s views are.

“The number of children showing up at school in California without routine shots has doubled since 1997, according to an analysis by the Los Angeles Times. If enough people stop vaccinating their children, we will lose “herd immunity” - the ability of a society to collectively resist a disease. (You typically need something like 85 percent of a population immunized to keep the nastiest communicable diseases from circulating.)”

If this writer’s parenthetical remark:

*“(You typically need something like 85 percent of a population immunized to keep the nastiest communicable diseases from circulating.)”*

is correct then, in today’s America, mechanisms other than vaccination must be keeping “*the nastiest communicable diseases from circulating*”.

This is the case because most of today’s vaccines, with the exception of the measles and rubella component of the Merck MMR® II vaccine and the diphtheria toxoid component of the various diphtheria-containing vaccines, only provide, at best, limited duration protection to probably no more than 85% of the population for the disease or, in many other cases, only to some strains of the disease for which protection is claimed.

Moreover, as those who have been exposed naturally to the various childhood diseases and have reacted to them in a manner that does provide long-term immunity (except for herpes varicella zoster, which causes chickenpox when a person is young and then shingles later) begin to die out and are replaced by mostly those who have been vaccinated, the percent of the population with disease

immunity will continue to decline and the risk of post-childhood disease outbreaks for childhood illnesses will continue to increase.

Indeed, for those American mass vaccination programs that are either not effective (e.g., herpes varicella zoster) or not cost-effective (e.g., the early childhood mumps, pertussis, hepatitis B, and rotavirus vaccination programs), the sooner we abandon mass vaccination and adopt healthcare programs to permit better managed childhood disease identification and treatment, the sooner American children can be effectively immunized from most childhood diseases and the periodic re-boosting needed to maintain protection from the diseases caused by herpes varicella zoster can be restored.

Factually, as the 2006 outbreaks of mumps in fully vaccinated teenagers and young adults or the recent pertussis outbreaks where many who were infected were fully vaccinated, clearly demonstrate that there is no general “herd immunity” per se in America today even though the vaccination programs are vaccinating more than 95% of the population with two doses of the MMR II vaccine (which may be only “societally cost-effective”) and 5+ doses of a diphtheria, tetanus and pertussis vaccine (which does not appear to be even “societally cost effective”).

Currently, though the disease cases and outbreaks are, respectively, isolated or relatively small, early case identification and identification and quarantine of the case contacts, and not vaccination per se, are stopping the spread of mumps and pertussis cases among the population.

Further, if we were to quarantine all returning from countries where a given contagious disease is endemic, then, a few would be inconvenienced but many of the recent small outbreaks of mumps, measles and other highly contagious diseases would not have occurred.

“It's impossible to tell how many swine-flu deaths were caused by the deficit of vaccine, but the numbers are serious: According to the CDC, about 10,000 people had died from the disease by the middle of last month, 1,090 of them children.”

All that this respondent can agree to here is that “[i]t's impossible to tell how many swine-flu deaths were caused by the deficit of vaccine”.

This is the case because:

- ◆ There has been no accurate accounting that has established exactly how many people have had a case of:
  - “Swine flu”,
  - One of the strains of human influenza in the “seasonal flu” vaccines,
  - Some other strain of influenza virus,
  - Some other virus (e.g., the common cold, SAR, RSV, and parainfluenza) or
  - Some other disease organism, and
- ◆ Most who have died had some other underlying health problem and actually died from some type of pneumonia.

Since the CDC's numbers are model estimates that count flu-related deaths as flu deaths, the CDC's numbers are, at best, inflated estimates, which should be ignored until and unless the number of deaths can be unequivocally confirmed by

autopsy findings to be caused by the “swine flu” virus and not some other virus or some other disease (e.g., bacterial pneumonia).

