Facility **A**utomation **M**anagement **E**ngineering Systems (*FAME* Systems)
33A Hoffman Avenue, Lake Hiawatha, NJ 07034-1922

Wednesday, 26 March 2014

On 7 February 2014, Paul G. King, PhD, downloaded an on-line February 6, 2014 article by "Frank Y. Wong", titled, "**Blind eye to scientific fraud is dangerous**", from http://www.cnn.com/2014/02/06/opinion/wong-scientific-fraud/.

Dr. King's response to that article follows these introductory remarks and a "table of contents" page.

****

****

This analytical response is titled, "**A Fact-based Assessment of 'Blind eye to scientific fraud is dangerous'**".

Introductory Remarks

First, each portion of article's text is quoted in a grayed "Arial" font.

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

Third, when quoting from the item's text, the quoted portions of the text are in an *italicized* "*Times New Roman*" font.

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

Finally, should anyone find any significant factual error in this assessment 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 fact-based assessment.

Respectfully,

<s>

Paul G. King, PhD
Founder, ***FAME* Systems**
paulgkingphd@gmail.com
Tel. 1-973-997-1321, after 21:00 Eastern Time
[To whom all responses should be directed]

[a] To qualify 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 assessment.

Table of Contents for:
A Fact-based Assessment of "Blind eye to scientific fraud is dangerous"

A Fact-based Assessment of "Blind eye to scientific fraud is dangerous"

The Assessment

This assessment compares Dr. Wong's article's statements to the sound science and scientific principles that undergird Dr. Paul G. King's current evidence-based understanding of the issues raised by its writer, Frank Y. Wong, PhD.

"**(CNN)** -- Recently, the United States has seen a resurgence [http://www.cdc.gov/pertussis/] of Bordetella pertussis, a highly contagious bacterial disease more commonly known as "whooping cough". The disease mostly afflicts children, though adults can catch it, too. Whooping cough is easily prevented with vaccination."

Realities about a Bacterium (*Bordetella pertussis*), a Disease (Whooping Cough [Pertussis]), the Vaccines, and Vaccination

First, Wong, "*associate professor at the Rollins School of Public Health, Emory University*" and "*an Op-Ed Project Public Voice fellow*", begins by misclassifying a bacterium, *Bordetella pertussis*[1] (*B. pertussis*), as a "*disease*".

Factually, the disease is "*whooping cough*" or, because *B. pertussis* was the original bacterium isolated in most instances, "pertussis[2]".

Moreover, according to the current scientific literature, in addition

---

1 http://microbewiki.kenyon.edu/index.php/Bordetella_pertussis, which "was last modified on 4 July 2011, at 15:08" and last accessed on 7 February 2014 (emphasis added),

> Description and significance
>
> *Bordetella pertussis* is a small, Gram-negative, coccoid bacterium about the size of 0.8 µm by 0.4 µm. It is an encapsulated immotile aerobe that does not make spores. *Bordetella pertussis* produces a number of virulence factors, including pertussis toxin, adenylate cyclase toxin, filamentous hemagglutinin, and hemolysin. It cannot survive in the environment; it must reside in a host either in small groups or singly. It grows at an optimal temperature of 35-37ºC. [1]
>
> *Bordetella pertussis* is a strict human pathogen that is the causative agent of pertussis (whooping cough). Its natural habitat is in the human respiratory mucosa. Whooping Cough, or pertussis, is a respiratory infection in which a "whooping" sound is produced when the sufferer breathes. Pertussis kills an estimated 300,000 children annually, most of which occur in developing countries. [6]
>
> 1. Baron, Samuel MD, Rhonda C. Peake, and Deborah A. James et al. Medical Microbiology. Galveston (TX): University of Texas Medical Branch, 1996.
> 2. Bauche C, Chenal A, Knapp O, Bodenreider C, Benz R, Chaffotte A, and Ladant D. "Structural and functional characterization of an essential RTX subdomain of Bordetella pertussis adenylate cyclase toxin." J Biol Chem. 2006. 281(25):16914-26.
> 3. Borisova O, Kombarova SY, Zakharova NS, van Gent M, Aleshkin VA, Mazurova I, and Mooi FR. "Antigenic divergence between Bordetella pertussis clinical isolates from Moscow, Russia, and vaccine strains." Clin Vaccine Immunol. 2007. 14(3):234-8.
> 4. Burnette, W., Mar, V., Whiteley D., and T. Bartley. "Progress with a recombinant whopping cough vaccine: a review." J R Soc Med. 1992. 85(5): 285–287.
> 5. Carbonetti NH, Artamonova GV, Van Rooijen N, and Ayala VI. "Pertussis toxin targets airway macrophages to promote Bordetella pertussis infection of the respiratory tract." Infect Immun. 2007. 75(4): 1713-20.
> 6. Crowcroft NS and Pebody RG. "Recent developments in pertussis." Lancet. 2006. 367(9526): 1926-36."

2 Since there are a number of agents that may sometimes be diagnosed as "whooping cough" and can cause severe coughing in those infected, the disease term "pertussis" should be abandoned.

to *B. pertussis*, human "whooping cough" cases can be caused by several other *B. species*, including *B. parapertussis*, *B. bronchiseptica*, and *B. holmesii*, as well as other bacteria (e.g., *Mycoplasma pneumoniae* and *Chlamydophila pneumonia*), as well as, in young children, RSV [respiratory syncytial virus] and some adenoviruses.

Second, Wong's, "*The disease mostly afflicts children, though adults can catch it, too*", is a generalization that glosses over the fact that vaccinated children and adults can have "whooping cough" several times.

However, unvaccinated children generally have "whooping cough" once, and unvaccinated adults, after having "whooping cough" as children, generally are not at risk of having "whooping cough" again for 30 to 50 years after their first clinical case as children.

Furthermore, in most of the recent outbreaks, more than 75% of the cases in children older than 6 months were in individuals who had been age-appropriately vaccinated (see footnote "**3**").

Third, Wong's, "*Whooping cough is easily prevented with vaccination*", is another factual misrepresentation.

When the "pertussis" vaccines were first introduced, they may have been thought to prevent whooping cough because most cases that led to a diagnosis of whooping cough were caused by *B. pertussis*.

However, as infection by *B. pertussis* was being suppressed, the other species of *Bordetella* began to occupy the biological "disease" niche left by the suppression of *B pertussis*.

In addition, other organisms began to be associated with infections that were sometimes diagnosed as whooping cough.

Moreover, unlike naturally acquired infection leading to whooping cough before there were vaccines containing "*B. pertussis*" components, "pertussis"-containing-vaccine inoculation[3]:

- Does not directly provide any protection from the bacterium *B. pertussis* but rather purportedly provide some protection from the "purified" toxins harvested from killed *B. pertussis* bacteria. [**Note**: This is the case because there is no recognized anti-body titer test in humans for possibly protective "pertussis"-component antibodies and the "role of the different components produced by *B pertussis* in either the pathogenesis of, or immunity to, pertussis is not well understood"[4].]

[3] "Draft Review of: 'Anti-vaccine Movement Causes the Worst Whooping Cough Epidemic in 70 Years' (6 August 2012, 39 pages)"

[4] Sanofi Pasteur, Inc.'s package insert for "Diphtheria and Tetanus Toxoids and Acellular Pertussis Vaccine Adsorbed Tripedia®", emphasis added, "CLINICAL PHARMACOLOGY ... Pertussis Pertussis (whooping cough) is a disease of the respiratory tract caused by *Bordetella pertussis*. This gram-negative coccobacillus produces a variety of biologically active components. The role of the different components produced by *B pertussis* in either the pathogenesis of, or immunity to, pertussis is not well understood".

- Does not provide protection from infection by the other *B. species.*
- Provides only limited-duration (one to five years) and incomplete protection from contracting *B. pertussis* to some unknown percentage of those who are up-to-date with their recommended pertussis-containing vaccine inoculations. [See the previous "**Note**".]
- Does not provide the 30- to 50-year protection from re-infection by any *B. species* that having *B. pertussis* naturally provided before there were any "pertussis" vaccines.
- Creates asymptomatic *B. pertussis* carriers ("Pertussis Harrys") that "silently" spread *B. pertussis* to those with whom they have contact.
- Induces an abnormal antigen exposure pattern that imprints the recipients' immune system with an artificial antigen pattern, which interferes with the immune system's recognition of *B. pertussis* when subsequently exposed to it, as was admitted in a 2012 paper addressing *B. parapertussis*[5].
- Has reportedly[6] caused the *B. pertussis* bacteria to mutate into more virulent strains.
- Renders those inoculated with "pertussis"-containing vaccines more susceptible to subsequently contracting whooping cough.
- Induces severe adverse reactions in some children that have been shown to be associated with sudden-infant-death syndrome (SIDS) and serious neurodevelopmental injuries.

In 1987, J. W. Bass predicted that the pertussis-vaccination proram would fail[7] and, in 1994, he was the lead author in a published follow-up paper that verified that the pertussis-vaccination program was failing as he had earlier predicted it would[8].

Consequently, the resurgence in whooping cough infections is a direct consequence of failed "pertussis-components"-containing vaccines that, on balance, cause more "whooping cough" cases than they

---

5 Cherry JD, Seaton BL. Patterns of Bordetella parapertussis Respiratory Illnesses: 2008–2010. *Clin Infect Dis*. 2012; 54(4): 534-537.

6 **a.** Bart MJ, van Gent M, van der Heide HGJ, Boekhorst J, Hermans P, Parkhill J, Mooi FR. Comparative genomics of prevaccination and modern Bordetella pertussis strains. *BMC Genomics* 2010, 11: 627. doi:10.1186/1471-2164-11-627.

b. Litt DJ, Neal SE, Fry NK. Changes in Genetic Diversity of the Bordetella pertussis Population in the United Kingdom between 1920 and 2006 Reflect Vaccination Coverage and Emergence of a Single Dominant Clonal Type. *J Clin Microbiol* 2009 Mar; 47(3): 680-688.

