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Wednesday, 16 October 2013

On 20 September 2013, Paul G. King, PhD, downloaded an on-line article, titled "**Failure to Vaccinate Children: An Unconscionable Twist of Faith**", which was authored by Claire Pomeroy, MD, from the ***Huffington Post's*** Internet web site, http://www.huffingtonpost.com/claire-pomeroy/failure-to-vaccinate-chil_1_b_3941563.html.

Dr. King's science-based response to the article follows these introductory remarks and a table-of-contents page.

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This analytical response is titled, "**A Formal Science-based Response to 'Failure to Vaccinate Children: An Unconscionable Twist of Faith'**".

Introductory Remarks

First, each portion of Dr. Pomeroy's text is quoted in a grayed "Times New Roman" font.

Second, Dr. King's comments follow in a "Verdana" font and are indented.

Third, when quoting from Pomeroy's text, the text is in an *italicized* "*Times New Roman*" font.

Fourth, when quoting or referencing other sources, the text is in an "Arial Narrow" font.

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

Respectfully,

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Paul G. King, PhD
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Tel. 1-973-997-1321, after 21:00 Eastern Time
[To whom all responses should be directed]

[a] To qualify as an independent document, the study should be published by researchers who have no direct or indirect conflicts of interest from their ties to either those commercial entities who profit from the sale of any product or practice addressed in this response or those entities, academic, commercial or governmental, who directly or indirectly, actively promote any product or practice, the development of any product or practice, and/or programs using any product or practice covered in this response.

Table of Contents for "A Formal Science-based Response to 'Failure to Vaccinate Children: An Unconscionable Twist of Faith'"

A Formal Science-based Response to 'Failure to Vaccinate Children: An Unconscionable Twist of Faith'

"by Claire Pomeroy" ", MD," "President, Albert and Mary Lasker Foundation"

Posted: 09/19/2013 6:11 pm

First, the writer, Claire Pomeroy, begins with a title that implies that the *unqualified* "***Failure to Vaccinate Children***" is somehow an "***Unconscionable***" act.

However, even the vaccination recommendations published by the U.S. Centers for Disease Control and Prevention (CDC) and the package inserts prepared by the vaccine manufacturer and approved by the U.S. Food and Drug Administration (FDA) for each vaccine that can be given to children in the United States of America (USA) warn that certain individuals should not be vaccinated.

Because Dr. Pomeroy, "an expert in infectious disease"[1] previously was "a professor of internal medicine and microbiology and immunology, as well as dean of the School of Medicine, chief executive officer of UC Davis Health System and vice chancellor for Human Health Sciences"[2], what seems to be "*Unconscionable*" is her article's title, which is intentionally misleading.

Like other credentialed establishment apologists, she couples a set of guilt mongering phrases and catchwords, "*Failure to Vaccinate*", "*Children*", "*Unconscionable*" and "*Twist of Faith*", into a title that appeals to the reader's emotions rather than addresses the article's subject.

Since the article purports to discuss the facts about measles and measles vaccination, this reviewer, Paul G. King, PhD, a researcher into the safety and in-use-effectiveness of such vaccines is bemused by the disinformation provided by Dr. Pomeroy in this article.

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1 http://www.sacbee.com/2012/11/20/4998856/amid-controversy-claire-pomeroy.html, last visited on 20 September 2013,

"Amid controversy, Claire Pomeroy to step down as UC Davis med school dean

By Marjie Lundstrom mlundstrom@sacbee.com Published: Tuesday, Nov. 20, 2012 - 12:00 am | Page 1A Last Modified: Tuesday, Nov. 20, 2012 - 8:15 am

Amid scrutiny from federal regulators and her own administration, the dean of the UC Davis School of Medicine announced Monday she will be stepping down.

Dr. Claire Pomeroy, whose seven-year tenure as dean was marked by fiscal growth and innovation but also by medical and ethical controversy, said she will leave the university on June 30, the close of the academic year.

Pomeroy, 57, told The Bee Monday that she plans to work during the transition with the University of California president's office to "represent the UC health systems in Washington, D.C., playing a role in helping define health care during this incredibly exciting moment in history."

Pomeroy is an expert in infectious diseases and a professor of internal medicine and microbiology and immunology. With nearly 10,000 employees and about 850 students, she has been a prominent figure in Sacramento, championing the university while supporting the work of humanitarian groups.

She said Monday the decision to leave was hers.

...

Pomeroy came to the School of Medicine in 2003 as executive associate dean and became vice chancellor and dean in 2005.."

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Read more here: http://www.sacbee.com/2012/11/20/4998856/amid-controversy-claire-pomeroy.html#storylink=cpy

2 http://dateline.ucdavis.edu/dl_detail.lasso?id=14336, last visited on 20 September 2013,

"The Albert and Mary Lasker Foundation, which for 68 years has championed the greatest advances in medical research, announced Wednesday (Jan. 23) the appointment of Claire Pomeroy as president of the Lasker Foundation. Pomeroy will join the foundation some time this spring.

Pomeroy, an expert in infectious diseases, is a professor of internal medicine and microbiology and immunology, as well as dean of the School of Medicine, chief executive officer of UC Davis Health System and vice chancellor for Human Health Sciences. She had previously announced that she would leave the university June 30 of this year."

Measles, Measles Vaccination, and Measles Immunity Realities

"The Eagle Mountain International Church in Newark, Texas, promoted National Immunization Awareness Month through tragic irony. Twenty-one children and adults connected to the church contracted measles, a highly contagious, incurable viral infection of the respiratory system that causes death in one to two of 1,000 cases. Ninety percent of people who are not immune or not vaccinated will become infected if exposed. None of the 11 children were vaccinated, and the majority of adults had only one of two shots recommended by the Centers for Disease Control and Prevention (CDC)."

Here, Dr. Pomeroy attempts to portray a few cases of measles originating at the "*Eagle Mountain International Church*"[3] as if these cases were "*tragic*" rather than a simple, natural disease reality whose only "*irony*" is her attempt to portray this measles outbreak as if it were somehow promoting "*National Immunization Awareness Month*" and some newly-designated "*incurable*" viral infection.

Factually, the viral disease known as "measles" has been around for centuries and has never previously been labeled "*incurable*".

Further, since no vaccination program of which Dr. King is aware provides "lifetime disease protection" (immunity), he finds it either "ironic" or "knowingly misleading" that Dr. Pomeroy and the Establishment continue to misuse the term "*Immunization*", which implies that vaccination does provide disease "*immunity*", when the science has shown that even the multiple vaccinations recommended for all childhood diseases clearly do not provide "disease immunity".

Next, Dr. King finds that Dr. Pomeroy mischaracterizes measles as (emphasis added) "*an incurable viral infection of the respiratory system*" when, *prior to the current live-virus measles vaccines*, millions of Americans:

- Contracted measles,
- Had their own immune systems "cure" almost all of those who were clinically infected by the measles virus[4] in less than a month from the first clinical symptom, a high fever — rendering measles clearly not "*incurable*"[5] , and

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[3] Eagle Mountain International Church, Kenneth Copeland Ministries, Fort Worth, TX 76192. Call the church office: 817-252-2900.

[4] http://www.who.int/mediacentre/factsheets/fs286/en/, last visited on 20 September 2013,

"…

Measles is caused by a virus in the paramyxovirus family. The measles virus normally grows in the cells that line the back of the throat and lungs. Measles is a human disease and is not known to occur in animals.

…

The first sign of measles is usually a high fever, which begins about 10 to 12 days after exposure to the virus, and lasts four to seven days. A runny nose, a cough, red and watery eyes, and small white spots inside the cheeks can develop in the initial stage. After several days, a rash erupts, usually on the face and upper neck. Over about three days, the rash spreads, eventually reaching the hands and feet. The rash lasts for five to six days, and then fades. On average, the rash occurs 14 days after exposure to the virus (within a range of seven to 18 days)."

[5] http://www.merriam-webster.com/dictionary/incurable, last visited on 20 September 2013,

- Recovered to apparently have life-long protection from ever contracting measles again as well as protection from developing some other chronic medical conditions.

In contrast, the "two-plus dose" live-measles-virus vaccination program recommended in the United States of America (USA) today:

a. Abnormally infects all those inoculated with a measles-containing vaccine at least twice with injected doses of a live measles virus and other immunologically active substances;

b. Provides some disease protection to most, but not all, who are doubly vaccinated, which lasts less than 25 years after the second dose;

c. Only provides protection for a limited period of time from contracting "wild" measles to about 95% of those who have been doubly inoculated – a period that, for some individuals, does not exceed 5 years after a second dose; and

d. Leaves an unidentified "5%" of those who have been multiply inoculated with little or no protection from getting measles if they are subsequently exposed to the measles virus.

Moreover, women, who are vaccinated rather than having had measles naturally, provide neither the level nor the length of immune-system protection in their breast milk[6] to their breastfeeding babies that their having measles naturally is known to provide.

Thus, each year about 7 million children are vaccinated with a vaccine containing a live-virus measles component, typically, the Merck M-M-R® II measles, mumps and rubella vaccine or, less commonly, the Merck ProQuad® measles, mumps, rubella and varicella vaccine.

However, at least 40%, and probably more than 50%, of the population of the USA today has no protection against measles infection when exposed to the measles virus.

In recognition of the lack of life-time protection after two doses of a live-virus measles vaccine, the CDC has recently published recom-

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6 "in·cur·able *adjective* \(ˌ)in-ˈkyu̇r-ə-bəl\ : impossible to cure : not curable ..."
http://www.eatsonfeets.com/docs/The_Immunolofic_Significance_of_Breastmilk.pdf, last visited on 20 Sept. 2013 (emphasis added),
"...The immune factors in breast milk have shared features:
1. they are common to mucosal sites;
2. they are capable of surviving in the gastrointestinal tract because they are resistant to digestive enzymes;
3. they kill certain bacterial pathogens synergistically;
4. their protection is achieved without triggering inflammatory reactions; and
5. the secretion of many soluble immune factors by mammary gland is inversely related to the ability of the recipient to produce them at mucosal sites (Goldman, 1993).
...
A similar immune response is seen after the introduction of antigens in the maternal bronchopulmonary tract. IgA antibody to specific respiratory tract viruses is present in breast milk (Fishaut, Murphy, Neifert, McIntosh, & Ogra, 1981)".

mendations in the CDC's journal, *Morbidity and Mortality Weekly Report* (*MMWR*), that certain groups, who are at a higher risk of exposure to the measles virus, like adults who are "students in post-secondary educational institutions" or who "work in a health-care facility", should get two (2) more doses of a live-virus measles-containing vaccine[7], typically Merck's M-M-R II vaccine, since Merck no longer distributes the single component live-measles-virus vaccine (Merck Attenuvax®).

