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Vaccines, Vaccination Programs and Knowing[1] Misrepresentations

Introduction

Before discussing the subjects in the title of this article, this commenter would be remiss if he did not first set forth his biases and conflicts concerning the issues discussed in the sections and paragraphs that follow this introduction.

As a scientist who understands that:

- Terms must be clearly defined,
- Statements must be supported by factual evidence and, where that evidence is not readily available, appropriate citations thereto,
- Much of the information on vaccines and vaccination programs available in the mainstream media and publications backed by the Establishment and its minions is more propaganda, cant and Orwellian newspeak than sound science, and
- Vaccines or vaccination programs where the vaccine is reasonably safe and the protection provided is either life saving (e.g., the rabies vaccines) or the prophylactic vaccine is reasonably safe and effective in protecting almost all (i.e., >90 %) of those vaccinated, long-lasting (i.e., protects that not less than 90 % of those vaccinated for a period of not less than 50 years), and medically cost-effective, for example, the measles only vaccine and vaccination program) should be supported,

this commenter must stand against: **a)** the misrepresentation of vaccines and vaccination programs in any manner, and **b)** vaccination programs in which: **i)** those inoculated with the vaccine are not protected or **ii)** more who are vaccinated suffer serious adverse injury from the vaccine than there are disease cases in the population segments that are being vaccinated (e.g., the early childhood hepatitis B vaccination program).

In addition, since the Establishment continually spews out a never-ending stream of near-religious vaccine and vaccination apologia, this author sees no need to spend any time discussing the inflated and often deceptive presentation of vaccines and vaccination programs as the "salvation" of mankind – because such discussions belong in the realm of religion and not science.

With the preceding in mind, this author will now begin to address fundamental vaccine and vaccination-program misrepresentations that stand in the way of our right to choose or decline any prophylactic medical treatment, including any prophylactic inoculation with any vaccine or serum as we, *and not society*, sees fit for ourselves and the minors and non-competent persons in our care.

1. "Vaccines Are Safe"

The first misrepresentation about vaccines and by far the worst is that, as a group (or individually), "*vaccines are the safest of medicines*" or, more simplistically, "*vaccines are safe*".

The factual evidence and the legislation protecting the vaccine makers, vaccine providers

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[1] Where the term "knowing" is used in the "*knowingly*" or "*knew*" sense that is defined in 21 U.S.C. § 321(bb) "*The term "knowingly" or "knew" means that a person, with respect to information - (1) has actual knowledge of the information, or (2) acts in deliberate ignorance or reckless disregard of the truth or falsity of the information*".

and the healthcare establishment clearly exposes a different reality, which, *in its most telling form*, can be found in the National Vaccine Injury Compensation Program (NVICP[2]; Title 42 of the United States Code in Sections 300aa-10 through 300aa-34 [42 U.S.C. § 300aa-10 – 300aa-34]) in § 300aa-22(b)(1) which, under: **a)** the umbrella of "***Standards of Responsibility***" (§ 300aa-22.) and **b)** the heading at § 300aa-22(b), "***Unavoidable adverse side effects****; warnings*", states:

> "*No vaccine manufacturer shall be liable in a civil action for damages arising from a vaccine-related injury or death associated with the administration of a vaccine after October 1, 1988, if the injury or death resulted from side effects that were* ***unavoidable*** *even though the vaccine was properly prepared and was accompanied by proper directions and warnings*". [Emphasis added]

If vaccines were truly safe, then there would be no need for: **a)** any NVICP legislation to protect the vaccine makers or the healthcare providers from civil lawsuits for damages, or **b)** any "*if the injury or death resulted from side effects that were* ***unavoidable***" language to absolve vaccine manufacturers from damages that include "*vaccine-related injury or death*".

Clearly, unbiased scientists, the federal lawmakers, and the informed public know that, *as a group or, in most instances, individually*, vaccines are not the safest medicines.

2. "Vaccines Are Effective"

If vaccines were truly effective, then there would be:

a. No need for any State to mandate any vaccination program for any vaccine – everyone would be demanding inoculations for themselves and their loved ones,

b. No need for any mention of the unproven theory of "*herd immunity*", which, in reality, can only be a theory of "herd protection" because vaccines do not provide blanket immunity (defined as lifetime [>50 year] protection from disease) to even those who have been inoculated with the recommended vaccines from 2 to 6 or more times, depending upon the vaccine, and

c. No need to license vaccines based on their manufacturers' claimed levels of "efficacy" as measured by some minimum-antibody-level surrogate for effectiveness.

Given the preceding factual realities, it is clear to any rational person that unqualified phrases, like "*vaccines are safe*" and "*vaccination programs are effective*", are simply propaganda slogans that vaccine makers, the healthcare establishment, pro-vaccine academics, pro-vaccine US governmental agencies (e.g., Department of Health and Human Services [DHHS], the Centers for Disease Control and Prevention [CDC], the Food and Drug Administration [FDA], the National Institutes of Health [NIH] and the Public Health Service [PHS], to name a few) and other vaccine apologists continually use in their efforts to both brainwash and coerce the public into accepting whatever vaccines and vaccination programs that "these groups" have decided, *at a given point in time*, are "good" for the public as a whole with little or no regard for the fiscal or physical health of

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[2] The full title of the NVICP in the United States Code is: **TITLE 42 - THE PUBLIC HEALTH AND WELFARE, CHAPTER 6A – PUBLIC HEALTH SERVICE, SUBCHAPTER XIX – VACCINES, Part 2 - National Vaccine Injury Compensation Program**.

any individual or individuals that such vaccination programs may harm, maim or kill or, *for that matter*, the fiscal and physical health of the people of the United States Of America (USA).

3. "Vaccine Panacea: The More Vaccines We Get, The Healthier We Will Be"

a. The Legacy (Pre-NVICP) Vaccination Programs

Reviewing the history of vaccines and vaccination programs in the USA, up until the early 1900s, the only widely used human prophylactic (disease-preventive) vaccine was the live-virus cowpox vaccine, vaccina; the only other general human-use vaccine was the attenuated rabies vaccine used to treat people who had been bitten by a rabid animal; and the only large-scale mass "vaccination" program was the "smallpox" inoculation program.

In the 1920s, a diphtheria vaccine was introduced and its use spread; in the 1950s, the use of pertussis vaccines became widespread but these morphed into the first combination the DTP vaccine, which was to become the first Thimerosal-preserved combination vaccine to be used in a mass vaccination program.

In the 1950s, the Salk inactivated-polio vaccines were introduced for mass use without adequate testing and purity leading to: **a)** an initial increase in paralytic polio cases until the clinical definition of paralytic polio was changed and **b)** the introduction of SV-40 and other animal viruses which were, to varying degrees and levels, contaminants of all the polio vaccines produced for the next three decades; and, a few years later in the early 1960s, the live-virus Sabin oral polio vaccines displaced the Salk inactivated-polio vaccines – the Sabin oral polio vaccines were used in the USA until 2000 when, *because all paralytic polio cases were cases caused by exposure to the vaccine-strains of the live vaccine*, the US switched back to a Salk-type inactivated-virus polio vaccines, which is still in use today.

