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Friday, 9 March 2012

Introduction

Following this page is this reviewer's assessment of "Public health decisions should be based on science" by Drew Harris, Chairman of the New Jersey Public Health Institute, which was downloaded on 26 February 2012 from:
http://blog.nj.com/njv_guest_blog/2012/02/public_health_decisions_should.html

This assessment, titled "**A Review of 'Public health decisions should be based on science'**", begins on the next page.

Introductory Remarks

First, to "simplify" this review, when portions of the article, *which are quoted in the original "***Verdana***" 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 Medium" font, **b)** follow each quoted portion of the article, and **c)** indented on both margins 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.

Finally, should anyone find any significant factual error in this review for which they have independent[a], scientifically sound, peer-reviewed published substantiating documents, this reviewer asks that he or she 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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Founder, *FAME* Systems
paulgkingphd@gmail.com
Tel. 1-973-997-1321, after 21:00 Eastern Time
[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.

Review of

“Public health decisions should be based on science”

by Paul G. King, PhD

9 March 2012

Table of Contents

Muted Witnesses

This review is dedicated to —
All the children of New Jersey who,
Having been harmed to guard others' health
And now destroying the public's wealth,
Stand as muted witnesses to their fate —
Seeking our help before it's too late.

--- Paul G. King, 6 March 2012

Initial Comments & Review of Writer's Initial Statements

This reviewer agrees with Drew Harris, the writer, that, *in principle*, all "*health decisions should be based on science*" provided those decisions that can affect the health of the individual are made by that uncoerced, informed individual or, when that individual is not competent to make such decisions, that individual's uncoerced, informed custodial parent or legal guardian.

Moreover, this reviewer notes that, under the "New Jersey State Constitution" of 1947, as amended, each New Jersey resident or, if that resident is not competent or not recognized as an adult by the laws of the State of New Jersey, the parent or guardian of that citizen should be free to make all health decisions without coercion[1] especially when it comes to his or her sincerely held "conscientious" beliefs.[2]

Further, absent war, insurrection, pestilence, or famine, the individual rights recognized by "ARTICLE I RIGHTS AND PRIVILEGES", paragraph "1." of the "New Jersey State Constitution", supersede any "*public health*" ("for the greater good") claims, as the Supreme Court of the United States of America clearly ruled in 1905.[3]

Keeping the preceding realities in mind, let us now assess the statements made by this writer using the prism of the applicable science upon which this writer claims public health decisions should be made.

"When public policy affects human health, it should stand on sound science, not opinion."

Subject to the clear constraints imposed by the "NEW JERSEY STATE CONSTITUTION"

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1 **NEW JERSEY STATE CONSTITUTION 1947** (UPDATED THROUGH AMENDMENTS ADOPTED IN NOVEMBER, 2010) **[emphasis added]:** "ARTICLE I RIGHTS AND PRIVILEGES 1. All persons are by nature free and independent, and have certain natural and unalienable rights, among which are those of enjoying and defending life and liberty, of acquiring, possessing, and protecting property, and of pursuing and obtaining safety and happiness."

2 **NEW JERSEY STATE CONSTITUTION 1947** (UPDATED THROUGH AMENDMENTS ADOPTED IN NOVEMBER, 2010) **[emphasis added]:** "ARTICLE I RIGHTS AND PRIVILEGES 3. No person shall be deprived of the inestimable privilege of worshipping Almighty God in a manner agreeable to the dictates of his own conscience; nor under any pretense whatever be compelled to attend any place of worship contrary to his faith and judgment; nor shall any person be obliged to pay tithes, taxes, or other rates for building or repairing any church or churches, place or places of worship, or for the maintenance of any minister or ministry, contrary to what he believes to be right or has deliberately and voluntarily engaged to perform." **[Note: As written, this covers not only those who believe in "Almighty God" but also, *as a matter of his own conscience*, choose not to worship "Almighty God".]**

3 **Jacobson v. Massachusetts, 197 U.S. 11 (1905), number 70, decided 20 February 1905, where the case hinged on the police power of the State when there was prevalent disease (smallpox). Absent the presence of a disease for which, at the time, there was no other effective treatment and an expressed claim by the Plaintiff Jacobsen that the his reason for declining smallpox vaccination were his concern that the inoculation would adversely affect his health, the Court ruled that the requirement to pay a fine of $5.00 if Jacobson refused to get a smallpox vaccination was within the police powers of the State of Massachusetts. Importantly, the Court did not assert that the Massachusetts law could compel Jacobsen to be vaccinated in order to attend school or hold a job (emphasis added, "**The highest court of Massachusetts not having held that the compulsory vaccination law of that State establishes the absolute rule that an adult must be vaccinated even if he is not a fit subject at the time or that vaccination would seriously injure his health or cause his death, this court holds that, as to an adult residing in the community, and a fit subject of vaccination, the statute is not invalid as in derogation of any of the rights of such person under the Fourteenth Amendment". **More importantly, the Court opined that had Jacobsen raised a credible "reasonable certainty of his unfitness for vaccination defense" or "vaccination would seriously impair his health or probably cause his death" defenses (emphasis added), "**Until otherwise informed by the highest court of Massachusetts, we are not inclined to hold that the statute establishes the absolute rule that an adult must be vaccinated if it be apparent or can be shown with reasonable certainty that he is not at the time a fit subject of vaccination or that vaccination, by reason of his then condition, would seriously impair his health or probably cause his death."**

as well as the "Constitution of the United States of America" **as discussed in this reviewer's opening remarks, this reviewer partially agrees with the writer.**

Actually, whenever a public policy purports to have scientific underpinnings, that public policy should "*should stand on sound science, not opinion*" **or dogma.**

"Unfortunately, in the public forum, where legislation touching millions of lives is shaped and debated, proven facts, conjecture and anecdotes are often treated as equal. They are not. The legislative process can obscure the distinctions and undermine the result we seek: healthier people living in safer communities."

Here, this reviewer must first respectfully observe that, *absent independent scientifically sound and appropriate substantiating unbiased documentation supporting so-called "proven facts",* this writer's "*proven facts*" **are nothing but unsubstantiated anecdotes dressed up as** "*proven facts*" **by those who purport to be "experts".**

Conversely, the heart of the scientific method is the dispassionate examination of anecdotal evidence (usually, in the form of the results from published, peer-reviewed studies) and the putting forth of conjectures (hypothesis), usually in the discussion and/or findings sections of such publications, based on the reported results observed, where, increasingly, these must be taken on faith because, *contrary to scientific ethics*, the researchers often refuse to provide the original HIPPA-compliant[4] raw data and ancillary files to independent researchers for confirmation.

Therefore, given today's realities, *absent the supporting independent, scientifically sound, peer-reviewed published studies that support this writer's view of "proven facts, conjecture and anecdotes"*, all of these should be given equal time and weight in the legislative process.

Moreover, it is <u>not</u> the information provided or the "*legislative process*" **that usually** "*can obscure the distinctions and undermine the result*" **but rather the corrupting influences of lobbyists, influence peddling, party politics, and campaign financing that: a) have generated New Jersey's admitted "pay to play" legislative realities and b) are corrupting the** "*legislative process*" **so that the results obtained often ignore the real science.**

"Our Legislature recently considered several important health issues that share one feature: The overwhelming scientific evidence strongly supports the public health position."

As a scientist, a PhD Analytical Chemist with decades of experience in addressing health issues, including hazardous waste, biocides, pharmaceuticals, quality management and vaccines and vaccination issues,[5] who has been intermittently

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4 The Health Insurance Portability and Accountability Act of 1996 (Pub.L. 104-191, 110 Stat. 1936, enacted August 21, 1996) as amended [HIPPA] requires that person-identifying medical information <u>not</u> be disclosed.

5 See <u>http://dr-king.com</u>.

involved in fighting for legislation that truly protects the public health and has been partially successful in getting the New Jersey legislators to at least consider sound science,[6] this reviewer understands both science and the legislative process.

Moreover, based on the applicable, independent, verified, scientifically sound and appropriate peer-reviewed published studies, this reviewer has been compelled to be: **1)** an on-going opponent of the fluoridation of drinking water and **2)** proponent of: **a)** a philosophical/conscientious exemption to vaccination and **b)** a state mandate that requires that all vaccines in New Jersey's school and workplace vaccination programs be proven to be: **i)** reasonably safe, **ii)** in-use effective, and **iii)** medically cost-effective.

Factually, there are no applicable, independently verified, scientifically sound and appropriate peer-reviewed published studies that support: **a)** the forced vaccination of public health workers, **b)** all of the current vaccination programs for New Jersey's children and adults, or **c)** the fluoridation of water with toxic industrial-grade fluorosilicates in any form or, *for that matter*, pharmaceutical-grade sodium fluoride.

The Non-scientific Flu Vaccination Mandate for HealthCare Facilities

"In December, the Legislature passed a bill mandating hospitals and other health care facilities provide flu shots to their health care workers. Research shows that fewer patients die when their caregivers are vaccinated against the flu, but last year, only 64 percent got the shot."

Factually, this reviewer has yet to find any independent, scientifically sound and appropriate, double-blind, true-placebo-controlled clinical studies that show "*fewer patients die when their caregivers are vaccinated against the flu*" and influenza vaccination does not appear to be either in-use effective or cost-effective[7].

Additionally, since live-virus influenza vaccines would have been allowed to be used and these are known to infect those who are vaccinated (as all live-virus vaccines are known to do) and spread influenza to others[8], the law, if enacted, would have

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6 For example, as the Science Advisor to WHEC, the Windsor-Hights Environmental Coalition, this reviewer was a leader in defeating then NJ S. 1300, legislation seeking to site hazardous waste landfills in New Jersey, when we already had more than enough hazardous waste "Superfund" sites. Partly based on this reviewer's testimony, the legislation was changed to require all hazardous waste to either be disposed of on the site where it was generated or shipped out of the state of New Jersey.

7 See, for example: a) Geier DA, King PG, Geier MR. Influenza Vaccine: Review of Effectiveness of the U.S. Immunization Program, and Policy Considerations. ***J Am Phys Surg*** 2006 Fall; **11**(3): 69-74, which shows that influenza vaccines are not in-use population effective in preventing influenza cases, hospitalization and deaths in the USA; **b)** Jefferson T. Influenza vaccination: policy versus evidence. ***BMJ*** 2006 Oct; **333**: 912-915; **c)** Emborg H-D, Krause TG, Hviid S, Simonsen J, Mølbak K. Effectiveness of vaccine against pandemic influenza A/H1N1 among people with underlying chronic diseases: cohort study, Denmark, 2009-10. **BMJ** 2011; 344: d7901 doi: 10.1136/bmj.d7901 (Published 25 January 2012); and **d)** the pertinent articles published by the independent Cochrane Collaboration.

8 See: MedImmune's FluMist® Package Insert, section "14.5 Transmission Study" (**emphasis added**): "... At least one vaccine strain was isolated from 80% of FluMist recipients; strains were recovered from 1-21 days post vaccination (mean duration of 7.6 days ± 3.4 days). The cold-adapted (ca) and temperature-sensitive (ts) phenotypes were preserved in 135 tested of 250 strains isolated at the local laboratory. Ten influenza isolates (9 influenza A, 1 influenza B) were cultured from a total of seven placebo subjects. One placebo subject had mild symptomatic Type B virus infection confirmed as a transmitted vaccine virus by a FluMist recipient in the same playgroup. This Type B isolate retained the ca, ts, and att phenotypes of the vaccine strain, and had the same genetic sequence when compared to a Type B virus cultured from a vaccine recipient within the same playgroup. Four of the influenza Type A isolates were confirmed as wild-type A/Panama (H3N2). The remaining isolates could not be further characterized.

caused increased influenza-related morbidity in those being inoculated with the live-virus influenza vaccines and probably have actually caused increased patient morbidity and mortality.