Thus, the CDC now appears to be effectively recommending four (4) doses of the MMR vaccine for these groups or, for those who graduate from "post-secondary educational institutions" and then go on to "work in a health-care facility", up to six (6) doses of the Merck M-M-R II vaccine.

Furthermore, documented cases of measles have been reported in two physicians who, respectively, had received at least three or five MMR inoculations and were subsequently exposed to a measles-infected person, who was shedding a "wild" measles virus[8].

Additionally, when it comes to the adverse effects from measles, mumps and rubella cases as compared to those that occur after a measles, mumps and rubella (M-M-R II) inoculation or a measles, mumps, rubella and varicella (ProQuad) inoculation, the data seem to indicate that, ***for deaths***, the post-vaccination risk is definitely ten times higher and possibly one hundred or more times higher than the audited death reports included in the Vaccine Adverse Events Reporting System (VAERS), a database of voluntarily reported adverse events occurring after vaccination, which is jointly maintained by the CDC and the FDA[9].

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7 Advisory Committee on Immunization Practices (ACIP) Recommended Immunization Schedule for Adults Aged 19 Years and Older — United States, 2013. *MMWR* 2013 Feb 1; 62(01): 9-19 (http://www.cdc.gov/mmwr/preview/mmwrhtml/su6201a3.htm?s_cid=su6201a3_w), emphasis added:

"7. Measles, mumps, rubella (MMR) vaccination

- Adults born before 1957 generally are considered immune to measles and mumps. All adults born in 1957 or later should have documentation of 1 or more doses of MMR vaccine unless they have a medical contraindication to the vaccine, or laboratory evidence of immunity to each of the three diseases. Documentation of provider-diagnosed disease is not considered acceptable evidence of immunity for measles, mumps, or rubella.

Measles component:

- A routine second dose of MMR vaccine, administered a minimum of 28 days after the first dose, is recommended for adults who
  - are students in postsecondary educational institutions;
  - work in a health-care facility; or
  - plan to travel internationally.
- Persons who received inactivated (killed) measles vaccine or measles vaccine of unknown type during 1963–1967 should be revaccinated with 2 doses of MMR vaccine.

Mumps component:

- ....

Rubella component:

- ...

HCP born before 1957:

- For unvaccinated health-care personnel born before 1957 who lack laboratory evidence of measles, mumps, and/or rubella immunity or laboratory confirmation of disease, health-care facilities should consider vaccinating personnel with 2 doses of MMR vaccine at the appropriate interval for measles and mumps or 1 dose of MMR vaccine for rubella."

8 JS, Hickman CJ, Sowers SB, Rota PA, Mercader S, Bellini WJ. Two Case Studies of Modified Measles in Vaccinated Physicians Exposed to Primary Measles Cases: High Risk of Infection But Low Risk of Transmission. *J Infect Dis*. (2011) 204(suppl 1): S559-S563. doi: 10.1093/infdis/jir098. [See http://jid.oxfordjournals.org/content/204/suppl_1/S559.long.]

9 See http://dr-king.com/docs/130906_Mealses_MeaslesVaccinationRealities_AFormlRespnseToEndangeringTheHerd_final_br1.pdf, pages "4" though

Finally, hidden in Dr. Pomeroy's distorted description of this minor measles outbreak are three (3) realities,

1. "*[T]he majority of adults had only one*" live-measles-virus-containing vaccination because that was all that the CDC recommended when they were growing up, confirming the failure of measles vaccination to provide the long-term disease measles protection that having natural measles does;
2. Some of the adults who contracted measles had at least two doses of a live-measles-virus-containing vaccine, confirming that even two doses of a live-measles-virus-containing vaccine does not provide the long-term measles disease protection that having natural measles does; and
3. The CDC's current (2013) two-plus-dose MMR vaccination program is a fraud because, rather than providing long-term protection from contracting a clinical case of the measles to those who have been vaccinated, it has moved the risk of having measles to those too young to be vaccinated and to those more than 10 to 15 years old, where the risk of complications from having measles is greater ("[u]nvaccinated children under age 5 and adults over 20 are most at risk"[10]).

Thus, the current CDC-recommended vaccination program for measles, mumps and rubella (because no single-diseases vaccines are currently being marketed in the USA) has transformed:

- Acute but, in most cases, harmless childhood diseases that generally provide natural lifetime immunity to recurrence of these diseases following their first infections and enable most females to be able to pass that protection to their offspring for a long-enough period to minimize their children's risk of serious complications —
- Into acute and chronic diseases that fail to provide the positive protective benefits of the natural diseases.

Worse, MMR vaccination actually increase the overall costs associated with these childhood diseases when the chronic diseases it provokes are considered.

Further, when these live viruses are injected into our children, a non-natural exposure pathway, the vaccination programs require an

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"8" and "Ref-1" through "Ref-3".

[10] http://www.nvic.org/vaccines-and-diseases/Measles.aspx, under the heading "Who is at Highest Risk for Suffering Complications of Measles?", last visited on 21 September 2013.

ever-increasing number of vaccine doses and a rigorous quarantine program to minimize the average number of annual clinical disease cases.

In addition, the public-health-reporting mechanisms seem to be designed to conceal the MMR-vaccination-related disease cases and most of the harm from the MMR vaccine's post-inoculation adverse reactions (side effects), including deaths, and the chronic diseases provoked by the CDC's current MMR-vaccination program.

Therefore, the MMR vaccination program directly and indirectly enriches the vaccine's maker, and the pharmaceutical, medical and healthcare industries, as well as increases the power and control of the government over our lives while impoverishing the fiscal and physical health of the American public, who, as a group, no longer have natural lifetime immunity to being re-infected by measles, mumps or rubella.

Finally, Americans are increasingly dependent upon a failed border security system and, *as the outbreak at this church in Texas confirms*, a porous custom's entry/re-entry quarantine system to prevent a massive disease outbreak or epidemic among the 40-plus percent of those who have no protection from contracting measles if exposed to someone shedding the causal virus.

Dr. Pomeroy's Mischaracterization of a Church's Position on Measles Vaccination and the CDC-backed Vaccination Programs

"An unconscionable twist of faith contributed to the health tragedy: Church leaders had been advising congregants against vaccination because of a scientifically unfounded belief that vaccinations could cause autism. Unfortunately, the church leaders' views are endorsed by an anti-vaccination public figure who speaks frequently against immunization and claims to have "cured" her son of questionable autism. While we cannot turn back the hands of time on unvaccinated lives affected by measles outbreaks, all members of society must urgently come together to stop the irresponsible voices that mock medical breakthroughs and place the public at risk of illness, disability and death."

Since no "*health tragedy*" occurred in the measles outbreak alluded to by Dr. Pomeroy, Dr. King finds her use of the phrase, "*twist of faith*", an apparent unbeliever's attempt to confound these believers' faith in God though Jesus Christ, the Son of God, using some selective reporting of some out-of-context remarks made by certain "*church leaders*", with her apparent unsubstantiated view that what she phrases as "*a scientifically unfounded belief*" has anything to do with these congre-

gants' religious beliefs because, the "*scientifically unfounded belief that vaccinations could cause autism*" is apparently her view.

Actually, all truly religious beliefs in God held by Christians, the followers of God through Jesus Christ, or any other religious group (e.g., Buddhists, Hindus, Israelites, Jews, Muslims, Shintoists, and Taoists, to name a few) have nothing to do with the logic and limitations that characterize "science", "scientific study" and the "scientific method".

Further, the understanding "*that vaccinations could cause autism*" is, *contrary to Dr. Pomeroy's unsupported statement*, a scientific reality, which:

- Has not been proven to be scientifically impossible,
- Was apparently first reported as a possibility by a German researcher in 1976[11],
- Is supported by dozens of independent, peer-reviewed published studies as well as by the pre-1998 post-vaccination serious adverse-event [SAE] MMR-vaccination-related or MMR-plus-other-Thimerosal-preserved-vaccine-related VAERS reports listing an "autism" or "autism"-related diagnosis that were filed in VAERS prior to the publication of a paper that vaccine apologists erroneously claim first triggered a link between MMR vaccination and a subsequent diagnosis of "autism"[12], and
- Has not been scientifically disproven by a few non-independent, non-reviewable studies overseen by the CDC and/or the industry that have erroneously been claimed to prove that there is no causal link between vaccination or the administration of Rho-D immune globulins and a subsequent diagnosis of "autism", where:
  - **a.** the exact details of every step leading up to the published studies have not been shared with any independent reviewers and

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11 Eggers C. [Autistic syndrome (Kanner) and vaccination against smallpox (author's transl)]. *Klin Padiatr*. 1976 Mar; 188(2): 172-180.
"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".

12 http://dr-king.com/docs/20130606_DrftRevuOf_Sticking_with_the_truth_b_r1.pdf, pages "3" through "7",
"Examining Table 1, before the "Wakefield" paper was published in *The Lancet* in February 1998, there are more than 15 instances (underlined entries in the last column of Table 1) where the reported and/or entered SAE for vaccinations with an MMR vaccine or an MMR vaccine and one or more other vaccines contained an "Autism" diagnosis or the narrative indicated a diagnosis of autism.
Most of the rest of the 71 VAERS entries associating MMR vaccination and autism were reported to the FDA and/or the CDC before 1998 although some were not entered into VAERS until later."

b. access to the anonymized raw datasets that underlie these non-independent studies has either been denied or the anonymized datasets have been claimed to have been "lost".

