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Wednesday, February 29, 2012

Introduction

Following this page is this reviewer's assessment of "**My Turn: Immunizations: Critical protection for state's families**" by Walter Clapp, director of the Vermont chapter of the March of Dimes, which was downloaded on 20 February 2012 from:
http://www.burlingtonfreepress.com/article/20120219/OPINION02/202190316/My-Turn-Immunizations-Critical-protection-state-s-families.

This assessment, titled "**A Review of 'My Turn: Immunizations: Critical protection for state's families'**", begins on the next page.

Introductory Remarks

First, to "simplify" this review, when portions of the article, *which are quoted in the original "***Helvetia***" font*, are: **a)** being evaluated and **b)** specifically addressed in this review, those portions are quoted in an *italicized* "*Times New Roman*" font.

Second, this reviewer's assessments are: **a)** written in a "Franklin Book Gothic" font, **b)** follow each quoted portion of the article, and **b)** indented to clearly separate the review remarks from the preceding portion of the document that is being addressed.

Third, when other sources are quoted, the text used is in an "Arial Narrow" font except for email text, where a "`Courier New`" font is used.

Finally, should anyone find any significant factual error in this review for which they have independent[a], scientifically sound, peer-reviewed published substantiating documents, please submit that information to this reviewer so that he can improve his understanding of factual reality and, where appropriate, revise his views and this review.

Respectfully,

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[To whom all responses should be directed]

[a] To qualify, the study should be published by researchers who have no conflicts of interest from their ties to either those commercial entities who profit from the sale of vaccines or those entities, academic, commercial or governmental, who actively promote inoculation programs using vaccines.

A Review of 'My Turn: Immunizations: Critical protection for state's families'

"Immunization is one of the most effective, safe and proven practices used to improve and protect the health of our infants, children and adult population" [sic; adults].

Initially, the writer of this "opinion" article begins by using Orwellian newspeak[1] to implicitly assert that "vaccination provides disease immunity", expressed as an unsupported claim, "*Immunization is …*", which morphs into the declaration of the implicit 'suggestion' that "vaccination" is an "*effective, safe, and proven*" practice that is "*used to improve and protect the health of our infants, children and adult population*", all without citing any proof to substantiate any of the assertions made.

With respect to the writer's claims concerning "*the health of our infants, children and adult population*", the published facts concerning the "*health*" of our infants when the numbers of vaccine agents are factored in are[2,3]:

- We have the highest infant mortality rate among the developed nations
- There is a statistically significant positive correlation between the number of early childhood diseases against which the nations vaccinate and these developed-nations' infant-mortality rates for those developed nations that have a sufficiently large infant population to ensure the number of reported infant deaths is an unbiased population estimate of each such developed nation's infant mortality.

As for children and adults, please explain what, *other than* increased number of vaccines and vaccine doses, is rationally correlated with the rise in both the number of childhood chronic diseases and the chronic childhood disease incidence rates that translate into the growing epidemic of lifetime chronic disease [see, the applicable observed outcomes reported in 1994, 2000, and 2006 NHANES (National Health and Nutrition Examination Survey) studies on cohorts of our children[4]].

Clearly, *at a minimum*, the time-correlated increases in vaccination, which are known

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1 Orwellian newspeak is the attrition or abolition of words, and the degredation of language to control and stifle intellectual and independent thought [see: http://answers.yahoo.com/question/index?qid=20080101122219AAeDNUS].

2 Miller NZ, Goldman GS. Infant mortality rates regressed against number of vaccine doses routinely given: Is there a biochemical or synergistic toxicity? ***Hum Exp Toxicol***. 2011 Sep; **30**(9): 1420–1428. doi: 10.1177/0960327111407644.

3 This "infant mortality rate (IMR) versus vaccines" relationship found in reference "**1**" has since been further investigated by performing an odds ratio analysis with the countries divided at the median for IMR and total vaccine doses, then controlling for the following factors for each nation: (1) child poverty rates, (2) low birth weights, (3)pertussis vaccination rates, (4) breast feeding rates, (5) teenage fertility rates, (6) births out of wedlock rates, (7) age at first marriage, (8) percent of divorces with/without children involved, (9) total fertility rates, and (10) pertussis incidence rates. Although child poverty rates, pertussis vaccination rates, and teenage fertility rates were significant predictors of IMR, none of these factors lowered the partial correlation below 0.62, thus, robustly confirming the study's findings [private communication].

4 http://www.medscape.com/viewarticle/717030, last visited in 6 January 2012 –

"February 16, 2010 — The rate of chronic health conditions among children in the United States increased from 12.8% in 1994 to 26.6% in 2006, particularly for asthma, obesity, and behavior and learning problems, according to results of a new prospective study published in the February 17 issue of the Journal of the American Medical Association" and "The end-study prevalence of any chronic health condition was 12.8% (95% CI, 11.2% - 14.5%) for cohort 1 in 1994, 25.1% (95% CI, 22.7% - 27.6%) for cohort 2 in 2000, and 26.6% (95% CI, 23.5% - 29.9%) for cohort 3 in 2006."

to negatively affect the natural balance and function of the immune system, are significant contributory factors to the increasing levels of chronic disease observed.

Based on the preceding realities, it is clear that, *in terms of both the number of vaccines and the number of doses for each covered disease*, our increased vaccination program has apparently decreased the overall health of our infants, children and adults (the writer's "*adult population*").

Furthermore, nowhere in the applicable, scientifically sound and appropriate, peer-reviewed, published literature has this reviewer seen claims of improved health – at best, this reviewer repeatedly sees claims that the current vaccines do not cause serious adverse effects at levels above the "background rate" attributable to what the disease "would cause" in an unvaccinated population experiencing the disease.

Thus, the facts do not support this writer's initial "*improve … the health*" assertion.

Turning to the second part of the writer's assertion, his "*protect the health*" claim for infants and children, the writer is, at best, mistaken, because the overall effect of the early infant and childhood vaccination programs for many contagious diseases is that vaccination only tends to postpone the risk of contracting the disease to a later date when the adverse effects of the disease are, for most of those who contract a clinical case of the disease, *much more severe than* the adverse effects of that same communicable childhood disease when contracted at the time in nature that infection generally occurred in the pre-vaccine population.

Once touted as providing "lifetime" protection, vaccines are currently being recommended for mass vaccination that provide *less than* 50% effective protection (and probably *less than* an actual "2%" reduction in the cases of influenza and related viral infections in the "winter") for *less than* a year (the influenza vaccines).

For pertussis, the claimed protection has been reduced to "3 years" for *less than* "85%" of those "fully" vaccinated [versus protection for *more than* 10 years for those who, regardless of the infection's severity, contract pertussis and recover from it].