If public health officials truly wanted to improve the health of the caregivers and decrease the risk of influenza infection in the patients[9], then, increasingly, the independent scientific evidence has established that giving both groups appropriate amounts of vitamin D-3[10] that are sufficient to raise the recipients 25-hydroxy-vitamin-D blood level to at least 50 nanograms (ng) per milliliter (mL) [or 125 nanomoles (nm) per liter (L).] would not only greatly decrease the risk of influenza infection but also allow the person's body to produce its own disease-organism-specific antimicrobial peptides[11] probably at a rate that is sufficient to control most infections by the specific disease-causing organism(s) by which he or she is, or might be, afflicted.

"Despite the fact that the vaccine mandate applied only to the facility — not the workers — and was supported by major health care organizations, the bill was vetoed over concerns about vaccine mandates."

Since this writer neither provides supporting science nor even addresses the issue of the science that supposedly supports this "*vaccine mandate*", this reviewer must accept that the real issue behind this writer's rhetoric is the unbridled "thirst" on the part of public health officials to impose their "will" and/or the "will" of the "*major health care organizations*" on New Jersey residents because both groups would not only profit from this imposition (mandate) but also increase their usurpation of the constitutional rights of the individual New Jersey resident to make unforced health care decisions.

Assuming a single transmission event (isolation of the Type B vaccine strain), the probability of a young child acquiring vaccine virus following close contact with a single FluMist vaccinee in this daycare setting was 0.58% (95% CI: 0, 1.7) based on the Reed-Frost model. With documented transmission of one Type B in one placebo subject and possible transmission of Type A viruses in four placebo subjects, the probability of acquiring a transmitted vaccine virus was estimated to be 2.4% (95% CI: 0.13, 4.6), using the Reed-Frost model.
The duration of FluMist vaccine virus replication and shedding have not been established."

9 **a)** 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; **91**: 1255–1260; and **b)** http://www.agoracosmopolitan.com/news/health/2011/10/09/1009.html, last visited on 29 February 2012.

10 http://us2.campaign-archive1.com/?u=f545cba30e1f9697fddbe8acb&id=8809d74f4f&e=b884134b04, "Why should you keep your vitamin D level around 50 ng/ml?", September 19, 2011 – Dr John Cannell, last visited on 29 February 2012.

11 a) Gombart AF. The Vitamin D–antimicrobial Peptide Pathway and Its Role in Protection against Infection. ***Future Microbiol***. 2009; **4**(9): 1151-1165, **b)** Liu PT, Stenger S, Li H, et al. Toll-like receptor triggering of a vitamin D-mediated human antimicrobial response. ***Science.*** 2006; 311: 1770-1773; **c)** Wang TT, Nestel FP, Bourdeau V, et al. Cutting edge: 1,25-dihydroxyvitamin D3 is a direct inducer of antimicrobial peptide gene expression. ***J Immun***. 2004; **173** :2909-2912. [published correction appears in ***J Immunol***. 2004; **173**: following 6489; **d)** Connor RI, Rigby WF. 1 alpha,25-Dihydroxyvitamin D3 inhibits productive infection of human monocytes by HIV-1. ***Biochem Biophys Res Commun***. 1991; **176**: 852-859; **e)** Wejse C. Vitamin D as supplementary treatment for tuberculosis—a double-blind randomized, placebo-controlled trial. ***Am J Respir Crit Care Med.*** 2009; **179**: 843-850; **f)** Martineau AR, Wilkinson RJ, Wilkinson KA, et al. A single dose of vitamin D enhances immunity to mycobacteria. ***Am J Respir Crit Care Med***. 2007; **176**: 208-213; **g)** Kawaura A. Inhibitory effect of long term 1alpha-hydroxyvitamin D3 administration on Helicobacter pylori infection. ***J Clin Biochem Nutr***. 2006; **38**: 103-106, and **h)** Avenell A, Cook JA, Maclennan GS, Macpherson GC. Vitamin D supplementation to prevent infections: a sub-study of a randomised placebo-controlled trial in older people (RECORD trial, ISRCTN 51647438) ***Age Ageing***. 2007; **36**: 574-577.

In addition to the personal rights protections provided in paragraphs "1." **and** "3." **of Article I of the New Jersey Constitution, Article I, paragraph** "5." **states (emphasis added),** "No person shall be denied the enjoyment of any civil or military right, nor be discriminated against in the exercise of any civil or military right, nor be segregated in the militia or in the public schools, because of religious principles, race, color, ancestry or national origin."

Moreover, 'give me a break', the writer's claim that "*the vaccine mandate applied only to the facility — not the workers —***", is ludicrous on its face.**

If "*the vaccine mandate applied only to the facility***", then the mandate would have required the facilities (e.g., buildings, rooms, equipment, furnishings) to be vaccinated with influenza vaccines that are only approved by the U.S. Food and Drug Administration (FDA) for use in humans and only recommended by the CDC to be given to humans.**

Since the workers are humans in these facilities, clearly the mandate was intended to apply to the workers.

Furthermore, it is plain to this reviewer that the science has proven that inoculation with any influenza vaccine is not in-use effective in preventing those who are inoculated from: a) getting some strain of influenza, b) spreading influenza to others or c) reducing influenza morbidity, hospitalizations and influenza mortality.

As such, the only real beneficiaries of the current annual flu vaccination program seem to be:

- **The public health officials (who get paid to administer the program [and apparently rewarded based on how well they do by the CDC]),**
- **The vaccine providers (who profit from giving the influenza vaccines [and, in some instances, from the apparent rewards provided by the health insurance companies when their practice meets or exceeds the goals set for the percentage of patients who are vaccinated] to the tune of more than U.S. $ 1 billion this flu season),**
- **The vaccine makers who get paid for the vaccine doses distributed (or about U.S. 1.5 billion this flu season), and**
- **The federal government who gets U.S. $ 0.75 for each dose purchased (or, for the about 132 million doses that have distributed so far this flu season [which stretches from August of 2011 through June of 2012], more than U.S. $ 96 million of which probably less than 10% will go to repay the serious vaccine injuries caused by influenza vaccination).**

The public's reward is to *directly or indirectly*:

a. **Pay for the preceding costs (probably U.S. $ 2+ billion),**
b. **Suffer the consequences of the serious adverse effects to influenza-vaccine inoculation, including, *for a few*, death, that some experience, and**

c. Pay for all of the excess personal, financial, and physical costs that the annual flu vaccination program engenders,

when the annual costs of a New-Jersey-wide program to supplement all children with vitamin D-3 would reduce the costs to New Jerseyans and not only probably drastically reduce the incidence of influenza infection but also ensure that the few cases that did occur would most likely be non-serious in nature.

The Scientifically Unsupportable Fluoridation of Potable Water

"A bill mandating fluoridation for all public water systems is moving through the Legislature."

Here, this reviewer finds that, *after having been repeatedly defeated by the efforts of the majority of New Jersey residents and major water utilities, public and private, who clearly do <u>not</u> want to:* ***a)*** *add an industrial waste product to our potable water,* ***b)*** *see their water costs to go up,* ***c)*** *see their costs for sewage treatment to increase significantly,* ***d)*** *see the risk of bone cancer increase in teenage males and/or e) experience the harm to developing teeth and bones and, in adults, the continual harm to their kidneys and pineal gland*, certain legislators, instead of responding to the public's science-based concerns and legislating a ban on all addition of fluoride to potable water, have simply re-introduced essentially the same legislation again this legislative session as they have done in the past.

Then, the same fluoridation-supportive groups have again trotted out the same lame, biased and faulty supportive studies to justify passing a law that they must by now know medically, physically and financially harms the public.

"Despite almost 60 years of nationwide experience proving the safety and tooth-saving benefits of maintaining a consistent level of this naturally occurring element in the water, fewer than 14 percent of New Jerseyans receive fluoridated drinking water.

As a scientist, all that this reviewer finds that the independent relevant science supports is that the United States of America does have "*60 years of nationwide experience*" with providing "fluoridated" water to many Americans.

However, nowhere does the hard science support that the added fluoride chemicals, typically, technical grades of fluorosilisic acids, have been proven to be safe to add to potable water.

Generally, to prevent corrosion of the potable water systems, when fluorsilisic acids are added to potable water, phosphates must also be added.

In addition, studies attempting to assess the effects of water fluoridated with the chemicals currently used have found evidence of significant harm (e.g., increased risk of kidney disease, increased risk of bone cancer in juvenile males, and pineal-gland atrophy) to those who consume fluoridated water as compared to those who do <u>not</u> drink water having any appreciable "natural" level of fluoride.

Thus, the writer is mistaken, because scientific studies <u>not</u> the historical usage prac

tices are required to prove safety.

Further, the independent, scientifically sound and appropriate studies conducted to date have found that the claimed "safety" of fluoridated water is, at best, illusory.

Factually, the sound science only supports some effectiveness in dental caries reduction with minimal risk to dental fluorosis when sodium fluoride preparations are applied topically to human "permanent" teeth and, with some fluorosis risk to developing permanent teeth, when such preparations are applied to human deciduous ("baby") teeth.

The scientifically sound studies for using fluoride in toothpastes show less positive effects and the unbiased double-blind studies evaluating the effectiveness of fluoridated water in matched populations, which is the minimum that would be required to truly prove the effectiveness of fluoridated water, do not seem to exist as far as this reviewer can ascertain from searching the literature.

Typically, the fluoridation of water carries with it an obvious risk of varying degrees of dental fluorosis, which not only mars the beauty of the natural tooth but, *by making the tooth's structure less deformable (brittle)*, also actually embrittles the teeth as well as the overall bone structure of the body.

Further, since most professions are interested in promoting their businesses, and protecting and expanding their income and prestige, it is illogical that the dental associations would be promoting water fluoridation if it really would reduce their business and income.

However, with the increased fracture risk and, increasingly profitable, widened cosmetic dental offerings, the reality is clear that water fluoridation does the opposite of what is claimed – it weakens tooth integrity and, through discoloration, adds very lucrative cosmetic dental procedures to the already profitable, restorative and, more profitable, alignment procedures.

"Opponents of fluoridation, citing concerns about cost, toxins and lack of consent, ignore the fact that 72 percent of the nation's water is already fluoridated without adverse health effects. Every dollar spent on fluoridation saves $38 in dental care."

Essentially, the writer does not dispute the validity of the issues raised by those who oppose water fluoridation but rather attempts to deflect them by pointing to the current level of coverage, "*72 percent of the nation's water is already fluoridated*", in the USA.

Then, to "sweeten the pot", the writer claims that every "*dollar spent on fluoridation saves $38 in dental care*" — again without his citing any independent, scientifically sound, peer-reviewed published study that even comes close to substantiating the his assertion.

Further, if public health officials truly wanted to improve the dental health of our children and reduce the dental costs, then they would be educating our parents to: **a)** increase the period of nursing to the 2.5 to 7 years found in healthy humans in an unstressed natural environment; **b)** not give their children: **i)** formula containing high levels of sugars, **ii)** high-fructose-corn-syrup-fortified juices; and **iii)** a diet loaded with sucrose and fructose, which promote dental caries.

Moreover, when it comes to "fluoridated" water, *if public health officials were truly interested in the health of the people of New Jersey*, they would be demanding that all fluoridation of potable water be stopped instead of promoting: **1)** the degradation of the quality of our potable water and increasing our potable water's cost; and **2**) the degradation of the quality of our sewage by lobbying to add toxic industrial fluorosilicate-based chemicals to our potable water that then requires adding phosphates to inhibit the corrosion of the water distribution system, which then must be removed from our sewage – raising our sewage treatment costs.

How can any "scientist" condone adding any form of fluoride or any other substance to potable water when that substance: **1)** is, or acts as, a narrow-therapeutic-range drug with serious adverse health effects to those with kidney disease, **2)** increases the risk of bone cancer in juvenile males, and **3)** damages the developing teeth of babies (causing variable levels of dental "fluorosis" depending upon not only the level of fluoride in the water but also how much potable water they consume each day)**?**

Moreover, for those whose health the added fluoride would damage, the proponents of water fluoridation provide no mechanism to: **a)** safely limit every healthy New Jersey individual's water intake or **b)** in the case of those with kidney disease and developing children,[12] provide those New Jersey residents and their families with potable water that is "free" of any added fluoride.