Moreover, Dr. Pomeroy's,

"*Unfortunately, the church leaders' views are endorsed by an anti-vaccination public figure who speaks frequently against immunization and claims to have "cured" her son of questionable autism*"

is a non-relevant and tasteless remark because Christian "*church leaders' views*" are supposedly shaped by their belief in God and in the God-given precepts about which the Apostle Paul charged Christians (emphasis added), "Wherefore, my beloved, as ye have always obeyed, not as in my presence only, but now much more in my absence, work out your own salvation with fear and trembling"[13].

Finally, while ignoring the non-relevant remarks about the past and "*medical breakthroughs*", Dr. King partially agrees with Dr. Pomeroy when she states, "*…, all members of society must urgently come together to stop the irresponsible voices that … place the public at risk of illness, disability and death*".

As Dr. King has clearly shown[14,15,16,17,18,19], the artificial disease protections provided by the claimed prophylactic (disease preventive) vaccine inoculations:

a. Do not, in general, protect those who are inoculated with them from the risk of illness, disability and death, but rather provided limited duration disease protection to some while they cause as much, *if not more*, illness, disability and death than the natural infections would have, though most of the adverse events following vaccination are never reported to the public nor tracked in the VAERS database, as well as

b. Exacerbate or cause many of the chronic medical conditions at epidemic levels that, *prior to the modern vaccination programs*, were rare or non-existent.

Though the prior articles cited by Dr. King have been open to peer review and cogent evidence-supported rebuttals to the factual infor-

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13 King James Bible, Philippians, Chapter 2, verse 12.

14 http://dr-king.com/docs/120127_RevisdDrft_RevuOfAutsmControvrsyNeedForResponsbleScienceJournlsm_b.pdf.

15 http://dr-king.com/docs/120806_PGKDrftRevu_Anti_vaccineMovementCausesTheWorstWhoopingCoughEpidemicIn70Yrs_fnlr2b.pdf.

16 http://dr-king.com/docs/120829_DrftRevu_VaccinationFearsAreOnlyUppingDanger_fnl_b.pdf.

17 http://dr-king.com/docs/130306_DrftRevu_Of_ForegoingImmunization___final_b.pdf.

18 http://dr-king.com/docs/20130606_DrftRevuOf_Sticking_with_the_truth_b_r1.pdf.

19 http://dr-king.com/docs/130906_Mealses_MeaslesVaccinationRealities_AFormlRespnseToEndangeringTheHerd_final_br1.pdf.

mation in his articles by those who promote the claimed "wonders" of the current CDC-recommended vaccination programs, Dr. King has, to date, not received any such responses.

Thus, based on the comments in her article, Dr. Pomeroy is apparently one of those "*irresponsible voices*" who are placing "*the public at risk of illness, disability and death*" by:

a. Misrepresenting the long-term effects of the current CDC-recommended childhood and adult vaccination programs as if they provide disease "immunity";

b. Illogically blaming the failure of the vaccination programs to provide disease immunity to the vaccinated population on the unvaccinated children even when disease outbreaks have even occurred in population groups where "100%" of the children had received the recommended multiple doses of the vaccines in the appropriate time windows;

c. Glossing over the grossly underreported post-vaccination "adverse events", which include serious harm, impairment, permanent disability, and death, as well as the generally unreported primary and secondary vaccination-related clinical cases of the live-virus diseases while fear mongering the American population about the comparatively rare prevalence of clinical cases of measles, mumps, or "whooping cough" in a population of 310-plus million residents; and

d. Ignoring the reality that vaccinations are causal factors for the current epidemics of childhood chronic medical conditions, allergies and food intolerances that were rare, or unknown, before the first "modern" vaccines were introduced starting in the 1930s.

Hopefully, the American public will soon wake up and realize that it has made a "bargain with the devil" that has:

- Exchanged natural childhood infection by a few childhood diseases that usually provided
  - lifetime immunity to having those diseases again (for measles, mumps, and rubella) as well as protections from other disease conditions, or
  - in the case of the alphaherpes varicella zoster virus (commonly called varicella zoster virus [VZV]) and "whooping cough", *commonly caused by Bordetella pertussis*,

  - the natural cycles of chickenpox provided long-term protection from disease recurrence as shingles by their periodic exogenous boosting for VZV as well as protections from other skin and brain disease conditions, or
  - for "whooping cough", long-term protection from subsequent infection (by any *Bordetella species*) that "lasts" up to 50 years —

❖ For short-term clinical childhood disease suppression by abnormal infection using vaccines containing:

- live viruses (e.g., the measles, mumps, rubella, rotavirus, and varicella vaccine components and one live-virus influenza vaccine in the USA) or
- inactivated, but not killed, viruses (e.g., most of the influenza vaccines and the polio vaccine currently used in the USA), or
- disease-related toxoids (e.g., the diphtheria toxoid and tetanus toxoid components) and toxins (e.g., the toxic pertussis components), or
- bacteria-related polysaccharide and conjugated polysaccharide components (e.g., the vaccines for the *Heamopholis influenzae type b*, various strains of the *Streptoccocus pneumoniae* that can cause "pneumonia" and "pneumococcal meningitis" and one to four of the human-infective serotypes of *Neisseria meningitidis*, the principal disease organism causing meningococcal meningitis) or
- genetically engineered virus-like particles produced by a modified yeast or other cell culturing system (e.g. the vaccines for hepatitis B and certain strains of the human papilloma virus [HPV]), and
- a number of toxic components, adventitious agents, DNA fragments and immune-system dysregulating substances (e.g., adjuvants).

These neither provide lifetime disease protection nor prevent a significant level of serious adverse reactions [see VAERS, which can easily be accessed and searched via an independent portal through http://www.medalerts.org/].

In the long run, the vaccines apparently adversely affect the long-term health of those who have been inoculated with them and have collectively contributed to the increase in or may have created many of the chronic childhood medical conditions, food allergies and intolerances that are now above, at, or approaching epidemic levels in the USA today.

Moreover, as Christians or other believers in God, need we be reminded that those firms that make vaccines and other pharmaceutical drug products have repeatedly proven that greed is their "god" by knowingly engaging in illegal practices for which they have:

a. Agreed to pay billions of dollars in fines, including criminal fines, and

b. "Persuaded" the federal government to ignore the Seventh Amendment of the Constitution of the United States of America[20] and to absolve the manufacturers of vaccines and those who dispense vaccines from being held liable for the harm that inoculation with these FDA-approved and CDC-recommended vaccines causes to some[21]?

Further, do not these vaccines' package inserts directly, or, by omission, indirectly, admit that these vaccine manufacturers have not, as they are required to do by law, proven that their vaccine formulations are safe[22]?

How, then, can we trust that such vaccines, lacking the requisite proofs of safety and produced by greed-driven manufacturers, are meant to promote the long-term health of our children and ourselves – an action which, if true, would obviously reduce their revenues?

As a servant of God through Jesus Christ, Dr. King is reminded of a passage in Matthew that is found in "*Christ's sermon on the mount*",

> "Beware of false prophets, which come to you in sheep's clothing, but inwardly they are ravening wolves. Ye shall know them by their fruits. Do men gather grapes of thorns, or figs of thistles?"[23]

Rather than speak further of these matters, Dr. King simply repeats the recently quoted position of the leaders of the ministries in

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20 Amendment VII of the Constitution (emphasis added), "In Suits at common law, where the value in controversy shall exceed twenty dollars, the right of trial by jury shall be preserved, and no fact tried by a jury, shall be otherwise re-examined in any Court of the United States, than according to the rules of the common law". [Ratified on December 15, 1791.]

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

22 http://dr-king.com/docs/20130501_Vaccines_The_Safest_of_Medicines_or_the_Biggest_Liequstn_e_b_r1.pdf.

23 King James Bible, Matthew Chapter 7, verses 15 and 16

question who have reportedly stated (emphasis added),

> "'Kenneth Copeland Ministries' position regarding dealing with any medical condition involving yourself or someone in your family is to first seek the wisdom of God, His Word, and appropriate medical attention from a professional that you know and trust,' a statement from the executive offices of the organization explains. 'Apply wisdom and discernment in carrying out their recommendations for treatment. This would include: vaccinations, immunizations, surgeries, prescriptions, or any other medical procedures'"[24].

Furthermore, Dr. King notes that this church of more than "1,000" congregants and its own medical staff reacted by following the recommendations of the public health officials to hold at least five (5) vaccination clinics, which were offering the MMR vaccine to the children and adults in the congregation who would accept it.

Finally, Dr. King would ask the reader, "How can anyone trust that the products, be they vaccines or other pharmaceuticals, produced by corporations, which have proven themselves to be driven by greed and self interest, are truly meant to promote the long-term health of the individuals recommended to be given these *purportedly* disease-preventive (prophylactic) products?"

An Orwellian View of Measles Vaccination History?

"The U.S. eliminated indigenous sources of measles in 2000. In its first 20 years[,] the vaccine prevented 52 million cases, 5,200 deaths, and 17,400 cases of retardation. The 159 cases reported this year are more than double what they were in 2012 and are on track to pass the 15-year high of 222 in 2011. 2013 is the 50th anniversary of the vaccine's availability in the U.S. The nation should be celebrating the disease's eradication, not its reintroduction."

First, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6115a1.htm?s_cid=mm6115a1_w, the document at the embedded link, actually begins by stating,

> "In 2000, the United States achieved measles elimination (defined as interruption of year-round endemic measles transmission) *(1)*. However, importations of measles into the United States continue to occur, posing risks for measles outbreaks and sustained measles transmission. …
>
> 1. Katz SL, Hinman AR. Summary and conclusions: measles elimination meeting, 16–17 March 2000. J Infect Dis 2004;189(Suppl 1):S43–7",

and, therefore, the cited article only claims that the "interruption of year-round endemic measles transmission" was achieved in the USA in 2000 – not that the "*U.S. eliminated indigenous sources of measles in 2000*".

Thus, *at a minimum*, Dr. Pomeroy's initial assertion is apparently misleading.

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[24] http://thinkprogress.org/health/2013/08/27/2532651/measles-outbreak-texas-megachurch/, last visited on 21 September 2013.

