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Introduction

Following this introduction page is this reviewer's analysis of "**Vaccine Safety: Why Parents' Alternative Immunization Schedules May Cause Harm**" by Bonnie Rochman, which was downloaded on June 19, 2012 from http://healthland.time.com/2012/06/18/why-listen-to-the-doctor-because-parents-alternative-vaccine-schedules-may-cause-harm/?iid=hl-main-lede%3Fxid%3Drss-topstories&utm_source=feedburner&utm_medium=feed&utm_campaign=Feed%3A+time%2Ftopstories+%28TIME%3A+Top+Stories%29.

This analysis, titled "A Review of: 'Vaccine Safety: Why Parents' Alternative Immunization Schedules May Cause Harm'", begins on the next page.

Introductory Remarks

First, to "simplify" this analysis, when portions of the article, which are quoted in a "Times New Roman" font, being evaluated are specifically addressed in this review, those portions will be quoted in an *italicized* "*Times New Roman*" font.

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

Third, when other sources are quoted or referenced, the text 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, please submit that information to this reviewer so that he can improve his understanding of factual reality and, where appropriate, revise his views and this analysis.

Respectfully,

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

A Review of:
"Vaccine Safety: Why Parents' Alternative Immunization Schedules May Cause Harm"

As most vaccine apologists do, the author, Bonnie Rochman, of this obviously fear mongering article begins with a title that misrepresents reality by using the word "***Immunization***" when the most appropriate word is "Inoculation" since this word properly presents the reality that persons receiving a vaccine are inoculated with it:

- By injection into the recipient,
- Orally in the case of the live rotavirus vaccines or, in some countries, the live poliovirus vaccines, or,
- In the case of the live-virus influenza vaccine, MedImmune's FluMist®, as an intranasal "spray".

The word "immunization" is commonly used by vaccine apologists and acolytes to mislead the uneducated reader into believing that the administration of vaccines provides disease immunity, when it does not.

At best, the use of any given vaccine provides only limited-duration protection against one or more specific disease strains (and may not be protective against heterologous strains).

Further, even the vaccines' claimed "efficacy" values are significantly less than 100 % and, in use, their effectiveness generally varies from significantly less than 60 % to no greater than 95 %.

However, in many instances, there is no proof that even those who are "fully vaccinated" are truly protected from subsequently contracting the claimed strain or strains of a disease or diseases, when the person inoculated is, *at some future date*, exposed to whatever strain or strains of that disease or those diseases for which some level of protection is claimed.

Therefore, the greatest harms that a parents' alternative inoculation schedule probably will cause in the USA are:

a. The loss of revenue to the vaccine makers and, from the tax on vaccines, the US government, and
b. The loss of income to those administering the vaccines.

In addition, *absent exposure to the disease in a manner that triggers a clinical case of the disease*, there is no inherent risk of harm to those children who are not inoculated with the vaccine against that disease.

Therefore, parents should limit their newborns' exposure to others, especially those who are ill and, *to the extent possible*, minimize the infants' exposures to public venues until their newborns are at least one year of age.

Furthermore, for healthy, breastfeeding babies whose mothers:

a. Have had the "childhood" diseases for which there are vaccines;

b. Consume near optimal levels of nutritionally appropriate foods, including appropriate dietary vitamins, minerals and key nutrients, and

c. Drink sufficient quantities of potable, fluoride-free water,

there is little compelling need for a healthy neonate born and raised in today's USA to be inoculated with any prophylactic vaccine until after breastfeeding ceases.

Finally, for a child to develop long-term to "lifetime protection" (immunity) from a preventive inoculation against a disease, the exposure to the disease organisms, or their proven surrogate equivalents, should mimic natural exposure to the disease-causing microbes and, *in general*, occur after the child is one year of age.

"Many parents have decided they know better than pediatricians: they're following their own vaccine schedules, but most children adhering to alternative models don't wind up fully immunized."

Here, the writer begins by implying that pediatricians know that the current US vaccination schedule[1] is supported by scientifically sound and appropriate independent scientific studies that have proven and currently support the safety, effectiveness and cost effectiveness of each vaccine and every possible combination of vaccines that may be given at the same time[2] and that this schedule is the best inoculation timetable for each and every child.

Moreover, this writer's statement implies that all pediatricians adhere to the same vaccination schedule.

However, in reality, some recognized pediatricians adhere to different general vaccination schedules; some others elect to tailor the vaccination schedules for each child based on the applicable family medical history; and a few, who provide healthcare services to the newborns and developing children in families who are opposed to vaccinating their children, recommend long-term breastfeeding and the development of natural immunity rather than vaccination.

Furthermore, since some of these parents who are "*following their own vaccine schedules*" are also physicians, including pediatricians, who see developing newborns and developing children in their practices, the writer's attempt here to make this a "knowledgeable us" against "an uneducated them" issue is, *at best*, misguided.

Turning to the rest of the writer's assertion, "*but most children adhering to alternative models don't wind up fully immunized*", this reviewer finds that the writer is confused.

Factually, for those "childhood" diseases for which we have licensed vaccines, the children who are most "*fully immunized*" are only those initially healthy children with normal immune-system development who are then naturally exposed to these

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1 The US childhood vaccination schedule is that inoculation schedule for children that, in terms of the specific vaccines, vaccine doses, and dose timing, is officially recommended by the U.S. Centers for Disease Control and Prevention [CDC] when the CDC publishes the recommendations of its intentionally misnamed Advisory Committee of Immunization Practice [ACIP] in the CDC's journal *Morbidity and Mortality Weekly Report* [***MMWR***].

2 Factually, no pediatrician can know this information because all of the scientifically sound and appropriate studies required to prove safety, in-use effectiveness and cost effectiveness have not been conducted.

childhood diseases during the appropriate time periods and, *with no or minimal clinical disease symptoms*, recover from these exposures in a manner that allows all of the layers of the child's immune system to develop the appropriate, long-lasting "immune system" responses to these childhood diseases.

In general, the disease protection provided by a vaccination (inoculation with a vaccine) that is called "an immunization":

a. Does not last nearly as long as the periods of protection provided by naturally acquired immunity;
b. Currently leads to only some percentage of the inoculated children actually having protection following one or multiple inoculations with a given vaccine, where that percentage that ranges from a few percent to *no-more-than* 95 percent, in a few instances;
c. Results in a claimed duration of any protection provided by a vaccine antigen that ranges from "1" year for influenza to "3" years for "pertussis" to "4 to 5" years for the covered strains of "meningococcal meningitis" to about "25" years for the measles vaccine component in the current MMR vaccines used in the USA; and
d. Is offset by the increasing evidence that, *for some diseases (e.g., influenza and pertussis [whooping cough])*, vaccination increases the susceptibility to contracting those diseases when the vaccinated individuals are subsequently exposed to them.