This patently unscientific and medically unsafe push to increase the fluoridation of water (*when the unbiased independent studies have clearly shown that no fluoride should be added to potable water*) is plainly about poisoning of our potable water supply with a waste by-product form of fluoride to:

- Significantly increase our potable water and sewage disposal costs – which further weakens the financial well being of every adversely affected New Jersey resident and business and violates the Safe Water Drinking Act (SWDA);[13]
- Make more of us chronically ill;[14]
- If we have kidney damage, increase our risk of more kidney damage and kidney failure;[15]

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12 http://www.cdc.gov/fluoridation/safety/infant_formula.htm, last visited on 29 February 2012.

13 http://www.newjerseywatereducation.com/pdfs/Booklet17.pdf, "Background Facts Considered in Opposition to Mandatory Fluoridation A·3709 / S·2856", **booklet pages 1-17 of 57, last visited on 29 February 2012.**

14 http://paulinemaria.blogspot.com/2012/02/flouride-cancer.html, **last visited on 29 February 2012.**

15 **a)** http://www.fluoridealert.org/health/kidney/, **last visited on 29 February 2012; b) Schiffl H. Fluoridation of drinking water and chronic kidney disease: absence of evidence is not evidence of absence. *Nephrol. Dial. Transplant*. 2008; 23(1): 411, on-line, doi: 10.1093/ndt/gfm663 (emphasis added),** "Of interest, the data of a recently published study suggested that drinking water contains fluoride levels over 2.0 mg/l—half of the fluoride concentration deemed safe by the US Environmental Protection Agency (EPA)—could cause damage to renal tubular structures in children. This conclusion is based on an investigation of 210 children living in areas of China with varying levels of fluoride in the community water (0.6–5.7 ppm). Children drinking water with more than 2 ppm fluoride were found to have increased levels of NAG and γGT in their urine—both markers of renal tubular damage [4]. [4] Xiong X, Liu J, He W, et al. Dose–effect of relationship between drinking water fluoride levels and damage to liver and kidney functions in children. *Environ Res*. 2007; 103: 122-116**"; and c)** http://www.reuters.com/article/2008/06/09/idUS123736+09-

- Increase our male juvenile children's risk of bone cancer;[16] and,
- As we get older, increase our risk of serious pineal gland "flurocalcification" and the problems that it creates[17]

in order to further line the pockets of the medical health care providers.

In addition, because of the dental fluorosis (spotting and embrittlement of the developing teeth) that adding fluoride induces in our developing children's teeth, adding fluoride also lines the pockets of the dental providers who: **a)** now have more teeth to repair and **b)** can greatly profit by offering cosmetic dentistry to the parents of children with the mottled teeth caused by the added fluoride – further weakening the financial health of our families.

Obviously, this push by public health officials to add fluoride to all of our potable water systems has nothing to do with public health or science – rather it is all about the money!

Jun-2008+PRN20080609 (**emphasis added**), "Kidney Foundation Drops Fluoridation Support Mon Jun 9, 2008 9:56am EDT Fluoride may damage bones of kidney patients NEW YORK, June 9 /PRNewswire-USNewswire/ -- The National Kidney Foundation withdrew its support of water fluoridation citing the 2006 National Research Council (NRC) report indicating that kidney patients are more susceptible to fluoride's bone and teeth-damaging effects.
The kidney-impaired retain more fluoride and risk skeletal fluorosis (an arthritic-type bone disease), fractures and severe enamel fluorosis, which may increase the risk of dental decay, reports the NRC.
Fluoride is added to US water supplies ostensibly to reduce tooth decay. Fluoride is also in foods, beverages, drugs and dental products.
The National Kidney Foundation's (NKF) former fluoridation position statement also carried surprising cautions. The NKF advised monitoring children's fluoride intake along with patients with chronic kidney impairment, those with excessive fluoride intake, and those with prolonged disease. But NKF now admits, "exposure from food and beverages is difficult to monitor, since FDA food labels do not quantify fluoride content."
The NKF's April 15, 2008 statement goes further: "Individuals with CKD [Chronic Kidney Disease] should be notified of the potential risk of fluoride exposure."
"More than 20 million Americans have CKD, and most don't even know it. More than 20 million others are at increased risk for developing CKD," NKF reports", **last visited on 29 February 2012.**

[16] **a)** Bassin EB, Wypij D, Davis RB, Mittleman MA. (2006). Age-specific Fluoride Exposure in Drinking Water and Osteosarcoma (United States). ***Cancer Causes and Control*** *2006;* **17**: 421-4288; **b)** Bassin EB. (2001). Association Between Fluoride in Drinking Water During Growth and Development and the Incidence of Ostosarcoma for Children and Adolescents. Doctoral Thesis, Harvard School of Dental Medicine; **c)** Bucher JR, Heitmancik MR, Toft J, Persing RL, Eustis SL, Haseman JK. Results and conclusions of the National Toxicology Program's rodent carcinogenicity studies with sodium fluoride. ***Internat J Cancer*** 1991; **48**(5):733-737; **d)** Cohn PD. (1992). A Brief Report On The Association Of Drinking Water Fluoridation And The Incidence of Osteosarcoma Among Young Males. New Jersey Department of Health and Environmental Health Services; **e)** Food & Drug Administration (FDA). (1991). Dose determination and carcinogenicity studies of sodium fluoride in Crl:CD-1 Mice and Crl:CD (Sprague Dawley)BR Rats. In: Department of Health & Human Services. (U.S. DHHS) (1991). Review of Fluoride: Benefits and Risks. Report of the Ad Hoc Committee on Fluoride, Committee to Coordinate Environmental Health and Related Programs. Department of Health and Human Services, USA. pp. D1-D7; **f)** Hoover RN, Devesa SS, Cantor KP, Lubin JH, Fraumeni JF (1991). Time trends for bone and joint cancers and osteosarcomas in the Surveillance, Epidemiology and End Results (SEER) Program. National Cancer Institute. In: Review of Fluoride: Benefits and Risks Report of the Ad Hoc Committee on Fluoride of the Committee to Coordinate Environmental Health and Related Programs US Public Health Service. Appendix E and Appendix F; **g)** Maurer JK, Cheng MC, Boysen BG, Anderson RL. (1990). Two-year carcinogenicity study of sodium fluoride in rats. ***J. Nation Cancer Instit.*** 1990; **82**: 1118-1126; **h)** Maurer JK, et al. Confounded carcinogenicity study of sodium fluoride in CD-1 mice. ***Reg Toxicol Pharmacol***. 1993; **18**:154-68; **I)** McGuire SM, Douglass CW, Joshi A, Hunter D, DaSilva J. Fluoride exposure and osteosarcoma. [Abstract] ***J Dental Res.*** 1995; **74**: 98; **j)** Mihashi M, Tsutsui T. Clastogenic activity of sodium fluoride to rat vertebral body-derived cells in culture. ***Mutation Res***. 1996; **368**:7-13; **k)** National Academy of Sciences. **Drinking Water and Health**. National Academy Press, Washington, DC. pp. 388-389 (1997); **l)** National Toxicology Program [NTP] (1990). Toxicology and Carcinogenesis Studies of Sodium Fluoride in F344/N Rats and B6C3f1 Mice. Technical report Series No. 393. NIH Publ. No 91-2848. National Institute of Environmental Health Sciences, Research Triangle Park, N.C.; **m)** Takahashi K, Akiniwa K, Narita K. Regression analysis of cancer incidence rates and water fluoride in the U.S.A. based on IACR/IARC (WHO) data (1978-1992). International Agency for Research on Cancer. J Epidemiol. 2001; **11**(4):170-9; **n)** World Health Organization (2002). **Environmental Health Criteria 227: FLUORIDES**. World Health Organization, Geneva; and **o)** Yiamouyiannis J. Fluoridation and Cancer: The Biology and Epidemiology of Bone and Oral Cancer Related to Fluoridation. ***Fluoride*** 1993; **26**: 83-96.

[17] **a)** Luke J. Fluoride Deposition in the Aged Human Pineal Gland. ***Caries Res.*** 2001; **35**: 125-128; and **b)** http://www.fluoridealert.org/health/pineal/, last visited on 29 February 2012.

Worse, the mandate would fluoridate all of our potable water when we only drink about 1% of it, with the rest being used for bathing, cooking, washing, flushing our toilets and watering our lawns and gardens .

Given that, after admitting that the current level of fluoridation "2 in 5 children in America show signs of fluoride poisoning (streaking, spotting or pitting of teeth due to dental fluorosis)",[18] **the U.S. Centers for Disease Control and Prevention (CDC): a) has lowered the upper limit for the level of fluoride in potable water from 1.2 parts-per-million (ppm) to 0.7 ppm, a 42% reduction, and b) now recommends that the water used to prepare a baby's formula essentially be fluoride free – a much lower in fluoride than the current maximum concentration of 0.7 ppm,[19]**

- **IF: the state public health officials truly cared about the overall health of the public,**
- **THEN: they would be demanding that the legislature of the State of new Jersey ban any fluoridation of New Jersey potable water and require that all public and private water systems that provide potable water to more than 20 residents must ensure that the level of fluoride in that potable water has a "fluoride" concentration that, *to provide a safety margin*, is not greater than 0.03 ppm.**

Given all of the preceding admitted scientific realities, adding "fluoride" to potable water: a) is neither safe nor effective in ensuring that the children who drink it will develop truly healthy teeth, b) increases the risk of bone cancer in our male children; and b) for adults, it slowly poisons the kidneys, skeletal bones, and the pineal gland.

Therefore, for both economic and health reasons, the actual sound science clearly indicates that all water fluoridation should be banned in the State of New Jersey.

Agenda-based Opposition to Raw Milk

"Raw milk is proven to cause infection, which is why we mandate pasteurization. Pennsylvania officials just announced a disease outbreak linked to drinking local raw milk contaminated with the intestinal bacteria Campylobacter. Ultimately, 77 people (including two New Jersey families) were infected and nine were hospitalized."

Here, this writer starts by asserting, "*Raw milk is proven to cause infection*", which is an obvious distortion of the reality that milk, be it raw or pasteurized, that is contaminated with pathogenic bacteria has been proven to sicken those individuals who drink it and not whether that milk is *per se* raw milk.

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18 http://www.naturalnews.com/030952_CDC_fluoride.html, last visited on 29 February 2012

19 http://www.cdc.gov/fluoridation/safety/infant_formula.htm (emphasis added), "Can I use optimally fluoridated tap water to mix infant formula? Yes, you can use fluoridated water for preparing infant formula. However, if your child is exclusively consuming infant formula reconstituted with fluoridated water, there may be an increased chance for mild dental fluorosis. To lessen this chance, parents can use low-fluoride bottled water some of the time to mix infant formula; these bottled waters are labeled as de-ionized, purified, demineralized, or distilled", last visited on 29 February 2012.

Pasteurization is only needed to sterilize milk that is probably contaminated with filth (e.g., puss, blood, and fecal contamination) because the conditions under which the cows are managed and the milk is collected, handled, processed and packaged are known to risk contaminating the milk with disease-inducing organisms so that the resultant pasteurized milk will not sicken those who subsequently drink that pasteurized milk unless it is re-contaminated after being pasteurized.

Conversely, for the production of safe USDA-certified-organic raw milk, the conditions under which the milk cows are managed and their milk is collected, handled, processed and packaged must be much more sanitary to ensure that the resultant raw milk is not at risk of contamination with pathogenic organisms and has maximal levels of the health-promoting bacteria and beneficial fatty acids as well as the natural enzymes that help us properly metabolize the lactose in such raw milk.

Even when the raw milk does not meet the standards for USDA-certified-organic raw milk, provided it is still produced, processed, and packaged under truly sanitary conditions, that raw milk still has the natural enzymes and health-promoting bacteria (which pasteurization destroys).

Absent the contamination of the raw milk with pathogenic organisms during or after the collection, handling and packaging processes, there is no scientific or public-health reason to pasteurize such clean raw milk, which actually contains beneficial enzymes and low levels of the bacteria that help the consumer digest that milk.