In 1963, a live-virus measles vaccine was introduced and put into mass use shortly after its introduction; the measles-only vaccine was followed by a measles-rubella (Merck's measles-rubella vaccines, MR® and MR® II, that have been discontinued); then a measles-mumps-rubella vaccine (Merck's MMR® vaccine); and finally an improved measles-mumps-rubella vaccine (Merck's MMR® II vaccine)[3].

In the early 1980s, though some other vaccines were being licensed, they were not being recommended for mass use in childhood vaccination programs because of the increasing number of lawsuits where the parents of vaccine-injured children, principally by the DTP vaccines and the Polio vaccines but also by the measles and MMR vaccines, were winning ever larger monetary judgments against the vaccine companies.

Faced with decreasing profit from the lawsuits, the major vaccine makers threatened to stop making vaccines unless the government passed legislation that protected them from most all direct civil legal actions for the harm their vaccines caused in some of the children who were being inoculated with these vaccines.

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[3] In addition to the combination measles-mumps-rubella vaccines (MMR® and then MMR® II), Merck continued to make the individual component vaccines, Attenuvax®, Mumpsvac®, and Meruvax® II until the mid-2000s. In 2010, Merck announced that, in spite of customer demand for the individual vaccines, Merck would not resume producing these vaccines.

In late 1986, comprehensive legislation was enacted that included the National Vaccine Injury Compensation Program (NVICP) that was codified in 42 U.S.C. §§ 300aa-10 through 300aa-34 and, in stages, became effective in 1987 and 1988.

This legislation was originally supposed to: **a)** provide a speedy, "no fault", non-litigious, fair compensation program for vaccine-injured children and their families, which, *after initial appropriations to start the program*, was to be paid for by a tax on each disease component in each dose of vaccine administered, and **b)** shield the vaccine makers from being easily sued.

In return for this protection, the vaccine manufacturers were supposed to make ever-safer vaccines that caused less adverse reactions under strict governmental oversight that would not only compel vaccine makers to make safer vaccines but punish them when they did not make vaccines as safe as possible and reduce the risk of adverse reactions.

In actuality, all that the NVICP has done is shield the vaccine makers from being sued and, *through an increasingly slow, litigious, convoluted, and unfairly administered "compensation program"*, its administrative hearings have only compensated a very small percentage of those who are damaged by adverse reactions to vaccines even though the program has been expanded to include adults in many instances.

In 1987, Congress took the first action to decrease the fairness of the program and reduce the financial burden on the federal government and the vaccine makers for any violation by repealing § 300aa-18, which indexed the compensation for both vaccine-related death and the vaccine manufacturers' fines to the rate of inflation.

Next, the NVICP program administrators started making it harder for children's families to collect for vaccine injuries by, in the 1990s, removing many of the indications from the "Vaccine Injury Table" (see: **Sec. 300aa-14. Vaccine Injury Table**) without any independent scientifically sound justification for removing them, which forced many more cases to be heard in a proceeding that has become increasingly litigious and unfair[4].

In the late 1980s, though it was clear that the diphtheria, tetanus, acellular pertussis (DTaP) vaccines produced a lower rate of adverse reactions in children given them than the corresponding diphtheria, tetanus, whole-cell pertussis (DTwP) vaccine, based on the data from Japan, which introduced the DTaP vaccine in 1981 and saw a sharp decline in both diphtheria-tetanus-pertussis-vaccine-related adverse reactions and vaccine-related deaths, the DTwP vaccines were still licensed and being given in the USA until 1997, when the vaccine makers finally switched to making the DTaP vaccine[5].

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[4] This continual indication reduction process has gone beyond the absurd, removing the rotavirus vaccine indication for intussusception even though all of the rotaviruses have been shown to cause intussusception in some vaccinated children and two new rotaviruses (a 5-component bovine-human hybrid rotavirus vaccine [RotaTeq®] and an attenuated human rotavirus vaccine [Rotarix®]) have been licensed and approved for mass use instead of amending the table entry for the withdrawn RotaShield ® rhesus-monkey/human hybrid rotavirus vaccine and, most recently, proposing to further alter the allowable time windows for the few remaining indications in the Vaccine Injury Table (see: ***Federal Register*** / Vol. **75**, No. 176 / Monday, September 13, 2010 / Proposed Rules / 55503 – 55507).

[5] As one article correctly reports, "4) The old whole-cell version of DPT, given until about 1997 in the US, was bad. It had a high rate of serious reactions, and these researchers calculated its effectiveness at only around 48%. But for the previous 20 years, parents in the US were being told their children must have this vaccine. **The real truth about a**

After all, after 1986, the vaccine maker's principal goad to make safer vaccines, *the monetary awards to successful plaintiffs in civil court cases seeking compensation for the injuries caused by their vaccines*, had been removed.

By comparison, the legal replacement for this goad was a weak and obviously ineffectual federal governmental bureaucracy over which the vaccine makers obviously had significant influence, and, *given Merck's Gardasil HPV vaccines' problems and the federal government's failure to take any substantial action against the vaccine or the vaccine maker*, currently have even greater influence.

b. The NVICP and Post-NVICP Vaccination Programs

With the passage of the NVICP legislation, the stream of vaccines from a growing number of vaccine makers and/or their subsidiaries has increased to a veritable river.

Discarding any semblance of a need for cost-effectiveness in any mass vaccination program, the Establishment has moved to not only add more doses of vaccines that were already marginally cost-effective or not even cost effective but also to propagandize vaccination programs where the underlying vaccine is not even truly effective or, in some cases, not even reasonably safe.

In addition, the Establishment, using a hired Institute of Medicine (IOM) committee as its surrogate, redefined the allowable "placebo" in a vaccine clinical safety trial from only a pH-buffered sterile isotonic saline solution to include: **a)** the entire vaccine formulation without the active antigens, **b)** some other experimental vaccine or **c)** some other licensed vaccine, and convinced the regulators to look at relative incidence of adverse events instead of their absolute incidence in determining that a given vaccine is "reasonably safe".

Together, these changes altered the basis for "safety" in phase 3 clinical trials and, *by increasing the adverse reactions in the "placebo" group*, reduced the relative level of each adverse reaction in the candidate vaccine compared to that adverse reaction in the "placebo" group.

Thus, when "three" children in the test group for Merck's RotaTeq® vaccine in as clinical trial (conducted in an overall population where sanitation is poor) developed intussusception and "one" child in the control group developed intussusception, the RotaTeq vaccine was still approvable and approved because the rate of intussusception was not significantly higher (on a statistical basis) than the rate in the controls because of the small size of the groups in phase 3 trial that Merck had conducted.