7 Bass JW, Stephenson SR. The return of pertussis. *Pediatric Infect Dis J* 1987 Feb; 6(2): 141-144. http://journals.lww.com/pidj/Citation/1987/02000/The_return_of_pertussis.1.aspx.

8 Bass JW, Wittler RR. Return of epidemic pertussis in the United States. *Pediatric Infect Dis J* 1994; 13(5): 343-344.1. http://journals.lww.com/pidj/Citation/1994/05000/Return_of_epidemic_pertussis_in_the_United_States.2.aspx.

prevent as well as, for some young children who are inoculated with them, cause those inoculated children to die or be seriously damaged.

"According to the Centers for Diseases Control and Prevention, vaccination, introduced in the 1940s, brought the number of cases per year down from 107,473 in 1922 to just 1,248 in 1981. Since 1982, however, the number of cases has steadily increased [http://www.cdc.gov/pertussis/fast-facts.html]."

As Bass JW, *et al*. predicted in 1987 and confirmed in 1994 (see footnotes "**7**" and "**8**"), the increase in the reported clinical cases of "whooping cough" since 1982 has been caused by a failed vaccine program.

Moreover, the failure is increasingly evident despite the CDC's attempt to conceal that failure by adding first more and more doses of the DTaP vaccine and, after the children are 7 years of age, now recommending that children be given a Tdap vaccine since giving a DTaP vaccine to anyone over 7 years of age can be fatal to the inoculated individual (see footnote "**4**").

As of February 2014, the CDC is continuing to recommend that each child get a DTaP-pertussis-containing vaccine at two months, four months, six months, 15 to 18 months, four to six years of age and a Tdap-pertussis-containing vaccine at 11 to 12 years of age for a total of six (6) doses of a pertussis-component-containing vaccine before 12 years of age, as well as at least one additional dose of a Tdap-pertussis-containing vaccine as adults starting at age 20.

Facts: No General Decline in Vaccination Coverage; and "Whooping Cough" Disease Realities

"In recent years, there has been a general decline in vaccination [http://onlinemastersinpublichealth.com/vaccination] to prevent many childhood diseases in the United States. In 2012, the number of whooping cough cases in the United States hit a long-time high of 48,277 [http://www.cdc.gov/pertussis/fast-facts.html]."

Based on the CDC's 2012 coverage data for USA children 19-35 months of age who are old enough to have received all of their early childhood vaccinations[9], the CDC's coverage data, typically uncertain by ± 0.5%, showed no "*general decline in vaccination*" based on the data published in that Internet web page (see **Table 1** on next page).

In fact, for the newer vaccines, those introduced after 2000, the general trend is for significantly increasing coverage.

Technically, the link provided did report,

[9] http://www.cdc.gov/vaccines/stats-surv/nis/figures/2012_map.htm , last accessed on 19 February 2014.

> "In 2012, 48,277 cases of pertussis (whooping cough) were reported in the U.S., … This is the most number of cases reported in the U.S. since 1955 when 62,786 cases were reported."

but the CDC did not characterize this number as a "*long-time high*".

Furthermore, the available annual reported cases data[10] clearly demonstrates that the "whooping cough" vaccination program has not worked as advertised.

This is the case because, *since 1976*, the annual number of cases reported has been increasing, generally at a rate faster than population growth (see **Table 2** on a following page [based on the CDC's table]), though the pertussis-containing-vaccine doses recommended for children has increased from three (3) to now six (6) doses.

Table 1. Data From CDC, "*Cov***erage with Individual Vaccines from the Inception of NIS, 1994 through 2012"**

Year	MMR (1+)	DTP/**DTaP** (3+)†	Polio (3+)	Hib (3+)§	HepB (3+)	Varicella (1+)	PCV (4+)	Rotavirus*	HepA (2+)*
1994	89	93	83	86	37				
1995	90	95	88	92	68				
1996	91	95	91	92	82	16			
1997	88.5	94.5	88	93	84	26			
1998	86	94	85	92	84	38			
1999	92	96	90	94	88	59			
2000	91	94	90	93	90	68			
2001	91.4	94.3	89.4	93	88.9	76.3			
2002	91.6	94.9	90.2	93.1	89.9	80.6			
2003	93	96	91.6	93.9	92.4	84.8	35.8		
2004	93	95.9	91.6	93.5	92.4	87.5	43.4		
2005	91.5	96.1	91.7	93.9	92.9	87.9	53.7		
2006	92.3	95.8	92.8	93.4	93.3	89.2	68.4		
2007	92.3	95.5	92.6	92.6	92.7	90	75.3		
2008	92.1	96.2	93.6	90.9	93.5	90.7	80.1		40.4
2009	90	95	92.8	54.8	92.4	89.6	80.4	43.9	46.6
2010	91.5	95	93.3	66.8	91.8	90.4	83.3	59.2	49.7
2011	91.6	95.5	93.9	80.4	91	90.8	84.4	67.3	52.2
2012	90.8	94.3	92.8	80.9	89.7	90.2	81.9	68.6	53

In addition, when, in the mid-1970s, Japan stopped its "pertussis" vaccination program, there was no marked change in the number of

[10] http://www.cdc.gov/pertussis/surv-reporting/cases-by-year.html, last accessed on 19 February 2014

children under one year of age who died even though the disease cases did increase[11].

Table 2. Whooping Cough (Pertussis) Reported Cases, USA

Year	Pertussis Cases	Year	Pertussis Cases	Year	Pertussis Cases	Year	Pertussis Cases
1976	1010	**1986**	4195	**1996**	7796	**2006**	15631
1977	2177	**1987**	2823	**1997**	6564	**2007**	10454
1978	2063	**1988**	3450	**1998**	7405	**2008**	13278
1979	1623	**1989**	4157	**1999**	7298	**2009**	16858
1980	**1730**	**1990**	**4570**	**2000**	**7867**	**2010**	**27550**
1981	1248	**1991**	2719	**2001**	7580	**2011**	18719
1982	1895	**1992**	4083	**2002**	9771	**2012**	48277
1983	2463	**1993**	6586	**2003**	11651	**2013**	24231 [Provisional]
1984	2276	**1994**	4617	**2004**	25827		
1985	**3589**	**1995**	**5137**	**2005**	**25619**		

An analysis of the reported deaths[12] found that vaccination did not reduce or prevent deaths in children less than 6 months of age, where most (> 70 percent) of the deaths are known to occur.

---

[11] Kanai K. Japan's experience in pertussis epidemiology and vaccination in the past thirty years. *Jpn J Med Sci Biol*. 1980 Jun; 33(3): 107-143.

[12] http://www.smartvax.com/index.php?option=com_content&view=article&id=84, titled "**Disease Risk – Pertussis**", under a heading titled "Case Fatality Rate:", reported (emphasis added),

"In the US, all of the recent deaths (9) from the epidemic in the highly vaccinated California population occurred in infants < 2 months and thus were not vaccine preventable.[6] Kanai documents that in 1977 (during the period when Japan stopped vaccinating), 14 of 19 deaths (74%) occurred in infants 2 months old or less, 17 of 19 were < 6 months old (89%) and the remaining deaths all occurred in infants < 1 year old.[11] These statistics illustrate that in modern times (in populations that have both high or low levels of vaccination), pertussis vaccination does not directly provide a significant reduction to risk of death for the individual since the vast majority of the risks to infants are at an age prior to vaccination. The vast majority of the reduction in pertussis fatalities in highly vaccinated populations is due to reduced pediatric disease circulation and the resulting herd immunity protecting the vulnerable infant population. This analysis is focusing on the individual incremental risk of death due to lack of vaccination. The statistics from Kanai show us that only 11% of the deaths in infants < 1 year of age were vaccine preventable given the age distribution of deaths. This is consistent with the notion that infants < 6 months account for the vast majority of serious and subsequently fatal cases of pertussis in both vaccinated and unvaccinated populations. The risk to infants < 6 months has changed from historical times because prior to universal vaccination, infants < 6 months would have been maternally protected if they were breast-fed. However, it would likely require at least two decades of non-vaccination for this lost pattern to re-emerge – the length of time for unvaccinated females to bear children. This analysis will base the incremental fatality ratio on the average US case fatality rate of 1% from Cherry [2]. The vaccine preventable case fatality rate used will be 0.11% of incidence from 0-1 year and 0 for all other ages. The case fatality rate for children between 6-12 months of age is therefore estimated to be 0.22%.

References:

[1] Gordon JE, Hood HI: Whooping cough and its epidemiological anomalies. AmJ Med Sci 1951; 222:333-361

[2] Cherry JD, Baraff LJ, Hewlett E: The past, present, and future of pertussis. The role of adults in epidemiology and future control. West J Med. 1989 Mar;150(3):319-28.

[3] Fine PEM, Clarkson JA. The recurrence of whooping cough: possible implications for assessment of vaccine efficacy. Lancet 1982;1:666-9.

[4] Cherry JD: Historical Review of Pertussis and the Classical Vaccine. J Infect Dis 1996 Nov;174 Suppl 3:S259-63

[5] Maclure A, Stewart GT. Admission of children to hospitals in Glasgow: relation to unemployment and other deprivation variables. Lancet 1984 Sep 22;2(8404):682-5.