Moreover, while even refrigerated raw milk slowly breaks down and becomes "sour" after a couple of weeks because of its being broken down by the enzymes and the beneficial bacteria that it naturally contains, it does not putrefy (rot) unless it is grossly contaminated with non-beneficial and/or pathogenic organisms.

In contrast, even when it is unopened, refrigerated bottled pasteurized milk actually putrefies (rots) from the action of the ambient non-beneficial and pathogenic bacteria with which it is invariably contaminated after it is pasteurized.

Thus, the Pennsylvania example cited, "*a disease outbreak linked to drinking local raw milk contaminated with the intestinal bacteria Campylobacter*", clearly establishes that it was not the "*local raw milk*" that caused the "*disease outbreak*" but rather that milk's contamination by "*the intestinal bacteria Campylobacter*"[20] – an event that has also occurred in some of the instances where the pasteurized milk sickened those who drank it.

Had that Pennsylvania dairy's milk been pasteurized and that bulk pasteurized milk

[20] http://www.cdc.gov/nczved/divisions/dfbmd/diseases/campylobacter/#food_water, last visited on 1 March 2012, that, in part, states (emphasis added), "Unpasteurized milk can become contaminated if the cow has an infection with Campylobacter in her udder or the milk is contaminated with manure." What is not said is that pasteurized milk can also be infected by a pathogenic bacteria, including Campylobacter, if it is infected after the milk is pasteurized and packaged for shipment whenever the post-pasteurization bulk milk is contaminated by Campylobacter or other pathogenic organisms, including, but not limited to, other bacteria, pathogenic fungi, pathogenic yeasts, and pathogenic gastrointestinal viruses.

then contaminated with Campylobacter during its subsequent handling and packaging, a similar or worse outcome would have been observed.

Thus, all this example underscores is the need for "raw milk" dairies to: **a)** maintain healthy disease-free cows, **b)** milk those health cows under sanitary and stress-free conditions; **c)** handle and package the raw milk collected under sanitary (aseptic) conditions; and **d)** continually test their packaged raw milk lots for the presence of pathogenic bacteria to ensure that their milk is safe to drink.

"Officials at the Centers for Disease Control say raw milk consumption is 150 times more likely to cause similar infections than pasteurized milk."

Here, the writer, perhaps <u>not</u> understanding the scientific assumptions and the limitations inherent in making those assumptions and then reporting <u>not</u> the facts but rather an apparently intentionally prejudiced derivative view of the actual data, did <u>not</u> even read the headline and the paragraphs in the CDC Press Release[21] that announced, "Majority of dairy-related disease outbreaks linked to raw milk".

Factually, the report actually reflected the number of <u>identified</u> dairy-related outbreaks linked <u>not</u> just to milk but rather linked to milk and milk products and focused on some measure of the ratio of: **a)** those <u>identified</u> dairy-related outbreaks associated with dairies where there was proof that the dairy sold raw milk and raw milk products to: **b)** the identified disease outbreaks associated with dairies that there was proof that they sold pasteurized milk and pasteurized milk products as well as omitting those dairies where there was <u>not</u>: **i)** clear documentation as to the type of milk produced (in one instance) or **ii)** proof that the contamination occurred on the dairies' premises (in two instances).

However, because, *relative to the numbers of dairies of each type*, the FDA and the local and state health officials focus a disproportionate amount of time and energy on those dairies that sell raw milk and raw milk products, the CDC's analysis of the "available" data was biased by the disproportionate scrutiny that the dairies that produce raw milk and raw milk products experience.

Turning to the published study,[22] this reviewer finds that the authors of that article begin by stating, "To determine the association of outbreaks caused by nonpasteurized dairy products with state laws regarding sale of these products, we reviewed dairy-associated outbreaks during 1993–2006. We found 121 outbreaks for which the product's pasteurization status was known; among these, 73 (60%) involved nonpasteurized products …".

Jumping to the start of the "results section", the authors of this CDC study reported

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21 http://www.cdc.gov/media/releases/2012/p0221_raw_milk_outbreak.html, last visited on 1 March 2012, "Majority of dairy-related disease outbreaks linked to raw milk *CDC Report Shows Higher Rates of 'Raw' Milk Outbreaks in States Where It's Legal*".

22 Langer AJ, Ayers T, Grass J, Lynch M, Angulo FJ, Mahon BE. Nonpasteurized Dairy Products, Disease Outbreaks, and State Laws—United States, 1993–2006. ***Emerg Infect Dis.*** 2012; **18**(3): 385-391, http://wwwnc.cdc.gov/eid/article/18/3/pdfs/11-1370.pdf, last reviewed on 1 March 2012.

(emphasis added),

"Results

During 1993–2006, a total of 30 states reported 122 foodborne disease outbreaks caused by contaminated dairy products. Dairy-associated outbreaks occurred in all years except 1996, and outbreaks involving nonpasteurized dairy products occurred in all years except 1994 and 1996. The number of reported dairy-associated outbreaks increased in 1998 after surveillance for foodborne disease outbreaks was enhanced (Figure 1).

Whether the product was pasteurized or nonpasteurized was known for 121 of the 122 outbreaks, and most outbreaks (73 [60%]) involved nonpasteurized dairy products. Of the 121 outbreaks for which product pasteurization status was known, 65 (54%) involved cheese and 56 (46%) involved fluid milk. Of the 65 outbreaks involving cheese, 27 (42%) involved cheese made from nonpasteurized milk. Of the 56 outbreaks involving fluid milk, an even higher percentage (82%) involved nonpasteurized milk.

Unfortunately, this article rapidly diverges from sound science when its authors admit that the "surveillance for foodborne disease outbreaks was enhanced**" in 1998 but do not address the issue of differential levels of "surveillance" between the pasteurized-products' "outbreaks" and the non-pasteurized-products' "outbreaks.**

On a raw "outbreaks" basis, for the 121 incidents (over 14 years or where the pasteurization status was known, the ratio of non-pasteurized outbreaks to pasteurized outbreaks was reported as "73/48" or "1.52" indicating that the levels of the outbreaks were similar in frequency for both the "raw-milk product" and the "pasteurized-milk product" facilities.

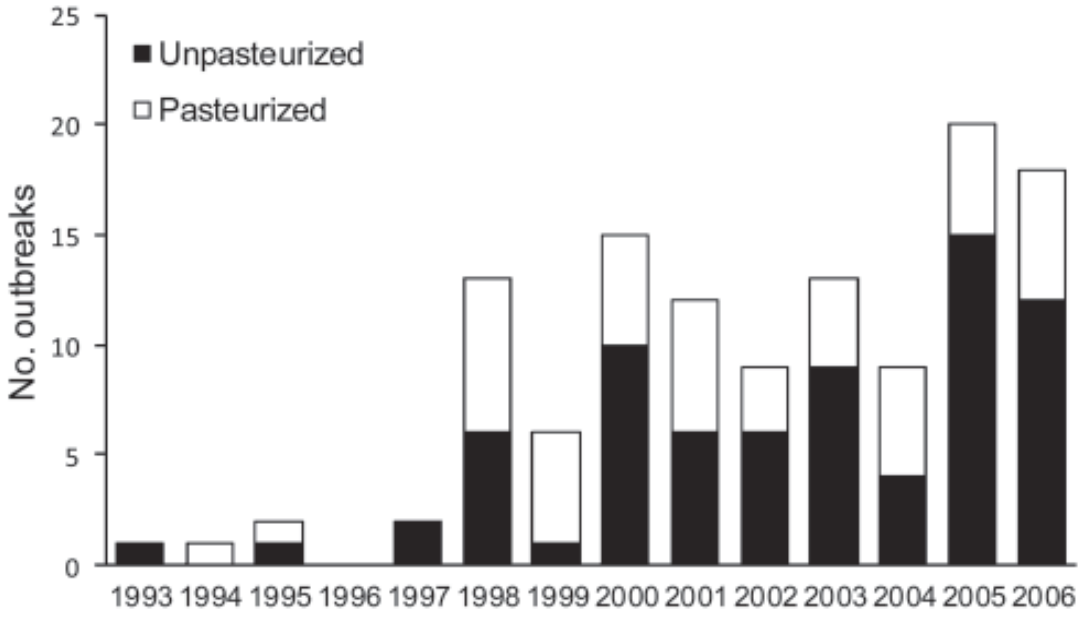

Figure 1. Number of dairy product–associated outbreaks, by year and pasteurization status of product, United States, 1993–2006."

Removing the 6 incidents, 2 pasteurized and 4 non-pasteurized, in the 5-year period from 1993 through 1997 as the researchers should have done because of the admittedly lower level of surveillance during that period of time, the number of

outbreak identified milk-products incidents for the 9-year period from 1998 through 2006 reduces the number of disease-outbreak incidents to 115, with 69 non-pasteurized and 46 pasteurized incidents and a 1.5 ratio of reported, identified unpasteurized to pasteurized outbreaks.

Unfortunately, the researchers provided no estimate of the differences in the levels of surveillance for the unpasteurized and the pasteurized milk or the raw-milk products and pasteurized-milk products nor an estimate for the difference in the percentage of operating dairies for each type of milk products that are actively evaluated each year.

Nor did the researchers explore the correlation between the level of cleanliness and the manner in which the dairy animals are raised and fed and the risk of milk or milk-product contamination.

Absent certain values, and not guesstimates and fuzzy extrapolated assessments, for the causal factor or factors that generated each outbreak, the reported relative risk factor was simply a contrived statistic whose generation was apparently driven by the researchers' conscious or subconscious bias.

Moreover, absent the relative level of surveillance for both types or milk and the numbers of dairies producing each type of milk, all that can be said is that neither type of milk or milk products is absolutely safe and, from the data provided in the paper, it is not possible to compute a valid relative-risk ratio for: a) raw milk versus pasteurized milk or b) raw-milk products versus pasteurized-milk products.

"Despite clear evidence of raw milk's risk, the state Assembly Agriculture Natural Resources Committee approved a bill allowing farmer" [sic; 'farmers' or 'the farmer'] "to sell raw milk after hearing anecdotes from supporters about allergies cured and autism allegedly treated."

Here, the writer begins by making a claim of "*raw milk's risk*" that ignores the fact that pasteurized milk and pasteurized-milk products also carry a disease risk and then lamenting the reality that "*the state Assembly Agriculture Natural Resources Committee approved a bill allowing farmer*" [sic; 'farmers' or 'the farmer'] "*to sell raw milk*".

Moreover, without presenting any evidence to support his views, the writer asserts that that committee based its decision on "*anecdotes from supporters about allergies cured and autism allegedly treated*".

Turning to the peer-reviewed published scientific literature, this reviewer finds that raw ("farm") milk consumption does reduce asthma and allergy[23,24].

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[23] **Waser M, Michels KB, Bieli C, Flöistrup H, Pershagen G, Von Mutius E, Ege M, Riedler J, Schram-Bijkerk D, Brunekreef B, Van Hage M, Lauener R, Braun-Fahrländer C, the PARSIFAL Study team. Inverse association of farm milk consumption with asthma and allergy in rural and suburban populations across Europe. Clin Experimen Allergy 2007 May; 37(5): 661-670. DOI: 10.1111/j.1365-2222.2006.02640.x, Published online: 20 DEC 2006, which concludes by stating, "**In conclusion, the results of the present study indicate that consumption of farm milk is associated with a lower risk of childhood asthma and rhinoconjunctivitis. These results might be transferred to non-farming populations as they were observed in all subpopulations of the PARSIFAL study. Dietary interventions are an attractive means for primary prevention**".**

Though the published articles that address the "*autism allegedly treated*" issue are not peer-reviewed studies, this reviewer could find no study that had critically evaluated the issue or that had provided evidence that drinking raw milk did not improve the behavior of children with a diagnosis of autism that are not allergic to casein.

Thus, the literature clearly reflects the validity of the asthma and allergy claims and does not prove that raw milk consumption does not help some children who have a diagnosis of autism.

Therefore, it is clear that the "*the state Assembly Agriculture Natural Resources Committee*" got it right when it "*approved a bill allowing farmer[s] to sell raw milk*"

"FDA scientists cite" [sic; 'cited' or 'have cited'] "numerous studies discounting any special benefits of raw milk and documenting many raw milk-related disease outbreaks."