Furthermore, based on the CDC’s inflated claims of “36,000” seasonal flu deaths a year coupled with published records that indicate no more than about 3,000 flu-related deaths and about 1,300 flu-related deaths per year on average for the “flu seasons” from 1979 – 2000, this respondent must reduce the CDC’s estimates by at least a factor of 12 and, if the data from the survey of states by CBS is to valid, by a further factor of 5 – leading to adjusted estimates of about 167 “swine flu”-related deaths and 18 “swine flu”-related deaths in children,

“The subtler but more insidious effect of the vaccine-autism movement is philosophical. The anti-vaccine folks have whipped up anti-science sentiment by painting scientists as corrupt elitists on the take from Big Pharma, cackling sadistically as they force us to get shots. This paranoia flows equally from woo-woo Hollywood liberals and the anti-government right; few other subjects can unite Jenny McCarthy and Jim Carrey with Glenn Beck and Rush Limbaugh.”

This writer’s first statement:

*“The subtler but more insidious effect of the vaccine-autism movement is philosophical”*

is a textbook example of the art of Doublespeak.

Here, the writer’s earlier creations of “*anti-vaccine activists*” and a “*movement blaming vaccines for causing autism*” to demonize all those whose research and studies have raised and, in many cases, established safety, effectiveness, and/or cost-effectiveness concerns about some vaccine, vaccine component and/or vaccination program are portrayed as “*the vaccine-autism movement*”.

Moreover, this writer portrays this movement negatively by using the phrase, “*subtler but more insidious*”, as an adjective describing the “*effect*” of the “*movement*”, which this writer has fabricated.

Next, this writer returns to his “*anti-vaccine*” views but now casts the group as “*anti-vaccine folks*” who have “*whipped up anti-science sentiment*”.

Since most of those who are demanding scientifically sound, appropriate and CGMP-compliant proof that: **a)** vaccines are long-term safe, **b)** they are long-term effective and **c)** the current mass-vaccination programs are cost-effective are scientists and science-based researchers, it is obvious that this group of educated degreed professionals are not “*anti-vaccine folks*”.

Moreover, since the real pro-safety, pro-effectiveness, pro-cost-effectiveness group is composed of scientists and science-based researchers demanding that the proofs required be based on sound science and this group is not addressing individuals, “*Big Pharma*” or “*corporate elitists*” per se, this writer is misrepresenting the actors, their motives and their actions in a manner designed to undermine their credibility.

In an obvious attempt to further discredit those seeking scientifically sound, appropriate and CGMP-compliant proof that: **a)** vaccines are long-term safe, **b)** they are long-term effective and **c)** the current mass-vaccination programs are cost-effective, this reviewer next states:

*“This paranoia flows equally from woo-woo Hollywood liberals and the anti-government right; few other subjects can unite Jenny McCarthy and Jim Carrey with Glenn Beck and Rush Limbaugh”,*

which portrays those who have legitimate concerns about vaccine safety, vaccine effectiveness and/or vaccine cost-effectiveness as if they are suffering from some form of “paranoia” that this writer ties to “woo-woo Hollywood liberals and the anti-government right” (cast respectively as “Jenny McCarthy and Jim Carrey” and “Glenn Beck and Rush Limbaugh”).

Unfortunately, the extreme twisting of reality that this writer’s rhetoric embodies only serves to alert the knowledgeable reader to the emptiness and absurdity of this writer’s remarks here.

“Of course, the only hope we have of treating autism and, God willing, preventing it comes from careful, rigorous science - the same process that created vaccines, eradicated polio and smallpox, and saved millions of lives. For the anti-vaccine crowd, that’s an irony that ought to prick.”

Here, this writer begins by making statements that, rather than being science based, are clearly faith-based appeals, “*the only hope we have of treating autism*” and “*the only hope we have of ..., God willing, preventing it*”, tied to some unspecified “*careful, rigorous science*”.

Unfortunately, this writer obviously knows little about science-based medicine and less about disease prevention.

The best course for treating a child given a label (“*autism*”), which is a diagnosis based on a specific set of symptoms and their expression in the child, is to use a comprehensive differential diagnostic work up of the child focusing on all of the systems that may be malfunctioning based on all of the clinical symptoms that the child exhibits.

To prevent an amorphous disease, once science-based medicine has identified the malfunctioning systems that are “causing” the symptoms exhibited, all that science needs to do is identify the causal factors for the malfunctioning systems identified and, to the extent possible, eliminate or minimize exposures to the causal factors identified.