[6] Pertussis Report, January 7, 2011. California Department of Public Health

[7] Melnick M. California's Whooping Cough Epidemic Hits Latino Babies Hardest. Time Healthland, Friday October 29, 2010. http://healthland.time.com/2010/10/29/californias-whooping-cough-epidemic-hits latino-babies-hardest/

[8] Ostrov BF. Whooping Cough (Pertussis) Epidemic in California: Tips for Convering the Story. Barbara Feder Ostrov's Helath [sic] Jounalism Blog. http://www.reportingonhealth.org/blogs/whooping-cough-pertussis-epidemic-california-tips-covering-story

[9] Romanus V, Jonsell R, Berqquist SO. Pertussis in Sweden after the cessation of general immunization in 1979. Pediatr Infect Dis J. 1987 Apr;6(4):364-71.

[10] ELEVEN YEAR REPORT Pertussis surveillance in Sweden Progress Report October 1, 1997 with an executive summary. SMITTSKYDDSINSTITUTETS RAPPORTSERIE NR 6:2009

However, this analysis did not report the level of vaccine-associated deaths that are an adverse event following inoculation (AEFI).

Table 3. AEFI with a Pertussis-containing Vaccine in VAERS, 1991 through 2013 [using the search terms, "death", "neonatal death", "sudden death" & "sudden infant death syndrome"]

Year of Inoculat'n	"0" to "7" mo. Old [% of total]	> "07" to "12" mo. old	"1" to "2" yrs old	"2" to "13" yrs old	"0" to "13" yrs old	Segment Mean (Standard Deviation [SD])
1991	77 [97.5]	2	0	0	79	
1992	83 [95.4]	3	0	1	87	
1993	90 [96.8]	3	0	0	93	
	Start of Phase-In of DTaP Vaccines Replacing DTwcP Vaccines					86.2 (7.0)
1994	59 [92.2]	5	0	0	64	
1995	51 [94.4]	3	0	0	54	
1996	47 [95.9]	0	2	0	49	
1997	44 [97.8]	1	0	0	45	
	Phase in of DTaP Vaccines is "Complete"					53.0 (8.2)
1998	41 [97.6]	1	0	0	42	
1999	31 [96.9]	0	1	0	32	
2000	38 [97.4]	1	0	0	39	
2001	33 [91.7]	3	0	0	36	
2002	31 [88.6]	4	0	0	35	
2003	39 [100.]	0	0	0	39	
2004	29 [90.6]	1	2	0	32	
2005	27 [100.]	0	0	0	27	
2006	29 [96.7]	0	1	0	30	
	Increased [Rotavirus] Reporting (Phase IV) Increases Reporting					34.7 (5.9)
2007	67 [93.0]	2	2	1	72	
2008	68 [94.4]	3	0	1	72	
	End of Increased Reporting					72.0 ("0)
2009	37 [88.1]	1	1	3	42	
2010	35 [87.5]	2	3	0	40	
2011	35 [85.4]	3	0	3	41	
2012	30 [88.2]	3	1	0	34	
2013	21 [80.8]	1	3	1	26	
	End of Reporting – Possible Downward Reporting Trend in Last Segment?					36.6 (6.7)
TOTAL	**1042** [93.9] (**965** were < 6 months old)	**42**	**16**	**10**	**1110**	48.3 per year overall [**35.4 per year** excluding the DTwcP only, DTwcP transition, and the increased-reporting periods]

[11] Kanai K. Japan's experience in pertussis epidemiology and vaccination in the past thirty years. Jpn J Med Sci Biol. 1980 Jun; 33(3):107-43.
[12] Cherry JD, Brunell PA, Golden GS, Darzon DT. Report of the task force on pertussis and pertussis immunization--1988. Pediatrics 1988; 81(suppl):939-84."

A search of VAERS, using the search terms, pertussis-containing vaccines and outcome of "death", found 1,110 VAERS reports of death in the United States Of America (USA) for those *less than* 13 years of age were distributed as shown in **Table 3** on the preceding page.

Omitting those years during which a whole-cell pertussis-containing diphtheria and tetanus vaccine (commonly abbreviated as DTwcP or DTP) may have been used or another vaccine, *given at the same time as the DTaP-containing vaccine doses*, increased the reporting because of a Phase IV (post-approval heightened monitoring for adverse events following inoculation [AEFIs]) requirement, overall DTaP-containing vaccines resulted in an average of 35.4 reports of death per year in VAERS.

Presuming:

a. 90% of these VAERS reports were reports where an unbiased review would find that the DTaP-containing vaccine was a causal factor in the infant's death and

b. 1%[13] of the actual instances were reported to VAERS,

on average, about 3,186 infants died each year as a result of receiving a DTaP-containing vaccine, where 965/1110 (86.9%) or 2,769 of these dead infants were too young (those 6 months of age or less) for the vaccine inoculations to have protected almost any of them from contracting "pertussis".

Moreover, these pertussis-containing vaccines provide no protection against the other organisms that, *as Dr. King has previously reported*, can cause a child to be diagnosed with the categorical symptom-based disease, "whooping cough".

Table 4. "Number of deaths from selected nationally notifiable infectious diseases — United States, 2003–2009" *

Disease	No. of deaths ▼							Average Deaths per year** ▼
	2003	2004	2005	2006	2007	2008	2009	
"Pertussis" a/k/a "Whooping Cough"	11	16	31	9	9	20	15	15.9 (± 7.8, SD)
	1/1059	1/1614	1/826	1/1737	1/1162	1/664	1/1124	-----
	11,647	25,827	25,616	15,632	10,454	13,278	16,858	17,044 (± 6,316, SD)
	No. of Notified Cases§ ▲							Average ▲ Cases/year¶

* From http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6053a1.htm?s_cid=mm6053a1_w

** These values were computed from the CDC-supplied annual deaths.

§ From the various annual summaries of notifiable diseases for the years 2003 – 2009 as reported in the ***MMWR***.

¶ These values were computed from the CDC-supplied annual notified cases.

[13] 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, where reporting for the most serious adverse events, like permanent disability and death was estimated to be no more than 1% of all the actual reportable incidents.

Turning to the issue of notifiable cases of diseases and notified deaths, Dr. King finds that, for "pertussis", the CDC reported the information as shown in **Table 4** on the preceding page.

From the data in **Table 4**, **a)** on average, the reported deaths for the notified pertussis cases occurred at a level of *less than* 0.1% (< 1 in 1,000) and **b)** there was no *obvious* correlation between the number of deaths from "pertussis" and the number of cases of "pertussis".

Based on the preceding realities, on average, the current vaccination program definitely causes more than 17 times (if the VAERS reporting rate for "pertussis" deaths were 10%) and probably causes more than 174 (2,769/15.9) times as many deaths in children under 6 months of age as there are notified deaths from "pertussis" each year.

Since the vaccines provide no real protection from pertussis in children under six months of age and, *on average*, probably are an annual causal factor in more than 2,700 deaths to infants under six (6) months of age, the "pertussis" vaccination program obviously kills more babies than those (near, if not, zero) it protects from contracting pertussis.

Based on these findings, *at a minimum*, the "pertussis"-components should be removed from the early childhood vaccines containing them, and a no-Thimerosal DT [diphtheria and tetanus toxoids] vaccine given in its place.

As Dr. King has previously suggested[14], a science-based orthomolecular medical, preventive/curative approach should then be used to address whooping cough prevention and cure.

That proven approach, *which was successfully used before there were vaccines and antibiotic drugs*, uses optimal nutritional supplementation of the child's diet with respect to the known vitamins, minerals and key nutrients to minimize the child's risk of contracting whooping cough.

Then, appropriately increased doses of vitamin C, vitamin D-3, magnesium, selenium, and zinc should be given if the child contracts whooping cough to reduce the severity of disease and shorten its duration.

Ideally, the mother should be breastfeeding the child or having a surrogate breastfeed the child for *not less than* two (2) years but, in no instance, for less than six (6) months.

---

[14] See http://dr-king.com/docs/120806_PGKDrftRevu_Anti_vaccineMovementCausesTheWorstWhoopingCoughEpidemicIn70Yrs_fnlr2b.pdf , footnotes "8" and "9".

Moreover, during that time, the breastfeeding mother's or breastfeeding surrogate's diet should be appropriately augmented so that the needed nutrients are at their optimum values in the breast milk that the breastfeeding children consume.

In about 20 years after the pertussis-specific components are removed from the childhood vaccines and most mothers are getting adequate levels of the key vitamins, minerals and nutrients and feeding their babies human breast milk, then deaths in children under six months in the USA should again be essentially nonexistent and the cases of whooping cough ("pertussis") in those six to 12 months of age should be no more than 0.22% (see footnote "**12**") with fewer than 1 deaths in 1,000 whooping cough cases (< 0.00022 %).

In the meantime, increased doses of vitamins C and D-3, and the minerals magnesium, selenium and zinc should be given to help the infant's body cure itself when the initial symptoms of whopping cough begin to occur.

Moreover, if properly provided, this approach could further reduce the deaths by a factor of two, or more, so that, in a birth cohort of about 3.9 million babies, less than 4 whooping cough deaths would be recorded annually in babies 6 to 12 months of age with virtually no deaths in older children in the USA provided the current levels of sanitation, nutrition, hygiene and societal infrastructure were maintained.

Facts: No Decline in Vaccination; and a Vaccine Safety, Effectiveness, and Cost-effectiveness Movement

"The decline in vaccination is in part due to the rise of the anti-vaccine movement, which has found spokespeople in celebrities like Jenny McCarthy and politicians like Michele Bachmann and Rick Santorum. It is a movement that relies on scientific fraud and pseudoscience."

First, as the CDC's data previously cited by Dr. King (see **Table 1**) clearly show, there has been no "*decline in vaccination*" for the core vaccines in the USA.

At worst, the level of vaccination for the vaccines that have been marketed for more than 30 years (MMR, DTaP and Polio) as well as the hepatitis B and varicella vaccines have stabilized at about 90% of the eligible population or higher.