Because the FDA is opposed to the consumption of "raw milk and raw milk products" and its position is supported by the large-scale "factory" dairies, this reviewer is not surprised that the FDA scientists can cite and/or have cited studies: a) discounting any special benefits of raw milk and b) documenting many raw-milk-related disease outbreaks since the CDC article has plainly presented evidence of these raw-milk-related disease outbreaks.

However, this reviewer observes that the CDC has also presented evidence that sanitation and contamination are serious problems that lead to pasteurized-milk-related disease outbreaks.

Further, because: 1) *absent contamination by pathogenic organisms*, raw cow's and goat's milk has been proven to: a) contain significant levels of active enzymes, beneficial bacteria, and other key nutrients that are virtually, or completely, absent in the corresponding pasteurized milks and b) suppress asthma and allergy in those who consume these raw milks rather than pasteurized milks and 2) both raw milks and pasteurized milks are apparently subject to similar[25] risks of being contaminated with pathogenic microorganisms by the producers of milk or milk products, the consumer should have the right to decide which risks (asthma and allergy or possible pathogenic-organism contamination) he or she is willing to take.

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24 **Loss G, Apprich S, Waser M, Kneifel W, Genuneit J, Büchele G, Weber J, Sozanska B, Danielewicz H, Horak E, Joost van Neerven RJ, Heederik D, Lorenzen PC, von Mutius E, Braun-Fahrländer C, GABRIELA study group. The protective effect of farm milk consumption on childhood asthma and atopy: The GABRIELA study. J Allergy Clin Immunol 2011 Oct; 128(4): 766-773.e4. Published online 29 August 2011, in which the abstract states, "**Results

Reported raw milk consumption was inversely associated to asthma (adjusted odds ratio [aOR], 0.59; 95% CI, 0.46-0.74), atopy (aOR, 0.74; 95% CI, 0.61-0.90), and hay fever (aOR, 0.51; 95% CI, 0.37-0.69) independent of other farm exposures. Boiled farm milk did not show a protective effect. Total viable bacterial counts and total fat content of milk were not significantly related to asthma or atopy. Increased levels of the whey proteins BSA (aOR for highest vs lowest levels and asthma, 0.53; 95% CI, 0.30-0.97), α-lactalbumin (aOR for interquartile range and asthma, 0.71; 95% CI, 0.52-0.97), and β-lactoglobulin (aOR for interquartile range and asthma, 0.62; 95% CI, 0.39-0.97), however, were inversely associated with asthma but not with atopy.

Conclusions

The findings suggest that the protective effect of raw milk consumption on asthma might be associated with the whey protein fraction of milk**".**

25 **The "reported outbreaks" incidences can be considered to be similar because the ratio off the raw milk to pasteurized milk incidents is less than a factor of two (2).**

Finally, the preceding dilemma underscores the reality that, because humans are mammals, for optimum health and well-being, our children should be consuming their own mother's milk or a surrogate mother's milk (wet nurse or donated bottled human milk) from the time we are born until about 2.5 to 5 or more years later, when their adequately fed and hydrated mothers naturally begin to dry up instead of drinking any other-source milk or formula.

Therefore, *in addition to allowing the consumer the choice to buy clean raw milks*, the State of New Jersey should be changing its child-rearing policies to:

a. Give in-depth pre- and post- delivery breastfeeding education and support for mothers[26],

b. Provide mandatory accommodations and strong breast-feeding-supportive incentives, for every woman who physical can, to nurse her child to nurse each of her children for more than two (2) years[27] and

c. stop providing bottles, formula and juice for children under the age of 24 months[28]

if, *as they claim to be*, the state's legislators, healthcare providers, and public health officials are truly interested in improving the health of our infants, rather than, *as they seem to be*, working on behalf of the themselves and the drug, formula and food industries to make our babies less healthy.

Vaccination Program Distortions & Fear Mongering

"The CDC also reports that New Jersey trails the nation in childhood vaccination. Ongoing whooping cough outbreaks have sickened and killed children too young to be vaccinated."

Since this writer: a) cites no studies to support his, "*CDC also reports that New Jersey trails the nation in childhood vaccination*", b) provides no definition of what constitutes meeting the CDC's expectations *vis-à-vis* childhood vaccination, c) does not quantify the distance by which New Jersey trails the nation; and d) provides no evidence that the reduced level of childhood vaccination has led to any significant increased the vaccine-covered disease in New Jersey.

Further, a review of the CDC's "annual" Summary of Notifiable Disease reports, published in the CDC's ***Morbidity and Mortality Weekly Report*** [***MMWR***], for the period from 2000 through 2009 for New Jersey (see **Table I** on the next page) clearly shows that, except for a mumps outbreak in 2009, there has been no increasing trend in the cases of disease for which there is a childhood vaccine.

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26 Gartner LM, Morton J, Lawrence RA, Naylor AJ, O'Hare D, Schanler RJ, Eidelman AI, American Academy of Pediatrics Section on Breastfeeding. Breastfeeding and the use of human milk. ***Pediatrics*** 2005; **115**(2): 496-506.

27 http://bhaktibirth.wordpress.com/2010/07/09/breastfeeding-court-letter-by-katherine-a-dettwyler-ph-d-anthropology/, last visited on 5 March 2012, which states, "…the normal and natural duration of breastfeeding for modern humans falls between 2.5 years and 7 years. Some children nurse less than 2.5 years, and some nurse longer than 7 years".

28 Palmer, Gabrielle. **The Politics of Breastfeeding: When Breasts are Bad for Business;** Pinter & Martin, London (2009).

Thus, this CDC-published data clearly indicates that the undefined decrease in the percentage of uptake for the writer's unspecified vaccines has had no significant impact on the disease protection provided by the current vaccination program.

The writer's perspective on pertussis ignores the reality that many, if not most, of the children and the adults infected in the recent "whooping cough" outbreaks were sufficiently vaccinated to the point that they were diagnosed with "whooping cough" even though they should have been protected from being infected by *Bordetella pertussis* (*B. pertussis*).

That these adequately vaccinated persons were still diagnosed with "whooping cough" indicates that: **a)** the pertussis-antigens-containing vaccines (DTaP and Tdap in the USA), which actually cause the body to make antigens against certain toxins released by *B. pertussis* and not against the *B. pertussis* organism *per se*, were not effective in preventing such infections, **b)** the infecting organisms were not *B. pertussis* but rather *B. parapertussis*, a related "whooping cough" causing pathogen, or some other organism that can cause the patient to present with the symptoms of "whooping cough", and/or **c)** *as has happened historically*, the testing used to diagnose a *B. pertussis* infection found a significant number of false positives.

Table 1 Selected Vaccine-Covered Notifiable-Disease Data[A]

State	Popula-tion in 1,000s	Hib in < 5yr-olds	Hepatitis A, B	Measles Total, Indig.	Mumps	Pertussis Reports			Rubella Adult, Congenital	*Strep. Pneumoniae* < 5yr olds	Teta-nus	Chickenpox [Varicella] Morbidity, Mortality
						Cases in NJ	Cases in the USA	Deaths in USA[C]				
New Jersey 2000	8,143	NR[B], NR	288, 179	--, --	4	56	7,867	12	1, NR	NR	1	NR, NR
New Jersey 2001	8,414	NR, NR	283, 286	1, --	4	23	7,580	17	1, --	NR	NR	NR, NR
New Jersey 2002	8,414	-- (7 tot. Hi)	188, 344	1 --	3	34	9,771	18	--, --	NR	1	--, --
New Jersey 2003	8,575	-- (11 tot. Hi)	208, 183	2, 1	6	181	11,647	11	2, --	4	--	--, --
New Jersey 2004	8,638	-- (3 tot. Hi)	188, 216	2, 1	8	223	25,827	16 [27][A]	1, NR	13	--	NR, NR
New Jersey 2005	8,699	-- (12 tot. Hi)	154, 239	2, 1	9	182	25,616	31 [39]	2, --	44	1	NR, --
New Jersey 2006	8,718	-- (14 tot. Hi)	111, 164	1, 1	12	301	15,632	9 [16]	--, --	73	1	NR, NR
New Jersey 2007	8,725	-- (8 tot. Hi)	124, 162	1, 1	2	229	10,454	9 [11]	4, NR	75	--	NR, NR
New Jersey 2008	8,686	-- (10 tot. Hi)	86, 118	1, --	13	226	13,278	-- [18]	--, NR	70	--	NR, NR
New Jersey 2009	8,683	-- (11 tot. Hi)	71, 93	2, 2	200	244	16,858	----	--, 1	70	--	470, --
New Jersey Average	8,569.5	-- (9.5 tot. Hi)	170.1, 198.4	1.3, 0.7	26.1	107.6	NC[C]	NC[C]	1.1, 0.17	2.4	0.44	NC[C], NC

A Data from the annual "Summary of Notifiable Diseases, United States ..." reports published in the CDC's MMWR, except for the values in brackets [ ], which are from http://www.cdc.gov/vaccines/pubs/pinkbook/pert.html, published in April 2011, from a tabled labeled "Pertussis Deaths in the United States, 2004-2008", last visited on 5 March 2012

B NR means not reported.

C NC means that the average was not calculated because there were fewer than 3 data points for New Jersey.

For more detailed discussions on these matters, the reader should read the pertinent sections of the recent review articles authored by this reviewer, which can be downloaded from the "Documents" section of his web site.[29]

29 http://dr-king.com. [**Note:** Recent articles that contain discussions relevant to "*pertussis*" issues include, but are not limited to:
a. http://dr-king.com/docs/120127_RevisdDrft_RevuOfAutsmControvrsyNeedForResponsbleScienceJournlsm_b.pdf;

Turning to the writer's "*whooping cough outbreaks have sickened and killed children too young to be vaccinated***", this reviewer observes that:**

a. Whooping cough outbreaks have also sickened, maimed and, in some instances, killed vaccinated children as well as fully vaccinated adults, and

b. Pertussis-containing vaccines have generated post-vaccination adverse-event reports in the jointly administered CDC/FDA VAERS [Vaccine Adverse-Events Reporting System] indicating that these vaccines may have permanently maimed and even killed[30] some of the babies, infants and young children inoculated with them.

Table 2 Pertussis-Vaccine-Related VAERS Reports – 1992 through 2011

Reporting Year	Death Reports for			Permanent Disability Reports for					Total for Adverse Events	Notes on the Changes to the Vaccine Prog.
	< 3yrs	3-6 yrs	Unknown	< 3yrs	3-6 yrs	6-9 yrs	9-12 yrs	All Other		
1992	129	1	1	24	1	1	0	2	4,047	End of the phase out of DTwcP & phase in of the DTaP vaccines
1993	145	3	0	57	5	0	0	4	3,680	
1994	124	2	0	43	2	0	0	3	3,891	
1995	83	0	0	32	4	2	0	2	3,706	Only the Thimerosal-preserved DTaP vaccines were approved & recommended
1996	79	0	0	43	6	0	0	1	3,460	
1997	80	1	1	57	5	0	1	7	2,755	
1998	73	0	2	43	4	1	0	8	2,302	
1999	70	1	0	56	6	0	0	4	2,966	
2000	77	1	3	53	6	1	0	1	3,183	Phase out of the Thimerosal-preserved DTaP vaccines & phase in of reduced-Thimerosal DTaP vaccines
2001	91	0	2	37	4	0	0	0	3,853	
2002	74	1	2	28	3	1	0	0	4,597	
2003	73	1	1	32	11	1	0	2	5,234	
2004	74	1	1	27	7	0	0	11	4,863	
2005	57	0	1	22	3	0	0	1	4,249	Reduced-Thimerosal DTaP & combo vac. & "no Thimerosal" vac. [complex chngs]
2006	52	0	1	35	8	2	0	0	4,348	
2007	83	0	0	19	1	0	0	3	4,919	
2008	75	1	0	18	7	0	0	2	4,474	
2009	43	1	0	6	2	0	0	1	3,750	"No Thimerosal" DTaP & DTaP combo with (Hib or HepB) & IVP
2010	45	0	0	13	4	0	0	0	3,842	
2011	39	3	0	5	1	0	0	0	3,117	
Total	1,566	17	15	650	88	9	1	52	77,236	
Average	78.3	0.85	0.75	32.5	4.4	0.45	0.05	2.60	3,862	

Furthermore, since former FDA Commissioner David Kessler, MD has observed that

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b. http://dr-king.com/docs/120214_DrftRevu_VaccinesAreEffective_SaveManyLives_b.pdf; and

c. http://dr-king.com/docs/120229a_DrftRevu_MyTurn_Immunizations_CriticalProtectionForStatesFamilies_b.pdf.]