On this basis, the FDA licensed Merck's genetically engineered, bovine-human-hybridized, pentavalent, oral, live-virus rotavirus vaccine, RotaTeq, even though this vaccine's actual rate of intussusception was 3 times that found in the control group.

Of course, after its approval in February of 2006, the pediatricians were told that, *unlike the previous "intussusception prone" rotavirus vaccine, Wyeth's RotaShield®, which was withdrawn shortly after its introduction in 1998*, RotaTeq's on-label use would not cause intussusception.

Even after being told that RotaTeq does not cause intussusception, the RotaTeq-related intussusception signal in the voluntary Vaccine Adverse-Event Reporting System (VAERS) [*where*

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particular vaccine being kind of dangerous and ineffective doesn't come out until the pharmaceuticals decide they have something better" (emphasis added). [See: http://www.exploringvaccines.com/?p=686]

typically less than 10% of actual adverse events for a given vaccine are reported] was even larger after RotaTeq began to be used than the signal seen from the previous, now-withdrawn "*intussusception prone*" RotaShield rotavirus vaccine and, in addition, RotaTeq-related cases of Kawasaki's disease were also reported[6].

Additionally, after the NVICP was enacted, several patently unsafe or problematic vaccines were licensed (e.g., LymeRX™ for Lyme disease and RotaShield® for rotavirus) and, *after causing horrendous or significant harm to those vaccinated with them from which the Establishment profited*, simply withdrawn from the market.

Thus, in addition to the pre-NVICP childhood vaccination programs for DTP, MMR and Polio, we now have ineffective and/or less-than-effective vaccines and less-than-effective and/or non-cost-effective mass vaccination programs for: **a)** late-childhood/adult diphtheria-pertussis-tetanus (Tdap), **b)** childhood Haemophilus influenzae, type B (Hib), **c)** early childhood/adult Hepatitis B (Hep B), **d)** childhood chickenpox, **e)** childhood/adult Hepatitis A (Hep A), **f)** childhood/adult meningococcal meningitis (Sanofi Pasteur's Menomune® and Menactra® vaccines), **g)** Streptococcus pneumoniae (Wyeth's Prevnar® and Prevnar ® 13[childhood] and Merck's 23-valent Pneumovax® [adult]), **h)** childhood rotavirus (Merck's RotaTeq® and GlaxoSmithKline's (GSK's Rotarix®), **i)** adult Shingles, and **j)** mid-childhood/young-adult human papilloma virus (HPV; Merck's Gardasil® and GSK's Cevarix®) as well as **k)** ineffective annual vaccines and annual vaccination programs for viral influenza in children and adults with "11" different vaccine formulations currently being produced in "eight" manufacturing sites.

Moreover, not only does this require more and more vaccines to be given during childhood but also, *further unmasking the reality that vaccination is not immunization*, to increase "coverage" (in reality, market size and market penetration), adults are increasingly recommended to: **a)** get "boosters" doses or "booster" vaccines, **b)** get periodic Tdap boosters in lieu of tetanus boosters, and **c)** accept additional vaccine doses whenever there is a disease outbreak of a "vaccine preventable" disease in their community regardless of their disease status.

In addition, no meaningful action has been taken against the vaccine makers for their failure to expeditiously safen US vaccines by removing all preservatives and reducing the level of adjuvants used or, *where possible*, eliminating the use of adjuvants altogether.

Instead, though there currently is a limit on the permitted level of aluminum adjuvant in each vaccine[7], the total level of aluminum adjuvants administered is being allowed to increase without limit and the vaccine makers are increasingly demanding that they be permitted to use so-called "oil-in-water" adjuvant systems even though, based on animal usage, these are known to be more serious immune-system disruptors than the current long-used aluminum adjuvants whose long-term safety for use in human vaccines has not been proven individually much less collectively.

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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.

7 If the FDA's proposed changes to **21 CFR § 610.15. Requirements for constituent material** as published in the Federal Register (see: ***Federal Register*** 2010 March 30; 75(60): 15639-15642) are adopted by the FDA, the FDA will be able to waive all of the current limits, including those for preservatives and adjuvants as it sees fit even though doing so is a subversion of the foundation upon which the regulation o all drugs is based – the applicable regulations as set forth in 21 CFR Parts 600-680 are current good manufacturing practice (CGMP) ***minimums***, which every covered biological drug product must meet.

Finally, in spite of being sued for the failure of the Secretary of the Department of Health and Human Services (hereinafter, the Secretary) to make vaccines safer and reduce the risk of adverse reactions, *as required by 42 U.S.C. § 300aa-27(a)*, by removing Thimerosal (49.55 % mercury by weight) from the list of approved chemicals that can be used to manufacture vaccine, the federal government has yet to ban the use of Thimerosal, *a chemical that is known to induce anaphylactic shock in some and mercury poison susceptible developing children*, in the manufacture of vaccines.

c. The Number of Vaccine 'Doses' Reality

Increasingly the public is being told that they must submit to ever-expanding vaccination programs for themselves and their children without regard for the risks to their own health or the health of their children because complying is for the "*greater good*".

For children up to 6 years of age, the recommended vaccination program reached a new high in 2009 when, in addition to all of the 38 vaccines in the 2007 and 2008 vaccination programs, three more doses of an 2009-A-H1N1 influenza vaccine was added for a nominal total of 41 doses of vaccines.

Relative to 1983, the maximum relative level of mercury from possibly Thimerosal-preserved vaccines (marked in red in **Table 1** on the next page) was 1.6 times the nominal level of exposure in 1983 and, *roughly correcting for 10-or-more-times-larger effect of the prenatal mercury dose*, effectively up to 5-plus times the level of adverse impact relative to the vaccine exposure to injected Thimerosal (49.55% mercury by weight) in 1983.

d. The Continuing Use of Mercury (Thimerosal, 49.55% Mercury by Weight) Reality

When it comes to the issues surrounding the serious adverse health impacts of Thimerosal (49.55% mercury by weight) on those vaccinated with vaccines containing it, the public is continually propagandized with one of two misleading and inaccurate slogans:

1. "Mercury has been removed from all childhood vaccines" or
2. "All vaccines given to children, except some flu vaccines, no longer contain any added mercury".

The reality is that the Establishment, *faced with a growing public outcry against the use of Thimerosal as a preservative in childhood vaccines*, did gradually reduce the level of Thimerosal in the previously Thimerosal-preserved vaccines from nominally 25 micrograms of mercury per 0.5-mL dose to about 1 mcg of mercury per 0.5-mL dose (a reduced-Thimerosal or "trace"-Thimerosal vaccine formulation) in the period from 2001 to 2005 and then starting in 2004, phased out the use of Thimerosal in childhood vaccines.