In addition, because, on average, about 3-million children were given a live measles-virus-containing vaccine in 1963 through 1989 and, from about 1990 onwards, about 7-million children have received a live measles-virus-containing vaccine annually as well as vaccine doses given to other individuals in outbreak situations and, in recent years, to certain other groups, the measles vaccination program has abnormally infected more than 162 million children with at least one dose of live measles virus and more than 84 million of these children with a second infectious dose of measles virus without providing any of these vaccinated children with lifetime protection from contracting measles ("measles immunity") and leaving at least 10 million of these children with no real protection from contracting measles whatsoever.

Yet, Dr. Pomeroy does not even mention, much less address, the preceding realities.

Further, her claims that "*In its first 20 years"[,] "the vaccine prevented 52 million cases, 5,200 deaths, and 17,400 cases of retardation*" are, at best, suspect estimates generated by those whose goals are to promote vaccination.

Moreover, these estimates apparently fail to account for the cases of vaccination-induced measles "*cases*", vaccine-associated atypical measles "*cases*", and post-vaccination-related "*deaths*".

Using a 1% reporting percentage for the most serious adverse events listed in VAERS, as reflected in a paper in which former FDA Commissioner David A. Kessler, MD was the lead author[25], Dr. King recently estimated [see footnote "**19**"] the average annual post-measles-vaccination-related death reports as 550 death reports in children under 6 years of age from the VAERS entries reporting "death" as an outcome that he audited or an estimated 11,000 measles-containing-vaccine-related deaths in children under 6 years of age in a 20-year period).

Based on Dr. King's estimate, vaccination with a measles-containing vaccine may have taken more lives than were "saved".

Furthermore, measles vaccination most certainly does not provide even those who were doubly vaccinated with lifetime protection from contracting measles.

In addition, since the vaccines that are currently used (MMR and MMRV) also infect those inoculated with them with the live mumps and

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25 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.

rubella viruses, these inoculees are also not provided lifetime protection from contracting mumps or rubella.

In addition, since more than 7 million doses of one strain of a live measles virus are produced and injected into children and adults each year, some cases of indigenous (non-import-related) "wild" strain measles continue to occur, and on the order of 300-plus measles-vaccine-strain-related measles cases occur annually, the measles virus obviously has not been eradicated in the USA.

Therefore, because, *as an infectious disease expert*, she should be well aware of the preceding live-measles-virus infection realities, Dr. Pomeroy's closing statement,

"*The nation should be celebrating the disease's eradication, not its reintroduction*",

appears to be knowingly false.

Dr. Pomeroy's Measles Experience and Her "Crocodile Tears"

"Five years before the vaccine first became available, I contracted measles along with thousands of other children. I was fortunate. I recovered after suffering from severe fever, rash, cough, coryza and conjunctivitis. Hundreds of other children perished. As an infectious disease physician, I cannot bear the thought of the country returning to those horrific times of despair. In this day and age it is shameful that measles is a leading cause of vaccine-preventable childhood mortality."

Here, Dr. Pomeroy begins by underreporting the number of children contracting measles, which she reports as "*thousands of … children*", when she should have either reported the approximate number of measles cases or stated that "*hundreds of thousands of … children*" contracted measles.

Factually, in 1958, "*[f]ive years before the vaccine first became available*" in 1963, more than 750 thousand children had a clinical case of measles (with about 600 deaths [about 1 death in 125,000 clinical cases]) and, in 1959, more than 400 thousand children contracted measles (with about 400 deaths [about 1 death in 100,000 cases]) [see, footnote "**19**", "Figure 1" on page "Ref-1"].

As a researcher recognizing the progress that has been made in understanding the nutritional deficits that increase the risk of serious complications from having a case of the measles, Dr. King thinks that, *with the appropriate initial interventions*, the death rate from natural measles infections could probably be reduced to on the order of one (1) in a million (1,000,000) in the USA.

This reduction could be accomplished by an appropriate initial bolus dose of vitamin A (possibly, 1,000-5,000 IU for young children) coupled with high-dose vitamin C supplementation (at the maximum tolerable oral dose of the sodium salt of vitamin C of on the order of 14 mg of vitamin C per pound [about 30 mg per kg] per day or intravenous sodium vitamin C at the highest tolerated levels in the most severe cases), and, *for 14 days*, 1,000 IU (25 micrograms [25 µg]) of vitamin D-3 orally per pound of body weight either with or in an appropriate probiotic powder or with 100 to 200 µg of vitamin K-2 for every 10 pounds of body weight to ensure that the vitamin D-3 is absorbed into the body until the child's blood level of 25-hydroxy vitamin D exceeds 55 nanograms per milliliter [ng/mL] or 137.5 nanomole /liter [nm/l] and, for better outcomes, is 90 ng/mL to 120 ng/mL [225 to 300 nm/l][26].

Moreover, having been born in 1945 and growing up in the late 1940s, 1950s and early 1960s, when measles repeatedly swept through my neighborhood and all of my younger brothers and sister and myself contracted measles as well as mumps, rubella, chickenpox, polio, and whooping cough in addition to at least one ear infection, some colds and fevers, probably a case of flu, and a case or two of mild diarrhea before entering high school, Dr. King knows that those times were not "*horrific times of despair*".

Rather these times were times when children had and recovered from these successive childhood diseases that strengthened the children's immune systems and, *with very few exceptions*, made them healthier while providing lifetime immunity to the "circulating" strains of measles, mumps, rubella, polio, and rotavirus.

In addition, some of the other childhood diseases furnished long-term protection.

For example, having "whooping cough" protected us from re-infection by any of the human-infective *Bordetella* species.

The external [exogenous] boosting from exposures to the VZV

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[26] For adequate production of disease-specific polypeptide antibiotics, the 25-hydroxy vitamin D blood level should exceed 55 ng/mL. Thus, for a person to have a fully effective level of vitamin D, the normal range for the blood level of 25-hydroxy vitamin D in healthy humans should be changed from "30 ng/mL to 100 ng/mL" to "55 ng/mL to 100 ng/mL". For some information on the role of 25-hydroxy vitamin D in the body's producing its own polypeptide antibiotics (e.g., Cathelicidins and Defensins), which can be tailored by the body to be effective against all classes of microbes, including viruses, see, Gombart, AF. The Vitamin D–antimicrobial Peptide Pathway and Its Role in Protection against Infection. *Future Microbiol*. 2009; 4(9):1151-1165, which may be accessed in a 10-plus-part segmented format starting at http://www.medscape.com/viewarticle/712847 for those who have a MedScape account or, for those who do not have an account, this article is also available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2821804/, both last accessed on 21 September 2013.

shed by those having chickenpox after we did provided us protection from the risk of having chickenpox again as well as extended protection from the recurrence of our initial VZV infections as shingles.

After having influenza, we apparently became resistant to getting annual influenza infections.

Moreover, in the late 1950s and early 1960s when a hepatitis A outbreak swept through the high and middle schools that he and his siblings were attending, we were all given immune globulin shots and none of us contracted hepatitis A though, because some of our classmates and those with whom we ate lunch did get hepatitis A, we were all clearly exposed multiple times to the hepatitis A virus being shed into our environment.

In contrast to that history of acute illnesses, full recoveries in almost all instances, and overall health in most children and their parents when he was growing up, today Dr. King is observing increasing "*times of despair*" in the USA as the percentage of today's parents and children with one or more chronic medical conditions continues to swell and the overall negative impacts to the health of our children and ourselves continue to pile up.

While exposure to GMO foods, pesticides and pesticide residues, other endocrine disrupting chemicals, the addition of poisonous fluorides to our foods and water supplies, and the chemicals that are continually being sprayed into the air we breathe are contributing factors, today's patently unsafe (see footnote "**22**") and less-than-in-use-effective vaccination programs are major factors that have created the epidemic levels of chronic childhood and adult medical conditions for medical diseases, disorders, and syndromes that, when Dr. King was born, were unheard of, nonexistent, or rare.

Since Dr. Pomeroy is "*an infectious disease physician*", Dr. King can understand why she does <u>not</u> want to return to a time when most children (99.99-plus percent of those children who had all of the childhood diseases) recovered to live relatively healthy and productive lives with little, or <u>no</u>, chronic medical conditions or childhood disease recurrences until they entered their 60s or later.

Furthermore, no pediatricians were needed; the biggest cancer risks were probably caused, or exacerbated, by inorganic-mercury-poisoning-related exposures (e.g., stomach cancer) and smoking-related exposures exacerbated by exposures to asbestos; fluoridated water and sunscreens were beginning to be pushed to weaken our

overall health; and, absent an injury or symptoms of a serious or life-threatening medical condition, children rarely saw any healthcare provider.

In addition, their minor illnesses were, for the most part, treated with simple home remedies using baking soda, vinegar, Epson salts, rubbing alcohol, aromatic rubs, hot toddies and cod liver oil; teas; plant-derived oils; poultices; herbal supplements; and a few "over-the-counter (O-T-C) medicines".

However, Dr. King finds that Dr. Pomeroy's closing statement here,

> "*In this day and age it is shameful that measles is a leading cause of vaccine-preventable childhood mortality*",

is itself "*shameful*" because,

1. Measles is <u>not</u> "*vaccine-preventable*" — at best, multiple MMR vaccinations abnormally simultaneously infect the inoculees with live measles, mumps and rubella viruses that do <u>not</u> protect at least 5% to 8% of them from getting measles and whatever protection that is provided to the other 92% to 98% of the inoculees does <u>not</u> last for the inoculees' lifetime.

   In general, for those vaccinees who are initially protected, the protection from contracting measles if exposed to the measles virus lasts less than 25 years from the last vaccination; in most instances, the protection from getting measles does <u>not</u> last longer than 10 years; and, in many instances, the protection from measles does <u>not</u> even last 5 years after the last vaccination;

2. In the USA, *on average*, less than one person of any age dies each year from the effects of a measles infection while, on average, more than three times the number of MMR- and MMRV- vaccination-related death reports in children under six years of age ("5.50") are posted annually in VAERS as compared to the average number of annual notified measles, mumps and rubella deaths combined ("1.71"), where "5.50" divided by "1.71" is 3.22 [see, footnote "**19**", pages "**4**" through "**8**"].