30 A search in the Vaccine Adverse-Events Reporting Systems (VAERS) database using the search engine that is located at http://www.medalerts.org/ for searching (http://www.medalerts.org/vaersdb/index.php) for reports during the period from 1992 through 2011 for reports of deaths associated with the pertussis-containing vaccines, the search engine found 1,566 death reports in children under 3 years of age, 17 death reports in children 3-6-years, and 1,598 total death reports in the VAERS database.

"only about one percent of serious events ... are reported"[31], the reported VAERS numbers for vaccination-related deaths and permanent disability probably should be multiplied by a factor of 100.

Thus, accepting the validity of Dr. Kessler's reported findings, the probable number of pertussis-antigens-containing-vaccine-related VAERS death reports for the period from 2000 through 2008 (see **Table 2**) is [656 times 100 (for 1% reporting)] or probably about 65,600 such pertussis-vaccine-related VAERS reports of death while, *using the higher reported numbers when both are available* (see **Table 1**), there were apparently *no more than* 169 pertussis-related deaths in the USA in the same 9-year period.

Moreover, from:

a. The numbers of annual notified pertussis cases in **Table 1** (from "7,580" to "25,827") when, for the diphtheria and tetanus antigenic components in the same vaccines (basically, the DTaP and Tdap vaccines),
b. The annual numbers of notified cases in the USA currently are essentially zero (0) for diphtheria and 28.4 cases, on average, for tetanus in the 10-year period from 2000-2009 with most of the reported cases occurring in those over 50 years of age, and
c. The periodicity of the highs and lows in the thousands of annual notified cases data for pertussis,

it is clear that the vaccination program has failed to eliminate cases of whooping cough in the our children and ourselves.

Even with the historical addition of pre-pubertal booster doses of the DTaP vaccines and, recently, recommending that booster doses of the adult formulations, the Tdap vaccines, be used in place of the traditional CDC-recommended tetanus boosters for older children and adults, it is clear to this reviewer that the antigenic pertussis components in these vaccines are not effective in preventing the thousands of "whooping cough" cases that occur annually in both infants that are too young to vaccinate and young children, vaccinated and unvaccinated.

In another recent review,[32] this reviewer has detailed the apparent reasons that the pertussis-vaccine antigens are not effective in preventing cases of whooping cough.

Finally, rather than recommending the use of a DTaP vaccine that seems to cause of contribute to deaths and permanently maimings of thousands of our children annually, at a minimum, for *B. pertussis*, our state and federal public health officials

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31 Kessler, DA, the Working Group, Natanblut S, Kennedy D, Lazar E, Rheinstein P, et al. Introducing MEDWatch: a new approach to reporting medication and device adverse effects and product problems. ***JAMA*** 1993; **269**(21): 2765.

32 A prior 2012 document, "A Review of Seth Mnookin's 'The Autism Vaccine Controversy and the Need for Responsible Science Journalism" published in the "Documents" section of http://dr-king.com addresses general pertussis-related vaccine and vaccination issues in the review's pages "14" and "15" (in the published document's pages 15 and 16). [http://dr-king.com/docs/120127_RevisdDrft_RevuOfAutsmControvrsyNeedForResponsbleScienceJournlsm_b.pdf].

and our health agencies should:

A. Replace the current "no Thimerosal" DTaP/Tdap vaccination program with a "no Thimerosal", non-adjuvanted DT/Td vaccination program; and

B. Mandate that all children in the USA who present with a severe cough be treated according to the following general guidelines:

1. Test an appropriate sputum sample for the causal organism and, presuming the organism may be bacterial, the antibiotic susceptibility, if any, of the organism in the sample;
   a. When the organism is bacterial, giving either:
      i. The patient-compatible antibiotics to which that the causal organism is more sensitive, using today's rapid-screening tests for those who have chosen an allopathic doctor, or
      ii. As appropriate, organic olive-leaf extract, oil of oregano or other proven naturopathic remedy for those who are treated by naturopathic doctors, and/or
      iii. The appropriate homeopathic remedy for those who are treated by homeopathic doctors, and
   b. When the organism is non-bacterial, depending upon the nature of the infectious organism identified, giving whatever antifungal, anti-yeast, or antiviral drug, dietary supplements, or homeopathic remedies that are known to effectively help the patient's body resolve such fungal, yeast or viral infections,
2. *While ensuring that optimal levels for the other needed dietary supplements are maintained*,[33] treat the patient by giving an appropriate bolus dose of vitamin D-3 that should boost the patient's blood level of 25-hydroxy vitamin D to <u>between</u> 65 nanograms (ng) per milliliter (mL) [or 133 nanomoles (nm) per liter(L)] <u>and</u> 125 ng/mL [313 nm/L)] and giving supplemental vitamin C until the patient's body is saturated with vitamin C for as long as the patient is exhibiting the symptoms of whooping cough.

"Recently, the Legislature considered a bill allowing parents to exempt their children from any or all vaccines. Vaccine deniers painted a somber portrait of children damaged by vaccines, while public health professionals cited detailed research studies showing that vaccinations prevent, rather than cause, serious disease."

This reviewer agrees that the Legislature recently considered a bill that would have

[33] In today's USA, the needed supplements include vitamins (e.g., vitamin A [generally as beta-carotene], the B vitamins including Biotin, vitamin C, the mixed vitamin Es, and vitamin K-2), minerals (e.g., bioavailable calcium, chromium, copper, magnesium, molybedum, potassium, iodide, selenium, sulfur, and zinc) and key dietary nutrients (e.g., alpha lipoic acid, L-carnotine, L-carnosine, N-acetyl cysteine, L-cysteine, L-lysine, Co-Q-10, and acetylcarnotine).

allowed parents having sincere conscientious/philosophical objections to any particular, *or all*, vaccines to exercise their God-given and constitution-supported "bodily integrity" rights to make informed decisions about the specific medical treatments that they should receive or that should be given to their children including which vaccines, *if any*, should be given to themselves or their children and when they or their children should be treated with these vaccines.

However, this reviewer objects to the writer's mischaracterization of these deeply concerned parents and independent scientists, who: **a)** know that the admitted risks associated with vaccination are <u>not</u> the same for all children and **b)** have experienced, or observed, the serious adverse after effects of vaccination on some of their or others' children.

The writer pejoratively labels them as "*Vaccine deniers*", when all they are seeking is to have the state government recognize the public's personal and parental right to make informed-consent, bodily integrity decisions concerning the medical treatments labeled "vaccination" that the public and parents, who, *as a rule*, know and love each of their children far better than any public health official or vaccine apologist, should have.

Further, this reviewer observes that the writer's "*somber portrait of children damaged by vaccines*" reflects the medical-record-confirmed realities that those supporting this bill offered as proof of the damage caused by today's "one-size-fits-all" childhood vaccination program.

However, the writer's unsupported claim, "*public health professionals cited detailed research studies showing that vaccinations prevent, rather than cause, serious disease*", is highly problematic.

This is the case because all that the putative "*public health professionals*" have been doing is to "*cite*" those "*research studies*" that said "*public health professionals*" claim show that vaccination with some particular vaccine (e.g., the Merck MMR II® vaccine) against some particular disease (e.g., measles) during some particular time window (e.g., 12-15 months) or windows (e.g., 12-15 months and 4-6 years) apparently prevents most of the children from subsequently contracting a "wild" or "native" case of the measles for some unspecified period of time (the writer's "*prevent, rather than cause, serious disease*").

Yet, the reality is that the inoculation of a child with the MMR II vaccine infects the child with "attenuated strains" of three live viruses (measles, mumps and rubella), which not only causes most, but <u>not</u> all, who are inoculated to develop circulating antibodies to measles, mumps and rubella but also causes them to:

a. Shed these live viruses and have adverse reactions that mimic some of the symptoms of the diseases in the MMR II vaccine they were given and/or
b. Have one or more of the serious adverse effects listed in the vaccine's package insert or, in rare cases, die shortly after being vaccinated in a "few"

instances for those who are inoculated with the MMR II.[34]

Worse, because the exposure to the live viruses (by intramuscular injection) differs from the natural exposure (by mucosal contact with, and inhalation of, these live viruses), the protection provided is both incomplete and abnormal.

Moreover, this abnormal stimulation of the human immune system has definitely contributed to today's epidemics of chronic childhood medical conditions that, in children, were uncommon (e.g., asthma) to nonexistent (e.g., childhood type 2 diabetes or life-threatening peanut allergy) prior to the 1970s.[35]

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34 http://www.fda.gov/downloads/BiologicsBloodVaccines/Vaccines/ApprovedProducts/UCM123789.pdf (MMR II package insert, dated "December 2007"), "ADVERSE REACTIONS

The following adverse reactions are listed in decreasing order of severity, without regard to causality, within each body system category and have been reported during clinical trials, with use of the marketed vaccine, or with use of monovalent or bivalent vaccine containing measles, mumps, or rubella:

Body as a Whole

Panniculitis; atypical measles; fever; syncope; headache; dizziness; malaise; irritability.

Cardiovascular System

Vasculitis.

Digestive System

Pancreatitis; diarrhea; vomiting; parotitis; nausea.

Endocrine System

Diabetes mellitus.

Hemic and Lymphatic System

Thrombocytopenia (see WARNINGS, Thrombocytopenia); purpura; regional lymphadenopathy; leukocytosis.

Immune System

Anaphylaxis and anaphylactoid reactions have been reported as well as related phenomena such as angioneurotic edema (including peripheral or facial edema) and bronchial spasm in individuals with or without an allergic history.

Musculoskeletal System

Arthritis; arthralgia; myalgia.

Arthralgia and/or arthritis (usually transient and rarely chronic), and polyneuritis are features of infection with wild-type rubella and vary in frequency and severity with age and sex, being greatest in adult females and least in prepubertal children. This type of involvement as well as myalgia and paresthesia, have also been reported following administration of MERUVAX II.

Chronic arthritis has been associated with wild-type rubella infection and has been related to persistent virus and/or viral antigen isolated from body tissues. Only rarely have vaccine recipients developed chronic joint symptoms.

Following vaccination in children, reactions in joints are uncommon and generally of brief duration. In women, incidence rates for arthritis and arthralgia are generally higher than those seen in children (children: 0-3%; women: 12-26%),[17,52,53] and the reactions tend to be more marked and of longer duration. Symptoms may persist for a matter of months or on rare occasions for years. In adolescent girls, the reactions appear to be intermediate in incidence between those seen in children and in adult women. Even in women older than 35 years, these reactions are generally well tolerated and rarely interfere with normal activities.

Nervous System

Encephalitis; encephalopathy; measles inclusion body encephalitis (MIBE) (see CONTRAINDICATIONS); subacute sclerosing panencephalitis (SSPE); Guillain-Barré Syndrome (GBS); febrile convulsions; afebrile convulsions or seizures; ataxia; polyneuritis; polyneuropathy; ocular palsies; paresthesia.

Experience from more than 80 million doses of all live measles vaccines given in the U.S. through 1975 indicates that significant central nervous system reactions such as encephalitis and encephalopathy, occurring within 30 days after vaccination, have been temporally associated with measles vaccine very rarely.[54] In no case has it been shown that reactions were actually caused by vaccine. The Centers for Disease Control and Prevention has pointed out that "a certain number of cases of encephalitis may be expected to occur in a large childhood population in a defined period of time even when no vaccines are administered". However, the data suggest the possibility that some of these cases may have been caused by measles vaccines. The risk of such serious neurological disorders following live measles virus vaccine administration remains far less than that for encephalitis and encephalopathy with wild-type measles (one per two thousand reported cases).