However, to offset this reduction in mercury exposure from childhood vaccines (and the serum Rho(D) products), the Establishment-controlled CDC began publishing recommendations in April of 2002 that, *during the annual flu season*: **a)** pregnant women who would be in their second and third trimesters and **b)** children 6 months to 23 months of age should get a flu shot (see Prevention and Control of Influenza Recommendations of the Advisory Committee on Immunization Practices [ACIP]. ***MMWR*** 2002 April 12; **51**(RR03): 1-31) at a time when all FDA-approved influenza vaccines were Thimerosal-preserved vaccines.

Table 1: The CDC-Recommended Vaccine Schedule Comparison in Children from Conception to 6 Years of Age, By Year (Recommended Month)

Year	USA 1983	USA 2007	USA 2009
Before Birth	---	**Influenza shot [25mcg Hg]**	**Seasonal influenza & 2009-A-H1N1 shots [50mcg Hg]**
Birth through 1 Year	DTP (2)	Hep B (birth)	Hep B (birth)
	OPV (2)	Hep B (1)	Hep B (1)
	DTP (4)	DTaP (2)	DTaP (2)
	OPV (4)	Hib (2)	Hib (2)
	DTP (6)	IPV (2)	IPV (2)
	[5 total]	PCV (2)	PCV (2)
	[75 mcg Hg]	Rotavirus (2)	Rotavirus (2)
		Hep B (4)	Hep B (4)
		DTaP (4)	DTaP (4)
		Hib (4)	Hib (4)
		IPV (4)	IPV (4)
		PCV (4)	PCV (4)
		Rotavirus (4)	Rotavirus (4)
		Hep B (6)	Hep B (6)
		DTaP (6)	DTaP (6)
		Hib (6)	Hib (6)
		IPV (6)	IPV (6)
		PCV (6)	PCV (6)
		Influenza (6)	Seasonal Influenza (6)
		Rotavirus (6)	2009-A-H1N1 (6)
		Influenza (7)	Rotavirus (6)
		[22]	Seasonal Influenza (7)
		[25; 50 mcg Hg]	2009-A-H1N1 (7)
			[25]
			[50; 100 mcg Hg]
1 through 2 years	MMR (15)	Hib (12)	Hib (12)
	DTP (18)	MMR (12)	MMR (12)
	OPV (18)	Varicella (12)	Varicella (12)
	[3; 8]	PCV (12)	PCV (12)
	[25; 100 mcg Hg]	Hep A (12)	Hep A (12)
		DTaP (15)	DTaP (15)
		Hep A (18)	Hep A (18)
		Influenza (18)	Influenza (18)
		[8; 30]	[8; 33]
		[12.5; 62.5 Hg]	[12.5; 112.5 Hg]
2 through 3 years		Influenza (30	Influenza (30
		Influenza (42)	Influenza (42)
		[2; 32]	[2; 35]
		[37.5; 100 mcg Hg]	[37.5; 150 mcg Hg]
4 through 6 years	DTP (48)	MMR (48)	MMR (48)
	OPV (48)	DTaP (48)	DTaP (48)
	[2; **10**]	IPV (48)	IPV (48)
		Varicella (48-60)	Varicella (48-60)
	[25; **125 mcg Hg**]	Influenza (54)	Influenza (54)
		Influenza (66)	Influenza (66)
		[6; **38**]	[6; **41**]
		[50; **150 mcg Hg**]	[50; **200 mcg Hg**]

Vaccines and values in a red font are for vaccines that were, in 1983, or, in the 2000s, may still be, Thimerosal-preserved.

The CDC made these recommendations in spite of the fact that the flu vaccines were "Pregnancy Category C" vaccines with no proof:

a. Of non-teratogenicity for the fetus or reproductive safety for the pregnant women;

b. That the flu vaccines were not mutagenic or carcinogenic; or

c. That the flu vaccines were in-use effective in preventing those vaccinated from contracting influenza.

There was, *as is the case today*, also no proof that flu vaccines, of any kind, are more in-use effective than a placebo injection in preventing those children under 2 years of age who are inoculated with a flu vaccine from contracting influenza.

As: **1)** the level in the childhood vaccines continued to declined, **2)** some doses of "trace"-Thimerosal flu vaccines became available, and **c)** a live-virus flu vaccine was introduced, the CDC recommendations continued to try to maintain the adverse effects of the average level of mercury exposure to Thimerosal by: **a)** removing the restriction as to when, during pregnancy in the flu season, flu shots could be given; **b)** increasing the upper limit on children to first 35 months, then to 59 months, then to 107 months, and, finally, to 18 years of age; and **c)** requiring children to get two flu shots (a month apart) the first time they were vaccinated.

In 2009, the maximum level of Thimerosal exposure was doubled in utero and at 6 months and 7 months when the CDC: **a)** added the "pandemic", "swine flu", 2009-A-H1N1 influenza to the vaccines recommended to be given once to pregnant women and twice to children under 9 years of age, and **b)** also designated pregnant women and young children as targeted "high risk" groups.

Since:

- Most of the doses of available influenza vaccines are Thimerosal-preserved doses,
- The CDC steadfastly refuses to even express a preference for pregnant women and young children to get "no Thimerosal" influenza vaccine doses and
- The FDA continues to illegally license Thimerosal-preserved vaccines for which the vaccine manufacturer has never proven that the level of Thimerosal used as a preservative in said inactivated-influenza vaccines is "sufficiently nontoxic …" as required by the applicable portion of the current good manufacturing practice (CGMP) safety regulations set forth in 21 CFR § 610.15(a),

pregnant women and children are continuing to be injected with toxic levels of mercury from these adulterated drugs[8]

Moreover, given the CDC's decision to increase the upper age limit for children to 18 years and recommend that all adults be vaccinated annually, if Thimerosal-preserved flu shots continue to be administered and some children and their mothers during pregnancy only get Thimerosal-preserved flu shots, clearly the total dose of mercury exposure will continue to exceed the maximum level that children born in the 1990s would have received from the three Thimerosal-preserved childhood vaccines, DTaP, Hib, and Hep B, given to all children before 2001 and to some

[8] Thimerosal-preserved vaccines for which the manufacturer has failed to meet the applicable clear CGMP minimum "sufficiently nontoxic …" requirement for the vaccine dose set forth in 21 CFR § 610.15(a) are adulterated drugs under 21 U.S.C. § 351(a)(2)(B).

children into the 2004 – 2005 timeframe, if no changes had been made to the Thimerosal-preserved childhood vaccines or in the recommendations for the use of Thimerosal-preserved inactivated-influenza vaccine formulations to inoculate pregnant women and developing children.

As long as the preceding realities continue to exist, any claim that there can be no link between: **a)** the level of mercury exposure and **b)** the risk of neurodevelopmental disorders, chronic illnesses and abnormal behaviors is obviously a specious claim because the ***maximum*** level of mercury has not dropped from the 2000 level but rather the maximum exposure level has increased.