   Even though almost all measles, mumps and rubella deaths are reported each year by the CDC, only some very small percentage of the actual MMR- and MMRV-related

short-term adverse events following vaccination that result in the death of the inoculees are reported to VAERS;

3. Dr. Pomeroy makes no mention of the higher measles-vaccination-related death reports in VAERS but chooses to obsess over the less than one average annual disease-related notified measles death report for all residents of the USA (an annual population incidence rate of less than 1 in 500 million residents ["0.57" notified for the period "2003" through "2009" {see, footnote "**19**", page "**5**", "'TABLE 12. Number of deaths from selected nationally notifiable infectious diseases — United States, 2003–2009'*"}]).

She treats measles deaths as if it were "*a leading cause of … childhood mortality*" when neither the number of these notified deaths that were children nor the age of those who died from complications related to measles was reported and, on average, less than one person dies from measles each year in the USA.

In 2010, the infant mortality (death in the first year of life) was formally reported as "24,585" deaths in the USA, which, *for about 4 million live births*, translated into an infant mortality rate in the USA of "614.7" deaths per 100,000 infants[27].

The third leading cause of infant death was reported as "Sudden infant death syndrome" (SIDS), which had "2,063" deaths associated with it[28].

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27 http://www.cdc.gov/nchs/fastats/infant_health.htm, last visited on 22 September 2013.

28 http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_04.pdf, Murphy SL, Xu J, Kochanek KD. Deaths: Final Data for 2010. *National Vital Statistics Report*, 2013 May 8; 61(4), page "19" [Note: "This document will be replaced by a reformatted, typeset report in the near future".], on 22 Sep. 2013.

"Table E. Number of infant deaths, percentage of total infant deaths, and infant mortality rates for 2010, and percentage change in infant mortality rates from 2009 to 2010 for the 10 leading causes of infant death in 2010: United States [Rates are infant deaths per 100,000 live births]

Rank[1]	Cause of death (based on ICD-10, 2004)	Number	Percent of total deaths	Rate	Percent change[2] from 2009 to 2010
…	All causes	24,586	100.0	614.7	-3.9
1	Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	5,107	20.8	127.7	-0.9
2	Disorders related to short gestation and low birth weight, not elsewhere classified (P07)	4,148	16.9	103.7	-5.6
3	Sudden infant death syndrome (R95)	2,063	8.4	51.6	-4.3
4	Newborn affected by maternal complications of pregnancy (P01)	1,561	6.3	39.0	0.3
5	Accidents (unintentional injuries) (V01-X59)	1,110	4.5	27.8	-2.8
6	Newborn affected by complications of placenta, cord and membranes (P02)	1,030	4.2	25.8	0.0
7	Bacterial sepsis of newborn (P36)	583	2.4	14.6	-7.6
8	Respiratory distress of newborn (P22)	514	2.1	12.9	-10.4
9	Diseases of the circulatory system (I00-I99)	507	2.1	12.7	-9.9
10	Necrotizing enterocolitis of newborn (P77)	472	1.9	11.8	0.9
…	All other causes (Residual)	7,491	30.5	187.3	…

… Category not applicable.

[1] Based on number of deaths; see "Technical Notes."

[2] Based on a comparison of the 2010 infant mortality rate with the 2009 infant mortality rate."

> Factually, SIDS is a cause of death that has been found to be strongly associated with the early childhood vaccine inoculations, especially the early DTP (diphtheria, tetanus and pertussis combination vaccine) inoculations, given to infants in their first year of life.

While "straining at the proverbial gnat" (the less than one [1] average annual notified measles death), Dr. Pomeroy not only "swallows the proverbial camel" (of thousands of annual SIDS deaths), but also ignores the reality that the first-year inoculations with a pertussis-containing vaccine are clearly a causal factor for SIDS deaths as well as a factor in the surviving children's subsequent risk of developing asthma and/or being diagnosed with a neurodevelopmental, developmental, or behavioral condition.

Fabricated: A "Church Crisis" and a Serious Threat to the Nation's Health Security

"The church crisis also highlights a serious threat to the nation's health security: importing measles into the U.S. The cases link to a man who was exposed to the virus in Asia, brought it back to the church and infected unvaccinated congregants, staff and children in their daycare center. This most recent outbreak highlighted an alarming trend among 2011 cases in the U.S.: Ninety percent were associated with other countries, including U.S. residents returning from abroad and foreign visitors to the U.S. Most infected persons (86 percent) were unvaccinated or had unknown vaccination status. The CDC warns that 'increased numbers of outbreaks and measles importations into the U.S. underscore ongoing risk for measles among unvaccinated persons and the importance of vaccination against measles.'"

Here, Dr. Pomeroy begins by mischaracterizing a small measles outbreak that infected less than 25 individuals with measles as if it were a "*church crisis*", which was somehow manufactured by the church rather than the failure of public health to prevent measles importation.

If, *as she implies*, measles importation were a "*serious threat to the nation's health security*", then, why are our borders allowed to remain porous to illegal entry on a grand scale — especially our Southern border where, since 1986, more than ten million have crossed illegally?

If "*importing measles into the U.S.*" were a "*serious threat to the nation's health security*", then, *at a minimum*, why are all persons entering the USA through customs from a country where measles is endemic or where there currently are large outbreaks of measles not quarantined until they are proven: **a)** not to be infected or **b)** if found to be infected, not capable of infecting anyone else?

Obviously, based on the federal and state governments' border security and customs policies and their actions, measles importation is not considered a "*serious threat to the nation's health security*".

Moreover, accepting that Dr. Pomeroy's portrayal of the sources for the outbreaks of measles in the USA in 2011 is correct, 14 percent or more of those infected with measles actually had an age-appropriate vaccination status for measles vaccination.

In addition, the CDC's warning,

> "*increased numbers of outbreaks and measles importations into the U.S. underscore ongoing risk for measles among unvaccinated persons and the importance of vaccination against measles*",

ignores the reality that most of those Americans, who were vaccinated against measles in childhood as the CDC has recommended, are no longer protected from contracting measles when exposed to someone shedding measles if their last measles vaccination occurred more than 5 to 10 years previously.

In contrast, almost every child who contracted natural measles recovered with no lasting ill effects and afterwards has "lifetime protection" (immunity) from getting measles again.

Clearly, the vaccination program for measles does not provide the lifetime protection (immunity) from measles that it was initially touted to provide.

Through the use of the term "immunization", the advocates for vaccination continue to imply that the now apparently multiple-dose[29] MMR vaccination program provides "immunity".

Worse, nowhere does Dr. Pomeroy address the very real issues of the serious adverse event risks, including death, which are associated with each dose of the MMR or MMRV vaccine, and the reality that the risk of the serious long-term adverse chronic outcomes increases with each successive dose of the vaccine as the inoculee's immune system is repeatedly rechallenged by an injection of three (or, for the MMRV vaccine, four) doses of live viruses and all of the other biologically

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[29] Based on the latest CDC-published recommendations for measles vaccination, the current vaccination program starts with 2 doses of the MMR vaccine in childhood and, for some, 2 more MMR doses separated by a month in early adulthood and/or 2 more MMR doses separated by a month in some working environments as well as at least one more MMR dose whenever there is a possible exposure during an outbreak. Thus, the currently recommended maximum MMR dosing over a person's lifetime is apparently 6 doses when a person is not a possible contact in an outbreak setting and more than that when a person is involved in an outbreak situation. However, since there have been documented cases in individuals receiving 5 separate measles vaccinations and, no matter how many times certain individuals are vaccinated, the vaccination provides them with no protection from subsequently contracting measles if exposed to someone shedding the measles virus, there is no assurance that 6 or more MMR vaccinations will provide the inoculees who receives them protection from contracting measles. In contrast, having measles naturally once during childhood provides lifetime protection from a subsequent re-infection.

reactive components in each vaccine dose, components that, with few exceptions, have never been proven to be "safe" to inject into humans at the levels used.

Dr. Pomeroy's real concern: Protecting "*the nation's public health achievements*"

"The Texas cases, this year's third major measles outbreak in the U.S., demonstrate how critical it is to avoid health complacency. Together we must diligently protect the nation's public health achievements. We must prevent the acts of a few from defeating hard-won health victories. We must commit to forever honoring the thousands of professional and voluntary medical and public health organizations and individuals who came together to find a measles vaccine and spent decades implementing a profoundly successful nationwide immunization program."

Here, Dr. Pomeroy elegantly regurgitates the distortions and misrepresentations used by vaccine apologists to wrap vaccination programs, which have clearly failed to provide disease immunity, in a proverbial "flag" and speaks as if the current vaccination realities were "*hard-won health victories*" rather than the substance-less distortions and propaganda used to support the current non-science-based vaccine-inoculation programs.

Even Dr. King is forced to agree that the CDC-recommended "universal" measles vaccination program has been "*profoundly successful*" in deceiving Americans, *apparently including Dr. Pomeroy*, into suspending logic and believing that the MMR vaccination program, which does not provide lifetime disease protection from measles, mumps or rubella to anyone, is somehow "*a profoundly successful nationwide immunization program*".

Clearly, Dr. Pomeroy's statements indicate that she is not truly concerned about protecting the fiscal and physical health of the public but rather sees her job as protecting the "measles" vaccination program.

Based on today's understanding of measles infection and measles immunity, a "natural measles" program would foster the long-lasting benefits of contracting natural measles once; provide the supportive nutritional supplementation known to minimize the duration and severity of that measles infection; and reap those benefits for not only the current generation but also each succeeding generation.

In addition, such a program would provide population immunity to those who reside in the USA.

In contrast, the recommended MMR vaccination program for "measles":

a. Fails to provide post-vaccination immunity (lifelong protection) to contracting measles to even those who have been vaccinated twice;

b. Does not provide significant post-partum disease protection to the breastfeeding newborn infants of those women who, rather than having measles, mumps and rubella when they were children, were given doses of measles (M), measles and rubella (MR), measles and mumps (MM), MMR and/or MMRV vaccines for measles; and

c. As the pattern of variably sized and infrequent outbreaks that are continually demonized indicates, fails to even provide extended (more than 10 years in duration) population protection to all those who were doubly vaccinated from subsequently contracting measles.