The coverage level for Hib (at about 81%) is still being affected by the CDC's recent (2009) recommendation for another dose.

Furthermore, the only relevant "*scientific fraud and pseudoscience*" that Dr. King is seeing is that contained in the less-than-accurate statements being made by Dr. Wong.

Moreover, without providing any definition for, or substantiation of, its existence, Dr. Wong, as most vaccine apologists do, creates a straw man, "*the anti-vaccination movement*" and inappropriately assigns that straw man non-scientist/non-medical "*spokespeople*".

Factually, Dr. Wong ignores the reality that the only "vaccine movement" of which Dr. King is aware is the science-based movement that is only challenging the Establishment and its apologists and acolytes to provide scientifically sound and appropriate proofs that each vaccine is:

1. As "safe" as the current statutes and regulations necessitate, including, at a minimum, proof that the vaccine meets the preclinical toxicological requirements that establish it is not carcinogenic, mutagenic or reproductively toxic in humans in any manner (since package inserts seem to indicate that these proofs of safety are nonexistent in the case of carcinogenicity and mutagenicity, or, at best, deficient in the case of reproductive toxicity);
2. Effective in preventing the disease(s) for which it is represented to provide disease protection (since even the vaccine package inserts do not make this claim); and
3. Medically cost-effective for universal recommendation for use under the current vaccination program when all of the costs, including all of those associated with:
    a. The adverse events following inoculation;
    b. For inactivated vaccines, the costs of the increased risk of other-organism infection (as has unequivocally been demonstrated for the inactivated influenza vaccines[15]);

---

[15] Cowling BJ, Fang VJ, Nishiura H, et al. Increased Risk of Noninfluenza Respiratory Virus Infections Associated with Receipt of Inactivated Influenza Vaccine. *Clin Infect Dis.* 2012 June 15; 54(12): 1778-1783. In the "DISCUSSION" section, this study reported (emphasis added), "In the prepandemic period of our study, we did not observe a statistically significant reduction in confirmed seasonal influenza virus infections in the TIV recipients (Table 3), although serological evidence (Supplementary Appendix) and point estimates of vaccine efficacy based on confirmed infections were consistent with protection of TIV recipients against the seasonal influenza viruses that circulated from January through March 2009 [16]. We identified a statistically significant increased risk of noninfluenza respiratory virus infection among TIV recipients (Table 3), including significant increases in the risk of rhinovirus and coxsackie/echovirus infection, which were most frequently detected in March 2009, immediately after the peak in seasonal influenza activity in February 2009 (Figure 1)".

Figure 1.
Timing of influenza and other respiratory virus detections in 115 participants aged 6–15 years (*A–D*), compared with local influenza surveillance data (*E*). Solid red bars indicate detections in 69 participants who received 2008–2009 trivalent inactivated influenza vaccine, and black dashed bars indicate detections in 46 participants who received placebo. The bottom panel shows local laboratory surveillance data on the proportion of influenza virus detections among specimens submitted to the Public Health Laboratory Service (PHLS). Less than 2% of PHLS specimens were positive for influenza B throughout the year. "Other viruses" included coronavirus, human metapneumovirus, parainfluenza, and respiratory syncytial virus.

c. For the live-virus vaccines, the costs associated with the acute vaccine-strain infections, the chronic vaccine-strain infections, and the secondary and tertiary transmissions; and

d. For all the vaccines, the short-term and long-term health costs of the actives, additives, adventitious organisms and bioactive DNA and rDNA fragments present in the vaccines

are included.

Given the current preclinical safety deficiencies that most vaccines' package inserts admit, it is clear that the vaccine establishment and its acolytes and apologists, as Dr. Wong represents himself to be, are the ones who rely "*on scientific fraud and pseudoscience*" by, for example,

1. Touting vaccines as "the safest of medicines" and "safe and effective" without even ensuring that the vaccines' manufacturers provide even the requisite proofs of preclinical safety;
2. For most of the clinical safety trials, allowing the use of another vaccine or some other non-inactive solution or suspension, such as the vaccine formulation being tested without the active antigens, as a "placebo" (inactive substance) when, for injected vaccines, the only scientifically sound, true placebos that should be used are doses of sterile, pH-balanced, isotonic saline or doses of sterile, pH-balanced, isotonic saline containing a low level of glucose; and
3. Not including the true costs of the adverse effects of the vaccination programs including the direct and indirect costs associated with the short-term adverse events, and, *more importantly*, inappropriately excluding the long-term costs of the chronic medical conditions generated by the inevitable immune-system damage caused by repeatedly administering the current vaccines to pregnant women, developing children and, increasingly, all adults.

Preventing Scientific Fraud and Misrepresentations are Still Key Concerns for the Independent Scientific Community

"In the not too distant past, one of the scientific community's primary concerns was preventing scientific fraud. Episodes like the 1998 fabrication of data [http://www.cnn.com/2011/HEALTH/01/05/autism.vaccines/index.html] indicating a connection between childhood vaccines and autism risk have clear public health and policy repercussions."

First, in what remains of the independent scientific community, "*preventing scientific fraud*" still is one of this community's primary concerns.

Second, with respect to Dr. Wong's,

> "*Episodes like the 1998 fabrication of data* [http://www.cnn.com/2011/HEALTH/01/05/autism.vaccines/index.html] *indicating a connection between childhood vaccines and autism risk have clear public health and policy repercussions*",

as far as Dr. King has been able to ascertain, the first published paper "*indicating a connection between childhood vaccines and autism risk*" was a 1976 article whose English translation was titled "[Autistic syndrome (Kanner) and vaccination against smallpox (author's translation)]." in *Klin Padiatr*. by Eggers[16], which closed the abstract with the statement, "But vaccination is recognized as having a starter function for the onset of autism".

Third, the withdrawn paper alluded to by Dr. Wong only stated that some of the parents of the children in the case study presented in that gastroenterology paper felt that there was a connection between vaccination and autism.

Fourth, the absurdity of Dr. Wong's posturing here is clearly shown by:

- The fact that, years before the paper in question was published in 1998, the data dictionary for diagnostic terms that were defined by the United States Vaccine Adverse-Events Reporting System (VAERS) included the terms "Autism" and "Autism spectrum disorder" and,
- More than 70 reports of an adverse event following inoculation (AEFI) that were generated prior to 1998 contained one of those terms,

which clearly indicate that medical professionals, who file *more than* 90% of all reports to VAERS; and VAERS, a database jointly set up and maintained by the U.S. Centers for Disease Control and Prevention (CDC), which makes vaccination program recommendations, and the U.S. Food and Drug Administration (FDA), which approves all drugs and drug products, including vaccines and serum products, had recognized this possible causal link.

For a more detailed discussion on the causal linkage realities, the

---

16 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."

reader is encouraged to read Dr. King's "Review of 'Sticking with the truth'"[17].

Additionally, in the world of independent scientists, like Dr. King, there is an ever-growing body of studies that have unequivocally established, and are continuing to prove, that a causal link exists.

That link is the link between the administration of Thimerosal-preserved vaccines and serum products to the developing child by injecting the child's mother during pregnancy and/or injecting the child with Thimerosal-preserved vaccines starting at the day of birth and afterwards, and the injected child's increased risk of subsequent neurodevelopmental harm, including the child's subsequently receiving a diagnosis of an autism spectrum disorder.

Thus, what is disingenuous is Dr. Wong's attempt to pretend that these inconvenient realities do not exist.

A Proven Link between Vaccination and the Increased Risk of "Autism", and the Broader Reality that Vaccine Inoculations are Linked to the Risk of Chronic Diseases and Death

"Claiming a link between vaccines and autism opens the door for false claims about the dangers of other vaccines, allowing, for example, politicians like Bachmann to inflame the public's doubts about the benefits of vaccination against the human papillomavirus, or HPV."

Since, as Dr. King has established, there is "*a link between vaccines and autism*" (see, for example, footnote "**17**" as well as Dr. King's other cogent writings and publications), this proven reality actually opens the door for concerns, *in Dr. Wong's words*, "*about the dangers of other vaccines*" (see, for example, the other pertinent articles posted in the "Publications (by year)" section of the "Documents" web page on Dr. King's Internet web site, http://www.dr-king.com).

Moreover, Dr. Wong's,

> "*allowing, for example, politicians like Bachmann to inflame the public's doubts about the benefits of vaccination against the human papillomavirus, or HPV*"

admits that the public has "*doubts about the benefits of vaccination against the human papillomavirus, or HPV*".

"In a 2011 interview on the "Today" show, Bachmann mentioned a woman whose daughter suffered from "mental retardation" as a result of receiving the HPV vaccination. In a subsequent interview, Bachmann defended her position [http://www.politifact.com/truth-o-meter/statements/2011/sep/16/michele-bachmann/bachmann-hpv-vaccine-cause-mental-retardation/], fueling the anti-vaccination movement. Given that HPV

[17] http://dr-king.com/docs/20130606_DrftRevuOf_Sticking_with_the_truth_b_r1.pdf.

can result in cancer, disseminating this kind of misinformation not based on scientific evidence is dangerous."

First, since Bachmann is not a scientist and, apparently, neither was the woman with whom she spoke, expressing the apparent adverse reaction that caused the woman's daughter to experience a loss of some mental abilities as "*'mental retardation' as a result of receiving the HPV vaccination*" is simply a layperson's view of what transpired being repeated by another lay person, politician Bachmann.

Second, all that Bachmann fueled was: **a)** the public's concern about the safety of the HPV vaccines and **b)** that segment of the independent scientific community that is interested in ascertaining the risks, and their frequencies, that occur after an HPV vaccine inoculation in some percentage of those given the current HPV vaccines.