At the same time, the levels of neurodevelopmental disorders, chronic medical conditions, and abnormal behaviors have not dropped but rather these levels have also collectively increased.

Based on the preceding and other key facts (e.g., the several-fold excess level of males as compared to females in the neurodevelopmental disorders and the fact that increases in these disorders were noticed a couple of years after the 3-dose regimens for Thimerosal-preserved Hep B and for Hib were implemented in the late 1980s in the USA and in the 2000s after similar program changes were implemented in New Delhi, India[9]), this author knows that mercury exposure from Thimerosal in vaccines and other drugs is the major causative factor in many, *if not all*, of the epidemic-level increases in neurodevelopmental disorders, chronic medical conditions, and abnormal behaviors.

4. "The Benefits Outweigh The Risks"

Pointing to our current increased life expectancies and ignoring their projected future decline, the Establishment continually tells Americans that the benefits of each new vaccination program outweigh the risks.

Unfortunately, there has been epidemic increases in many chronic diseases (e.g., asthma in children from < 1 in 1,000 children in the 1970s to > 1 in 10 children in the 2000s) and the morphing of previous chronic diseases only seen in adults (e.g., type 2 diabetes) into chronic diseases seen in children to the point that, in 2006, more than 26 % of American children have one or more chronic diseases (up from 12.8 % in 1994)[10] that they most probably will have over their lifetime.

Thus, the "greater good" for whom each of us is supposed to sacrifice ourselves and our loved ones is, in actuality, the "greater good" for one or more segments of an Establishment that feeds on us and grows ever stronger as more of us weaken and become chronically ill and/or financially and physically drained trying to care for our chronically ill loved ones.

Worse, there is increasing evidence that those who are effectively in control of this Establishment decided have, unconsciously or consciously, that they need to:

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[9] The reality of this linkage was recently strongly reinforced by the emergence of a similar pattern's being observed in a New Delhi, India nursery school after the New Delhi pediatricians began recommending the addition of 3-doses each Thimerosal-preserved Hib and Hep B vaccination programs to the Indian government's recommended Thimerosal-preserved DTP vaccination program in 2000 and the worsening of the outcomes when these programs, originally designed to finish the 9-shot vaccination series by the time the children are 6 months of age, were shortened to be completed by 4.5 months of age and the incidence of neurodevelopmental dysfunction doubled. [See: http://dr-king.com/docs/100711_ParallelsinNewDelhiIndia_AnEpidemic_b.pdf.]

[10] Van Cleave J, Gortmaker SL, Perrin JM. Dynamics of Obesity and Chronic Health Conditions Among Children and Youth. ***JAMA*** 2010 February 17; **303**(7): 623-630.

- Increase the harm,
- Further drain our fiscal and physical strength, and
- Reduce our numbers and our life expectancy, while feeding on our fiscal and physical strength.

To that end, increasingly expensive vaccines (e.g., Merck's Gardasil and GSK's Cervarix, where the private-sector list price for each dose is than US $125.00[11]) that: **a)** are less-and-less curative and/or effective and **b)** seem to be more-and-more harmful are being approved and delivered to the public as preventives for conditions whose incidence, in many instances, may have been caused or aggravated by other vaccines, drugs, processed and genetically altered foods, and chemicals that the Establishment markets to the public as "safe" without any real proofs of the short-term and, *more importantly*, true long-term safety for any of these Establishment products.

To sell these less-than-effective, less-than-proven-safe, and much-more-expensive vaccines, the Establishment continually reminds the public of the horrors of the deaths from "vaccine-preventable disease" for certain highly contagious and lethal diseases from the era before vaccines (e.g., smallpox, polio and measles), *diseases that have disappeared (e.g., smallpox) or only occur at low levels (e.g., measles) in the USA today*, while ignoring or minimizing the following critical realities:

- Clean water, sanitation, basic food safety, improved housing, and antibiotics did more to reduce the level of the disease-related injuries and fatalities from the highly contagious and lethal diseases than the vaccines for them have done,
- Without any vaccine, scarlet fever, a highly contagious and lethal disease, has virtually disappeared
- Many of today's vaccines are for diseases that: **a)** are <u>not</u> highly contagious (e.g., influenza and hepatitis B) or **b)** do <u>not</u> have any significant mortality levels (e.g., chickenpox, mumps, rubella, and tetanus).
- The obviously vaccine-related increases in chronic diseases, especially chronic diseases that have a significant autoimmune component, like asthma, multiple sclerosis, chronic fatigue syndrome, lupus, and diabetes, to name a few, as well as epidemic increases in abnormal childhood neurodevelopment, abnormal behaviors, other developmental abnormalities and bowel disorders.

In addition, *when we were first being sold on mass vaccination programs as a means to protect the health of the public*, we were told that a mass vaccination program for any vaccine depended on the vaccine's being effective and the mass vaccination program's being cost effective.

Consider the "chickenpox" vaccination program where the vaccine, Merck's Varivax®, is a live-virus vaccine that infects every one inoculated with it with a certain strain, the Oka/Merck strain, of herpes varicella zoster (HVZ) – a vaccine strain that is <u>not</u> effective in preventing

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[11] CDC Vaccine Price List (Prices last reviewed/updated: September 24, 2010): Merck's HPV-Quadrivalent (Types 6, 11, 16 and 18) Recombinant Vaccine, Gardasil, US$ 130.27/dose; GSK's HPV-Bivalent (Types 16 and 18) Recombinant Vaccine, Cervarix, $ 128.75/dose, where both process include a US$ 0.75 excise tax nominally collected for the NVICP in 10-dose vials: $1302.70 plus shipping and handling for each Gardasil vial and $1287.50 vial. The commercial list price costs of the two 3-dose series are US$ 390.81 and US$ 386.25, respectively.

everyone vaccinated, or even all of those with a "sufficient" vaccine-strain antibody titer level, from also being infected by the "native"/"wild" strains of HVZ circulating in the USA.

When the initial licensing for this vaccine was sought in the 1990s, the justification for licensing a chickenpox vaccine for a normally mild and innocuous childhood disease was that vaccination was marginally cost-effectiveness on a societal productivity-loss basis under the presumptions that: **a)** one dose of vaccine would provide lifetime protection for most young children inoculated with the vaccine and **b)** there would be no serious adverse reactions to being inoculated with the vaccine.

Yet, today, two doses of Varivax® are the minimum recommended for all children, and older adults are being recommended to receive a dose of Merck's Zostavax®, a higher-concentration Oka-strain HVZ vaccine to "prevent" a recurrence of the HVZ (native or vaccine-strain) with which they have been infected.

W*ithout even considering the costs to treat those who have severe adverse reactions to the Varivax or Zostavax vaccines*, a conservative 2009 cost analysis placed the US excess shingles' cases' costs, *caused by the US childhood chickenpox vaccination program*, at US$ 700 million annually.