Moreover, through the ever-increasing number of vaccinations being required, and their increasing costs; the increasing level and severity of adverse reactions and their costs; and the decreased protections provided to the newborn infants and their costs, the MMR vaccination program is clearly draining the fiscal and physical vitality of the American people while fattening the coffers of the vaccine manufacturers, the pharmaceutical industry, the healthcare providers and, *through an excise tax of US$ 2.25 on each dose of MMR vaccine and US$ 3.00 on each dose of MMRV vaccine*, the U.S. federal government.

The Real Lessons We Can Learn from the MMR and Other Vaccination Programs

"We must learn from the lessons of the measles vaccine experience, and we must extend those lessons to all vaccines. The CDC's Aug. 30 "Morbidity and Mortality Weekly Report" found troubling gaps and varied rates among states in vaccination coverage for adolescents and teens. Only 36 states have achieved Healthy People 2020 targets for Tdap, 12 for meningococcal meningitis and nine for chickenpox. No state met the national target for human papillomavirus vaccination coverage among girls. Clinicians, public health agencies, parents, educators and other stakeholders are missing substantial opportunities to assure that all children are fully vaccinated."

Unlike Dr. Pomeroy, who apparently ignores the documented issues with the MMR-based and the DTP-based vaccination programs,

which the Establishment once promised would provide us with "disease immunity", although these vaccines have clearly failed to fulfill that promise for measles and pertussis, Dr. King understands that we must learn from these failures.

Moreover, remembering:

- ❖ The late 1990s withdrawals for:
  - The now-Pfizer, then-Wyeth-Lederle RotaShield™ vaccine, made using a genetically engineered, live, human-monkey hybridized rotavirus, and
  - The now-GlaxoSmithKline, then-SmithKline-Beecham LYMErix™ vaccine, made from a recombinant outer surface protein A (OspA) from *Borrelia Burgdorferi*, as well as
- ❖ The proven failure of the current vaccines for the alpha-herpes varicella zoster virus, commonly called the varicella zoster virus (VZV, which causes chickenpox initially and later reactivates to cause shingles; respectively, Merck's Varivax® and Zostavax®) to be cost effective in the USA[30],

Dr. King understands that, *for the current FDA-approved vaccines that are a part of today's CDC-recommended "universal" vaccination programs*, "*we*" should *independently* evaluate each vaccination program separately to establish that each vaccine is truly safe for mass use and, *as it is currently recommended*, in-use medically cost-effective when ***all*** direct and indirect costs for the current recommended maximum dosing level are factored in, including all of the costs associated with the projected maximum levels for the short-term and long-term serious adverse effects associated with that vaccine, including recent U.S. "vaccine court" payouts for damage claims related to each vaccine.

Thus, for each FDA-approved vaccine, there needs to be pre-clinical proof that each such "prophylactic" ("disease preventive") vaccine is truly long-term safe with respect to its carcinogenicity, mutagenicity and reproductive toxicity (including such issues as fertility reduction, conception difficulty, loss of the ability to reproduce, premature puberty, premature menopause, and adverse effects on the offspring) as well as its short-term and long-term adverse effects on the

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30 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* 2013 March 25; 31(13): 1680-1684 (open access) [http://www.sciencedirect.com/science/journal/0264410X/31/13, article "6"]

inoculees in appropriate, scientifically sound, double-blind, true-placebo-controlled studies before any of the current FDA-approved vaccines can continue to be mandated as a pre-condition for any activity (e.g., school attendance or employment[31]).

Until all of the missing proofs of safety can be established, for those individuals and parents who want to start, or continue, to vaccinate themselves or their children or wards, each competent person, parent or guardian should be fully informed as to what the missing proofs of safety are for each vaccine and their written consent obtained which verifies that they understand that the vaccine may increase the recipient's risk for cancer, mutations, and non-reversible reproductive impairment, and, despite these risks, they are agreeing to the administration of each vaccine dose.

Though Dr. Pomeroy's closing statement in this paragraph,

> "*Clinicians, public health agencies, parents, educators and other stakeholders are missing substantial opportunities to assure that all children are fully vaccinated*",

glibly speaks about "*missing substantial opportunities*", the reality is that legal mandates; in-school clinics where non-emancipated children, who legally cannot enter into a contract, are "allowed" to give "consent" to be vaccinated; financial and other attractive inducements; and incessant fear mongering are being used to drive the vaccination agenda.

Thus, rather than being naturally impelled by the proven benefits that each vaccination obviously provides to our children, vaccine apologists and propagandists are increasingly using compulsion, deception, fear and inducements to drive the vaccination programs.

However, as Dr. King understands, and increasingly the public and parents are starting to comprehend, today's vaccination programs are, *at best*, false "gods", which do not furnish the disease protections that their advertising and propaganda claims they do.

If each vaccine inoculation program were to perform as the vaccine apologists, like Dr. Pomeroy, claim and the vaccines were actually safe, in-use effective and cost-effective, then there would be no need to mandate any truly safe and effective vaccination program as a general condition for a child's attending a licensed childcare facility or school – parents would be lining up to have their children vaccinated whether or not their children were attending such institutions.

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[31] This requirement is a must because, *though required to do so by law*, the manufacturers of these FDA-approved vaccines have admittedly failed to prove that their vaccine formulations are not carcinogenic, mutagenic and reproductively toxic before their vaccines were administered to any human being (see, footnote "**22**").

If the influenza vaccines were truly safe and effective, there would be no need for employment mandates to force employees to get an annual flu-vaccine inoculation.

If the childhood vaccination programs were capable of providing disease immunity or long-term (> 50 year) protection to almost all who were inoculated one time or, at most, twice, there would be no need for more than two (2) doses of any vaccine and, hence, no need for an adult vaccination program.

However, because coercive mandates, inducements and incentives, misrepresentations, deception, and propaganda are the tools being used by the Establishment to push the vaccination agenda, any rational student of the current CDC-recommended vaccination programs knows, as Dr. King has repeatedly established, the goal "*to assure that all children are fully vaccinated*" has nothing to do with "*health safety*" and everything to do with Establishment's greed-driven agenda to further enslave the American people in a manner that fattens the corporate bottom lines while adversely impacting the fiscal and physical health of each American, starting before they are born and continuing at an ever-increasing level, to maximize the number of chronic medical conditions that each child will have as well as the period that they and all adults will be chronically ill.

Demand Vaccines that Protect Our and Our Children's Overall Health — Not Ones that Protect "*the nation's public health achievements*"

"Now is the time -- and recent outbreaks demonstrate how quickly it can become too late -- for all members of society to join forces and voices in leveraging vaccines to help provide health safety to everyone who lives in the U.S. Adults who opt out of vaccination, either for themselves or their children, betray all we stand for as a socially responsible, united nation. Denying children life-saving vaccinations violates the most fundamental principles of morality, disregards the core tenets of human decency and breaks the contract of ethical responsibility between generations. Everyone has the chance to do the right thing."

In her closing paragraph, Dr. Pomeroy begins with a call, "*Now is the time*" which inserts a fear mongering *non sequitor* about what she apparently *implicitly* feels that the measles outbreaks, which continually occur, demonstrate.

Dr. King has repeatedly shown that the current measles vaccination program and some other vaccination programs (DPT and VZV) are not actually providing "*health safety to everyone who lives in the U.S*".

If Dr. Pomeroy were truly interested in providing "*health safety*" to all residents of the USA, she would be calling for an in-depth review of safety, in-use effectiveness and cost-effectiveness of each of the current FDA-approved vaccines and CDC-published vaccination recommendations as well as proof that the worst-case vaccination dosing schedules are truly scientifically safe, but she is not.

Moreover, Dr. Pomeroy's inflammatory,

> "*Adults who opt out of vaccination, either for themselves or their children, betray all we stand for as a socially responsible, united nation.*"

indicates that she either does not care or does not know that, for non-emergency medical care, a category that clearly includes "disease-preventive" vaccines, every adult has the right and the duty to decide for himself or herself whether to follow a medication recommendation or to pursue some other course of action for himself or herself as well as each of his or her minor children and wards.

This right is commonly called "bodily integrity".

In addition, each competent adult is supposed to be given full and complete information about the potential benefits and risks associated with each medical procedure, including vaccination, and his or her written "informed consent" to that medical procedure obtained before that procedure could proceed.

Yet, in the USA, CDC-generated "Vaccine Information Sheets", which, at best, provide a biased overview of the information on each vaccine that does not even fully disclose the risks information that the vaccine manufacturer has included in the vaccine's package insert is all that the healthcare provider is required to provide (but often does not) before asking the responsible adult to give his written consent and not proceeding to administer the vaccine until written consent has been given (but even this pre-approval requirement is often ignored).

After all, whether the healthcare provider complies with all of the requirements or not, he or she, like the vaccine's manufacturer, is immune from subsequently being sued when a vaccination causes a problem even when, had the responsible adult been properly and fully informed, he or she would not have given his or her consent for the vaccination or the vaccine is administered when prior written consent to vaccinate was denied or not obtained.

Moreover, in the constitutional republic that is the USA, where the rights of the individual to be free in his or her own person are explicitly recognized, no conscious medical decision can actually betray anything

and such decisions actually support the freedoms for which our founding fathers and previous generations of Americans fought and died to secure and defend.

Given her choice of phrasing, "*a socially responsible, united nation*", Dr. Pomeroy apparently believes that the USA should not be a republic with a limited federal government that our founding fathers created, a nation that is supposed to be of the people, by the people and for the people, but rather that the USA should be a socialist democracy ruled by a dictatorial elite, a government of the corporate rich and powerful, by the rich and powerful, and for the rich and powerful in which the people are the serfs whose lot is to be obedient to their masters.

Finally, the problems with her next statement,

> "*Denying children life-saving vaccinations violates the most fundamental principles of morality, disregards the core tenets of human decency and breaks the contract of ethical responsibility between generations*",

include, but are not limited to:

1. A conflict with the reality that, in today's America, most childhood vaccinations probably kill and permanently maim many more children than they actually protect from subsequently contracting a disease-covered illness.
2. Since children are supposedly healthy when vaccinated, the vaccination cannot be "*life-saving*".