However, this writer’s attempt to tie “*careful, rigorous science*” to the “*process that created vaccines*” is an obvious distortion of the historical record – vaccines were developed by “trial and error” and not by “*careful, rigorous science*”.

Historically, serums/crude vaccine preparations were generated and then administered to one person or a few test subjects.

If a serum/preparation “showed promise”, the mass inoculation campaigns were carried out without any rigorous controls – again a “trial and error” approach devoid of sound science, which demands that there be double-blind, true-placebo-control studies and, after a suitable interval, a disease challenge so that the true protective effects of the serum/vaccine could be determined.

Since this respondent has already discussed the less-than-scientifically-sound, mass inoculation process that “*eradicated ...smallpox*” by essentially infecting everybody inoculated and, in some instances, their close contacts with cowpox and letting the cowpox infection weed out those who were susceptible to severe smallpox infection much like the live cowpox vaccine weeded out several of the first responders that recently were inoculated with the current live vaccinia virus.

Since polio has not been “*eradicated*” throughout the world even though there is clear evidence that the native polio strains have all been replaced with virtually

ubiquitous mutated polio strains derived from the live-virus polio vaccines, this writer's "*eradicated polio*" is obviously his wishful thinking.

Moreover, since the inactivated (Salk) and live (Sabin) polio vaccines were, and may still be, contaminated with many other viruses, including SV-40, offsetting the lives saved are the lives lost from the apparently SV-40-induced-aggressive cancers that continue to kill a significant number of Americans every year.

Further, polio was never a highly lethal disease – even at its peak less than 1 in 2300 Americans had an extended case of paralytic polio; only a few percent of those with paralytic polio died; and most (99+ %) of children had a sub-clinical infection.

With respect to this writer's "*and saved millions of lives*", this respondent notes that if this be true of vaccines, then, *before there were vaccines other than the vaccinia vaccine*, improvements in sanitation, hygiene, water and food purity and safety, and housing saved hundreds of millions of lives.

Finally, this respondent finds that, while this writer's closing statement:

*"For the anti-vaccine crowd, that's an irony that ought to prick",*

conjures up another "*anti-vaccine*" reference, this time as an "*anti-vaccine crowd*", it is but another misguided quill from this vaccine apologist's Newspeak repertoire.

Since this respondent is a strong advocate for: **a)** vaccines that are proven safe and provide long-term disease-effective protection, and **b)** truly cost-effective vaccination programs, this respondent understands this writer's desire to belittle all such scientists and researchers because this writer lacks any understanding of the facts with which to argue for the maintenance of the status quo – a status quo where:

- ◆ Less-than-safe and ineffective vaccines are held in high esteem, and
- ◆ All of the recommended vaccination programs are humanity's salvation regardless of whether or not they are: **a)** individual safe, **b)** truly long-term disease preventive or **c)** at all cost effective when all of the costs, including increased chronic disease rates and severe adverse reactions, including death, are considered.

*Clive Thompson is a contributing writer for the New York Times Magazine and Wired.*

"Clive Thompson writes about science and technology regularly for the New York Times Magazine, Wired, and New York magazine. He is the video-game columnist for Slate, and covers finance for Details, the men's magazine. He also regularly comments on the cultural impact of science and technology for NPR, CNN, the Canadian Broadcasting Corporation, and many other media outlets. He publishes the blog [collisiondetection.net](http://collisiondetection.net), and is a two-time National Magazine Award winner in Canada. In 2002/2003, he was Knight Science Journalism Fellow at MIT. His writing has been widely anthologized, including in the 2003 Best American Science Writing." –

<http://projects.olin.edu/seminar/index.cfm?itemid=cTho>

Paul G. King, PhD, Lake Hiawatha, NJ, Founder of FAME Systems and CoMeD Science Advisor, is a researcher, consultant, reviewer, respondent, writer, advocate, and activist. For more on this respondent's background, the reader can visit the respondent's web site: <http://www.dr-king.com/>