Clearly, the Establishment has discarded the requirements for vaccine effectiveness and vaccination-program cost-effectiveness.

In their place, Establishment profitability seems to have: **a)** overruled the federal government's concern for public's fiscal and physical health and **b)** trumped the significant costs from the collective long-term vaccination-induced physical harm, *including maiming and death*, that some of those who are vaccinated suffer[12] *when the serious adverse effects caused by the initial vaccine, Varivax® (which was claimed to cause no serious adverse effects in the FDA-licensing/approval process), Merck's MMR-Varicella vaccine, ProQuad® (which has a significantly higher risk of serious adverse effects), and Merck's shingles HVZ vaccine, Zostavax®, are factored in.*

Currently, the Establishment is engaged in introducing vaccines, like Merck's Gardasil® and GlaxoSmithKline's Cervarix®, with no proof of long-term effectiveness and self-generated, self-serving "cost effectiveness", which clearly ignore the costs to those who have had, are having and will have serious adverse reactions

Furthermore, after their approval, the CDC immediately recommended mass vaccination programs for these vaccines with almost no in-use proof of safety and no in-use proof of effectiveness in preventing cervical cancer.

Worse, both the CDC and the FDA seem almost total indifferent to the hundreds of reported vaccine-induced injuries as well as the tens of vaccine-linked deaths, which, quite predictably, the Establishment attributes to mere coincidence.

In addition, the Establishment has introduced vaccines, like the current rotavirus vaccines, that have clearly negative US cost-effectiveness (where the cost of the vaccination program far

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[12] Tellingly, before Merck's Gardasil® HPV vaccine was introduced, Varivax consistently had the highest incidence of adverse-event reports in the VAERS database in the 1990s and early 2000s.

exceeds the costs of the background level of rotavirus in the USA) and, f*or Merck's genetically engineered RotaTeq*®, have clearly increased US rotavirus disease risk in those children and adults who were previously "immune" to the native human rotavirus strains to which they have been exposed during their childhood but are not protected from being infected by the genetically engineered bovine-human hybridized viruses in Rotateq.

Moreover, the standards for licensing a vaccine in the USA have been reduced from the vaccine: **a)** must be truly effective in preventing the disease in most of those who have been vaccinated and **b)** must reduce the harm from the disease in those who are vaccinated and still contract the disease as well as **c)** reduce the transmission of the disease to:

- In the case of the rotavirus vaccines, *for the limited and biased clinical trials conducted*, the vaccines were approved based on a finding that the risk of the serious harm caused by the vaccines is not statistically higher than the risk of harm caused by the natural disease in the control population used in the phase-3 clinical trials.
- In the case of the human papilloma virus (HPV) vaccines, the vaccines were approved based on claims that the vaccines ***may***, *in this instance*, prevent some vaccine-associated cervical cancers in some of the vaccinated women three to five decades after they complete the initial 3-dose vaccination schedule, even though:
  - **a.** There is no proof that HPV infection causes cervical cancer — only proof that HPV infection levels are associated with cervical cancer,
  - **b.** The "efficacy" data indicates a post-vaccination loss of efficacy in less than a decade,
  - **c.** The strains of HPV in either vaccine (HPV types 6, 11, 16, and 18 in Gardasil and types 16 and 18) are not even the major strains of the disease prevalent in the USA – in fact the type 11 strain is almost non-existent ("0.1%") in the US women[13], and
  - **d.** The approvals are not questioned when the levels of adverse-event reports, including serious maiming and death, currently far exceeds the level of the other vaccines even though only a small percentage of the eligible population is being vaccinated with these vaccines while the level of vaccination in most of

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[13] Dunne EF, Unger ER, Sternberg M, McQuillan G, Swan DC, Patel SS, Markowitz LE. Prevalence of HPV Infection Among Females in the United States. ***JAMA***. 2007 February 28; **297**(8): 813-819.

"**RESULTS**

The most common HPV types detected were HPV-62 (3.3%; 95% CI, 2.2%-5.1%) and HPV-84 (3.3%; 95% CI, 2.2%-5.1%), HPV-53 (2.8%; 95% CI, 2.1%-3.7%), and HPV-89 (2.4%; 95% CI, 1.4%-4.3%) and HPV-61 (2.4%; 95% CI, 1.6%-3.8%) (**FIGURE 2**). HPV-16 was detected in 1.5% (95% CI, 0.9%-2.6%) of females aged 14 to 59 years. There was no statistically significant difference in the prevalence of HPV-16 and the 13 more commonly detected types, except for HPV-84 and HPV-62. HPV-6 was detected in 1.3% (95% CI, 0.8%-2.3%), HPV-11 in 0.1% (95% CI, 0.0 %-0.3%; relative SE_30%), and HPV-18 in 0.8% (95% CI, 0.4%-1.5%) of female participants. Most participants infected with HPV (60.1%) had only 1 HPV type detected (95% CI, 53.2%-67.9%); however, 23.9% had 2 types (95% CI, 18.3%-31.3%) and 16% had 3 or more types detected (95% CI, 12.0%-21.2%). Overall, HPV types 6, 11, 16, or 18 were detected in 3.4% of the study participants, corresponding with 3.1 million females with prevalent infection with HPV types included in the quadrivalent HPV vaccine. Few participants (0.10%) had both HPV types 16 and 18 and none had all 4 HPV vaccine types. At least 1 of these 4 HPV types was detected in 6.2% (95% CI, 3.8%-10.3%) of females aged 14 to 19 years."

"**CONCLUSION**

… Our data indicate that the burden of prevalent HPV infection among women was higher than previous estimates. However, **the prevalence of HPV vaccine types was relatively low**". [Emphasis added.]

the other vaccine programs that generate significant levels of serious adverse events generally exceed 75 % of the population segments covered by the vaccines.

5. "The Establishment's Efforts To Increase Their Protection From Civil Lawsuits Are Appropriate"

Furthermore, through an appeal in ***Bruesewitz v. Wyeth*** being heard by the US Supreme Court this Fall, the vaccine makers and the rest of the Establishment are essentially attempting to have the Supreme Court rule that the **7th Amendment[14] of the Constitution of the United States of America**, *an integral part of the "Bill of Rights" reserved to the people of the United States of America*, does not apply to those who have suffered, or are the guardians of those who have suffered, a vaccine-induced injury.

The artifice being used to carry this argument is that **42 U.S.C. § 300aa-22. Standards of responsibility** is an issue that can be decided once, and for all, by the judiciary, outside of a civil trial by jury on the facts of each case.

This argument is being advanced even though, *under the NVICP*, the vaccine maker's lack of liability under **§ 300aa-22** is supposed to be the issue decided in the first phase of any vaccine-related civil jury trial.