In addition, there is an ever-increasing body of evidence that the early childhood vaccination programs significantly increase the child's risk for: **a)** developing a lifetime chronic disease, disorder, syndrome, or allergy, and/or **b)** having a developmental, including neurodevelopmental, or behavioral problem from which some children, *even with today's best interventions*, never recover.

Finally, there is growing evidence that inoculations given to children before they are one year of age:

a. Do not provide any effective long-term protection to most all of those so inoculated and
b. Significantly increase the vaccinated child's risk of dying as measured by the current "infant mortality" statistics.

"A generation ago, childhood vaccines weren't so controversial. Doctors told parents that vaccines saved lives, and parents listened."

While the preceding statements may be true, they mask the reality that childhood vaccines have always been controversial within the independent scientific community which has collectively long recognized that the vaccination realities were not as positive as the hype associated with each vaccination program.

Moreover, the "'group a' told 'group b' that 'outcome c' was true and 'group b' listened" paradigm implicitly admits that the doctors did not provide unequivocal

proof to the parents that vaccines saved lives but the "*parents listened*" to, *and implicitly believed*, what they were told without demanding unequivocal proof of the claims being made.

"But then, a widely publicized but since-retracted study in the *Lancet* journal linked vaccines with autism, and autism activists like *Playboy* model Jenny McCarthy spread scary stories of watching their children regress after being vaccinated — you've heard the tales, unless you've been hiding in a hole."

Here, the writer begins, as most vaccine apologists do, by attempting to rewrite history.

Actually, the first article that discussed the possibility of a link between "autism" and a "vaccine" was published in Germany in 1976 by Eggers, C[3], and predates the unidentified ***Lancet*** article by about 22 years.

Additionally, in 1972, a note by Damluji SF and Tikriti S in the ***British Medial Journal*** (***BMJ***) briefly reported thousands of instances of the mercury poisoning of Iraqi farmers' families by an ethylmercury compound with the trade name Granosan M (ethyl mercury p-toluene sulphonanilide) that had been applied to wheat seed to protect it from fungal growth[4].

This report confirmed that ethyl mercury compounds are accumulatively toxic to humans.

Further, in 1973, a set of "chronic exposure" studies designed to study the pathology of alkylmercury poisoning in developing piglets[5] found serious neurological deficits, including incoordination, using a methyl mercury compound and an ethyl-mercury compound.

Moreover, *though this was no surprise to this reviewer*, the ethylmercury compound exhibited serious neurological toxicity at a dosing level significantly lower than the dosing level for the methylmercury compound.

Finally, the observed delayed onset of the severe neurological toxicity confirmed that, *for both alkylmercury compounds studied*, some form of mercury accumulated in the pigs' central nervous system and disrupted their gastrointestinal system.

In addition, a 1985 article looking into the trace in hair samples from autistic and neurotypical children[6] found that the patterns for mercury in the hair were different for males and females and had a complexity, *as a more modern study using*

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3 Eggers C. [Autistic syndrome (Kanner) and vaccination against smallpox (author's transl)]. *Klin Padiatr*. 1976 Mar; 188(2): 172-180. [Article in German] (emphasis added):
"Abstract
3-4 weeks following an otherwise uncomplicated first vaccination against smallpox a boy, then aged 15 months and last seen at the age of 5 1/2 years, gradually developed a complete Kanner syndrome. The question whether vaccination and early infantile autism might be connected is being discussed. A causal relationship is considered extremely unlikely. But vaccination is recognized as having a starter function for the onset of autism."

4 Damluji SF and Tikriti S. Mercury Poisoning from Wheat. *BMJ* 1972 Mar 25; 1(5803): 804.

5 Tryphonas L, Nielsen NO. Pathology of chronic alkylmercurial poisoning in swine," *Am J Vet Res*. 1973; 34(3): 379-392.

6 Wecker L, Miller SB, Cochran SR, Dugger DL, Johnson WD. Trace element concentrations in hair from autistic children. *J Ment Defic Res.* 1985 Mar; 29(Pt 1): 15-22 (emphasis added):
"Abstract

carefully matched test and control groups of vaccinated "autistic" and "neurotypical" children in different age ranges has confirmed[7], that precluded the hair mercury levels found from directly being useful as a diagnostic tool for "autistic children"[8].

Importantly, animal studies using radiolabeled (^{203}Hg)-ethylmercury compounds that were conducted in the late 1960s[9] and early 1970s[10] clearly established that:

a. These ethylmercury compounds were <u>not</u> rapidly excreted via the gut and
b. The mercury from the ethylmercury compounds administered was:
    1. Bioaccumulating in the brain and kidney of the animals studied (rat and monkey) and
    2. Found at wet tissue concentrations in the kidneys and the brain <u>above</u> the animal's whole-body inoculation concentration when the animals were sacrificed even though the animals' blood mercury levels were much lower than the dosing concentration (in micrograms per kilogram [or gram] of animal body weight)[11].

Turning to the issue of post-vaccination regression, this writer first attempts to minimize the reality of the thousands of similar parental reports, *backed up in some cases by photographs and videos as well as by the child's medical records*, of neurodevelopmental regression, often coupled with the development of gastrointestinal conditions and seizure disorders, that began or sharply accelerated after a given set of vaccine antigens were administered to their child by stating, "*autism activists like Playboy model Jenny McCarthy spread scary stories of watching their children regress after being vaccinated — you've heard the tales, unless you've been hiding in a hole*".

This statement is an obvious attempt to discredit the most well-documented and medically supported observations of the regression following vaccination <u>even in</u>

The concentrations of 14 elements were determined in scalp hair samples from control, autistic and autistic-like children. <u>Significant differences were noted between normal males and females for calcium, magnesium and mercury</u>. The autistic population had significantly lower levels of calcium, magnesium, copper, manganese and chromium and higher levels of lithium as compared to sex- and age-matched controls. … Results indicate that the concentrations of trace elements in hair from normal children differ from patterns observed in both autistic and autistic-like children. Furthermore, evidence suggests that hair analysis may have potential use as a diagnostic tool for autism."

7 Majewska MD, Urbanowicz E, Rok-Bujko P, Namyslowska I, Mierzejewski P. Age-dependent lower or higher levels of hair mercury in autistic children than in healthy controls. ***Acta Neurobiol Exp*** 2010; 70: 196-208.

8 The importance of this observation is that the pattern of mercury excretion in hair is, for the same level of mercury exposure from vaccination and other sources, significantly different for children with serious neurodevelopmental disorders than the pattern for matched unaffected "neurotypical" children. Moreover, in nations where Thimerosal-preserved vaccines are used, the early childhood hair mercury pattern for the children diagnosed with serious neurodevelopmental disorders shows lower levels of hair mercury compared to the hair mercury levels in the matched neurotypical children (when the majority of the doses of the Thimerosal-preserved vaccines were administered). In the matched groups of older children, the children with the serious neurodevelopmental disorders are now excreting higher levels of mercury in thie hair samples than the hair mercury levels in the matched neurotypicals. These findings clearly seem to be indicative of higher mercury retention by the children diagnosed with a serious neurodevelopmental disorder than by the neurotypical children. These findings also support the reality that the affected children are comparatively worse excretors of the mercury from vaccines than the non-affected neurotypical children are.