Third, Dr. Wong's unrestricted misinformative generalization that "*HPV can result in cancer*" confuses a virus, HPV, which cannot cause anything, with a disease outcome, e.g., cancer.

Factually, one has to have an HPV infection before any adverse outcomes can be triggered by that HPV infection and, *in this instance*, the infecting HPV has to be one of the few strains that are linked to some form of cancer in humans.

In addition, there is no unequivocal proof that the HPV infection causes the cancers with which it is associated or merely replicates better in tissues that are cancerous.

Furthermore, Dr. Wong's

> "*disseminating this kind of misinformation not based on scientific evidence is dangerous*"

makes assertions that are not supported by any cited scientific study.

For example, Bachmann's remarks must be considered information unless Dr. Wong has proof that an HPV vaccine inoculation cannot cause any of the inoculees to lose mental abilities, either temporarily or permanently.

In addition, Dr. Wong neither provides nor cites any such scientifically sound studies proving that a person inoculated with either of the current HPV vaccines cannot have an adverse reaction to the HPV vaccine inoculation that causes the inoculees to lose mental skills.

Therefore, Dr. King, who is a scientist, is compelled to accept that HPV-vaccine inoculation probably does cause some of those inoculated with an HPV vaccine to lose mental skills based on the many observations posted by: **a)** those suffering serious adverse outcomes after getting an HPV inoculation; **b)** the parents and friends of those suffer-

ing those harms; and **c)** the physicians who are treating those harmed individuals.

Thus, until the requisite randomized, double-blind, true-placebo-control studies are conducted on an initial population of not less than 30,000 initially healthy females with a follow-up period of not less than 10 years and the study's findings are fully published, Dr. King must continue to accept that the harms reported by these mostly female inoculees are real and that, *for the most part*, the HPV-vaccine inoculations must be a possible causative factor in most instances.

Furthermore, what Dr. King finds "*dangerous*" are those, like Dr. Wong, who have a "benefit-centric" view of any vaccine, a view that is blind to the harm that a vaccine may be causing especially when the validity of the initial purported benefit, "protection from cervical cancer" in women will not be able to be evaluated until the middle of the 21st century – 30 to 40 years from now.

In addition, since even a three-dose HPV-vaccine inoculation program does not seem to provide any benefit in the USA for preventing cervical cancer, its initial target, beyond the pre-existing benefit provided by annual pap-smear testing, Dr. King wonders how can the additional cost of this expensive vaccination program ($90.399 to $141.38 per vaccine dose, plus the administration and record keeping costs) be justified in the USA?

Finally, since the HPV vaccines have been linked to *significantly more than* 120 deaths occurring in young women shortly (from a few minutes to a few months) after they received an HPV-vaccine inoculation, how can one ethically justify a vaccine that diminishes the lives of a significant percentage of those inoculated with it and kills some?

Those adverse events are especially troubling because the HPV-vaccine inoculation series may not even provide any long-term protection to any of those receiving it from being diagnosed with cervical cancer, a disease with which only a very small percentage of the inoculees are likely to be diagnosed 30 to 40 years after their initial series of vaccinations.

Published Article and Author Integrity Issues

"The general public thinks of scientific journals as unimpeachable, but the rise of e-commerce and e-media has created an unprecedented opportunity for charlatans to inflate credentials and corrupt scientific publications."

Here, Dr. Wong begins by stating what must be his view of what the "*general public thinks*" since he neither provides an embedded link nor cites some source to substantiate his initial assertion.

As a scientist, sometime journal submission reviewer, and one of the authors in articles published in peer-reviewed journals around the world, Dr. King's view is that few in today's world view scientific journals as anything more than periodicals where articles purporting to provide scientifically sound information are published.

Moreover, in today's greed-driven world, "scientific" articles published in peer-reviewed journals cannot be trusted based on the reputation of the journal, particularly journals that deal with any aspect of medicine, especially those addressing drugs (including vaccines) and medical devices.

As Marcia Angell, MD, former acting Editor-in-Chief for ***The New England Journal of Medicine*** wrote speaking of articles published in medical journals (emphasis added),

> " ... Similar conflicts of interest and biases exist in virtually every field of medicine, particularly those that rely heavily on drugs or devices. It is simply no longer possible to believe much of the clinical research that is published, or to rely on the judgment of trusted physicians or authoritative medical guidelines. I take no pleasure in this conclusion, which I reached slowly and reluctantly over my two decades as an editor of *The New England Journal of Medicine* "[18].

Thus, there is no need "*for charlatans to inflate credentials and corrupt scientific publications*" because money and incestuous relationships have already corrupted most of the "medical" journals that publish "scientific articles".

"In this process, pseudoscience has become rampant. In a recent article, "Who's Afraid of Peer Review?" [http://www.sciencemag.org/content/342/6154/60.full] published in Science, the flagship journal of The American Association for the Advancement of Science, John Bohannon revealed that it is relatively easy to publish fake scientific data in open-access journals."

While agreeing with Dr. Wong that "*pseudoscience has become rampant*", Dr. King sees Wong's focus on "*fake scientific data in open-access journals*" as a diversionary tactic to draw attention away from the bigger problem.

That problem is researchers, who have disclosed and hidden, or indirect, conflicts of interest and who intentionally design their studies and/or adjust the datasets or treatment of the results to produce findings favorable to the interest in which they, or the institution for which they work, have a monetary or equity stake.

[18] Marcia Angell (January 15, 2009). Drug Companies & Doctors: A Story of Corruption . *The New York Review of Books*. Retrieved 20 February 2014.

This is especially problematic when those researchers have a concealed interest in the study's finding a "favorable" outcome to increase their monetary reward, or success in having their research funded, and/or to help ensure other future benefits.

Finally, Dr. King notes that Dr. Wong appears to be an author in at least one paper that appeared in an open-access journal[19].

"Unfortunately, Bohannon's piece barely received any attention from the popular media, squandering a vital opportunity to alert and inform the general public how to differentiate the wheat of real science from the chaff of pseudoscience. For the sake of public health, this issue must move beyond the confines of academia."

While Dr. Wong's rhetoric here is carefully constructed, it actually appears to be disinformative and, to borrow from his "*wheat*" analogy, does not inform the reader how he or she can differentiate the "germ" of "*real science*" published in any journal from the bushels of wheat containing twisted, self-serving 'tobacco-science'[20], his "*pseudoscience*", which passes for scientifically sound discourse about any issue where the interests of the Establishment are in play.

"It is somewhat unnerving to read some of the comments [http://comments.sciencemag.org/content/10.1126/science.342.6154.60] posted below Bohannon's article, where a number of readers think 'scientific counterfeits' are a fact of life, that falsifying data is old news, and that scientists should focus on our scientific work instead of worrying about counterfeiting."

Here, while commenting on the reality that many "*think 'scientific counterfeits' are a fact of life, that falsifying data is old news, and that scientists should focus on our scientific work instead of worrying about counterfeiting*", Dr. Wong's "*our scientific work*" attempts to portray himself as a scientist and his work as somehow "*scientific*".

However, his current article repeatedly violates the fundamental tenet of science that one's assertions should generally be directly, or indirectly, supported by suitable citations of the scientifically sound and appropriate, peer-reviewed, published literature that supports one's pronouncements.

Finally, given that most of the tobacco-science-based articles published in peer-reviewed journals are not counterfeit, Dr. Wong's focus on the issue of counterfeit articles, at best, seems to be intended to

---

19 Li X, Gao J, Zhang Z, Wei M, Zheng P, Nehl EJ, Wong FY, Berg CJ. Lessons from an Evaluation of a Provincial-Level Smoking Control Policy in Shanghai, China. *PLoS ONE* 2013 Sep 10; 8(9) e74306 (7 pages), doi: 10.1371/journal.pone.0074306.

20 For an informative overview of today's 'tobacco-science' that provides cogent examples and pertinent references, please read the November 2013 article by journalist and author Catherine J. Frompovich that is posted at http://www.activistpost.com/2013/11/the-realities-of-tobacco-science-in.html, which Dr. King last accessed on 20 February 2014.

divert the readers from the general problem, the tobacco-science that pervades the "*scientific*" literature.

Public Discourse in Science – *Caveat Emptor*

"Scientists sometimes think it is not their role or responsibility to engage in public discourse regarding their work. In this instance, however, they could not be more wrong. As scientists, we have a responsibility to speak up about the damage that pseudoscience could inflict on society."

Clearly, Dr. Wong, the writer of the article being assessed, and Dr. King, an analytical chemist and the assessor of that article, think that it is a personal imperative that they engage in public discourse about those specific areas of science for which they have expertise.

However, if we adhere to the scientific method and the principle that our actions should be designed to minimally bias the systems we are studying, Dr. King thinks that, as scientists, we should limit our discourse to those areas where the findings of our studies and those of our colleagues clearly establish that tobacco-science has damaged or is damaging the fabric of our society.

Since Dr. Wong cites no published studies in which the data is completely fabricated that have inflicted damage on society as a whole, Dr. King must conclude that, while harmful and a problem, wholly counterfeit studies are not the major problem.

Moreover, since, as Dr. Angell has observed, most of today's clinical studies appear to be based on the type of "*pseudoscience*" generated by the intentional introduction of biased designs, twisted data analyses, and finding manipulations rather than sound science, Dr. King finds that such tobacco-science studies on key issues,

- global warming/climate change,
- genetically modified organisms,
- natural or man-made farming,
- the hazardous chemicals in the products that make up our environment and their bioactive breakdown products,
- bio-engineering,
- geo-engineering,
- water fluoridation,
- mercury amalgam dental fillings,
- the use of mercury compounds in medicine, and
- pharmaceutical drug products including vaccines

have been or are being used by the Establishment to justify its agendas while society suffers.