That such liability decisions belong to the trial jury is clearly set forth in **§ 300aa-23. Trial**, which at **§ 300aa-23(b)**, states:

"(b) Liability

The **first stage of such a civil action shall be held to determine if a vaccine manufacturer is liable under section 300aa-22** of this title". [Emphasis added.]

Moreover, the Establishment's arguments knowingly ignore **§ 300aa-22(b)** with respect "**warnings**", in general, and **§ 300aa-22(b)(2)**, which states:

"For purposes of paragraph (1), a vaccine shall be presumed to be accompanied by proper directions and warnings **if the vaccine manufacturer shows that it complied in all material respects with all requirements under the Federal Food, Drug, and Cosmetic Act [21 U.S.C. 301 et seq.] and section 262 of this title (including regulations issued under such provisions) applicable to the vaccine and related to vaccine-related injury or death for which the civil action was brought unless** the plaintiff shows - …" [Emphasis added.]

Since:

- As the putative causative DTP vaccine in question is a Thimerosal-preserved vaccine given to the child and
- The vaccine manufacturers have admitted knowingly failing to comply with Title 21 of the Code of Federal Regulations (**21 CFR**) as set forth in **section 610.15(a)** (**21 CFR § 610.15(a)**), *which requires the level of preservative must be proven to be*

[14] "In Suits at common law, where the value in controversy shall exceed twenty dollars, the right of trial by jury shall be preserved, and no fact tried by a jury, shall be otherwise re-examined in any Court of the United States, than according to the rules of the common law".

> "*sufficiently nontoxic so that the amount present in the recommended dose of the product will not be toxic to the recipient"*, in testimony given before a Congressional committee which investigated the vaccine makers and the US Food and Drug Administration' actions from 1999 and which subsequently published a formal Congressional report, "Mercury in Medicine – Taking Unnecessary Risks" in 2003[15] and the requirement in question is a material requirement under the Federal Food, Drug, and Cosmetic Act [**21 U.S.C. 301 et seq**.] as well as a safety regulation issued under the provisions in "**section 262** of this title"[16] [emphasis added],

the Wyeth defendant is clearly guilty of failing to comply "*in all material respects with all requirements under the Federal Food, Drug, and Cosmetic Act [21 U.S.C. 301 et seq.] and section 262 of this title (including regulations issued under such provisions) applicable to the vaccine and related to vaccine-related injury or death for which the civil action was brought*".

Moreover, recognizing defendant Wyeth's knowing and intentional failure to comply with the black letter law, the US Supreme Court should, *when it hears the case this Fall*: **a)** find for the Bruesewitz plaintiffs and **b)** take whatever actions needed to ensure that the Bruesewitz plaintiffs are awarded appropriate punitive damages for defendant Wyeth's knowing and willful failure to comply with **21 CFR § 610.15(a)** for the preservative Thimerosal in the vaccine that caused the harm to the Bruesewitz child.

However, given the Establishment's denial of reality of vaccine-induced mercury toxicity in susceptible children, like the Bruesewitz child, who were, and are still being, given vaccines preserved with Thimerosal (49.55% mercury by weight) and the power that the Establishment wields, the people will be lucky if the US Supreme Court finds for the *Bruesewitz* plaintiffs.

Finally, should the US Supreme Court find for *Wyeth*, then, the people will most assuredly know that both the Establishment and the US Supreme Court are knowingly severing those who bring vaccine cases against the vaccine manufacturers in the legal manner provided by NVICP from the right to a civil jury trial for damages that is supposedly guaranteed by the 7th Amendment to the Constitution of the USA.

6. "The 'Life Saving' Annual Influenza Vaccination Program"

Factually, there is no scientific proof that the influenza vaccine prevents even most (> 50%) of those who are "vaccinated" with an influenza vaccine from contracting and spreading influenza during the "flu season" – none whatsoever (see, *for example*, Geier DA, King PG, Geier MR. Influenza Vaccine: Review of Effectiveness of the U.S. Immunization Program, and Policy Considerations. ***J. Am. Physicians and Surgeons*** 2006 Fall; **11**: 69-74 [the only US-population-

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[15] See Finding 3, "3. Manufacturers of vaccines and thimerosal, (an ethylmercury compound used in vaccines), have never conducted adequate testing on the safety of thimerosal. The FDA has never required manufacturers to conduct adequate safety testing on thimerosal and ethylmercury compounds" (page 6), in May 2003, Subcommittee on Human Rights & Wellness of the Government Reform Committee, US House of Representatives (Chairman Dan Burton – following a 3 year congressional investigation), "Mercury in Medicine – Taking Unnecessary Risks" pgs 1-80 and, in abbreviated form, published in the Extended Congressional Record: Subcommittee on Human Rights and Wellness, Committee on Government Reform of the House of Representatives, "*Mercury in Medicine Report*," Washington, DC, as published in the ***Congressional Record***, pgs. E1011-E1030, May 21, 2003

[16] Here, "this title" is "**TITLE 42 - THE PUBLIC HEALTH AND WELFARE**" of the United States Code.

wide retrospective of in-use effectiveness evaluation – not model – for the influenza vaccination programs in the USA for the years 1979 through 2001]); and other unbiased independent studies as well as the independent reviews of the published studies (see, *for example*: Jefferson T, Di Pietrantonj C, Rivetti A, Bawazeer GA, Al-Ansary LA, Ferroni E. Vaccines for preventing influenza in healthy adults. ***Cochrane Database of Systematic Reviews*** 2010, Issue 7. Art. No.: CD001269), which clearly show that the inoculation of populations with influenza vaccines, both inactivated- and, more recently, live-virus, is not effective in preventing those who are inoculated from getting "influenza" during the "flu season".

Furthermore, there is some evidence that getting an influenza inoculation in one year may increase the inoculated individual's risk of contracting an influenza infection in a subsequent year (http://www.ageofautism.com/2010/05/with-flu-season-over-canada-shows-flu-vaccinations-to-be-worse-than-worthless-.html).

Additionally, a recent double-blind clinical trial study found that supplementation with vitamin D-3 was much more effective in preventing influenza-type-A infections than influenza vaccination (see: Urashima M, Segawa T, Okazaki M, Kurihara M, Wada Y, Ida H. Randomized trial of vitamin D supplementation to prevent seasonal influenza A in schoolchildren. ***Am J Clin Nutr***. 2010 May; **91**(5): 1255-1260. Epub 2010 Mar 10. PMID: 20219962).

Finally, *as is usually the case*, Establishment's fear mongering and propagandizing carefully hides the fact that influenza is not a highly contagious disease (see: Cannell JJ, Zasloff M, Garland CF, Scragg R, Giovannucci E. On the epidemiology of influenza. ***Virol J***. 2008 Feb 25; **5**: 29 [**Note:** Among the issues this electronically published review article addresses is the absence of any valid value for the sick-to-well infectivity for human influenza in spite of numerous attempts to determine even a valid estimate, which clearly establishes that influenza is not highly infective.]).