9 Takeda Y, Kunugi T, Hoshino O, Ukita T. Distribution of Inorganic, Aryl, and Alkyl ^{203}Hg-labeled Mercury Compounds In Rats. *Toxicol Appl Pharmacol* 1968; 13: 156-164.

10 Takahashi T, Kimura T, Sato Y, Shiraki H, Ukita T. Time-dependent Distribution of $^{[203]}$Hg-Mercury Compounds in Rat and Monkey as Studied by Whole Body Autoradiography. *J Hygenic Chem* (Japan) 1971; 17(2): 93-107.

11 Based on these findings, it is plain that clearance of the ethyl-mercury-derived mercury from the circulating blood is not indicative of the clearance of that mercury from the test animals' kidneys and brain.

those instances where:

a. The child was subsequently shown to have been mercury poisoned by the mercury from the Thimerosal-preserved vaccines and serums to which he or she was exposed from before birth until vaccination stopped and

b. Appropriate healing and detoxification treatments were started that have been proven to help the child to partly-to-mostly recover from the regression that he or she had experienced as well as to lose his or her mercury-poisoning diagnosis.

"Multiple studies have disavowed any link between immunization and autism, but the power of storytelling is hard to counter with data, as evidenced by the increasingly vocal numbers of parents who refuse to vaccinate their children and a growing percentage who agree to vaccinate but do so according to their own schedule, spreading out the required immunizations over a much longer time period than is recommended by public-health organizations."

With respect to the writer's "*[m]ultiple studies have disavowed any link between immunization and autism*", this reviewer notes that, *with possibly a couple of exceptions*, the published studies in question are little-more-than anecdotal[12] stories told by, or on behalf of, groups with vested interests.

Factually, the evidence provided by the parents is hard to counter because the datasets on which the published studies (to which the writer apparently refers) are based have been kept from review by independent researchers or "lost" so that no one can confirm the findings in the writer's non-cited "*[m]ultiple studies*".

In addition, at least one of the statistical studies to which this writer is probably referring has been proven to have been falsified[13].

Further, there is independent evidence that many of the other similar statistical studies to which the writer implicitly refers are less than scientifically sound.

Finally, the toxicological data that is required to prove that neither mercury poisoning by Thimerosal-preserved vaccines nor brain inflammation by the MMR vaccines can be causal factors for the subsequent neurodevelopmental disorders in any normally developing child whose symptoms begin or rise to clinical levels after the administration of such vaccines has not been published.

Nor, *as far as this reviewer can ascertain*, has any governmental agency or vaccine manufacturer conducted and published any such scientifically sound and appropriate toxicological vaccine component and vaccine studies.

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12 These studies are anecdotal in the sense that the published papers are based on short personal accounts of an incident or event even when published in most peer-reviewed journals. This is the case because the datasets upon which the article is based are generally not made available to the peer reviewers and peer-reviewed by them before publication of the article nor, *in most instances*, made available for independent assessment and confirmation by independent scientists after publication (as the ethics of science expects for honest studies). Independent review of the original datasets, study design, and exclusion/inclusion criteria is especially important in studies based on a retrospective review of population records because such studies can easily be designed and/or manipulated to produce the authors' "expected results".

13 http://dr-king.com/docs/20120331_FalsusInUnoFalsusInOmnibusAThimerosalpreservedVaccineConundrum_b.pdf

Since, *as this article demonstrate*s, the story telling of the parents is continually being buried under a flood of story telling by vaccine apologists, vaccination acolytes, and vaccine and vaccination profiteers, the power in the parents' story telling is in its obvious truthfulness and not in its volume because few such parental accounts appear in the mainstream media.

Moreover, the writer's,

> "*the increasingly vocal numbers of parents who refuse to vaccinate their children and a growing percentage who agree to vaccinate but do so according to their own schedule, spreading out the required immunizations over a much longer time period than is recommended by public-health organizations*"

is indicative of the growing number of parents who are studying the facts about the:

a. Development of the human immune system from birth onwards,
b. Various current CDC-recommended vaccinations and their scheduled timings,
c. Very real risks and the probable incidence associated the serious risks for each vaccination and/or multiple vaccinations at the same time,
d. Theoretical benefits for each vaccine active and the percentage of those who are inoculated who possibly may get those benefits,
e. Duration and breadth of protection offered by each vaccination,
f. Risks for the development of long-term chronic diseases, disorders, syndromes, and allergies possibly causally linked to each vaccine active,
g. Increasing evidence in the USA and Canada that, f*or the early childhood vaccinations occurring before one year of age*, delaying the vaccination reduces the risk of serious adverse outcomes, and
h. Increasing evidence that certain vaccines are, *on the whole*, not in-use effective at providing adequate disease protection and/or, *as the number of recommended "doses" or "booster shots" has increased*, not cost-effective.

For those parents who have proverbially "done their homework" and not merely listened to the Establishment's propagandization of the current vaccination programs and its ever-increasing appetite for expanding the number of vaccinations and vaccine actives, those parents, who obviously love and care for their children more than the current "healthcare" system does, seem to be qualified to make an informed decision to completely forego vaccination or to choose which vaccines and when, *if ever*, each will be given.

Since, *unlike most other types of drug*s, vaccines more or less permanently alter the overall immune system of the person who is given even one dose, *a fact that is generally not even mentioned by the vaccination-promoting Establishment*, it would seem that these parents are the some of the few who truly understand the realities about the current CDC-recommended vaccination programs.

Hopefully, more parents will "do their homework" and actively participate in all vaccination decisions knowing that, *should the worst happen*, they alone, *and not the healthcare providers, the vaccine makers and the federal government*, bear the immediate consequences of their decisions concerning their children's vaccination and vaccination timing.

"It's this latter group that a team of researchers in Oregon — a state that has historically had a high number of parents opting out of vaccinations for religious reasons — decided to study. The researchers found that "shot limiting" — when parents restrict the number of shots their child receives at each doctor's visit — increased from 2.5% children in 2006 to 9.5% in '09. The altered schedules ultimately resulted not only in increased intervals between vaccinations but overall lower levels of immunization, according to the research published Monday in *Pediatrics*."

Here, the writer is simply restating the obvious – more parents are becoming actively involved in making the medical treatment decisions for their children when it comes to vaccination and vaccination timing.

However, there is no evidence that these actions have significantly increased the overall disease incidence rates for those vaccines for which there is an FDA-licensed vaccine that is recommended by the CDC for mass use in children.