For the four (4) currently covered strains of *Neisseria meningitidis*, currently an uncommon disease with an incidence of *less than* 1 case in 300,000 U.S. residents, protection may be provided[5] to *no more than* "75%" of those vaccinated for *less than* "5" years for the covered strains with no protection for the remaining 5-plus human disease-causing strains that are not currently covered by a vaccine [versus "silent" infection and immune protection in most of those who have a healthy immune system (because, at any time, the U.S. Centers for Disease Control and Prevention

[5] Since, for the current polysaccharide-conjugate vaccines, there have been no volunteer trials to show that the vaccine actually "works" when healthy volunteers are exposed to the disease nor large-scale outbreaks where vaccination has shown suppression, the in-use effectiveness of these vaccines is purely theoretical and there is some evidence that all vaccination does is identify those who would mount an effective circulating immune response if they were infected. However, since the disease is rare and the incidence was declining significantly before mass vaccination was introduced, the vaccine makers can claim "efficacy" because they know the risk of infection in the USA is low and, because the vaccine does not protect everyone nor cover all of the circulating human-infectious strains, if someone who was vaccinated contracts the disease for a covered strain, the vaccine makers and public health officials can simply shrug their shoulders and proclaim that person as one of the "15%-25%" for whom vaccination provides no protection.

(CDC) estimates that 10%-15% of the population is carrying some infectious strain of *N. meningitidi*s in their nasal, oral and/or throat mucosa)].

Turning to the live-virus vaccines that are claimed to provide long-term protection from contagious disease (measles, mumps, rubella, chickenpox, and rotavirus), the first reality is that these vaccines infect those inoculated with them.

Except for the rotavirus vaccines, these infections are introduced by injection (a different mode of exposure from the natural disease) and, because this is the case, the infections induced following these inoculations shed fewer virus particles than having the "natural" diseases, which is one of the reasons why these vaccination-induced infections are *less communicable than* the natural infections.

Like the oral polio vaccines before them, the rotavirus vaccines are highly infectious and contagious such that instances of secondary and tertiary infection are neither uncommon nor rare.

Additionally, since rotaviruses survive in the environment and, because children are continually being vaccinated with them, most everyone is continually at "risk" of being re-exposed, the residual rotavirus levels[6] in the population are probably sufficient to maintain immunity so that, *as long as the rotavirus vaccines are being given*, the vaccine recipients will: **a)** contract some form of the clinical disease and **b)** *for the most part*, develop sufficient protection so that later encounters with the shed rotavirus from the inoculations/infections of subsequent cohorts of children will probably maintain their protection from re-infection unless they have a compromised immune system.

For measles, mumps and rubella vaccine, the apparent immunity periods following the second dose of Merck's MMR II® vaccine appears to be *no more than* 25 years for measles in a fully vaccinated population[7].

For the mumps-virus component in the MMR II, the national incidence data for the USA clearly show that the vaccination program does not provide immunity but merely postpones the susceptible period from the "natural" timeframe (of 5 to 9-plus years of age) until those who have been doubly vaccinated are in their late teens and early twenties or older when, *if they are then exposed to the mumps virus*, the resultant infections cause much more serious side effects in those who contract mumps when they are older.[8]

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6 The residual rotavirus levels will come from the initial three (3) infections by the five (5) genetically engineered strains of human-bovine hybridized rotavirus (Merck's RotaTeq®) or two (2) infections by multiple strains of human rotaviruses (for GlaxoSmithKline's Rotarix®). One general-population side effect of RotaTeq use has been a resurgence in rotavirus-induced diarrhea in adults who previously were immune to the human rotaviruses but apparently are not immune to infection by the genetically engineered human-bovine hybridized rotaviruses in the RotaTeq vaccine. In addition, severe intestinal twisting, intussusception, is a serious infant side effect for both rotavirus vaccines; for RotaTeq, Kawasik's disease is a serious rare infant side effect; and Rotarix is associated with an increased risk of pneumonia.

7 See http://dr-king.com/docs/120127_RevisdDrft_RevuOfAutsmControvrsyNeedForResponsbleScienceJournlsm_b.pdf, pp. 17-31

8 In 2009, for example, where 1991 mumps cases were reported, probably *less than* 24% (< 480) of the mumps cases occurred in children under 10 years of age and *more than* 1320 (> 66%) occurred in the 10-39-year-old cohort with 50% (999) of those cases occurring in the 15-39-year-old cohort and 36% (719) occurring in the 15-25-year-old cohort.

Though the disease level for rubella virus is very low (3 cases in 2009), the current 2-dose MMR II vaccination program provides antibody levels that seem to wane so that many women who are pregnant in their late teens, twenties and thirties have rubella-virus antibody titers that are not considered medically sufficient to provide protection to the child developing inside of them.

Though currently a rare occurrence in the USA (2 reports in summary of notifiable diseases report for 2009), this can lead to very serious congenital rubella cases in the unborn child when the mother is unlucky enough to be infected, usually silently, by rubella during pregnancy.

For more details on the preceding and other vaccine realities, this reviewer suggests that the reader consult the following review documents and the pertinent references that are cited in the following prior reviews:

1. http://dr-king.com/docs/101001_VaccinesVaccinationProgramsAndKnowingMisrepresentationsb.pdf,
2. http://dr-king.com/docs/081017_DrftRevuPrt1ofSept2008FLDoHReprt-b.pdf, and
3. http://dr-king.com/docs/081017_DrftRevuPrt2ofSept2008FLDoHReprt-b.pdf

Furthermore, for the general adult population*, those 19 to 64 years of age,* except for the annual influenza and the recent pertussis (Tdap) and human papilloma virus (HPV) recommendations, the reported[9] current percentage of U.S. adults covered by a given vaccination recommendation who are vaccinated according to the federal governmental (CDC) recommendations ranges from about 11% for hepatitis A in the 19-49-year-old cohort to about 64% for tetanus in those who are in the 19 to 64-year-old age group, for recommendations that were in effect for *more than* 5 years,

Given the general vaccination propaganda that only a fully vaccinated population (typically, claimed to be at the 80 to 90-plus percentage level) provides "herd protection" to that population, the preceding data seem to indicate that there is no "herd protection" in the adult population.

However, though there is no "herd protection", the general adult U.S. population is not experiencing outbreaks of those covered diseases for which the historical data indicate the overall vaccination program appears to be effective.

Based on all of the preceding realities, it appears that factors *other than* vaccination (e.g., sanitation, hygiene, clean water, adequate food, housing and clothing, improved wound care, and freedom from armed conflict) have combined to reduce the risk of exposure to both the vaccine-covered infectious and communicable diseases that lead to clinical disease *more than* vaccination has reduced that risk.