Post-marketing surveillance of the more than 200 million doses of M-M-R and M-M-R II that have been distributed worldwide over 25 years (1971 to 1996) indicates that serious adverse events such as encephalitis and encephalopathy continue to be rarely reported.[17]

There have been reports of subacute sclerosing panencephalitis (SSPE) in children who did not have a history of infection with wild-type measles but did receive measles vaccine. Some of these cases may have resulted from unrecognized measles in the first year of life or possibly from the measles vaccination. Based on estimated nationwide measles vaccine distribution, the association of SSPE cases to measles vaccination is about one case per million vaccine doses distributed. This is far less than the association with infection with wild-type measles, 6-22 cases of SSPE per million cases of measles. The results of a retrospective case-controlled study conducted by the Centers for Disease Control and Prevention suggest that the overall effect of measles vaccine has been to protect against SSPE by preventing measles with its inherent higher risk of SSPE.[55]

Cases of aseptic meningitis have been reported to VAERS following measles, mumps, and rubella vaccination. Although a causal relationship between the Urabe strain of mumps vaccine and aseptic meningitis has been shown, there is no evidence to link Jeryl Lynn™ mumps vaccine to aseptic meningitis.

Respiratory System

Pneumonia, pneumonitis (see CONTRAINDICATIONS); sore throat; cough; rhinitis.

Skin

Stevens-Johnson syndrome; erythema multiforme; urticaria; rash; measles-like rash; pruritis.

Local reactions including burning/stinging at injection site; wheal and flare; redness (erythema); swelling; induration; tenderness; vesiculation at injection site.

Special Senses — Ear

Nerve deafness; otitis media.

Special Senses — Eye

Retinitis; optic neuritis; papillitis; retrobulbar neuritis; conjunctivitis.

Urogenital System

Epididymitis, orchitis.

Other

Death from various, and in some cases unknown, causes has been reported rarely following vaccination with measles, mumps, and rubella vaccines; however, a causal relationship has not been established in healthy individuals (see CONTRAINDICATIONS). No deaths or permanent sequelae were reported in a published post-marketing surveillance study in Finland involving 1.5 million children and adults who were vaccinated with M-M-R II during 1982 to 1993.[56] …."

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

Further, each of the lifetime chronic diseases, disorders, syndromes and life-threatening allergies that have been triggered in our children (to which, at a minimum, the U.S. childhood vaccination programs have clear clearly contributed) is a "*serious disease*", which, *because it is a chronic condition requiring treatment over a period of from years to most of the patient's entire lifetime*, is much more profitable to the health and the medical establishments than the acute childhood disease that it has replaced.

Thus, the writer is obviously mistaken when he makes the unqualified claim, "*vaccinations prevent, rather than cause, serious disease*", because the current childhood vaccination program is clearly a significant causal factor in the current epidemics of chronic childhood diseases, disorders, syndromes and life-threatening allergies that are often lifetime-debilitating to the health of the affected children.

"If vaccine mandates are weakened, we will see pockets of unvaccinated kids putting at risk infants, pregnant women and people whose immunity has waned or never took when" [sic; when they were] "first inoculated."

This reviewer finds that the writer's forecast of impending risk from "*pockets of unvaccinated*" children is not only illogical but also <u>not</u> supported by current vaccination and population realities.

First of all, the childhood vaccination program does <u>not</u> provide lifetime protection from the covered diseases in the adult population.

In addition, 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[36] current percentage of U.S. adults covered by a given 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 vaccination recommendations that have been in effect for more than 5 years.

Given the general vaccination propaganda that only a fully vaccinated population (typically, claimed to be at the 87 to 90-plus percentage level) provides "herd protection" to that population, the preceding data seem to indicate that there is <u>no</u> "herd protection" in the adult population.

Thus, since, *on average*, more than 50% of adults have <u>no</u> general vaccination-generated protection from the covered disease for which there is a childhood vaccination program, the "*infants, pregnant women and people whose immunity has waned*

"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."

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

or never took when" are clearly more at risk of contracting a covered disease from an adult than from the "*pockets of unvaccinated kids*"

Yet, although there is no "herd protection" in the U.S. adult population, neither the "*infants, pregnant women and people whose immunity has waned or never took*" [when they were] "*first inoculated*" nor adult Americans are experiencing other than isolated outbreaks of those covered diseases for which the historical data[37] indicate the overall vaccination program appears to be effective.

"For mainstream public health scientists, these are settled issues, but in the political world, they remain open questions."

First, this reviewer agrees that, for "*mainstream public health scientists*", the position that "*vaccinations prevent, rather than cause, serious disease*" is a "*settled*" issue.

However, from the viewpoint of the independent, peer-reviewed science, the position of these "*mainstream public health scientists*", which apparently includes the writer, is not supported by the scientifically sound and appropriate animal model and clinical studies.

Factually, the issues surrounding:

a. Each vaccine (i.e., vaccine's safety and the vaccine's in-use, effectiveness for the inoculated-individual's disease protection following disease exposure) and
b. The overall U.S. vaccination programs for our developing children, adults and elderly (i.e., the "herd protection" provided by the vaccine and the medical cost-effectiveness of the overall vaccination program when all of the costs are appropriately considered)

are, *from the viewpoint of science*, issues that have not been properly addressed or, *if addressed*, the studies supporting the viewpoint of the "*mainstream public health scientists*" are fundamentally flawed, poorly designed, falsified, or nonexistent.[38]

Thus, in contrast to the writer's "*but in the political world, they remain open questions*" assertion, independent scientists, researchers, parents, some politicians, and even some mainstream media reporters know that the safety, effectiveness and cost-effectiveness of FDA-licensed/CDC-recommended vaccines have not been proven.

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37 For "notifiable diseases", the CDC publishes an annual "Summary of Notifiable Diseases" report for the reported cases of the diseases covered by the current U.S. vaccination program and other diseases in the ***Morbidity and Mortality Weekly Report*** (***MMWR***) [available by searching the web site: http://www.cdc.gov/mmwr/ using the search phrase "Summary of Notifiable Diseases"]. In general, these "annual" reports clearly show that: **a)** for the MMR vaccine, the mumps component is not in-use effective in providing long-term immunity to the inoculated American population; **b)** the chickenpox (*Herpes varicella zoster* [HVZ]) inoculation program is not in-use effective in preventing chickenpox cases; **c)** for the DTaP and Tdap vaccination programs; the pertussis component is not in-use effective in providing long-term immunity to the inoculated American population;

38 See the pertinent sections in all of the vaccine-related documents posted on the "Documents" section of this reviewer's web site, http://dr-king.com and the supporting references contained therein for the independent science that supports this autonomous reviewer's science-based viewpoint on the studies upon which "*mainstream public health scientists*" rely.

These groups are well aware that: a) claims of lack of proof of harm are continually asserted and b) biased (rigged) and less-than-appropriate safety testing has been inappropriately substituted for the scientifically sound and appropriate proofs of safety, which are required of drugs that are not vaccines.

These independent groups understand that measurements of a given vaccine's efficacy (based on some industry-regulatory-agency-negotiated measurement of antibody titer and antibody-titer-persistence) provides little, or no, proof that:

a. **The vaccine is in-use effective in preventing disease in a fully inoculated individual when he or she is subsequently exposed to the disease-causing organisms, or**
b. **Any level of population vaccination, including 100%, provides effective "herd protection" from disease when, *for whatever reasons*, that disease re-emerges in or is reintroduced into that "fully vaccinated" population.**

Thus, in the independent and unbiased scientific, public and political worlds, these safety, effectiveness, and cost-effectiveness issues "*remain open questions*".

"There is another way."

Having shown what is required, but is currently missing from the information cited by the "*mainstream public health scientists*", to appropriately address the issues of vaccine safety, in-use effectiveness and medical cost-effectiveness, this reviewer is bemused by the writer's suggestion here that "*[t]here is another way*".

"The Legislature relies on independent analysts to score the economic impact of various proposals."

Accepting that the New Jersey governor and the Legislature sometimes rely "*on independent analysts to score the economic impact of various proposals*", this reviewer notes that the "*mainstream public health scientists*" have repeatedly proven that they are anything but "*independent analysts*" or reliable sources for unbiased, scientifically sound and appropriate studies of vaccine safety, effectiveness and medical cost-effectiveness.

"No similar objective analysis is required or sought for the health impact of legislation."

Regrettably, no objective analyses are available for the health impacts of legislation because:

- **The "*mainstream public health scientists*" are allowed to block independent scientists from evaluating the population-wide vaccination records' data that, using public funds, these "*public health scientists*" are accumulating (e.g., the Vaccine Safety Datalink [VSD] database for children's records) and the published reports generated by these "*mainstream public health scientists*" using these unavailable publicly-funded databases have repeat-**

edly been shown to be flawed, unacceptably biased, falsified or otherwise fundamentally flawed, as shown earlier in this reviewer's appraisal of the writer's unsubstantiated assertions about the link between Thimerosal-preserved vaccines and the risk of autism;

- Access to the raw data and related records required for the independent confirmation of the validity of the study is denied or the study's authors or the institutions, where these records are supposed to be maintained, have even claimed that these records have been lost in some instances – rendering these studies scientifically invalid because, absent access to the original data records and design documents, such studies cannot be independently replicated;[39] and
- The adverse events system for vaccines to which the public does have access, the joint CDC-FDA Vaccine Adverse Events Reporting System (VAERS), is a voluntary reporting system which, when then FDA-Commissioner David Kessler reviewed the issue in 2003, he reported, "only about one percent of serious events ... are reported".[40] The VAERS database itself, which rarely contains reports for more than 10% of the actual adverse events associated with a given vaccine, does not provide sufficient adverse-event information nor data for the number of doses of each vaccine administered to permit accurate independent analyses of the health impacts of a vaccine much less the vaccination-related health impacts of legislation because the levels of underreporting are not known for each vaccine and vaccine combination nor are the number of administered doses of each vaccine recorded and, *for the reports logged*, the information in each record is often incomplete or inaccurate.

"Instead, self-proclaimed experts citing personal anecdotes or cherry-picked factoids fresh off the internet" [sic; Internet] "are heard in the same forum and often given the same credence as scientific experts with decades of training and experience dedicated to advancing public health."

Here, the writer begins by attacking those independent scientists and researchers who support informed consent and vaccination choice because the laws and the science both indicate that this path would improve the mental, fiscal and physical

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39 The absolute necessity of independent replication of the results using the original data records and design documents in vaccine-related studies is clearly illustrated when independent researchers, MC DeSoto and RT Hitlan, asked for and were given the data records and design and execution information for a key 2004study by Ip P, Wong V, Ho M, Lee J and Wong W titled, "Mercury exposure in children with autistic spectrum disorder" (***J Child Neuro***. 2004; **19**: 431-434). When the datasets were re-analyzed, a major calculation error was discovered which changed the valid findings and provided support for a "mercury-autism" causal link (see: DeSoto MC and Hitlan RT. Blood Levels of Mercury Are Related to Diagnosis of Autism: A Reanalysis of an Important Data Set. ***J Child Neurol*** 2007; **22**; 1308-1311). After the error was found in the review, the authors of the original article, Ip P, Wong V, Ho M, Lee J, and Wong W, agreed that this significant error had been made which, when corrected, invalidate the original study's findings.

40 Kessler, DA, the Working Group, Natanblut S, Kennedy D, Lazar E, Rheinstein P, et al. Introducing MEDWatch: a new approach to reporting medication and device adverse effects and product problems. ***JAMA*** 1993; **269**(21): 2765.

health of the public far more than the current coercive, one-size-fits-all, for-the good-of-the-whole approaches used and favored by our public health officials.

The writer does this by mischaracterizing these pro-choice, pro-informed-consent individuals, researchers and scientists as "*self-proclaimed experts citing personal anecdotes or cherry-picked factoids fresh off the [I]internet*"

Next he portrays his "*mainstream public health scientists*" as (with emphasis added) "*scientific experts with decades of training and experience dedicated to advancing public health*".