Moreover, the overall average mortality incidence rates from vaccine-covered diseases seem to be generally declining even in some instances for which the current vaccines are either not in-use effective or do not cover the actual disease or disease strain/type/serogroup with which those with a clinical case are infected.

"'We've been concerned about vaccine hesitancy for a while in Oregon,' says Steve Robison, an epidemiologist in the Oregon Health Division and the study's lead author. 'It's published in books, it's on the Internet, and in Portland, you may even hear it from your barista.'"

Here, this reviewer agrees that the more knowledgeable parents are making vaccination decisions that alter their children's vaccination schedule.

However, their actions should be characterized positively as "actively making vaccination choices" rather than as "*vaccine hesitancy*", which the writer negatively reports here.

Since "*your barista*" (a person who operates an espresso maker at a coffee bar) may also be an informed parent who may want to share his or her knowledge with others, this reviewer sees nothing wrong with the spread of the concept of vaccination choice by a "*barista*".

"Researchers from the Oregon Immunization Program took a look at the various alternative schedules out there, everything from published advice to homegrown plans, and decided to focus on two specific alternative schedules that parents commonly follow. Both are created by physicians — Dr. Stephanie Cave and Dr. Robert Sears — and both

limit the number of shots received at any particular visit to one or two, but Cave's plan is more restrictive.

Other studies have surveyed parents about their practices, but this was the first study to analyze immunization records. Researchers pored over records of babies born in the Portland area between 2003 and '09 and tracked them up to 9 months of age, a period that covers the 2-, 4- and 6-month well-child visits at which infants are supposed to receive three or four injections at a time. They found that 4,502 of 97,711 children, or 4.6%, met the definition of consistent shot limiters. By 9 months of age, these babies had received fewer injections — 6.4 compared with 10.4 — but had logged more doctor visits at which they received immunizations — 4.2 vs. 3.3 — than children who followed the recommended schedule. Most delayers never ended up receiving all the recommended vaccines. In Oregon, 16% of 2-year-olds are not up-to-date with the standard schedule."

First, this reviewer notes that, for a study published in 2012, the researchers only tracked the records in the Portland, Oregon "Oregon ALERT Immunization Information System" for children who had apparently received some of the CDC-recommended vaccines by the time they were 9 months of age.

While this reviewer has no immediate concerns about the statistics reported, this reviewer finds the writer's, "*[m]ost delayers never ended up receiving all the recommended vaccines*", to be problematic because this statement should have included some appropriate qualifying phrase like, "within the study period".

Moreover, the writer's last sentence, stating that "*16% of 2-year-olds are not up-to-date with the standard schedule*", fails, *as it should*, to define the Oregon "*standard schedule*" or to specify the date when the non-cited source made this statement or published this statistic.

"'They're getting less protection for more hassle,' says Paul Cieslak, medical director for the Oregon Immunization Program. 'The main problem with alternative schedules is they're tough to stick to.' The current vaccination schedule calls for five visits between birth and 15 months for the primary childhood vaccines (some preschool booster shots and a final dose of hepatitis A come later), but some alternative schedules spread the shots out over nine visits within that same span. 'It is harder for parents to pull it off,' says Cieslak."

First, this reviewer notes that other than the statements attributed to "*Paul Cieslak, medical director for the Oregon Immunization Program*", who has clear conflicts of interest that make him a less-than-objective commenter, the writer provides no proof that, *on the whole*, those vaccinated according to one of several alternative vaccination programs overall have "*less protection*" or that the "*main problem with alternative schedules is they're tough to stick to*".

Further, the writer fails to mention, much less address, the reality that the parent may have purposely elected to skip some vaccines altogether (e.g., the initial

3-dose hepatitis B series[14] or the 2- or 3-dose rotavirus series[15]).

Finally, since only the available medical records in the database were reportedly examined; the parents apparently were not interviewed; and parent-guided vaccination plans are subject to change, there is no scientifically sound way to derive the parents' planned schedule and thereby establish the true causes for each of the divergent outcomes observed.

"Parents who choose to delay often do so because they're concerned about sticking their baby with needles multiple times or worried that too many shots clustered in one visit can trigger complications. But vaccine advocates note that no evidence has been found to show that delaying vaccination is helpful for babies — and it can be harmful. 'There is absolutely no scientific data that shows a delayed schedule is any safer,' says Wendy Sue Swanson, a pediatrician who blogs for Seattle Children's Hospital under the handle Seattle Mama Doc. 'It carries exactly the same amount of risk. You can still have life-threatening side effects, but you increase the time your child is not protected.'"

In an April 2012[16] article published in a recognized peer-reviewed journal that examined the adverse events reported to Vaccine Adverse Event Reporting System (VAERS) jointly maintained by the CDC and the FDA for children from "0" to "0.9" year of age during the period from the beginning of 1990 through the end of 2010, the authors stated,

"Our findings show a positive correlation between the number of vaccine doses administered and the percentage of hospitalizations and deaths".

Given that finding alone, it would seem that reducing the number of vaccine actives administered at once to children who are less than 1 year of age would reduce the risk that the inoculated child would be hospitalized or die as a consequence of receiving too many vaccine actives at once.

Again, with respect to the writer's unsubstantiated claim,

"*But vaccine advocates note that no evidence has been found to show that delaying vaccination is helpful for babies*",

this reviewer also notes that, in a 2008 article[17], the abstract's "Results" section reported,

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14 The parents may have skipped the "hepatitis B" inoculations because their child's exposure risk for hepatitis B is almost non-existent – and certainly significantly lower than the risk of a serious adverse post-inoculation reaction to the hepatitis B vaccine.

15 In the live-rotavirus-vaccine instance, the parents may have elected to skip the rotavirus inoculations because, before the first rotavirus vaccine was approved, most healthy children in the USA developed long-lasting immunity to rotavirus without the serious rotavirus-vaccine-associated risk of intussusception, which can permanently maim or kill the rotavirus-inoculated infant, and, in the USA, *absent inoculation*, the risk for a serious clinical rotavirus infection was very low and declining. Moreover, there is no proof that the intussusception risk for healthy Portland, Oregon babies who are inoculated with either rotavirus vaccine is, *as it should be*, significantly less than the pre-vaccine-approval's background rate for rotavirus-associated intussusception in Portland, Oregon.

16 Goldman GS, Miller NZ. Relative trends in hospitalizations and mortality among infants by the number of vaccine doses and age, based on the Vaccine Adverse Event Reporting System (VAERS), 1990–2010. *Hum Exp Toxicol* 2012 Apr 24; 2012 0960327112440111

17 McDonald KL, Huq SI, Lix LM, Becker AB, Kozyrskyj AL. Delay in diphtheria, pertussis, tetanus vaccination is associated with a reduced risk of childhood asthma. *J Allergy Clin Immunol.* 2008 Mar; 121(3): 626-631. Epub 2008 Jan 18.