"For example, we are in the third decade of the AIDS pandemic, and there are still well-trained scientists such as Peter H. Duseberg, once an HIV/AIDS control and prevention adviser to the former president of South Africa, who denies that HIV causes AIDS [http://briandeer.com/death-by-denial.htm]. Duesberg says that recreational drugs are the culprits for AIDS among homosexual men in the West, while the cases in Africa are largely due to malnutrition and other diseases."

However, not blinded by the "Germ Theory" of disease, Professor Duseberg clearly understands that this germ theory is flawed and has moved past it to a more wholly integrated view like that of the French scientist Professor Pierre Jacque Antoine BéChamp, DSc, MD[21], who had a view that one's lack of health was the cause of the proliferation of the organisms that characterize a given disease.

In Chapter 5 of her 1995 book, IMMUNIZATION THE REALITY BEHIND THE MYTH, Second Edition, Walene James characterized BéChamp's views as "The Cellular Theory" of disease in which disease/unhealth is caused by an imbalance, injury or other insult that gives rise to conditions that favor the generation and proliferation of certain organisms whose job is to clean up the diseased cells, which, in attempting to fulfill their role, may create the symptoms used to diagnose a given pathogenic medical condition.

Under the Cellular Theory of disease, there is no contraindication between:

a. The observation that 10% to 15% of the population in the USA harbors one or more strains of *Neisseria meningitides*, a "bacterium" that is deemed to be responsible for cases of meningococcal meningitis, and

b. The reality that clinical cases of meningococcal meningitis are reported for *less than* 1,000 people a year in the USA (which has a population of greater than 300 million).

Therefore, although *less than* "1,000" contract the disease meningococcal meningitis, at least another 29,999,000-plus to 44,999,000-plus residents "carry" culturable quantities of these bacterial organisms in their mucosal membrane surfaces in the nose, throat and lungs.

Thus, *in keeping with the Cellular Theory of disease*, infection only occurs when the body becomes unwell in a manner that allows the *N. meningitides* to proliferate and "cause" the symptoms used to diagnose the medical condition known as meningococcal meningitis.

---

[21] https://en.wikipedia.org/wiki/Antoine_Béchamp , last accessed on 21 February 2014.

Similarly, though "unpopular" with, and attacked by, the allopathic medical establishment, "*Duesberg says that recreational drugs are the culprits for AIDS among homosexual men in the West, while the cases in Africa are largely due to malnutrition and other diseases*" meaning that, among other triggers, the use of "*recreational drugs*" in the USA is a principal causative factor that creates the disease conditions in the body under which the HIV thrives and the "infected" person is then diagnosed with AIDS, while, in Africa, "*malnutrition and other diseases*" are the principal "*culprits*" that create the unhealthful conditions that permit the HIV virus to proliferate and "cause" the symptoms used to diagnose AIDS.

"People like Duesberg are not shy [http://www.rethinkingaids.com/] about spreading their half-baked, unproven ideas in spite of overwhelming contradictory scientific evidence."

Here, Dr. Wong cannot get past his ingrained allopathic medical views, and substitutes the relative magnitude of the published "*evidence*" on the "Germ Theory" side of the ledger for the lack of proof that Dr. Duesberg's views are totally wrong.

Therefore, he paints all those, including, for example, Nichola Tesla, who similarly had anti-consensus views that threatened the profits of the Establishment and the livelihoods of those it employed in industry and academia, as being "*not shy about spreading their half-baked, unproven ideas in spite of overwhelming contradictory scientific evidence*".

After all, if Dr. Duesberg's views are correct, the billions made by the pharmaceutical-medical complex and the grants that now fund Dr. Wong's studies could be threatened.

The Authors, Not the Publishers, are Primarily Responsible for the Scientific Soundness of Their Articles, but the Reviewers and the Publishers Also Have Responsibilities

"In this new business environment, publishers are often no longer responsible for preventing fake or less than credible data. Meanwhile, some scientists who have the financial resources might opt for a quick and easy publication, though their findings may be questionable. A key scientific currency, peer-reviewed publication, is being corrupted outright by the unscrupulous pursuit of profit."

First, the responsibility for "*preventing fake or less than credible data*" has always rested, and clearly rests, with those who produce such and not with the "*publishers*" because they do not generate data.

Moreover, the responsibility for the quality of the papers accepted for publication rests with the ethics of the peer reviewers who, usually without pay, review each submission and make recommendations as

to whether a given paper should be published or rejected or whether significant revision must be made and/or missing key information must be provided before the paper's fate can be decided – absent which the paper must be rejected.

Finally, for those journals, digital or print, whether "open access", not open access" or "both", it is the responsibility of the publishers to ensure that the underlying data sets will be preserved by the authors and that the anonymized data and all ancillary information will be made available to any qualified researcher seeking that data and the associated information after a paper that is chosen to be published has been published in the official journal ("on paper" or "digitally") by immediately retracting any paper for which these conditions are not met and publishing an appropriate, hopefully open, notice of retraction.

With respect to Dr. Wong's unsupported statement,

> "*Meanwhile, some scientists who have the financial resources might opt for a quick and easy publication, though their findings may be questionable*",

Dr. King first notes that at least one paper in which Dr. Wong is an author was published in an open-access journal.

However, Dr. King has no problem *per se* with authors, who can afford the "open access" fees that journals, both open access and those with an "open access" option, charge, and elect to pay those fees so that their papers will reach a wider audience and, in some instances, reach the general public.

Moreover, from personal experience as a sometime reviewer and author, Dr. King knows that choosing a reputable "open access" journal does not guarantee publication – much less "*a quick and easy publication*".

Furthermore, in the areas which Dr. King does his research, vaccines, vaccination, immunology, toxicology, pharmacology, pharmaceutics, biometry/epidemiology and analytical chemistry, Dr. King finds little correlation between the journal in which an article is published and the quality of the article or the validity of the article's findings *per se*.

As Dr. King stated earlier, it is the responsibility of the researchers preparing and submitting a paper for publication to ensure that the data and models used are valid, the raw data is appropriately analyzed and the findings thoroughly checked for validity before the paper is submitted to any journal.

Next, it is the responsibility of the reviewer to thoroughly check the paper and, if not provided, request the anonymized raw data and models used to verify the accuracy of the result values reported in the paper before doing any in-depth review of a manuscript that he or she has agreed to review.

The publisher's responsibilities include:

- Making certain that the peer reviewers that it uses for each paper are qualified;
- Having a sufficient number (usually, two [2] to five [5]) of qualified reviewers review each paper;
- Making certain that the reviewers have thoroughly vetted the manuscript and made science-based recommendations as to how the manuscript should be viewed (accepted, accepted with minor revision, accepted with major revision, or rejected), or is unclassifiable because of missing key information;
- Making a final determination as to whether to publish the finalized, reviewer-acceptable papers and when to publish them;
- Publishing the accepted papers and appropriately handling post-publication reader comments on each paper; and
- Post-final-publication, retracting any paper where proof of fraud is found, violation of ethics is proven, or where the authors refuse to provide all of the anonymized data, models and ancillary information to other researchers who wish to check the data to verify the original results or to examine it in any other scientifically sound manner to see whether there is additional knowledge that may be gleaned from the original complete anonymized datasets and/or records used in the study.

Furthermore, with respect to Dr. Wong's lament,

> "*A key scientific currency, peer-reviewed publication, is being corrupted outright by the unscrupulous pursuit of profit*",

Dr. King first notes that the "*key scientific currency*" is not "*peer-reviewed publication*" *per se* but rather peer-reviewed publication in a prestigious journal that rigorously reviews, provides formal post-publication feedback and rebuttal, and enforces post-publication ethics to ensure that articles are retracted with an official notice in those instances where post-publication fraud, misrepresentation, or failure of the authors to provide access to the datasets, models and ancillary information is found.

Second, in Dr. King's view, "*the unscrupulous pursuit of profit*" on the part of those who directly and indirectly profit monetarily from the findings published in peer-reviewed journals has, as any inflationary factor, simply devalued the "*currency*" of journal publication to the point that the public is starting to treat an increasing number of journals as mass-media publications.

Third, the Establishment tactic of burying any inconvenient scientific finding under an avalanche of tobacco-science articles touting opposite findings that, in many instances, defy common sense[22], has the effect of devaluing the "science" and the "scientists".

Thus, the corrosive effects of money on all aspects of "science", including the publication of findings, have reduced the value of publication in any journal to the point that many scientists, including Dr. King, are increasingly choosing to bypass the journals and directly publish some of their "findings" on the Internet – making those articles open to peer-review and critique by anyone in the public who reads them.

Greed, Distortion, and Good Data?

"Sadly, the profit motive has begun to play an increasingly distortive role in the dissemination of scientific research findings. What's at stake here? Lives, obviously. Less dramatic, but no less important is the question of how we define 'knowledge,' and how much we can trust science and scientists. Reasonable people can disagree on how to interpret data, but first, we need good data."

Here, Dr. Wong is both right and wrong.

He is right when he closes with,

"*Reasonable people can disagree on how to interpret data, but first, we need good data.*"

However, he is wrong when he states,

"*the profit motive has begun to play an increasingly distortive role in the dissemination of scientific research findings*",

because what the profit motive has corrupted are the academic scientists and academic institutions that, until they allowed themselves to be co-opted and corrupted by "partnership" and "cooperative arrangements" with greed-driven for-profit corporations and corporate-influ-

[22] For example, epidemiological studies where Thimerosal-preserved vaccine doses are injected into developing children at levels that are more than an order of magnitude above the toxic threshold for Thimerosal that report finding: **a)** injected children had improved neurological function over the controls who received no-Thimerosal vaccines or **b)** those receiving the Thimerosal-preserved vaccines were protected from neurological damage more than the controls who received no-Thimerosal vaccines.

enced governmental agencies, were relatively free from the pressure to slant and distort their research to mesh with the goals of their "partners".