With the preceding realities in mind, let us return to assessing the validity of the writer's statements.

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9 Adult Vaccination Coverage — United States, 2010. ***Morbidity and Mortality Weekly Report*** (***MMWR***) 2012 Feb 3; **61**(04): 66-72.

"All of us in Vermont have been freed from risk of the crippling effects of polio due" [sic; due to] "the pioneering work of the March of Dimes and immunization efforts in partnership among health providers and the school system."

Here, the writer, a "March of Dimes" state official, again makes unsubstantiated claims that are clearly at odds with the facts[10]:

a. Before there was a polio vaccine most everyone (>99%) probably had a mild poliovirus infection until the chlorinated pesticides were introduced and the cases of "paralytic polio" (where the paralysis lasted for any length of time) increased to about 1 case in 3,000 children in the late 1940s/early 1950s [with only a small percent of these cases resulting in permanent paralysis], and then, *when the general use of DDT was banned in the USA*, the incidence of clinical cases of polio began to fall;

b. When the first "inactivated" polio vaccines were introduced, the incidence of polio actually increased;

c. Then, the public health officials changed the definition of polio and subdivided what was polio into three categories (polio, coxackie viruses, and "aseptic meningitis"); and

d. After the redefinition of polio and a requirement that the paralysis must last for an extended period, the incidence of polio fell to a small percentage of what it was before the redefinition of what was "polio" with most cases being diagnosed as "aseptic meningitis".

Thus, the true "pioneering work" with regard to polio was the redefinition of what was a polio case to greatly decrease the disease incidence irrespective of the level of vaccination.

Moreover, perhaps the early polio vaccines are contributors to the recently noticed, elevated level of "silent", non-lifestyle-related instances of hepatitis C infection in those born between 1945 and 1965.[11]

Further, the polio vaccines contaminated with Simian virus 40 (SV-40) infected humans with a virus that has been shown to be: **a)** passed from generation to generation and **b)** a major factor in human mesothelioma cancers.[12]

Based on the preceding realities concerning polio vaccines, the "*pioneering work of the March of Dimes and immunization efforts in partnership among health providers and the school system*" has definitely led to more harm (from the adventitious viruses in the crude Salk and early Sabin polio vaccines), and death from the SV-40 in both the Salk (inactivated injected) and the Sabin (live oral) polio vaccines from the mid-1950s until sometime in the 1970s or, *possibly*, later – a legacy that, for SV-40, has

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10 Miller NZ. The polio vaccine: A critical assessment of its arcane history, efficacy, and long-term health-related consequences. ***Medical Veritas*** 2004; **1**: 239-251.

11 http://www.medscape.com/viewarticle/758957 , last visited on 25 Feb 2012.

12 http://www.ccid.org/addviruses/sv40.htm, last visited on 22 Feb 2012.

been proven to be passed from generation to generation – polio vaccines that, *in the USA*, have clearly caused more harm than they have prevented cases of severely paralytic polio and, *for a few with compromised immune systems*, polio-vaccine-induced-paralysis and, most recently in 2009, the ongoing rare polio-vaccine-strain-induced death.[13]

"Immunization rates are falling in Vermont and the health and safety of our population, particularly children and infants, is" [sic; are] "increasingly at risk."

For a more-recent appraisal of the issues surrounding vaccination and vaccination exemptions, this reviewer suggests that the writer of this opinion piece read the document that rebuts similar claims made by the New Jersey Department of Health and Senior Services in their opposition to adding philosophical/conscientious exemption to the current New Jersey medical and religious exemptions.[14]

Clearly, the CDC-reported "notifiable disease" data indicate that, in 2006, there is no apparent correlation between the disease incidence rates and vaccine exemption types in the highly populated states, California, Florida and Texas whether these states (California and Texas) have a "conscientious/philosophical" exemption or the state (Florida) does not have this exemption, where the states' populations are of sufficient size to record rarer disease events.

Table Selected Vaccine-Covered Notifiable-Disease Data

State	Populat'n in 1,000s	Hib in < 5yr-olds	Hepatitis A, B	Flu-associated pediatric death	Measles Total, Indig.	*N. Meningitidis* Covered-strain	Mumps	2009 A-"H1N1"	Pertussis	Rubella Adult, Congenital	*Strep. Pneumoniae* < 5yr olds	Tetanus	Chickenpox [Varicella] Morbidity, Mortality
Vermont 2000	594	NR[A], NR	10, 6	NR	3, --	NR	--	Not offered	254	--, NR	NR	--	NR, NR
Vermont 2001	609	NR, NR	16, 5	NR	1, 1	NR	--	Not offered	113	--, --	NR	NR	149, NR
Vermont 2002	609	-- (-- tot. Hi)	4, 7	NR	--, --	NR	--	Not offered	172	--, --	2	--	799, --
Vermont 2003	616	-- (1 tot. Hi)	6, 4	NR	--, --	NR	--	Not offered	71	--, --	5	1	930, --
Vermont 2004	619	-- (1 tot. Hi)	8, 6	NR	--, --	NR	1	Not offered	180	--, NR	3	--	NR, NR
Vermont 2005	621	-- (2 tot. Hi)	5, 6	2	--, --	2	--	Not offered	90	--, --	6	--	693, --
Vermont 2006	623	-- (2 tot. Hi)	9, 4	1	--, --	--	--	Not offered	110	--, --	--	--	790, NR
Vermont 2007	624	-- (1 tot. Hi)	8, 5	--	--, --	1	--	Not offered	63	--, NR	2	--	380, --
Vermont 2008	621	-- (-- tot. Hi)	2, 3	1	--, --	--	1	Not offered	12	--, NR	2	--	323, --
Vermont 2009	621	1 (5 tot. Hi)	2, --	---	--, --	--	2	59	11	--, --	4	--	112, --
Vermont Average	…616	0.25 (1.5 tot. Hi)	7.0, 4.6	-----	0.4, 0.1	0.6	0.4	-----	107.6	0, 0	2.4	0.11	522, "0"
W. Virginia 2009	1,814	-- (34 tot. Hi)	6, 84	3	1, 1	3	1	243	40	--, --	25	--	493, --
W. Virginia/ Vermont	2.92	NC[B] (6.8 tot. Hi)	NC, NC	NC	NC, NC	NC	NC	4.11	3.6	NC, NC	6.25	NC	4.4, NC

[A] NR means not reported.

[B] NC means not calculated because Vermont total was " --- ", West Virginia total was " – ", or Vermont number of cases was 3 or fewer.