"Among 11, 531 children who received at least 4 doses of DPT, the risk of asthma was reduced to (1/2) in children whose first dose of DPT was delayed by more than 2 months."

Obviously, this "more than 2 months" delay for the initial DPT vaccination was very helpful to babies because, *by itself*, it reduced those babies risk of subsequently developing asthma by half.

Plainly, this delay was helpful and, *if studied*, perhaps other delays would be equally, or more, helpful[18].

Thus, based on the reported findings in the cited studies, *which vaccine advocates cannot find, purposely ignore, or knowingly seek to conceal*, this reviewer must suggest that the rest of the statements in this paragraph are best ignored.

"Up to 40% of children in Oregon experience some degree of delay in their vaccination schedule, perhaps due to a shortage or a conflict with a doctor's appointment; that figure is on par with national figures. About 1 in 5 has parents who have chosen to delay the child's immunizations on at least one visit."

Here, the writer notes that, overall, the "*some degree of delay in their vaccination schedule*" percentage (40%) in Oregon is "*on par with national figures.*"

To this reviewer, it seems that the writer's statements confirm that most US parents truly are interested in making the best decisions on how to protect their children from the risk of serious harm from the acute, but usually mild, childhood diseases for which there are recommended vaccines.

However, they are equally, or more, interested in protecting their children from the risks of developing lifetime chronic medical conditions that have been, and are increasingly being, found to be causally linked to today's vaccines and the currently recommended inoculation programs.

Until the Establishment:

a. Starts being as concerned about the many chronic childhood medical conditions for which vaccination increases the lifetime risk as it is for preventing children from having the natural childhood diseases that are endemic in the USA and, *with the proper care and nutrition*, recovering from these childhood diseases with minimal risks for the serious complications that a given childhood disease may occur trigger, and

b. Stops denying that the increasing and epidemic levels for these chronic childhood medical conditions are related to the increasing number of vaccines and vaccine doses,

more and more parents in the USA will elect to stop vaccinating their children, delay vaccination or selectively vaccinate.

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18 For example, based on this reviewer's observations of the general vaccination start dates for Japanese children, it appears that much of today's significantly lower infant mortality in Japan (which is less than half of today's infant mortality in the USA) may be attributable to the Japanese parents' general delay in starting inoculation for most of Japan's recommended childhood vaccines.

"'With the best of intentions, parents are wanting to do this, and doctors are accommodating parents who are nervous about kids getting lots of shots at one visit,' says Cieslak. A study in Washington state, which has the country's highest proportion of unvaccinated kindergartners, found that 60% of pediatricians are comfortable with alternative vaccine schedules. 'The problem is that with some diseases, you need to get vaccinated early. Whooping cough is much more serious in infancy. Pneumococcal disease and haemophilus are much more serious under the age of 3'."

Up to the point that the writer starts talking about "*you need to get vaccinated early*", this reviewer generally agrees with the writer's statements.

However, *as those who keep abreast of the developments in immunology know*, vaccination is <u>not</u> the best way to protect our young children from contracting a vaccine-covered disease.

Breastfeeding mothers who have previously had the highly communicable childhood diseases (e.g., pertussis, measles, mumps, rubella, and chickenpox, to name the most infectious) and recovered from them; and can, therefore, pass immune factors and immune-system support substances to their infants during their early years of life; coupled with sound hygiene, sanitation, clean air and potable water, healthy and adequate foodstuffs (including dietary supplements) and adequate clothing and shelter from the elements are the keys to reducing or eliminating the risk of an infant's contracting a childhood disease before the developing infant's natural immune system has appropriately matured.

Further, *to minimize the risk of severe infection*, it is important that all parents understand how they should intercept and/or reduce their children's exposures to microbes that can be infectious and follow these practices in a manner that allows the child to develop immunity to them while having only a sub-clinical infection or a mild clinical infection from which the child fully and quickly recovers.

After all, humans are mammals.

Moreover, human breast milk is not only the best source for the critical nourishment that a developing child needs but also, *to the extent it is able*, furnishes a wide range of immune support and antibody factors designed to protect the infant from many diseases <u>until</u> the child's own immune system appropriately matures.

"Ultimately, vaccination as a linchpin of childhood health is a victim of its own success: immunization has been so skillful at eradicating deadly disease in the U.S. that few parents have any firsthand knowledge of someone who's contracted a vaccine-preventable condition. That has made plunging a needle into a newborn a tough sell."

Here, the writer is mistaken.

Far from being a "*linchpin of childhood health*", the successes of the vaccination programs are more "*smoke and mirrors*" propaganda than substance *in most cases*.

Moreover, rather than giving parents healthy children, our current vaccination programs are, *on balance*, taking initially healthy infants and apparently giving some

percentage of them at least one chronic disease in childhood which, on average, currently translates into more than 26% of our children's having at least one (1) lifetime chronic disease, according to the results from the last National Health and Nutrition Examination Survey [NHANES] 2006 cohort study published in 2010[19].

To put this into perspective, the average lifetime chronic disease percentage reported in 2010 is more than twice the reported average lifetime chronic disease incidence rate in the cohort of children selected 12 years earlier (in 1994, where the percentage of correspondingly affected children was less than 13%).

Thus, the vaccination programs have been and are the "lynchpin" that drives the increasing healthcare costs that benefit all facets of the healthcare system, including: **a)** the vaccine makers, **b)** the health-insurance providers, **c)** the various medical professionals, and **d)** the institutional providers of care in hospitals, nursing homes, rehabilitation centers, and hospices.

Without the current vaccination programs, most of the childhood cancer cases, the abnormal developmental conditions, including neurodevelopmental disorders and abnormal behaviors, and a wide variety of chronic childhood medical conditions[20] would again probably become "rare" diseases or, *at worst*, diseases with peak incidences at or below 1 in 10,000 in the USA, like Pink disease and, offset by 30 years, stomach cancer, when their major causal factors (the Calomel-laced[21] teething powders and worming preparations) were finally removed from the market in the middle of the last century.

Thus, the phrase "*vaccine-preventable condition*" is more propaganda and hype than substance.

Moreover, this reviewer, who is a parent, grandparent, uncle and great uncle, has personal knowledge of some who, though "fully vaccinated", still contracted one or more of the diseases for which they were vaccinated or, worse, became permanently disabled after a given set or group of vaccine inoculations.

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

20 Example chronic childhood medical conditions include, but are not limited to, asthma, serious food allergies and intolerances, autoimmune disorders, type 2 and non-genetic type 1 diabetes, developmental malformations [e.g., cleft palate, microcephaly, and pyloric stenosis, to name a few], gastrointestinal disorders, and obesity.