Thus, the Establishment is recommending mandates for various groups of people, and the State of New Jersey is currently mandating, a *non-effective* vaccination program for a disease that is *not highly contagious* on the grounds that, *to say the least*, this less-than-scientifically-sound, non-effective prophylactic treatment, influenza vaccination, will somehow protect those who submit to it from spreading a disease that it does not prevent them from contracting, and, *when those inoculated get the live-virus vaccine*, a disease with which those receiving it not only are directly infected by three strains of live viral influenza but have also been shown to shed the live virus for at least 21 days after being inoculated with said live-virus vaccine.

Furthermore, in spite of an ever-increasing body of evidence that vitamin D-3 supplementation is a more effective preventive for type "A" influenza than any influenza vaccine, this Establishment continues to ignoring this proven and highly effective prophylactic use of vitamin D-3, which protects all against contracting all strains of type "A" human influenza, instead of suboptimal protection from getting the two (2) type A strains of flu in the flu vaccine.

Obviously, the Establishment's recommendations and actions are not grounded in sound science nor based on public health concerns; they are clearly driven by other imperatives.

7. "Medical Mandates Are Required For The 'Greater Good'"

Whenever this author hears any group or zealot, including any vaccine apologist, recommending that any person should surrender his or her right to make his or her own informed

medical decisions to some "higher authority" (be it employer, state or nation) "for the greater good", this commenter knows that the group or person advocating for such is a medical fascist[17] who is seeking to take away our personal freedom to make medical choices for ourselves and those for whom we are responsible and who is advocating for a "religious cult", the cult of the "public health" vaccinationists, who seek to mandate that all must sacrifice or risk sacrificing some aspect of their own or their children's health on the vaccine altar "for the greater good" – the good of the Establishment – of which the group or individual demanding the surrender of the rights to informed choice and consent is a well-paid member, who depends on promoting these sacrifices for his or her status, position, and/or livelihood.

8. "Vaccines, the Safest of Prophylactic Healthcare Measures"

We are repeatedly sold the myth that "vaccines are the safest disease-preventive medicines", when the truth is that, *as a group*, they are the least safe of disease-preventive medicines (see: Neil Z. Miller's **Vaccine Safety Manual For Concerned Families and Health Practitioners**, 2nd edition (2010), ISBN 978-188121737-4) and the only class of prophylactic medicines for which there are no long-term safety studies and, *increasingly*, not true-placebo-controlled short-term large-scale safety studies (in a vaccinated versus totally unvaccinated [using sterile isotonic pH-balanced saline for the controls] with ≥ 50,000 in each arm of the study).

In addition, instead of proof of effectiveness and long-term (lifetime [≥ 50-year protection]) effectiveness, we are given antibody-titer-based measures of claimed efficacy of limited duration (typically, 10 years or less) for "most vaccines" after typically 2 to 5 inoculations for most (typically, ≥ 60%) of those who are initially inoculated multiple times, with a carefully concealed reality that each such inoculation campaign kills a few[18] who are inoculated and harms some additional multiple of that number each year to varying degrees.

9. "Vaccines Do Not Cause Autism Or Any Other Chronic Medical Condition"

How much longer will Americans tolerate the increasingly obvious lie that the Establishment's vaccination programs are not a causal factor in 'Autism' and other chronic childhood medical conditions that once were rare (≤ 1 to 2 instances in every 10,000 children) but are now at epidemic levels (≥ 1 instance in every 10 to 1,000 children)?

How much longer will the American public continue to tolerate the epidemics of chronic diseases; and epidemic rates of chronic disease that, for asthma, now exceed 10 % of our children and, *in the aggregate*, have brought us to a nation where, in 2006, more than 25%[19] of our children have at least one chronic lifetime medical condition so that the Establishment may continue to grow

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[17] Defined here as any member of medical community who favors dictatorial medicine where all medical decisions are under the control of the "medical police" and "medical courts"; and the individual has no rights to make his or her own informed medical decisions without fear of any retribution, ostracism or oppression.

[18] Based on the reality that vaccination accounts for most of our excess infant mortality rate over that infant mortality rate in Japan in the first year of life, this "few" deaths per vaccination collectively translates to about 2 per 1,000 live births or about 8,000 – 9,000 newborn babies in the USA each year.

[19] "*The rate of chronic health conditions among children in the United States increased from 12.8% in 1994 to 26.6% in 2006*". [http://www.medscape.com/viewarticle/717030?sssdmh=dm1.591574&src=nldne&uac=140083MY] [**Note:** 26.8/12.8 is about a factor of 2.1 – without considering the increase in population of children by about 50% – making the population percentage increase not 210 % but rather 300+ %.]

and profit at the expense of the increasing damage to the fiscal and physical health of ourselves and our children?

How much longer will the American public be blinded by the propaganda spewed forth daily by these servants of greed who have been and are knowingly sacrificing our health and prosperity so that the Establishment they serve may continue to grow in size and profit while our fiscal and physical health is stolen from us?

Even though this commenter cannot answer for those who read these questions, his past and on-going efforts clearly point out the reality that he has lost his tolerance for the status quo and, *with eyes wide open*, he is seeking to open the eyes of the public to the preceding realities and to march with that informed and enlightened public to change the USA, not for the "greater good", but rather for a return to a system of laws in which the rights of every competent citizen are respected and everyone has the freedom to freely choose, or reject, all prophylactic vaccination programs without any penalty, stigma, or recriminations from those who do not share the same views.

In addition, this commenter is: **1)** seeking to change the laws protecting the Establishment's vaccine purveyors from being held directly accountable for the harm their vaccine products cause and the lack of safety and/or appropriate effectiveness of many of their vaccine products and **2)** hoping that, after reading this commentary, those who 'get it' will join with this commenter in demanding: **a)** direct vaccine purveyor accountability and **b)** the absolute right to choose which, if any, vaccination programs and when, if ever, the vaccines chosen should be administered – or, simply, "opt in" vaccination laws in every State, which would repeal the current mandates and eliminate any and all need for an exemption of any type from any prophylactic or other vaccination mandate.

About Paul G. King, PhD

Paul G. King, PhD Analytical Chemist, is a scientist who has studied both vaccines and vaccination programs intensively for more than a decade and has sorted out the underlying science to the extent that he could find such from all of the published information available from those with differing views about vaccination and vaccination programs.

If any, after reading this article, any reader finds any significant error for which there is unbiased science that clearly supports your alternative views, then, by all means, send your alternative view or views and their supporting documentation to me through dr-king@gti.net and, if your studies are truly unbiased, this author will be glad to: ***a)*** *modify his views accordingly and* ***b)*** *publish an updated article. If you find areas where the text has grammatical, spelling or word-usage errors, please let the author know so that he may appropriately correct them and published a revised version of this article.*

For additional information about Dr. King and his interests, the reader can visit his personal web site, http://www.dr-king.com/.