13 Summary of Notifiable Diseases --- United States, 2009. ***MMWR*** 2011 May 13; **58**(53): 1-100.

14 http://dr-king.com/docs/081105_PGKdrftRespnsToNJDHSSPostnOnS1071_ConscintsExmptn_f.pdf, "Table '1'".

Updating the information to 2009 using the CDC's "Summary of Notifiable Diseases -- United States, 2009"[15] for those childhood diseases for which there is a vaccine yields the pertinent data for 2009 for both Vermont and West Virginia.

In addition, for Vermont, the pertinent data from "Summary of Notifiable Diseases" reports for nine previous years clearly reveals no significant disease increases for the covered childhood diseases (as shown in the **Table** on the preceding page).

Since West Virginia, a state with similar environmental factors, only allows medical exemptions and has a population that is roughly three (3) times that of Vermont, a state that currently has medical, religious and philosophical exemptions, *if exemptions were a significant factor*, then, for vaccine-covered diseases where *more than* a few cases (> 3) were reported in Vermont, we would expect the ratio of West Virginia to Vermont cases to be significantly *less than* 2.92.

However, for the *Bordetella pertussis*, *Streptococcus pneumoniae*, and Chickenpox (*Herpes varicella zoster* [HVZ]) diseases, the ratios were *significantly greater than* 2.92 indicating that, *for whatever reasons*, having more choices as to vaccination exemption apparently resulted in less disease.

Thus, the actual experience in Vermont does not support the writer's opinion.

Finally, the writer's unsubstantiated claim that the vaccination rates are falling, *if true*, seems to indicate that, *if anything*, the claimed decreases in vaccination seem to be leading to lower disease rates in Vermont, a state that has all three (3) types of exemptions, than in West Virginia, which currently only has a medical exemption.

"Vermont has become one of the most lenient states in the nation in allowing parents to opt out of having their kids vaccinated against polio, measles and other diseases."

Since the "opt out" rules are apparently *no less stringent than* those in 16 other states (or, including Vermont, 34% of the states and *more than* 40% of the population); "*20 states*" effectively permit some form of all three types of exemptions; and the vaccine-covered disease incidence rates in Vermont are not increasing, the writer's statement here should simply be ignored.

"As a result, immunization rates among incoming kindergartners dropped from 93 percent in 2006 to 83 percent today according to the Vermont Department of Health."

Comparing the 2006 data to the 2009 data, the reported, but unsubstantiated and undefined drop in vaccination rates from "*93 percent in 2006*" to "*83 percent today*", does not seem to have had any significant deleterious effect (an increase of *more than* 5 cases) on the data *other than* the misleading "110" reported cases of pertussis in 2006 were 'reduced' to "11" reported cases in 2009 – an effect of the highly variable year-to-year nature of pertussis infection in the population of Vermont.

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15 See, ***MMWR*** 2011 May 13; **58**(53): 1-100, last visited on 26 February 2012.

"Vermont has fallen from one of the states with the highest rates of immunization to one of the lowest. At the same time, the number of cases of whooping cough in Vermont increased from 18 in 2010 to 90 in 2011, including 11 in Chittenden County."

> Since the number of reported cases was "110" in 2006 and "11" in 2009, the writer's stated increase in reported cases, "*from 18 in 2010 to 90 in 2011*", is obviously well within the year-to-year variability for reported *Bordetella pertussis* ("whooping cough") cases in Vermont
>
> Further, *when the growth of Vermont's population is considered*, indicate a possible slightly downward trend in pertussis cases over time because, on average, the number of cases in 2011 ("*90 in 2011*") is progressively *less than* the "110" notified cases of pertussis in 2006 (82%, for cases in 2011 /cases in 2006), the "180" notified cases in 2004 (50%, for cases in 2011 /cases in 2004), the "172" notified cases in 2002 (52%, for cases in 2011 /cases in 2002) and the "254" notified cases in 2000 (35%, for cases in 2011/cases in 2000) [see the data in the **Table**].

"So, whooping cough is back and rapidly expanding in Vermont and it can be fatal, particularly for infants. Action must be taken to reverse this resurgence and spread of preventable communicable diseases in Vermont and to protect the health of our children and families."

> When the reported case data is placed in its proper context, it is clear that the writer of this opinion piece is again mistaken because the reported case level in 2011, "*90*", is *less than* the notified level of pertussis cases in 2006, 2004, 2002 and 2000 with a downward trend in the peak-pertussis-case rates.
>
> Thus, the only action that needs to be taken is for the public to demand that:
>
> a. Such intentionally distortive, fear-mongering misrepresentations of the facts be stopped, and
> b. Vermont public health officials and healthcare providers admit that the current vaccine for "pertussis" is <u>not</u> effective in preventing cases of "whooping cough" and whooping-cough-like infection in very young children.[16]
>
> Factually, the current vaccination program attempts to replace "natural immunity" that provided disease protection to the nursing infant and long-term protection to the mothers and other adults with an "artificial immunity" that, depending upon the disease, provides a lower level of, a shorter duration of, or <u>no</u>, maternal protection to either the nursing infant or the mother.

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16 This is the case because the vaccination of the children's mothers suppresses the production of the broad range of immune factors that a mother, who had had these childhood diseases naturally, once was able to provide her young offspring by nursing him or her, but, because she was vaccinated to block childhood diseases, she possess, at best, a lesser level of a narrower range of immune factors from which her newborn infant can only derive reduced immune-protective benefits from nursing.

"According to Dr. Harry Chen, the Vermont commissioner of health, the principal cause of the declining rate of immunizations is the philosophical exemption."

While Dr. Chen is entitled to his opinion, this writer presents no data to support the claim that the reported decline in vaccination compliance is the principal cause for the decline in the undefined rate of vaccination for an unspecified group of diseases.

Moreover, this reviewer understands that the real reason for the actual decline in the vaccination rates is not, per se, the availability of a philosophical exemption.

The real reasons for the declines being seen across the country even in states with no philosophical exemption are:

1. An ever increasing number of vaccines and vaccine doses that artificially lowers the vaccination rate until the public adjusts to the new schedule and
2. *More importantly*, the growing admission by public health officials and the increasing realization by the public that the current vaccination programs:
    a. Do not provide "immunity" (lifelong protection) to those who are vaccinated with most of the current vaccines,
    b. Provide only limited-duration protection to some percentage of those who are vaccinated for most vaccine-covered diseases, and
    c. *At the current levels in the US vaccination program*, are clearly damaging the overall health of our children and increasing the risk of severe neurodevelopmental, developmental, and immune-system damage.