21 Calomel was and is a trade name for mercurous chloride or mercury (I) chloride [Hg_2Cl_2], which, in the late 1800s and the 1900s was advertised as a "special form of mercury" that was "claimed to be safe" without any toxicological proof of its safety, unlike mercuric chloride or mercury (II) chloride [$HgCl_2$], which was, and still is, admitted to be a highly toxic form of mercury. The weight percentage of Calomel in teething powders often exceeded 25% of the weight of the formulation. The claim that Calomel was safe was partially based on the differences in its physiochemical properties when compared to the physiochemical properties of mercuric chloride. The fact that, when ingested, Calomel disproportionates in the stomach into mercuric chloride and elemental mercury was ignored. Collectively, the parallels between Thimerosal and Calomel are compelling. Like Calomel, Thimerosal is advertised as "special form of mercury" that is "claimed to be safe" without the requisite proofs of safety. In Thimerosal's instance, the admittedly toxic form of mercury is the misnomer "methyl mercury" that is used to represent "environmental methylmercury species of all types". Like Calomel, injected Thimerosal's demethylative conversion in the body into "methylmercury species" is simply ignored. Essentially the same distortions and lies that were used to market Calomel in pharmaceutical drug products in the last century have been appropriately repackaged and are still being used to misrepresent to justify the use of Thimerosal in today's pharmaceutical drug products.

As a Vietnam-era veteran, this reviewer is also well aware of those military draftees, including himself, who, *though they had had all the childhood diseases*, were compelled to be vaccinated with the vaccines for these childhood diseases as well as with experimental vaccines without their consent.

In general, after having studied what giving vaccines actually does and causes, this reviewer has reluctantly concluded that many of the vaccines that are currently recommended by the CDC for infectious diseases in children simply:

- Postpone the risk of acquisition of the disease until a time when the disease may cause much more harm (e.g., postponing the risk of mumps[22] until after puberty where the risks of reduced fertility and severe arthritis are much higher than they were before the vaccine, when the children typically contracted mumps when they were 5 to 10 years of age);
- Increase the risk of disease recurrence (e.g., even after two, according-to-schedule doses of the Merck Varivax® vaccine, about 20 % of those who are vaccinated with the live vaccine strain of the varicella zoster virus [VZV] still get the disease [commonly called chickenpox]; and the risk of a subsequent recurrence of the VZV as shingles, a much more serious medical condition, has more than doubled[23]);
- Trigger chronic medical conditions and/or serious allergies;
- Convert some vaccinated persons into a disease carrier (e.g., a Pertussis Harry[24]); or
- Increase the vaccinated person's susceptibility to a related illness (e.g., *Bordetella parapertussis* infection after vaccination against *B. pertussis*, or non-b-type *Haemophylis influenzae* after vaccination against *H. Influenzae* type b [Hib]), or a non-related illness that can fill the same niche (e.g., *Serratia*-species pneumonia after vaccination against various *Streptococcus pneumonae* species).

Collectively, all of the preceding problems has made it increasingly clear to this reviewer that the current vaccination programs should be:

a. Abandoned when the vaccine active is either non-effective in preventing infection by all circulating human-infective strains of the disease in almost every person who has been vaccinated or, *because of all of the*

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22 Part of the problem with the current mumps component in the Merck MMR II® vaccine may be that the current efficacy of that component is, with the reduction in the level of plaque forming units of mumps virus, about half as effective in protecting those inoculated with a vaccine containing it than the original mumps component was in the 1960s (see the Amended Complaint [document 12, filed on 27 April 2012] in 10-cv-4374 (CDJ), a False Claims lawsuit filed in the US District Court for the Eastern District of Pennsylvania as USA ex realtors Stephen A Krahling and Joan A. Wlochowski, Plaintiffs, versus Merck & Co, Inc. Defendant alleging fraud by falsification of the efficacy to the mumps virus formulated in Merck & Co vaccines since at least 1999).

23 Goldman GS, King PG. Review of the United States universal varicella vaccination program: Herpes zoster incidence rates, cost-effectiveness, and vaccine efficacy based primarily on the Antelope Valley Varicella Active Surveillance Project data. *Vaccine* 2012 May 31; http://dx.doi.org/10.1016/j.vaccine.2012.05.050.

24 Field LH, Parker CD. Pertussis Outbreak in Austin and Travis County, Texas, 1975. ***J Clin Microbiol*** 1977 Aug; **6**(2): 154-160.

overall costs associated with the many doses required, the vaccine is not in-use cost-effective when used in a mass vaccination program or

b. Altered to remove the associated problematic disease and formulation antigens (e.g., for the DTaP and Tdap vaccines, remove the pertussis components, reduce the aluminum-based adjuvant levels, and use early diagnosis and an appropriate non-antibiotic protocol to treat the resulting whooping cough [that are caused by *B. pertussis* and related organisms] to effect patient recovery[25]).

Reviewer's Thoughts on Revised Vaccines and Vaccination Programs[26]

General Suggestions[27]

First and foremost, based on the existing studies and evidence, the safety of each vaccination program should be proven to the standard that the risk of any and all serious adverse inoculation reactions are less than one-tenth the risk of a comparable serious adverse disease effects[28].

Second, based on the observed increased risk of serious adverse effects as the number of vaccine components inoculated at the same time is increased and the lack of scientifically sound studies that prove the safety of concomitantly injecting multiple vaccine components:

a. For live-virus vaccines, the maximum number of disease antigens allowed in a recommended vaccine should be no more than the antigens for two diseases (e.g., measles and rubella);

b. For vaccine components that are genetically engineered virus fragments

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25 For example, a suitable treatment regimen might be an appropriately adjustable daily high-dose vitamin C regimen for 90 days and, when the blood level for 25-hydroxy vitamin D is below 80 nanograms per milliliter {200 nanomoles per liter}, sufficient vitamin D-3 supplementation to get that level up to, and maintain it at, a level of 80-100 nanograms per milliliter]

26 **Nota bene:** The following suggestions are based on this reviewer's in-depth study of the CDC's notifiable disease data, the CDC/FDA VAERS database, the available information and reviews on the proofs, or lack thereof, of safety, effectiveness, and cost effectiveness for each vaccine as well as the accessible literature and the vaccines' package inserts for more than 5 years (see the "Documents" page in http://www.dr-king.com for the pertinent articles).

27 Given the lack of double-blind, true-placebo-controlled safety studies for most all vaccines and the recent study showing that for current early childhood vaccination programs, more vaccine components injected at once translates to an increased risk of hospitalization and death in the inoculated children under the age of one year, the recommendation for the mass use of all three-or-more-different-disease-component vaccines should be suspended.