Unfortunately, the positions taken by the "*mainstream public health scientists*" have disqualified them as reliable sources for scientifically sound vaccine-related information.

These positions include their near-religious adherence to vaccine and vaccination dogma and their continual attempts to distort and rewrite factual history to tout vaccines and vaccination programs as the saviors of the health of the public rather than, as they truly are, drugs and medical practices that are not nearly as beneficial as they are advertised.

In several instances, the vaccine or the recommended mass vaccination program is or, for the withdrawn vaccines, was, clearly more harmful than beneficial when all the costs and risks are or were properly considered.

Factually, before administration, the theoretical[41] prophylactic (disease preventive) benefits to the health of each person given these vaccines according to the current recommended program are just that, benefits which the vaccinated person can only realize: a) when the person inoculated with them in a manner that is claimed to provide protection from disease does not suffer significant serious vaccination-related injury to his or her health and b) *when subsequently exposed to an infective level of that disease*, does not contract the disease or become a silent disease carrier and then infect others.

Tellingly, the writer phrasing implicitly acknowledges that these "*scientific experts*" are dedicated to advancing the interests of "*public health*" and not, *as they should be*, to protecting and improving the overall mental, fiscal and physical health of each member of the public.

Given the preceding realities, this reviewer finds that the "*experts*" on both sides of the vaccine, vaccination program and vaccine exemption issues appear to be "*self-proclaimed experts*", who, when it comes to legislation, should be "*heard in the same forum and … given the same credence*".

41 Factually, the benefits are theoretical until the person inoculated with a given vaccine in a manner that is claimed to provide protection from disease is provably exposed to a disease strain covered by the vaccine and neither contracts the disease nor becomes a disease carrier who spreads that disease to others.

This is the case because, with few exceptions, the legislators lack the ability to independently assess the validity of the supporting evidence and testimony given by either side of the vaccination-exemption debate.

"Unfortunately, health professionals contribute to this confusion by their silence."

Here, this reviewer finds that, *as this writer's opinion piece and those of his colleagues in other forums clearly demonstrate*, not only are public health professionals not silent but they also easily get their unsupported views published.

In contrast, the proponents of safer vaccines, in-use effective vaccines, and medically cost-effective vaccination programs appear to be silenced by a mainstream news media that often refuses to publish the countervailing views of those who are seeking less coercive vaccination mandates that:

1. **Truly recognize the need for vaccination mandates to explicitly recognize, and defer to, the individual's rights to: a) 'bodily integrity' and b) 'informed consent'.**
2. **Only cover those vaccines that have been unequivocally proven to be: a) reasonably safe, b) in-use effective, and c) medically cost-effective.**

In addition, those who take positions against vaccination orthodoxy are subjected to: a) requirements of proof, b) demands for full disclosure of any potential conflicts of interest, and c) having their motives questioned and their integrity attacked, while the vaccination apologists are usually not only given a pass in these areas but also defended by the mainstream media even in instances where a "public health" scientist is: i) indicted for mail fraud and money laundering in the USA, ii) has previously been let go by his Danish employer for gross violation of his employment agreement, ii) has been indicted in Denmark for gross tax evasion, and iii) has been implicated in the apparent knowing falsification of the findings in a key peer-reviewed paper published in 2003 in *Pediatrics*, where the paper[42] reported that the rates for autism increased after the Thimerosal-preserved vaccines were removed from the Danish vaccination schedule.

However, internal pre-submission e-mails between the Danish authors and their CDC liaison, obtained under the U.S. Freedom of Information Act (FOIA), clearly state that the incidence and the prevalence of autism were decreasing after all the Thimerosal-preserved vaccines were removed from the Danish childhood vaccination schedule.[43]

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42 Madsen KM, Lauritsen MB, Pedersen CB, Thorsen P, Plesner A-M, Andersen PH, Mortensen PB. Thimerosal and the Occurrence of Autism: Negative Ecological Evidence From Danish Population-Based Data. ***Pediatrics*** 2003; **112**; 604-606.

43 http://dr-king.com/docs/120229a_DrftRevu_MyTurn_Immunizations_CriticalProtectionForStatesFamilies_b.pdf, pages "13" and "A-1".

"Some who dare to speak out are attacked professionally and personally. Some have trouble communicating complex issues in understandable language. Many work for public institutions, such as universities and health agencies, with strict rules about "lobbying" and can't speak directly to legislators without their employer's consent.

> **Here, this reviewer finds that the writer's "gripes" should be given no credence because some of those on both sides of the vaccination-exemption issue, who speak out: a) are verbally attacked and b) "*have trouble communicating … issues in understandable language*".**
>
> **Moreover, this reviewer suggests that the writer's closing statement in this passage should simply be ignored because there are those on both sides of this issue who, *because of their work situation*, are unable to speak directly to their legislators.**

An Assessment of the Writer's General Opinions

"The Legislature deserves congratulations for advancing the vaccine and fluoridation bills. They got it right."

> **As the scientific evidence that this reviewer has presented, the Legislature got it wrong in passing legislation mandating annual influenza vaccination for healthcare workers and supporting the fluoridation of potable waters.**
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> **Fortunately, the Governor "*got it right*" when he refused to sign the influenza vaccination mandate into law.**
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> **Hopefully, the Legislature will:**
>
> **a. Wake up,**
> **b. Realize that the costs to the fiscal and physical health of the residents of New Jersey cannot be justified, and**
> **c. Not only reject the current bills but also enact legislation banning the addition of any toxic fluoride compound or other similar toxic chemical, which has:**
> **i. medicinal properties (e.g., some lithium salt) and/or**
> **ii. for some, serious adverse health effects,**
>
> **to any potable water in New Jersey.**

"However, when lives are at stake, a health impact assessment should be performed. Legislators should invite academic researchers to present objective testimony without concerns over lobbying. The state's significant data resources and newly developed health information networks should inform their deliberations."

> **When any public health official, like this writer, raises the "*lives are at stake*" claim even though there is no evidence that anyone in New Jersey is even sick, much less dying (e.g., the 2009 Swine Flu Scare), the first thing the Legislators should do is find out who stands to profit from this claimed impending catastrophe and make**

certain that those entities are neither directly nor indirectly funding the activities of the person(s) or group(s) issuing the warning.

Second, given the worldwide connectivity of the Internet, the Legislators should have their staff examine the independent evidence that supports the warning.

Third, the Legislators should then reach out to independent qualified individuals, *whether they are in academia or elsewhere*, only when that in-depth assessment of the threat-specific applicable information confirms that the threat to life may be real.

In general, unless: **a)** the academic has relevant real-world experience in addressing the particular type of threat or understanding of the overall ramifications of each of the different approaches to handling that threat and **b)** he or she has no direct or indirect conflicts of interest or potential conflicts of interest, he or she should not be invited to testify

Since the writer admits that the state has "*significant data resources*" and "*newly developed health information networks*", this reviewer, an independent researcher and scientist, thinks that, ***just this reviewer does***, the Legislators should be able to gather the unbiased information they need to decide upon the best course of action to address a "public health" issue without, *in most cases*, convening a panel of independent experts to give their opinions on how best to address the problem – because the opinion of most academics embodies their subjective views.

Then, time permitting, the Legislators should hold open hearings at which they present the problem and their proposed solution or solutions choices and let the general public, not the academics, present their objection and views so that the public will "buy into" and support whatever solution the Legislators then propose as long as that solution clearly puts the mental, fiscal and physical health of the people of New Jersey ahead of those who stand to profit from the decision the Legislators propose.

Having walked the halls of academia, industry and the political system, this reviewer finds that the solutions offered by academics often are the least practical and most burdensome, and, therefore, cannot recommend, as the writer does, that "academics" be given special access to New Jersey's Legislators.

Closing Statement

"The debate over public health policy should bias" [sic; be biased] "toward provable facts, for neutrality is no virtue when weighing junk against real science."

First, this reviewer agrees that the "*debate over public health policy*" should have a predisposition.

However, that predisposition should be toward scientifically sound and appropriate,

factual information.

It should not be biased, *as it often seems to be*, toward the unsupported, "evidence-based" pronouncements of public health officials, the mainstream media, or the industries who tout practices from which they clearly benefit more than the public or, for that matter, *as this writer asserts*, "*toward provable facts*".

Since this reviewer has plainly established[44] that, when it comes to vaccines and vaccination programs, most of the "science" upon which public health scientists and officials rely falls into the category of "*junk*" science, this reviewer agrees that, when assessing "*real science*", the unsupported "*science*" cited in the written and verbal testimony typically offered by public health personnel should, at a minimum, be heavily discounted.

When it comes to vaccine issues, only the document-supported testimony provided by the parents of vaccine-damaged children, vaccine-damaged individuals, and independent scientists and researchers should be given due consideration and deference provided these individuals do not stand to financially profit from the positions that they are espousing.

Similarly appropriate rules should apply for testimony on the other issues that the writer has raised concerning New Jersey's potable water and the availability of clean raw milk and milk products.

"Drew Harris is chairman of the New Jersey Public Health Institute."

Here, this reviewer observes that "Drew Harris", who is apparently reachable via e-mail at drewaharris@gmail.com, is being too modest about who he is, as the following biographical information[45] clearly demonstrates:

> "Dr. Drew Harris is Chairman and Co-founder of the New Jersey Public Health Institute, a non-profit public health advocacy organization dedicated to advancing public health policy and research in New Jersey. He was President of the NJ Association for Biomedical Research, a nonprofit organization serving the interests of the biomedical research community.
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> Previously, Dr. Harris was the Assistant Director of the NJ Center for Public Health Preparedness (NJCPHP) at the University of Medicine and Dentistry of NJ and Assistant Professor in the UMDNJ School of Public Health, where he conducted education, training and research on a variety of topics including public health law, assessment and preparedness through grants with the CDC, New York City Department of Health and Mental Hygiene, the NJ Department of Health and Senior Services, and other state and federal agencies and private foundations. At the NJCPHP, Dr. Harris conceived and managed the Public Health Leadership Initiative for Emergency Response (PHLIER)—a fellowship program for emerging public health leaders.

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44 See the applicable review documents and the references cited by them that are posted on this reviewer's web site: http://dr-king.com as well as those cited in this review.

45 http://www.apha.org/about/board/Drew+Harris.htm, last visited on 6 March 2012. The American Public Health Association [APHA] apparently is a Washington-based 'lobbying' organization (800 I Street, NW Washington, DC 20001-3710. Tel.: 202-777-APHA; FAX: 202-777-2534)

Dr. Harris has joint appointments as an adjunct assistant professor at the UMDNJ-NJ Medical School and UMDNJ-School of Public Health in the Department of Preventive Medicine and Community Health and Department of Environmental and Occupational Health, respectively.

As a public health activist, Dr. Harris has been involved in several statewide campaigns and coalitions to guarantee universal access to health care; control diabetes, obesity and tobacco use; and remove barriers to community-based research. Other activities include a stint as the host for "HouseCalls," a radio talk show focusing on health care and public health topics.

Dr. Harris is a podiatric physician, with 17 years of private practice experience concentrating on the care of people with diabetes and non-healing wounds, as well as research into new wound healing modalities. He obtained his Masters of Public Health from the UMDNJ-School of Public Health. His research interests lie at the vital nexus of public health science and practice, public policy and politics."

In contrast, this reviewer, 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.

In addition, since the mid-1970s, Dr. King has been a strong proponent for protecting the public from unnecessary exposures to toxic materials in the air we breathe; the water that we drink and in which we cook our food and bathe; the food we eat; the clothes that we wear; the home, work and recreational environment in which we live; and the substances we personally use to control weeds and pests in our environment.

Further, he is a proponent of the natural breastfeeding of children and, when he and his family have lived in a city where raw milk is commercially available, has elected to buy and drink raw milk from a dairy that operated under sanitary, near aseptic conditions rather than buy and drink pasteurized milk from the commercial dairies, where the conditions were much less sanitary.

For more information about Dr. King and access to his recent publications, please visit http://www.dr-king.com.