While the public health officials continue to focus on the short-term adverse effects following vaccination and claim serious adverse reactions are rare, in the case of childhood asthma, a chronic childhood disease, which was rare in the 1960s and is still rare in our breastfed, never-vaccinated children, this chronic childhood disease currently affects *more than* 10% of our vaccinated children and, *in terms of children who will have one or more chronic diseases for their lifetime*, "now" (as of the 2006 NHANES cohort) *more than* 1 in 4 of our children are projected to have one or more chronic diseases for his or her lifetime[17] and, *based on the 2006 NHANES cohort study's findings*, one or more chronic childhood diseases affected about 1 child in 2 in the study's cohort children at some point in their childhood).

For those who are able to appreciate:

a. The growing understanding of exactly how complex the human immune system is;
b. How little we understand exactly how that human immune system functions;

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17 http://www.medscape.com/viewarticle/717030, last visited in 6 January 2012 –
"February 16, 2010 — The rate of chronic health conditions among children in the United States increased from 12.8% in 1994 to 26.6% in 2006, particularly for asthma, obesity, and behavior and learning problems, according to results of a new prospective study published in the February 17 issue of the Journal of the American Medical Association" and "The end-study prevalence of any chronic health condition was 12.8% (95% CI, 11.2% - 14.5%) for cohort 1 in 1994, 25.1% (95% CI, 22.7% - 27.6%) for cohort 2 in 2000, and 26.6% (95% CI, 23.5% - 29.9%) for cohort 3 in 2006."

c. The harm that vaccines inflict on the Thymus gland and its ability to properly incubate and provide the ever-growing types of "T" cells critical to immune-system function; and

d. The disconnect between "antibody titer" and protection from disease,

it is increasingly obvious that most vaccines are *little more than* vehicles designed to ensure that our children's immune systems will be damaged as soon as possible in order to generate the maximum number of years of chronic illnesses on which the Establishment may grow both its income and its control while:

i. The people, treated as its "herd", are weakened and

ii. Parents are forced to invest an ever-increasing share of their income on their own, their children's and other's chronic-disease-related health care.

IF the preceding were not the Establishment's plan, THEN, *given even our current limited knowledge of how the human immune system functions*, human vaccines would, *at a minimum*, contain no: **a)** non-specific adjuvants, **b)** non-disease-related proinflam-matory components, **c)** adventitious viruses, **d)** preservatives, **e)** gelatin, or **f)** other substance in a form that is not exactly as found circulating in the human body.

Moreover, to maximize proper immune-system engagement, all vaccines would be separately administered in the same manner and same timeframe that each disease agent separately infects the body, which, *even for some future vaccine for malaria (a mosquito-borne disease that mosquito injects directly into the human body) or similar mosquito-borne disease (e.g., West Nile Virus) that could be introduced subcutaneously*, would not be intramuscular (IM) injection.

This reviewer is amazed that, *in an age where we are turning to nature and trying to develop materials that emulate the manner in which nature solves problems for all manner of "high tech" devices*, "vaccinologists" are still clinging to, using, and justi-fying unnaturally constituted vaccines that, *ignoring the manner in which the natural disease infects humans*, are unnaturally injected intramuscularly or subcutaneously into our children and ourselves.

"Vermont is one of 20 states that allow parents to exempt their children from vaccination requirements due" [sic; due to] "philosophical objections, and one of just seven states that makes it unduly easy. Parents just have to sign a form. The number of parents using that exemption has been growing, such that Vermont is now second only to Washington state where their Legislature has already taken action to tighten requirements."

Since the disease data show no real problem in Vermont with a truly significant[18] increase in the incidence of any notifiable disease for which there is a current U. S.

[18] In the context of communicable diseases for which there is a vaccine, a significant increase would be one that was greater than 3 times the previous peak level of that childhood disease in the previous two (2) cycles of disease incidence data or, for diseases for which there have been "0" reported cases in the previous 5 years in Vermont, 10 or more confirmed non-vaccine-virus-related, vaccine-covered cases in the current year.

Food and Drug Administration (FDA)-licensed vaccine, there is no "need" to take "*action to tighten requirements*".

Furthermore, if the state applies increased force to compel vaccination, the effects will be to: 1) generate a disproportionately larger push back by the people and 2) increase the general public's growing suspicion that vaccines and vaccination programs have less to do with protecting the health of the children or the general public than to do with increasing the Establishment's market share and profits at the expense of the long-term health of both our children and ourselves.

"An education campaign will be essential to help parents and policy makers unravel the myths and determine the real benefits and risks associated with immunization."

Here, this reviewer agrees with the writer of this pro-vaccine opinion piece that we, the people, truly need to "*unravel the myths and determine the real benefits and risks associated with*" our current vaccination programs.

To that end, this reviewer, who is not paid for this recommendation, would recommend that every Vermont resident, who can read and understand American English, obtain and carefully study the second edition of Neil Z. Miller's "Vaccine Safety Manual For Concerned parents and Health Practitioners" (ISBN: 978-188121737), which is available on Amazon.com for *less than* US$ 15 plus shipping.

"The safety of vaccines continues to improve and" [sic; and the] "risk of contracting any disease from vaccines is exceedingly remote."

Here, the reviewer finds that this writer is mistaken about the safety of vaccines because, *shielded from the liability for the harm their vaccines may cause*[19] *and not being actively compelled by the federal government to safen their vaccines*,[20] the vaccine makers, *with the tacit approval of the federal agencies that "regulate" the lawful conduct of the vaccine makers and, recently, the support of the US Supreme Court in a decision*[21] *that ignored the Seventh Amendment to the Constitution of the United States of America,*[22] have concentrated on "gaming the vaccine safety determination process" so that the safety of each vaccine with respect to its short-term adverse events has not tested against only a "true placebo"[23] and neither the

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19 **42 U.S.C. §§ 300aa-10 through -34. National Vaccine Injury Compensation Program.** [TITLE 42 - THE PUBLIC HEALTH AND WELFARE, CHAPTER 6A - PUBLIC HEALTH SERVICE, SUBCHAPTER XIX – VACCINES, Part 2.]

20 **42 U.S.C. § 300aa-27. Mandate for safer childhood vaccines.** [TITLE 42 - THE PUBLIC HEALTH AND WELFARE, CHAPTER 6A - PUBLIC HEALTH SERVICE, SUBCHAPTER XIX – VACCINES, Part 2 - National Vaccine Injury Compensation Program, subpart c - assuring a safer childhood vaccination program in united states.]

21 Bruesewitz et al. v. Wyeth LLC, FKA Wyeth, Inc., et al., Supreme Court of the United States No. 09-152, decided February 22, 2011.

22 The Seventh Amendment (Amendment VII) of the Constitution of the United States of America, ratified December 15, 1791 states (emphasis added):

"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."