28 In general, to be certain that inoculation with a vaccine is truly safer than the disease and the fact that clinical trials do not test hundreds of thousands of infants from the general population of the USA, the study of the vaccine's safety must establish that giving the vaccine in the healthy subjects evaluated in the vaccine studies is at least 10 times safer than the risk of the serious disease effects in the general population. Under this precautionary rubric, the current vaccines for rotavirus and childhood hepatitis B would have to be abandoned in the USA and probably the recommendation to inoculate children with an influenza vaccine would need to be withdrawn. Specifically, prior to the approval of the first rotavirus, intussusception was almost unknown and currently the rate of intussusception in US-trial inoculees is higher than the "background rate" in the USA. For hepatitis B, since there is about 0.002% (2 in 100,000) risk of childhood hepatitis B and the risk in healthy children of the hepatitis B's infection becoming a chronic infection is less than 10% (or about 2 in 1,000,000 children) while the risk of a serious short-term adverse event is more like 1 in 10,000 (e.g., xxx) and the risk of a serious longer-term vaccine-related adverse effect (e.g., significant neurological pathologies) is more like 1 in 100,000. For influenza, there issues of strain mismatch and lack of effective protection for almost all (>90%) of those who are inoculated with any influenza vaccine that should cause the recommendation for influenza vaccination in children to be rescinded.

or polysaccharide antigens conjugated to a tetanus or diphtheria toxoid, the maximum number of related diseases in a vaccine should also be two (e.g., hepatitis A and hepatitis B);

c. For vaccines whose actives are toxoids, no vaccine should contain more than the toxoids for two diseases; and

d. Unless and until, the absolute safety of administering more than one vaccine at once can be established, the general vaccination program in the USA should recommend:

   i. No vaccine should be administered "at birth",
   ii. *No more than* two single-component vaccines should be given at once,
   iii. *No more than* one two-component vaccine should be given on the same day,
   iv. The period between any inoculation session should be no less than 28 days, and
   v. After a vaccine containing live measles virus is administered, no other vaccine should be administered for at least 9 months.

Finally, unless scientifically sound and appropriate independent studies clearly establish that a given vaccination program is a cost-effective program when all of the costs[29] are considered, there should be no recommended universal vaccination program for that vaccine component.

Suggestions for the new DT and Td vaccines

After the removal of the pertussis components from the current no-Thimerosal DTaP and Tdap vaccine formulations and an appropriate adjustment of the "tetanus toxoid" and "diphtheria toxoid" antigen levels and the level of adjuvant to minimize the vaccine's risk for its dysregulation of the recipients' immune system components, the vaccination programs using the resulting no-Thimerosal DT and Td vaccines should be adjusted so that their first inoculation occurs after the child is one year of age or, if still breastfeeding, after breastfeeding is stops, and the total number of doses reduced to no more than three doses[30].

Remove the Varicella Zoster Virus component and other vaccine components from all vaccines where they increase the risk of worse outcomes or are not cost effective

Similarly, based on overall cost-effectiveness (see footnote "23"), the live-virus

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29 Those costs must include, but are not limited to, 1.2 times the current costs associated with all adverse reactions and chronic disease risks; the current or proposed pricing times the recommended number of doses; and the full costs of administration of the vaccine times the number of recommended doses.

30 Subsequently, when a deep puncture wound presents a tetanus infection risk, thorough wound cleaning, appropriate wound closure and tissue oxygenation should be conducted. At the same time, the patient should be given an appropriately sized dose of tetanus antiserum, which should quickly destroy any C. tetani organisms that escaped the cleaning, and not a tetanus booster shot, which will take days to produce a significant increase in the patient's circulating tetanus-antibody levels and actually reduces the patient's immune system's ability to properly handle wound healing. In addition, the patient should be instructed to take appropriate supplemental doses of vitamin C, vitamin D-3, vitamin K-2, bioavailable minerals (e.g., silica, magnesium, potassium and zinc); and key nutrients that promote wound healing.

VZV vaccination programs for chickenpox and shingles should be abandoned as should the recommended annual influenza vaccination program, the recommended rotavirus vaccination program, and probably the recommended childhood vaccination programs for Hib and *S. pneumonae* in the USA.

Given the coverage, efficacy, and protection-duration deficiencies that exist in the current vaccines for meningococcal meningitis and the rarity of the disease in the USA today (about a thousand cases a year in a population of more than 312 million people [< 1 case per 300,000 population]), the meningococcal vaccines should be removed from the US recommended universal vaccination programs because the current vaccines are neither in-use effective nor cost-effective for use in a recommended universal vaccination program[31].

"Temporarily" abandon the current recommended HPV vaccination programs

Given the problematic realities surrounding the current human papilloma virus (HPV) vaccines[32], the current recommended HPV vaccination program should be abandoned and the HPV vaccines removed from the list of vaccines covered by the National Vaccine Injury Compensation Program (NVICP) as set forth in 42 U.S.C. §§ 300aa-10 through 300aa-34.

In women, the preceding actions should be continued until sufficient time has elapsed (which may require another 20 to 30 years) for independent studies to unequivocally prove that: **a)** the HPV vaccines truly prevent cervical cancer and **b)**, in the hundreds of thousands of US young women who have already been vaccinated with at least one dose of an HPV vaccine, the HPV vaccines doses administered did actually prevent more cervical cancer and cervical disease cases than instances where the HPV vaccines may be a probable causal factor for the observed cervical cancers and cervical disease or caused serious chronic disease or disability in those who were vaccinated when the outcomes for HPV-vaccinated young women are compared to the outcomes observed for matched young women who never received a HPV inoculation but have had regular cervical exams and "pap" tests.

In men, the suspensions should continue until there is unequivocal independent proof that: **a)** HPV causes the mouth and throat cancers with which it is associated and for which it is claimed to be a causal factor, and **b)** the HPV vaccines do not cause significant chronic disease and/or disability in those thousands of young US males who were vaccinated with an HPV vaccine than cases of cancer that they prevent when the overall health outcomes of those vaccinated with an HPV

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31 In its place, a rapid, highly accurate meningococcal meningitis blood test that clearly identifies active infection should be developed and healthcare professionals trained to require it whenever a patient presents with the clinical symptoms that may be meningococcal meningitis so that all cases can be rapidly identified and effective interventions, including high-dose intravenous vitamin C, implemented to minimize the disease's virulence, duration and mortality risk.

32 http://menstruationresearch.org/2012/06/26/when-one-less-becomes-one-more/, last visited on 27 June 2012. [Posted on the Society for menstrual research as "Blog of the Society for Menstrual Cycle Research, When One Less Becomes One More, June 26th, 2012 by Elizabeth Kissling" as "When One Less Becomes One More Abnormal Pap Smears, Cervical Dysplasia and Cervical Cancer Spike Post-HPV Vaccination Guest Post by Leslie Botha, Women's Health Freedom Coalition Coordinator, Natural Solutions Foundation, and Janny Stokvis, VAERS Research Analyst"

vaccine are compared to the outcomes observed in a matched general population of young US males who were not vaccinated with an HPV vaccine.