   At best, a vaccination for measles may provide some limited-duration protection from contracting a disease that is "covered" by the vaccine to most of those who are vaccinated with it for some limited period.

   At worst, for a flu vaccine that does not match the influenza virus to which the child is exposed, all that a vaccination may do is weaken the child's immune system and damage that child's ability to mount an effective response to the non-vaccine strain of influenza or other viral infection to which the vaccinated child is exposed[32] or, *for both an*

[32] Cowling BJ, Fang VJ, Nishiura H, Chan K-H, Ng S, Ip DKM, Chiu SS, Leung GM, Peiris JSM. Increased Risk of Noninfluenza Respiratory Virus Infections Associated With Receipt of Inactivated Influenza Vaccine. *Clin Infect Dis* 2012 June15; 54(12):1778-1783. [***Nota bene***: This study is a double-blind, true-saline-placebo controlled inactivated-influenza-vaccine effectiveness study in children 6–15 years of age with extended follow up through the flu season. The lead in states (emphasis added), "We randomized 115 children to trivalent inactivated influenza vaccine (TIV) or placebo. Over the following 9 months, TIV recipients had an increased risk of virologically confirmed non-influenza infections (relative risk: 4.40; 95% confidence interval: 1.31-14.8). Being protected against influenza, TIV recipients may lack temporary non-specific immunity that protected against other respiratory viruses." In addition, the study found no statistically significant difference between the cases of influenza in those vaccinated with an influenza vaccine and those given a sham inoculation with a sterile saline placebo as shown in the article's "Table 3". This article can be accessed at http://cid.oxfordjournals.org/content/54/12/1778.full.

influenza vaccine and a measles-containing vaccine, the vaccination may harm, maim or kill the vaccinated child.

Thus, at the time of administration, no childhood vaccination can be "*life-saving*" even though, *as documented in VAERS reports*, it most certainly can be, and is, permanently life altering or even life ending for some who are vaccinated with a given vaccine[33].

Moreover, *unless the child is subsequently exposed to the disease during the limited period of time that the vaccination outcome is "*disease protective*"*, the vaccination cannot even be "disease protective".

3. Because an infant is born with an undeveloped immune system, generally, immunologists recognize that any vaccination given before a child is one-developmental-year old does not tend to provide long-term disease protection to the inoculated child.

Isn't it more decent, moral, and ethically responsible to ensure that babies are breastfed for at least one year of age and to delay the first vaccine until the infant's immune system has a chance to naturally develop and the child is at least twelve (12) developmental months of age or older?

4. Factually, giving: **a)** the first DTP-containing vaccine inoculation at two months of age apparently doubles the inoculated child's risk of developing asthma as compared to administering the first dose at four months of age or later[34] and **b)** the first measles-containing vaccine at less than or equal to 14 months of age apparently provided less protection from contracting measles after exposure to the measles virus than getting the first MMR vaccination at 15 months of age or later[35]. Moreover, based on information in the "Abstract" of a

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[33] Since there are no studies, using volunteered children, comparing the measles disease outcomes in initially healthy, breast-fed children who have never been vaccinated and are given a sham injection of sterile pH-balanced isotonic saline (a true placebo") at 15 months of age to matched initially healthy, breast-fed children who are vaccinated against measles at 15 months, there are no valid comparisons by which a true comparison of the health-improving effects, if any, of vaccination versus no vaccination can be assessed.

[34] 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 Clinical Immunol* 2008; 121: 626-631. http://www.sciencedirect.com/science/article/pii/S0091674907023792

[35] Hersch BS, Markowitz LE, Hoffman RE, Hoff DR, Doran MJ, Fleishman JC, Preblud SR, Orenstein WA. A measles outbreak at a college with a prematriculation immunization requirement. *Am J Public Health*. 1991 March; 81(3): 360–364 (emphasis added).

"ABSTRACT

BACKGROUND. In early 1988 an outbreak of 84 measles cases occurred at a college in Colorado in which over 98 percent of students had documentation of adequate measles immunity (physician diagnosed measles, receipt of live measles vaccine on or after the first birthday, or serologic evidence of immunity) due to an immunization requirement in effect since 1986.

paper reviewing the outcomes from those receiving a measles containing vaccination at 12 to 23 months of age that was published online in the journal *JAMA Pediatrics*[36],

"Objective To examine the potential modifying effect of age on the risk of fever and seizures following immunization with measles-containing vaccines.

Design, Setting, and Participants Retrospective cohort study at 8 Vaccine Safety Datalink sites of a total of 840 348 children 12 to 23 months of age who had received a measles-containing vaccine from 2001 through 2011.

Exposures Any measles-containing vaccines and measles-containing vaccines by type.

Main Outcomes and Measures Fever and seizure events occurring during a 42-day postimmunization observation period.

Results In the analysis of any measles-containing vaccines, the increased risk of seizures during the 7- to 10-day risk interval, using the remainder of the observation period as the control interval, was significantly greater among older children (relative risk, 6.5; 95% CI, 5.3-8.1; attributable risk, 9.5 excess cases per 10 000 doses; 95% CI, 7.6-11.5) than among younger children (relative risk, 3.4; 95% CI, 3.0-3.9; attributable risk = 4.0 excess cases per 10 000 doses; 95% CI, 3.4-4.6). The relative risk of postimmunization fever was significantly greater among older children than among younger children; however, its attributable risk was not. In the analysis of vaccine type, measles, mumps, rubella, and varicella vaccine was associated with a 1.4-fold increase in the risk of fever and 2-fold increase in the risk of seizures compared with measles, mumps, and rubella vaccine administered with or without varicella vaccine in both younger and older children.

Conclusions and Relevance Measles-containing vaccines are associated with a lower increased risk of seizures when administered at 12 to 15 months of age. Findings of this study that focused on safety outcomes highlight the importance of timely immunization of children with the first dose of measles-containing vaccines",

and the fact that the "background risk" for seizures peaks when vaccinated children are at about 18 months of age[37], delaying the first dose of the MMR vaccine until the child is older than 23 months of age and forbidding the use of the

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METHODS. To examine potential risk factors for measles vaccine failure, we conducted a retrospective cohort study among students living in campus dormitories using student health service vaccination records.

RESULTS. Overall, 70 (83 percent) cases had been vaccinated at greater than or equal to 12 months of age. Students living in campus dormitories were at increased risk for measles compared to students living off-campus (RR = 3.0, 95% CI = 2.0, 4.7). Students vaccinated at 12-14 months of age were at increased risk compared to those vaccinated at greater than or equal to 15 months (RR = 3.1, 95% CI = 1.7, 5.7). Time since vaccination was not a risk factor for vaccine failure. Measles vaccine effectiveness was calculated to be 94% (95% CI = 86, 98) for vaccination at greater than or equal to 15 months.

CONCLUSIONS. As in secondary schools, measles outbreaks can occur among highly vaccinated college populations. Implementation of recent recommendations to require two doses of measles vaccine for college entrants should help reduce measles outbreaks in college populations."

36 Rowhani-Rahbar A, Fireman B, Lewis E, Nordin J, Naleway A, Jacobsen SJ, Jackson LA, Tse A, Belongia EA, Hambidge SJ, Weintraub E, Baxter R, Klein NP. Effect of Age on the Risk of Fever and Seizures Following Immunization with Measles-Containing Vaccines in Children. *JAMA Pediatr*. Published online October 14, 2013. doi:10.1001/jamapediatrics.2013.2745. http://archpedi.jamanetwork.com/article.aspx?articleid=1750204

37 http://www.familypracticenews.com/single-view/measles-vaccination-at-12-15-months-lower-seizure-risk/08e95dfd0beae0fee6a2ba56e2638603.html and http://www.familypracticenews.com/single-view/measles-vaccination-at-12-15-months-lower-seizure-risk/d910bfa40b81cbce11d581333857d54f.html?tx_ttnews%5BsViewPointer%5D=1 Moon MA. Measles vaccination at 12-15 months = lower seizure risk. *Family Practice News Digital Network* 2013 October 14; 2013: 2 pages.

MMRV vaccine in children under the age of 4 years should provide increased-duration protection from measles to those whom vaccination will protect and decreased risk of post-vaccination seizures.

Isn't it more decent, moral, and ethically responsible to delay the first doses of these vaccines until the child is sufficiently older rather than to *knowingly* increase the child's; **a)** risk of contracting asthma for the pertussis-containing vaccines or **b)**, for the current measles-containing vaccines, having shorter-duration protection from contracting measles?

5. At least two peer-reviewed published studies have respectively linked: **a)** the risk of infant mortality and hospitalization to the number of vaccine-disease components administered at once in the range from 2 to 8 such components to children under one year of age[38] and **b)** the level of infant mortality (deaths in the first year of life) in the developed countries to the total number of vaccine-disease components administered in the first year of life according to each country's recommended early childhood vaccination schedule[39].

Given the preceding findings, isn't it more decent, moral, and ethically responsible to reduce: **a)** the number of vaccine-disease components that can be administered at once and **b)** the total number of vaccine-disease components that can be given in the child's first year of life rather than what is happening, allowing: **i)** more vaccine-disease components to be given at once and **ii)** an increasing number of vaccine-disease components to be given in the first year of life?

6. The current understanding of disease protection has clearly shown that having the childhood diseases (for which there is an FDA-approved childhood vaccine) naturally and recovering from them provides significantly longer and broader disease protection to children and adults than the disease-protections, if any, provided by the multiple doses of the current vaccines.

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38 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 Oct; 31(10):1012-1021. doi: 10.1177/0960327112440111. Epub 2012 Apr 24. Erratum in: *Hum Exp Toxicol*. 2012 Nov; 31(11): 1190. This article can be accessed at http://www.ncbi.nlm.nih.gov/pubmed/22531966.

39 Miller NZ, Goldman GS. Infant mortality rates regressed against number of vaccine doses routinely given: Is there a biochemical or synergistic toxicity? *Hum Exp Toxicol*. 2011 Sep; 30(9):1420-1428. [This article can be accessed at http://het.sagepub.com/content/30/9/1420.full.pdf+html.]