23 For vaccines that are injected, as most vaccines are, a "true placebo" would be an isotonic, pH "7.2", sterile, particle-free

vaccine's long-term safety (a large-scale study lasting *not less than* 10 years of the same subjects as studied in the short-term safety studies) nor its concomitant administration with all of the vaccines that may be administered at the same time(s) as the vaccine being tested are studied.

Moreover, the writer's "*risk of contracting any disease from vaccines is exceedingly remote*" is a false assertion because: **a)** the live-virus vaccines infect everyone inoculated with them to varying degrees; **b)** some are also directly or indirectly infected by the vaccine-strain viruses shed by those inoculated with a live-virus vaccine; and **c)** the components in all the vaccines combine to be major causal factors in the varying nature and degree for the chronic diseases that are "caused" by immune-system dysregulation and/or the vaccine-related induction of autoimmunity in vaccinated individuals.

"Myths linking immunization to autism have been disproved through extensive scientific study."

The writer's opinion here is at odds with the facts for several reasons:

1. To date, the "safety studies" upon which this writer is apparently relying are epidemiological (statistical) studies that cannot prove the absence of a link — only:
   a. double-blind case-control studies where the case group is a large group (*of no less than 10,000*) of parent-volunteered vaccinated children and the control group is a matched cohort (*of no less than 10,000*) parent-volunteered children who are given a true-placebo injection or
   b. well-designed, scientifically sound and appropriate, human-relatable animal toxicological studies

   can unequivocally prove that there is no link between any vaccine usage, or component thereof, and the risk of:
   I. neurodevelopmental harm, including the harms that are labeled as "autism", and/or
   II. other developmental or behavioral harms; and

   for Thimerosal, most of the definition-conforming human-relatable animal toxicological studies have proven that links exist between injected-Thimerosal-exposure and the neurodevelopmental symptoms used to diagnosis "autism" and other related neurological disorders as well as other developmental and behavioral symptoms that have been observed in those having a diagnosis of "autism" or a related neurodevelopmental disorder (see the applicable references in footnote "**25**").
2. Most of the statistical studies overseen by the CDC appear to have significant design, execution, or other defects and, because the studies authors continue to refuse to provide all of the raw and design data to independent reviewers –

aqueous solution.

in several instances claiming that they have "lost" the data – the published findings from such studies must be discounted because their results cannot be independently verified — i.e., their results and findings are irreproducible.

3. Recently, US Freedom of information Request Act (FOIA) requests have clearly established that CDC officials and one Danish study's authors apparently colluded to publish a false conclusion with respect to the withdrawal of Thimerosal-preserved vaccines and the subsequent changes in the rates (incidence and prevalence) of autism in Denmark. This apparent collusion occurred in conjunction with a study publication titled "Thimerosal and the Occurrence of Autism: Negative Ecological Evidence From Danish Population-Based Data", which was: **a)** authored by Kreesten M. Madsen, Marlene B. Lauritsen, Carsten B. Pedersen, Poul Thorsen, Anne-Marie Plesner, Peter H. Andersen and Preben B. Mortensen; **b)** published in ***Pediatrics*** (2003; **112**: 604-606), and **c)** in its abstract concluded, "The discontinuation of thimerosal-containing vaccines in Denmark in 1992 was followed by an increase in the incidence of autism." However, part of one of the pre-publication internal e-mails (copy provided at the end of this article) from one of the authors to two (2) of the other authors and a CDC administrator states (emphasis added):

> "Attached I send you the short and the long **manuscript about Thimerosal and autism in Denmark**. [redacted]
> I need to tell you that the figures in the **manuscripts do not include the latest data from** 2001. I only have these figures as a paper version and they are at work [redacted] **But the incidence and prevalence are still decreasing in 2001.** [redacted]
> I look forward to hear from you again."

Based on the e-mail, it is clear that the "discontinuation of thimerosal-containing vaccines in Denmark in 1992 was followed by" a decrease in the "incidence and prevalence" "of autism" — an actual finding that is the opposite of what the article claims to be the situation.

4. An independent study of the data from Denmark has provided evidence of a link between the MMR vaccine and the risk of neurodevelopmental disorders labeled as "autism".[24] Specifically, the first paragraph in the "CONCLUSIONS" section of the cited 2004 article states, "Trends in prevalence data in Denmark suggest a temporal association between the introduction of MMR vaccine and the rise in autism. Because thimerosal was not used in any pediatric vaccine in Denmark since 1992 and the greatest increase in autism prevalence followed that year, it is likely that one or more of the viral components or their combination in the MMR vaccine contributed to the reported increase."

5. With respect to the probable causal link between the level of Thimerosal-exposure and neurodevelopmental disorders, including "autism", in addition to the Denmark e-mails, many published studies have provided strong evidence of a causal linkage in mercury-poisoning susceptible developing children.[25]

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[24] Goldman GS, Yazbak FE. An Investigation Between MMR Vaccination and Autism In Denmark. ***J Am Phys&Surg*** 2004; **9**(3): 70-75.

[25] **a)** Laurente J, Remuzgo F, Ávalos B, et al. [Neurotoxic effects of thimerosal at vaccines doses on the encephalon and development in 7 days-old hamsters]. ***An Fac Med (Lima)*** 2007 Sep; **68**(3): 222-237 [Spanish]; **b)** Marques RC, Dórea JG,

6. Finally, if any, the linkage between most of the other childhood vaccines that do not contain Thimerosal and subsequent neurodevelopmental symptoms that characterize "autism" has not even been studied using statistics-based population approaches. However, a peer-reviewed 2011 study did find a positive correlation between the level of vaccination uptake across the USA and the incidence of both "autism and "speech or language impairment.[26]

Based on the preceding citation-supported information, it is obvious that:

a. The vaccine component Thimerosal has been *unequivocally* linked, and

b. The Danish MMR vaccines have been *apparently* linked

to the set of neurodevelopmental symptoms labeled as "autism".

"However, the risks of allowing the vaccination rates to fall, threaten not only the unvaccinated, but also the population at large."

Again, the writer states his opinion but provides no facts to support that opinion.

Furthermore, at the current levels of vaccination in Vermont, the CDC's reported "notifiable disease" data for vaccines administered to young children does not support the writer's opinion.

Therefore, the writer seems to be making this unsupported statement here in an attempt to plant baseless, divisive fears into the minds of both those who do not vaccinate and those who do vaccinate.