Since it is virtually impossible to work for a corrupt entity without becoming corrupted by that entity, both academic institutions and academic researchers have been corrupted by the corporations and corporate-interest-dominated federal and state agencies to which they are increasingly bound and by which they are increasingly influenced and controlled.

In turn, the corruption of the academic scientists has had the effect of increasing the corruption of the scientists who directly work for these corporations, as these corporate scientists increasingly have nowhere to turn for support in resisting their corporation's demands for slanted studies and positive findings.

If, as Dr. Wong surmised, "*we need good data*", the root-cause problem is not "*in the dissemination of scientific research findings*" but rather it is that the mechanisms for getting "*good data*" are increasingly being corrupted to the point that today, in many fields, only a few independent scientists are able to produce the scientifically sound data required for valid findings.

However, since the corporations:

- Now have "hit lists";
- Are currently getting "bothersome" papers retracted; and
- Are seemingly engaged in actively destroying the careers and reputations of any independent scientists who conduct studies that produce findings that threaten the corporation's self-serving tobacco science,

most of these independent scientists now conduct their studies in less-controversial areas while the "tethered" academic scientists are increasingly constrained to only conduct exactly those studies that their corporate partners decide should be done.

"The longer we turn a blind eye to scientific fraud, the more we encourage a pay-to-play system that puts dollars before scientific data, and the more we will erode the public's trust in science and its authority. That way is perilous."

Since, in the USA and many other nations, corporations, the direct or indirect source of the money that corrupts scientists:

- Have also corrupted governmental agencies that are supposed to regulate their lawful conduct;

- Have corrupted many of the most prestigious academic institutions and their academic researchers;
- Are actively engaged in corrupting other independent researchers;
- Are actively engaged in destroying the careers and reputations of those whose research could or does produce findings contrary to the industry's tobacco-science research; and
- By their actions, consider the costs of their knowing non-compliance with the laws regulating their activities just a "cost of doing business", which they factor in when marketing their products to the public,

Dr. King is amazed that Dr. Wong thinks that there still is any meaningful level of "*public trust in science and its authority*" left to be eroded.

Dr. King's Concluding Remarks

Finally, Dr. King thinks that this assessment has appropriately addressed both Wong's laments and the real root causes of the problems surrounding today's vaccines and vaccination programs.

Given that:

- The allopathic paradigms resting on the "Germ Theory" of disease are increasingly being proven to be fatally flawed;
- No one truly understands exactly how the overall human immune system functions;
- It is becoming increasingly obvious that the innate immune system, which is <u>not</u> about antibody production, is the major source of long-term protection (immunity) from "contagious" disease recurrence; and
- The critical nature of the microbiome that surrounds each of us and without which we would soon cease to exist,

it appears that the war on disease, which we are clearly losing, needs to be stopped.

Instead, we should adopt a proactive peaceful coexistence with the microbial world if we are to lose our current chronic diseases and, as a nation, regain the health and vitality we once had before vaccines and manmade antibiotics, when appropriate diet allowed us to produce our own antibiotics and, in health, we tended to peacefully coexist with and thrive in the microbial world.

To accomplish this we must recognize the scientific frauds and failings in allopathic medicines and vaccines and replace them with the

natural paradigms advocated by orthomolecular, naturopathic and holistic medicine to maintain and nurture the public health and the health of the public's children, grandchildren and great-grandchildren.

In addition, we must abandon genetically engineered crops, pesticides, and artificial colors and flavors, and adopt natural alternatives that work with, rather than war against, nature.

Recognizing that all "wars" are frauds designed to enrich the rich and powerful at the expense of the fiscal, physical, emotional and spiritual health of the people, and that, *collectively*, we, the people, are losing the war on poverty, the war on drugs, the war on terror, and all of the other wars from which only the rich and powerful profit, it is time for all the world to abandon these wars and turn to working with nature to provide what is needed while restoring the natural ways of managing "pests" and "weeds" by nurturing, not killing off, the beneficial organisms at every level in our environment.

Furthermore, rather than polluting our world with plastics, we need to use the natural alternatives that, if we only look for them, really are ecologically friendly and inherently superior to the artificial alternatives for most all of our daily needs, not wants.

Finally, if you want to stop scientific fraud, simply start by prohibiting our institutions of higher learning from forming any partnership with any greed-driven entity and enact laws that put corporations out of business (revoke their charters) whenever they are found to have knowingly violated the laws governing their conduct or knowingly falsified or intentionally biased, by design or otherwise, any study submitted to any governmental agency that purports to prove their products are safe and/or effective.

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.

Additionally, Dr. King specifically thanks Catherine J. Frompovich, Gary S. Goldman, and Eileen Dannemann for their support, suggestions, corrections and alternate wordings that helped him to finalize this response.

About Frank Y. Wong, PhD, Author of the Article Being Assessed

Source: http://www.cfar.emory.edu/bio/investigator/wong.html

Frank Y. Wong, PhD

CFAR Investigator

Phone: 404-727-9568
Email: fwong3@emory.edu
School: Emory University/Rollins School of Public Health
Department: Behavioral Science and Health Education / Hubert Department of Global Health

See also these other websites:
• Emory University: Studies in Sexualities
• RSPH: BSHE

I have expertise in community-based research efforts targeting racial/ethnic and underserved populations (including immigrants, refugees, and linguistic and sexual minorities) with a history of or who are currently using alcohol, tobacco, and other drugs (ATOD) and engaging in HIV-related risk practices. My NIH-funded research focuses on the social epidemiology of ATOD and HIV/STI (sexually transmitted infection) targeting Asian Americans and Pacific Islanders in the U.S.; and lesbian, gay, bisexual, and transgender individuals in the U.S. and South Africa, as well as China. I am one of the first investigators to examine ATOD use/abuse and HIV-related risks among Chinese money boys (men who engage in commercial or transactional sex with other men) in Shanghai.

My most recent project is as PI of a proposed initiative, the "Global Partnerships for Social Science AIDS Research." Dr. James Curran (CFAR PI and Dean of the Rollins School of Public Health) and Professor Velma A. Kameoka (University of Hawaii at Manoa) will serve as Co-Chairs of the Global Partnership's Advisory Committee.

CFAR Involvement

Member:

- CFAR Science Council
- Social and Behavioral Science Research Network
- Translational Research Interdisciplinary Group
- The CFAR Network Soiree
- The Vaccine Dinner Club

Research Domains

• Clinical & Translational Science Research Domain

Opportunistic Infections & Co-infections:

STIs

Translational Science:

Clinical Studies of: Behavioral and Biomedical Prevention

• Prevention Science and Epidemiology

Distribution and Determinants of HIV:

Among: Adults, Drug Users, MSM, Asian, Native Hawai'ian, and other Pacific Islander MSM in the U.S.; Chinese MSM

Intervention Development and Implementation:

For: MSM

In: China

Research Locations

Other US:

DC; SF; LA; Oakland; San Jose; Boston; Philadelphia; New York

Africa:

Cape Town

Asia:

China

Research Populations:

Age:

Adults

Gender:

Men

Racial/Ethnic Group:

Asian, Hispanic, Southeast Asian, Native Hawai'ian and Other Pacific Islander

Sex Partnerships:

MSM

Stage of Infection:

HIV-negative

Vulnerable Populations:

Drug Users, Non-English Speakers, Refugees/Immigrants, Sex Workers

Key Collaborators:

Professor N He, Fudan University's School of Public Health, China
Dr. Eric Nehl, Emory University's Rollins School of Public Health
Dr. Z. Jennifer Huang, Georgetown University's School of Nursing & Health Studies
Dr. Joseph D. Tucker, School of Medicine (Infectious Diseases) University of North Carolina at Chapel Hill
Professor Michael W. Ross, School of Public Health, University of Texas Health Science Center at Houston

Publications:

Click this link to generate a PubMed search of Dr. Wong's publications

Source: http://www.minority.unc.edu/institute/2008/spkrbios/FrankWong.cfm

Frank Y. Wong, Ph.D.

Frank Y. Wong, Ph.D., a social psychologist, is an Associate Research Professor in the Department of International Health at the Georgetown University School of Nursing and Health Studies (webpage) with expertise in community-based research on HIV-related risk behaviors and alcohol, tobacco, and other drugs (ATOD) use/abuse among racial/ethnic and under-served populations. Dr. Wong currently has multiple NIH-funded R01 grants supporting his research programs. His NIH-funded research focuses on social epidemiology as well as prevention of ATOD and HIV targeting migrant and/or non-indigenous populations and sexual minorities and the effects of migration on ATOD use/abuse and HIV-related knowledge, attitudes, beliefs, and behaviors in the U.S. and China. He also has conducted and published research in South Africa.

Since 1994, Dr. Wong has served as a member and/or chaired 47 plus standing and/or ad-

doc committees and study sections of various agencies of the U.S. Department of Health and Human Services (DHHS), including the Center for Scientific Review, National Center on Minority Health and Health Disparity, National Institute of Dental & Craniofacial Research, National Institute on Alcoholism and Alcohol Abuse, National Cancer Institute, National Institute on Drug Abuse (NIDA), National Institute of Mental Health, Office on AIDS Research, Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), Office of Minority Health (OMH), and Substance Abuse and Mental Health Services Administration. Presently, Dr. Wong serves on the Steering Committee of the NIDA AAPI Scholar and Researcher Workgroup advising NIDA on substance abuse related issues affecting AAPIs (Asian Americans and Pacific Islanders). He serves on the editorial board of three scientific journals (AIDS Education and Prevention, Globalization and Health, and Journal of LGBT Health Research). He is fluent in both written and spoken Chinese (Cantonese, Chiu Chow, and Mandarin), and has served as an interpreter for Indo-Chinese refugees since the 1980s.