> Then, how is it decent, moral, and ethically responsible to continue to use live-virus vaccines that infect all who are inoculated with the live viruses in the vaccine formulation each time the children are inoculated with these vaccines?
>
> Further, some of these inoculees do shed the live viruses with which they have been infected, and do directly and indirectly infect others.
>
> However, these vaccines still do not provide lifetime or long-term protection from these diseases when having these diseases naturally and living in an environment where periodic flares of these live-virus diseases naturally occur does provide lifetime, near-lifetime, or long-term disease protection.

Obviously, Dr. Pomeroy's article is clearly intended to support the current vaccination recommendations and to use the claimed successes and perceived compliance problems as if, *contrary to the facts*, the recommended vaccines are produced, approved, recommended, and administered by those whose actions are somehow based on morality, decency and ethical responsibility, when, *as Dr. King has repeatedly shown*, their actions clearly seem to be driven by greed and self interest rather than altruism.

Finally, Dr. King remains hopeful, based on Dr. Pomeroy's closing remark,

"*Everyone has the chance to do the right thing*",

that, *after reading this review and verifying the assertions he has made*, Dr. Pomeroy will, at a minimum, stop misrepresenting the facts about the current CDC-recommended vaccination programs in the USA, which, collectively, are neither "disease preventive" nor "life saving" when their overall effects on all those who are given them are appropriately considered, and, in some instances, are also neither effective (e.g., the DTP-vaccination programs for "pertussis prevention" in children [currently using the DTaP-containing and Tdap vaccines] and adults [currently using the Tdap vaccines]) nor cost-effective (e.g., the VZV-vaccination programs [which presently recommend at least "two doses" of Merck's Varivax® for children and "one dose" of Merck's Zostavax® for older adults]).

Dr. King's Concluding Remarks

Hopefully, after reading this response and verifying the accuracy of the key references cited as well as, by accessing the applicable independent peer-reviewed published papers posted on the Internet, each person will, at least, know that the "stories" by vaccination apologists and believers that appear in the mainstream media or in articles published by those with vested interests in supporting and promoting vaccination by any and all means are generally less than factual.

Equipped with this knowledge, may each of us stand up and renounce those vaccination programs that have not been proven to be safe, long-term effective in preventing disease, and/or medically cost-effective when all of the costs are properly considered.

Acknowledgements

For contributing valuable insights and providing their personal experience-based knowledge in various areas, Dr. King thanks Mayer Eisenstein, MD, JD, MPH; Gary S. Goldman, PhD; Boyd E. Haley, PhD; Melissa and Doug Troutman; Eileen Dannemann; Brian Hooker, PhD; Janet K. Kern, PhD; Catherine J. Frompovich; Neil Z. Miller; Mark R. Geier, MD, PhD; and David A. Geier.

In addition, Dr. King specifically thanks Catherine J. Frompovich, Melissa Troutman, Gary S. Goldman, and Eileen Dannemann for their support, suggestions, corrections and alternative wordings, which helped him to finalize this response.

About the Writer, Claire Pomeroy, MD

http://www.sacbee.com/2012/11/20/4998856/amid-controversy-claire-pomeroy.html

"Amid scrutiny from federal regulators and her own administration, the dean of the UC Davis School of Medicine announced Monday she will be stepping down.

Dr. Claire Pomeroy, whose seven-year tenure as dean was marked by fiscal growth and innovation but also by medical and ethical controversy, said she will leave the university on June 30, the close of the academic year.

Pomeroy, 57, told The Bee Monday that she plans to work during the transition with the University of California president's office to 'represent the UC health systems in Washington, D.C., playing a role in helping define health care during this incredibly exciting moment in history.'

Pomeroy is an expert in infectious diseases and a professor of internal medicine and microbiology and immunology. With nearly 10,000 employees and about 850 students, she has been a prominent figure in Sacramento, championing the university while supporting the work of humanitarian groups.

She said Monday the decision to leave was hers.

She said she is ready to move to the 'national stage,' and that her departure is 'a natural evolution of my career' that she's been 'thinking about for a while.' She said she is talking to a 'small number of organizations' about the next step but is not in a position to provide specifics.

'I'd love Barack Obama to call me,' she said, chuckling.

Pomeroy came to the School of Medicine in 2003 as executive associate dean and became vice chancellor and dean in 2005.

A woman with an unusual personal story – she spent her teenage years in foster care – Pomeroy presided over tremendous growth for the UC Davis School of Medicine, which tripled its outside research funding during the last decade.

Some of that research has fallen under a cloud as Pomeroy's neurological surgery department became the focus of multiple investigations over the past 18 months.

At issue is the work of two neurosurgeons, Dr. J. Paul Muizelaar and Dr. Rudolph J. Schrot, who were banned last year by the university from any research activities involving human subjects."

…

"During her tenure at UC Davis, she helped develop medical education programs to prepare doctors to serve in rural areas. She was named a Businesswoman of the Year in 2010 by the Sacramento Metropolitan Chamber of Commerce.

'Sacramento is an amazing place,' Pomeroy said. 'The community has really engaged with UC Davis Health System. That coming-together to make advances in health care and health has been so inspiring for me.[']

'I'm just grateful for the opportunity I've had here.'

MEDICAL SCHOOL DR. CLAIRE POMEROY

UC Davis vice chancellor for human health sciences; dean, School of Medicine

Education: Received bachelor's and medical degrees from the University of Michigan in 1976 and 1979; MBA from the University of Kentucky in 2000

At UC Davis: Executive associate dean of the School of Medicine, 2003. Vice chancellor and dean in 2005."

http://dateline.ucdavis.edu/dl_detail.lasso?id=14336

"Pomeroy, an expert in infectious diseases, is a professor of internal medicine and microbiology and immunology, as well as dean of the School of Medicine, chief executive officer of UC Davis Health System and vice chancellor for Human Health Sciences. She had previously announced that she would leave the university June 30 of this year.

As a clinician, Pomeroy is a long-time advocate for patients with HIV-AIDS. She has a special interest in health care policy and has led efforts to advance electronic records to improve patient care. Pomeroy succeeds Maria Freire, who led the foundation from 2008 until her appointment as president of the Foundation for the National Institutes of Health in Bethesda, Md., last November.

Alfred Sommer, chairman of the Lasker Foundation Board, announced the appointment: 'We are thrilled to welcome Claire Pomeroy as the Lasker Foundation's new president. Dr. Pomeroy has demonstrated leadership, scholarship and vision, both as a researcher and as an advocate of bringing the benefits of medical research to the bedside and to the improvement of the health of the population as a whole.'

Joseph L. Goldstein, chair of the Lasker Medical Research Awards Jury, said: 'Claire Pomeroy's versatile background in research, advocacy and policy will enrich the foundation and enhance it in its mission to recognize fundamental discoveries in biology and important advances in clinical practice.'

In her new post, Pomeroy will take the lead role in guiding the Lasker Foundation in its mission of supporting biomedical research toward conquering disease, improving human health and extending life, and in presiding over the Lasker Awards, which since 1945 have recognized the contributions of scientists, physicians and public servants who have made major progress in understanding, diagnosing, treating, curing and preventing human disease worldwide. Eighty-three Lasker laureates have received the Nobel Prize, including 31 in the last two decades.

Pomeroy said, 'I am honored to join the Lasker Foundation and inspired by its mission to celebrate medical research and the benefits it brings to each of us as individuals and as a society. The Lasker Foundation's history of honoring the leading minds of medical research, advocating for ongoing investment in research and reaching out to the public to share the importance of this research is a national treasure. I look forward to partnering with the board of directors, the awards jury and the Lasker staff to build on this legacy and further advance the important work of the foundation.'"

About the Responder, Paul G. King, PhD

In addition to the information that is available on his Internet web site, http://www.dr-king.com/, Dr. King is the Science Advisor to the Coalition for Mercury-Free Drugs (CoMeD, Inc., which is a 501(3)(c) not-for-profit corporation (http://www.mercury-freedrugs.org/) as well as the Science Advisor to the National Coalition of Organized Women (NCOW).

As a scientist and student of the federal regulations and statutes that govern pharmaceutical drugs, including vaccines, Dr. King has led CoMeD, on two 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 (DHHS) and the FDA Commissioner to comply with the statutes, laws (regulations) and policies that regulate the lawful conduct of the DHHS Secretary, the FDA commissioner and CDC and FDA officials.

Furthermore, 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 and state regulations that are not in the public interest or appear to be at odds with the law, reviewed numerous documents, and written articles on a multiplicity of vaccine-related and other issues.

Moreover, Dr. King has provided diverse groups with his analysis of various Congressional bills, resolutions and treaty documents as well as federal and state judicial proceedings.

In addition, he has been an author of papers bearing on issues related to the toxicity of Thimerosal and other compounds and, if any, their connection to a range of chronic neurodevelopmental, other developmental and behavioral abnormalities that appear to be well-above (> 1 in 10 children; asthma and obesity), above (> 1 in 100 children; the autism spectrum disorders), at (> 1 in 1000 children; non-genetic childhood type 1 diabetes), or approaching (peanut allergy) epidemic childhood levels in the USA.

More recently, Dr. King was the co-author of a paper in the journal ***Vaccine*** with Gary S. Goldman, PhD, which reviewed the United States universal varicella vaccination program[40].

This paper established that the current CDC-recommended two-dose vaccination program was neither truly effective in preventing all of those who are twice vaccinated from getting chickenpox nor, since it greatly increases the public's risk of having clinical cases of shingles, even societally cost-effective for universal use.

Finally, Dr. King was also one of the authors of a paper in the ***Int. J. Environ. Res. Public Health***, where the lead author was Janet K. Kern, PhD. This paper reviewed Thimerosal exposure and the roles of sulfation chemistry and thiol availability in autism[41].

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40 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* 2013 March 25; 31(13): 1680-1684 (open access) [http://www.sciencedirect.com/science/journal/0264410X/31/13, article "6"].

41 Kern JK, Haley BE, Geier DA,Sykes LK, King PG, Geier MR. Thimerosal Exposure and the Role of Sulfation Chemistry and Thiol Availability in Autism [Review]. *Int. J. Environ. Res. Public Health* 2013 Aug, 10, 3771-3800, which can be downloaded from http://www.mdpi.com/1660-4601/10/8/3771/pdf.