"According to Dr. Louis DiNicola, a leading pediatrician in Randolph and president of the Vermont Chapter of the American Academy of Pediatrics, physiological differences in the

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MF, Wanderley et al. Hair mercury in breast-fed infants exposed to thimerosal-preserved vaccines. ***European J Pediatrics*** 2007; **166**(9): 935-941; **c)** Minami T, Miyata E, Sakamoto Y, et al. Induction of metallothionein in mouse cerebellum and cerebrum with low-dose thimerosal injection. ***Cell Biol Toxicol*** 2010; **26**(2): 143-152; **d)** Rodrigues JL, Serpeloni JM, Batista BL, et al. Identification and distribution of mercury species in rat tissues following administration of thimerosal or methylmercury. ***Arch Toxicol*** 2010; **84**(11): 891-896; **e)** Olczaka M, Duszczyk M, Mierzejewski P, Meyza K, Majewska MD. Persistent behavioral impairments and alterations of brain dopamine system after early postnatal administration of thimerosal in rats. ***Behavioural Brain Res*** 2011 Sep; **223**(1): 107-118; **f)** Ida-Eto M, Akiko Oyabu A, Ohkawara T, et al. Embryonic exposure to thimerosal, an organomercury compound, causes abnormal early development of serotonergic neurons. ***Neurosci Lett*** 2011 Nov; **505**(2): 61-64; **g)** Shandley K, Austin DW. Ancestry of Pink Disease (Infantile Acrodynia) Identified as a Risk Factor for Autism Spectrum Disorders. ***J Toxicol Environ Health, A*** 2011; **74**(118): 1185-1194; **h)** Sulkowski ZL, Chen T, Midha S, et al. Maternal Thimerosal Exposure Results in Aberrant Cerebellar Oxidative Stress, Thyroid Hormone Metabolism, and Motor Behavior in Rat Pups; Sex- and Strain-Dependent Effects. ***Cerebellum*** 2011 Oct 21; online: DOI: 10.1007/s12311-011-0319-5; **i)** Hewitson L, Houser LA, Stott C, et al. Delayed Acquisition of Neonatal Reflexes in Newborn Primates Receiving A Thimerosal-Containing Hepatitis B Vaccine: Influence of Gestational Age and Birth Weight. ***J Toxicol Environ Health, A*** 2010; **73**(19): 1298-1313; and **j)** Olczak M, Duszczyk M, Mierzejewski P, Wierzba-Bobrowicz T, Majewska MD. Lasting neuropathological changes in rat brain after intermittent neonatal administration of thimerosal. ***Folia Neuropathol.*** 2010; **48**(4): 258-269.

26 Delong G. A Positive Association found between Autism Prevalence and Childhood Vaccination uptake across the US Population. J Toxicol Environ Health A 2011; **74**(14): 903-916, where the Abstract states (emphasis added):
"Using regression analysis and controlling for family income and ethnicity, the relationship between the proportion of children who received the recommended vaccines by age 2 years and the prevalence of autism (AUT) or speech or language impairment (SLI) in each U.S. state from 2001 and 2007 was determined. A positive and statistically significant relationship was found: The higher the proportion of children receiving recommended vaccinations, the higher was the prevalence of AUT or SLI."

immune systems among individuals result in 3-5 percent of the population failing to develop adequate resistance to communicable diseases even after being vaccinated."

First, this reviewer notes that, *again without citing any supporting documents*, this writer now provides us with his opinion of the views of another vaccine apologist, Dr. DiNocola, who, based on his "credentials", is a "*leading pediatrician*" who, *as most pediatricians who push vaccines do*, has a conflicting financial self-interest in promoting vaccination.

However, based on the remainder of the remark that is attributed to this pediatrician, "*physiological differences in the immune systems among individuals result in 3-5 percent of the population failing to develop adequate resistance to communicable diseases even after being vaccinated*", it is obvious that this pediatrician and apparently the writer of this opinion piece are confusing antibody titers, to which those who are vaccinated develop varying levels, with protection from contracting a disease when an individual is somehow exposed to that disease.

Moreover, as the examples cited by this reviewer clearly establish, depending upon the vaccine, the percentage who fail to develop and/or maintain "protective" antibody titers ranges from about 5-7% for one dose (for the injected live measles-virus vaccine component[27]) and 3-5% for measles in a 2-dose MMR program, to *more than* 50% (for the inoculated live influenza viruses or the injected inactivated-influenza viruses in a given seasonal influenza vaccine).

Since the human immune system has many layers designed to identify, intercept and neutralize incoming pathogens, there can be and is no direct correlation between antibody titer levels and general disease protection.

Finally, because the Establishment now admits that, *for most vaccine actives*, the protection is *much less than* lifelong and, *without exogenous (external) boosting or repeated booster doses*, seldom lasts *longer than* 3 to 10 years, most of the adults who were vaccinated in childhood against the "preventable" childhood diseases in America have little, or no, antibody protection from contracting an infectious disease agent and, *because disease-agent exposures are fairly uncommon for most of the diseases in the mostly vaccinated Vermont population*, these adults also have lower levels of the innate immune-system factors that, were they fully active, would probably prevent most low-level disease exposures from infecting the body.

"As a public policy we owe it to all our citizens, to protect them from preventable communicable diseases."

Here, this reviewer finds the writer's opinion to be, at best, simplistic.

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27 See, for example, http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004407.pub3/abstract, last visited on 25 Feb 2012, which is an intervention review by the Cochrane Collaboration that addresses the apparent effectiveness of measles, mumps, and rubella (MMR) vaccination as well as serious vaccination adverse-outcome effects associated with the use of various MMR vaccines.

Actually, as "*public policy*", we owe it to all of our citizens to provide them with reasonably safe, in-use effective and cost-effective vaccines that, *after no more than three (3) doses*, provide our citizens with protection from preventable disease in childhood that does not later increase our citizens' risk of having a much more serious infection by that disease or a recurrence/flare-up of the disease when they are adults (e.g., mumps and *Herpes varicella zoster* [HVZ][28]).

Unfortunately, state and federal governmental agencies, public health officials, and the healthcare providers are shortchanging the public—apparently in order to increase the profits of all aspects of the businesses providing vaccine-related and chronic-disease health-related services to the public.

"We can provide that protection with universal immunization with allowances only for religious or medical exemptions."

Clearly, when it comes to the vaccines for hepatitis A, hepatitis B, "pertussis", *Streptococcus pneumoniae* and "chickenpox" (varicella), the "notifiable disease" data shows that the universal vaccination program in Vermont and West Virginia, a state similar to Vermont in many respects, that only recognizes medical exemptions, does not provide true "population protection"[29] from hepatitis A, hepatitis B, *B. pertussis*, *Streptococcus pneumoniae* or chickenpox [HVZ] – and, on a relative population basis, the medical-exemption-only West Virginia program provides *less protection than* the 3-exemption Vermont program.