Rework the current licensed Hepatitis vaccines

The Hepatitis B and Hepatitis A vaccine formulations should be reworked to reduce the long-term risks of inducing serious autoimmune dysfunction; the recommended Hepatitis B vaccination program should not include an at-birth dose; and, *provided the reworked vaccines are proven to be safe, effective and cost effective*, no mass vaccination program should recommend giving doses of any hepatitis B vaccine to healthy children born to non-hepatitis-B-infected mothers before the child is at least 1 year of age.

Similarly, in the USA, the hepatitis A vaccination program's initial dosing should be delayed until the child is at least 2 years of age and weaned from breastfeeding, or one year after the first MMR vaccine is administered, whichever is later.

Replace the MMR vaccines with MR vaccines and adjust timings

For the MMR vaccine, even if the efficacy of the mumps component can be "restored" (see footnote "22"), based on the mildness of natural mumps and the subsequent "lifetime" protection from a recurrence, the vaccine mumps strains' proven ongoing lack of full disease control, and the fact that its use simply postpones the risk mumps in vaccinated children until after the child reaches puberty, *at a minimum*, the current mumps component should be removed from all MMR vaccines to convert them to measles and rubella (MR) vaccines and the dosing schedule changed to move the first dose to the longer of 24 months or the date when breastfeeding stops and moves the second dose to 9-10 years of age so that the women of childbearing age should have at least some protection against contracting rubella during pregnancy.

Factually, recommending mass vaccination against mumps converts a benign childhood disease with little risk of lasting harm to healthy children and subsequent "lifetime" immunity into a much more serious disease because many of those who are vaccinated with the live-virus mumps component vaccines will simply contract mumps after puberty, when the adverse disease effects are much more serious.

Except to fill the coffers of all those who profit from a mass vaccination program including a mumps component and, *in this instance*, the more-severe-disease and chronic-health-deficit risks that the mumps vaccine component creates, the proven risks associated with mass mumps vaccination far outweigh the claimed benefits of the transient protections provided by a mass childhood mumps vaccination program.

Moreover, the additional doses used during the resultant mumps outbreaks in the fully vaccinated are probably ineffective in providing any additional mumps protection and certainly only serve to render the current MMR vaccines even less cost effective.

Finally, single-disease vaccines need to be made available for measles and for rubella so that, *if an additional vaccine dose is needed and truly effective for*

measles or rubella and there is no need to include the other viral component, the specific measles only or rubella only vaccine needed will be available.

Make interim revisions to the inactivated poliovirus program

Further, until all use of the live-virus polio vaccines is stopped worldwide, the use of the current inactivated-poliovirus vaccines may need to be continued although the first dose should not be administered until the child is at least 12 months of age or weaned from breastfeeding, whichever is later, and, with a later start date, the number of doses required for long-term protection might be reduced.

Reviewer's Alternative

Adopt a holistic approach to health centered on those childrearing conditions that helped healthy infants thrive for the eons before the first vaccine was devised

Finally, given the continuing pervasive deficits in key vitamins, minerals and key immune-system regulating nutrients (e.g., the vitamins C, D, K-2 and folic acid; the minerals magnesium and zinc; and the nutrients lysine, cysteine and quercitin) in developing children and women of child-bearing age in the USA, the healthcare systems in the USA need to be refocused on holistic healthcare and orthomolecular medicine.

Holistic healthcare and orthomolecular medicine should be pursued in a manner that proactively addresses the ongoing assessment and maintenance of the optimal levels of the key vitamins, minerals, and nutrients as well as healthy gastrointestinal flora that reduce the risk that anyone will contract a serious clinical disease case along with the use of natural antimicrobial and immune-system boosting supplementation to shorten disease length and reduce its severity.

In this approach, the use of any allopathic drugs would be a second choice rather than the first choice for the maintenance of the patients' health and well-being as well as the prevention and treatment of incipient infectious diseases, including cancers.

In other words, we need to abandon the relatively blind "allopathic only" approach to the first use of side-effect-ridden pharmaceutical drug products for the prevention and the treatment of disease, which may, *in the long run*, cause more harm to the individuals' health, and adopt a holistic approach that seeks to assess, support, maintain and enhance the long-term health of our children in a manner that:

a. Allows their naturally developed, healthy immune systems to cope with, and be strengthened by, the common infectious childhood diseases, and
b. Minimizes their chronic disease risks.

End of the Review

"Bonnie Rochman is a reporter at *TIME*. Find her on Twitter at @brochman. You can also continue the discussion on *TIME*'s *Facebook* page and on Twitter at *@TIME*."

"*Bonnie Rochman*

Bonnie Rochman writes about parenting for TIME. She is a former TIME intern who has also reported from the Middle East, Myanmar and Vietnam for the *Boston Globe*, the *Jerusalem Report* and *Fortune*. A former staff writer at *The News & Observer* in Raleigh, N.C. — where she was the paper's parenting blogger, chronicling the wacky yet universal idiosyncracies [sic] of her three children — she now lives in Seattle".

http://healthland.time.com/author/brochman/

About the Reviewer

In addition to the general information available on his web site, http://www.dr-king.com/, Paul G. King, PhD Analytical Chemist, is the Science Advisor to and current Secretary for the Coalition for Mercury-Free Drugs (CoMeD, Inc., a 501(3)(c) corporation), http://www.mercury-freedrugs.org/.

As a scientist and student of the federal regulations and statutes that govern drugs, including vaccines, Dr. King has led CoMeD, on two (2) separate occasions, in the drafting and submission of a "Citizen Petition" seeking to have the federal government comply with the law, and, based on the improper denial of the Citizen Petition submitted, a federal lawsuit seeking to have the Federal District Court for the District of Columbia compel the Secretary of the Department of Health and Human Services and the Commissioner of the FDA to comply with the statutes and regulations regulating their lawful conduct. The second civil suit, 1:2009-cv-00015, is still being litigated at the present time.

Further, Dr. King has, on several occasions, drafted legislation for submission to the Congress of the USA as well as to the legislatures of various States, submitted cogent comments in opposition to proposed changes to federal regulations that are not in the public interest or appear to be at odds with the law, reviewed numerous documents, and written several articles on a variety of vaccine-related and other issues.

Finally, Dr. King has: **a)** provided various groups with his analysis of various other Congressional bills, resolutions and treaty documents, **b)** been an author of several papers bearing on issues related to the toxicity of Thimerosal and other compounds and, if any, their connection to various chronic neurodevelopmental, other developmental and behavioral abnormalities that appear to be well-above (> 1 in 10 children; asthma), above (> 1 in 100 children; the autism spectrum disorders), at (~ 1 in 1000 children; childhood type 1 diabetes), or approaching (life-threatening peanut allergy) epidemic childhood levels in the USA and **c)** most recently, the co-author of a paper that reviewed the United States universal varicella vaccination program and found that that CDC-recommended vaccination program was neither effective in preventing those who are vaccinated from contracting chickenpox nor, since it greatly increases the population's risk of having clinical cases of shingles, cost effective for universal use (see footnote "**23**" in the review).