Based on the preceding science-based analysis, the Vermont exemptions should be retained and not modified because, by so doing, Vermont officials will reassure the

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28 The mumps vaccine is an obvious example of a failed vaccine component because the current two-dose early childhood schedule using MMR vaccine has not only failed to prevent "fully vaccinated" adults in their late teens and beyond from contracting mumps when subsequently exposed to it but has also increased the incidence in those over 10 years of age as compared to the reality that, before mass vaccination, almost every child had the mumps before he or she was 10 years of age. For a recurring disease, HVZ is an obvious example of a vaccination program that, even with two doses, which renders the program not even societally cost-effective, not only has failed to drop the incidence of chickenpox cases to near zero (i.e., "prevent chickenpox") but also fails to prevent the HVZ viruses lying dormant in vaccinated child's root ganglia from flaring up as a shingles case when the vaccine-provided protection wanes and is clearly very cost-ineffective with an annual net increased healthcare cost, *ignoring the true costs of the second, third or more doses of a HVZ-containing vaccine and the true costs of the adverse reactions from each vaccination that are associated with an HVZ-containing vaccine*, of more than US$ 700 million annually just from the increased incidence of shingles (the much more serious recurrent form of HVZ disease) in adults that is directly attributable to the HVZ vaccination program. [See: Patel MS, Gebremariam A, Davis MM. Herpes zoster-related hospitalizations and expenditures before and after introduction of the varicella vaccine in the United States. ***Infect Control Hosp Epidemiol***. 2008 Dec; **29**(12): 1157-1163].

29 When a vaccine truly provides "population protection", the average annual incidence of clinical cases of the disease should be less than 1 in 1,000,000 or, in Vermont's population of about 621,000, less than 0.62 case per year on average absent case importation by infected travelers returning to Vermont. Based on this criterion, only the vaccination programs for: **a)** diphtheria (not shown in the Table because the average number of notified cases in the entire USA and its territories is typically < 1 in 100,000,000); **b)** measles; **c)** mumps; **d)** rubella; and **e)** tetanus appear to provide adequate population protection absent population exposure from infected travelers returning to Vermont. The Hib program appears to provide population protection in those under 5 but not in the entire population (data not shown). Furthermore, the vaccine components for hepatitis A, hepatitis B, pertussis, and varicella (chickenpox) do not provide population protection. Finally, the childhood vaccination program against *S pneumoniae* fails to provide adequate population protection even for those under five years of age.

public about their recognition of the public's concerns and may reduce the growing antipathy towards themselves and the Vermont vaccination program.

In addition, based on the outcomes' data, the vaccines for hepatitis A, hepatitis B, *B. pertussis* and HVZ should be removed from the Vermont vaccination mandates[30] and other approaches used to manage these diseases because: **a)** these vaccines are not in-use effective in providing population protection from these diseases to vaccinated Vermonters and **b)** doing so will reduce: **i)** the adverse immune-system impacts on Vermont children's immune system and, thereby, **ii)** the chronic-disease risk for Vermont children.

"The Vermont Chapter of the March of Dimes has joined with seven other Vermont organizations to urge the Vermont Legislature to take action to reduce a growing health risk by strengthening immunization efforts and closing a philosophical exemption loophole in current health policy. By advancing evidence-based science in service to the people of Vermont, we can restore our leadership in advancing health policy and protect the health of Vermont's children and adults."

Here, this reviewer recommends that the Vermont Legislature, after considering the factual evidence, simply ignore the non-science-based (nonsense-based) statements made by the writer of this opinion in this paragraph.

Nonetheless, this reviewer must congratulate the writer for his repeated use of Orwellian 'doublethink'[31,32], which repeatedly shows up in the writer's statements and is exquisitely embodied in the writer's closing statement, especially because the writer has presented no evidence or science to support any aspect of his opinions.

Roger Clapp of Waterbury is state director of the Vermont chapter of the March of Dimes.

Dr. Paul G. King is a PhD Analytical Chemist with an MS in Inorganic Chemistry and a technical degree in Computer Programming and Systems Analysis. He is the Founder of FAME Systems. For more than a decade, he has been engaged in the study of all aspects of vaccines, vaccination programs and the human immune and other systems upon which vaccine components act. For more information about Dr. King and his publications, please visit http://www.dr-king.com.

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30 Further more, an in-depth medical cost-effectiveness analysis should be undertaken for the Hib (*Haemophilus influenzae type B*) vaccines and the meningococcal meningitis vaccines because the overall in-use effectiveness of each of these types is not supported for the Hib vaccines (data not reflected in the **Table**) and is, *at best*, marginal for the vaccines for *Neisseria meningitidis*.

31 "To know and not to know, to be conscious of complete truthfulness while telling carefully constructed lies, to hold simultaneously two opinions which cancelled out, knowing them to be contradictory and believing in both of them, to use logic against logic, to repudiate morality while laying claim to it, …" [George Orwell (1949). **Nineteen Eighty-Four**, chapter 1, page 24.]

32 "Doublethink is the act of simultaneously accepting as correct two mutually contradictory beliefs." [http://www.websters-online-dictionary.org/definitions/Doublethink?cx=partner-pub-0939450753529744%3Av0qd01-tdlq&cof=FORID%3A9&ie=UTF-8&q=Doublethink&sa=Search#906]

Attached Email Correspondence

10-05-2005 02:55pm From-

Schendel, Diana

ORIGINAL EDITED
FILE COPY
DO NOT RELEASE

From: Kreesten Meldgaard Madsen [KMM@SOCI.AU.DK]
Sent: Wednesday, November 13, 2002 5:33 AM
To: Marlene Briciet Lauritsen; Poul Thorsen; Schendel, Diana
Subject: RE: Manuscript about Thimerosal and autism

Hi Marlene,

[redacted] I am not currently at the university but I will contact you and Poul tomorrow to make up our minds. Best regards, Kreesten

-----Original Message-----
From: Marlene Briciet Lauritsen [mailto:mbl@dadlnet.dk]
Sent: Wed 13-11-2002 09:24
To: Poul Thorsen; Kreesten Meldgaard Madsen; dcs6@cdc.gov
Cc:
Subject: Manuscript about Thimerosal and autism

Dear Poul, Kreesten and Diane Schendel
Attached I send you the short and long manuscript about Thimerosal and autism in Denmark. [redacted]

I need to tell you that the figures in the manuscripts do not include the latest data from 2001. I only have these figures as a paper version and they are at work [redacted] But the incidence and prevalence are still decreasing in 2001. [redacted]

I look forward to hear from you again.
Best regards
Marlene