Examples of past work

Dr. Wong was Scientific Advisor for the only five-year, AAPI-focused demonstration study on integration of HIV/AIDS care for AAPIs (especially those with limited English-speaking, immigrants, or refugees) living with AIDS/HIV funded by the Special Projects of National Significance (SPNS), HRSA. This project was one of 34 SPNS projects participating in a cross-site evaluation utilizing various standardized quantitative and qualitative methodologies. He was a past chairperson of the Special and Under-served Populations Workgroup of SPNS, providing scientific advice on the construction and utilization of core data elements for the cross-site evaluation. Dr. Wong was PI for a two-year study sponsored by the OMH of the U.S. DHHS evaluating the effectiveness of the Bilingual/Bicultural Health Service Grant Program with respect to increasing access to health care for limited English-speaking populations. The study used both survey (quantitative) and site visit (qualitative) modalities, and focused on community-level impacts. Many of the grantee projects target Asian and Southeast Asian populations. Recommendations of this project have led OMH to initiate a study to create a uniform data system for all its community-based programs - as part of GPRA (Government Performance and Results Act). Dr. Wong served as Strategic Advisor for this two-year study. As chairperson of the Project Advisory Committee, he worked with a team of experts representing the various agencies (including CDC, Center for Substance Abuse Prevention, HRSA), private foundations (e.g., Robert Woods Johnson Foundation), and national organizations (e.g., State and Territorial Health) as well as OMH grantees on the strategic plan, which guides the development and pilot testing of the uniform data system.

Dr. Wong has a significant history in providing technical consultation and programmatic development on health care related interventions for less educated and acculturated Asian Americans, as well as for Afro- and Hispanic/Latino-Americans, who utilize inner city health centers and community-based organizations. For example, he developed an Asian Teen Clinic (including evaluation efforts) for the South Cove Community Health Center (the only primary health center in New England targeting AAPIs - especially immigrants and refugees), Boston, MA, funded by HRSA. Dr. Wong had served on the Community Characteristics and Indicators Panel of the Center for HIV, STDs, and TB Prevention, CDC. He was a member of the Editorial team for the Healthy People 2010: The LGBT Companion Document. Dr. Wong had served as a member of the Center for Substance Abuse Treatment (CSAT) LGBT (lesbian, gay, bisexual, and transgender) Workgroup. Dr. Wong was a member of the National Minority HIV Action Plan Working Group of OMH, DHHS.

Read more about Dr. Frank Wong

Source: http://cfusion.sph.emory.edu/Faculty/Profile.cfm?Network_ID=FWONG3&DEPT=BSHE

Frank Y. Wong

Associate Professor(Graduate Faculty)

Department of:
Behavioral Sciences and Health Education

1518 Clifton Road NE
Room 534
Atlanta, GA 30322
fwong3@emory.edu
tel: 404-727-9568
fax: (404) 727-1369

Updated: 01/20/2014 [update]

Ph.D., 1990, Texas A&M University

Courses Taught:

BSHE 500: Behav Sciences/Public Health
BSHE 560R: BSHE Seminar
BSHE 590: Capstone Seminar
BSHE 599R: Thesis

Areas of Interest/Research:

Community Based Research
Global Health
HIV/AIDS
Infectious Disease
Sexual Behavior

Selected Research Projects:

Risks for HIV/STIs and Their Psychological Correlates among Chinese MSM, NICHD: PI

A Molecular-Social Network Investigation of HIV-HCV Co-infection in Chinese MSM, NIAID: PI

Selected Publications:

Lin H, He N, Zhou S, Ding Y, Qiu D, Zhang T,
Wong, FY

Behavioral and molecular tracing of risky contacts of HIV-infected men having sex with men in Taizhou, Easten

China

American Journal of Epidemiology, 177: 343-350, 2013.

Gao J, Li Y, Peng W, Dai J, Lin L, Nelhl EJ,
Wong, FY, Zheng P.

Newspaper coverage of HIV/AIDS in China from 2000 to 2012

AIDS Care, Epub: 2013.

Nehl EJ, He N, Wang X, Lin L,
Wong, FY, Yu F

Willingness and feasibility of three types of e-technologies in HIV prevention targeting Chinese MSM

AIDS Care, Epub: 2012.

Wong, FY,
Nehl EJ, Han JJ, Huang ZJ, Young D, Wu Y, Ross MW

Findings of HIV testing and HIV management from a national sample of Asian/Pacific Islander men who have sex with men

Public Health Reports, 127(2): 186-194, 2012.

Nehl EJ,
Wong, FY, He N, Huang ZJ, Zheng T.

Prevalence and correlates of alcohol use among a sample of Chinese MSM in Shanghai

AIDS Care, 24(3): 324-330, 2012.

Tucker JD,
Wong, FY, Nehl EJ, Zhang F

HIV testing and care system focused on sexually transmitted HIV in China

Sexually Transmitted Infections, 88(2): 116-119, 2012.

Huang ZJ, He N, Nehl EJ, Zheng T, Smith BD, McNabb S,
Wong, FY

Social network and other correlates of HIV testing: Findings from male sex workers (“money boys”) and other MSM in Shanghai, China

AIDS and Behavior, 16: 858-871, 2012.

Wong, FY,
DiGangi JA, Huang ZJ, Young D, Smith

Intimate partner violence, depression, and alcohol use among a sample of foreign-born Southeast Asian women in an urban setting in the U.S.

Journal of Interpersonal Violence, 26(2): 211-239, 2011.

Wong, FY,
Crisostomo VA, Bao D, Smith BD, Young D, Huang ZH, Buchholdz ME, Frangos SE

Development and implementation of a collaborative, multi-stakeholder research and practice model on HIV

prevention targeting Asian American and Pacific Islander men who have sex with men

American Journal of Public Health, 101(4): 623-631, 2011.

Huang ZJ, Wang W, Martin MC, Nehl EJ, Smith BD,
Wong, FY

"Briding population": sex workers or their clients? -- STI prevalence and risk behaviors among clients of female sex workers in China

AIDS Care, 23(Sup 1): 45-53, 2011.

Fu Z, He N, Duan S, Ye R, Yang Y, Xiang L, Zhao G, Jiang Q, Huang ZJ,
Wong, FY

Sexual network and HIV infection among rural ethnic minorities in Yunnan Province, China

AIDS & Behavior, 15(5): 1033-1033, 2011.

Berg CJ, Nehl EJ,
Wong, FY, He N, Huang ZJ, Jasjit S, Zheng T

Prevalence and correlates of tobacco use among a sample of MSM in Shanghai, China

Nicotine and Tobacco Research, 13(1): 22-28, 2011.

Simoni JM, Safren SA, Manhart LE, Lyda K, Grossman CI, Rao D, Mimiaga MJ,
Wong, FY, Catz SL, Blank M, DiClemente RJ, Wilson IR

Challenges in addressing depression in HIV research: Assessment, cultural context, and methods

AIDS & Behavior, 15(2): 376-388, 2011.

Wei C, Raymond HF,
Wong, FY, Silvestre AJ, Friedman MS, Docuent PI, McFarland W, Stall R

Lower HIV prevalence among Asian/Pacific Islander men who have sex with men: A critical review for possible reasons

AIDS & Behavior, 15(3): 535-549, 2011.

Wong, FY,
He N, Huang ZJ, Young D, O'Conor C, Ding YY, Fu C, Arayasirkul S

Migration and illicit drug use among two types of male migrants in Shanghai, China

Journal of Psychoactive Drugs, 42(1): 1-9, 2010.

Wang W, Wei C Buchholdz ME, Martin MC, Smith BD, Huang ZJ,
Wong, FY

Prevalence and risks for sexually transmitted infections among a population-based sample of migrants vs. non-migrants in China

International Journal of STDs & AIDS, 21: 410-415, 2010.

Wei C, Guadamuz TE, Stall R,
Wong, FY

High STD prevalence, risky sexual behaviors and sex with women among a national sample of Chinese MSM

American Journal of Public Health, 99: 1978-1981, 2009.

Wong, FY,
Huang ZJ, Wang W, He N, Marzzurco J, Frangos S, Buchholz ME, Young D, Smith BD

STIs and HIV among men having sex with men in China: A ticking time bomb?

AIDS Education and Prevention, 21: 431-448, 2009.

Wong, FY,
Huang ZJ, He N, Smith BD, Ding YY, Fu C, Young D

HIV risks among gay and non-gay-identified migrant money boys in Shanghai, China

AIDS Care, 20: 170-180, 2008.

Wong, FY,
Huang ZJ, DiGangi JA, Park RJ, Thompson EE

Gender differences in intimate partner violence on substance abuse, sexual risks and depression among a sample of South Africans in Cape Town, South Africa

AIDS Education and Prevention, 20: 56-64, 2008.

Wong, FY,
Thompson EE, Huang ZJ, Park RJ, DiGangi J, De Leon JM

Alcohol, drugs, and HIV risk behaviors among a community sample of Black and Coloured South Africans

Journal of Drug Issues, 37: 489-502, 2007.

He N,
Wong, FY, Huang ZJ, Ding YY, Fu C, Smith BD, Young D, Jiang Q

HIV risks among two types of male migrants in Shanghai, China: Money boys vs. general male migrants

AIDS, 21: S1-S7, 2007.

He N,
Wong, FY, Huang ZJ, Thompson EE, Fu C, Ding Y

Substance use & HIV risks among two types of male migrants in Shanghai, China

AIDS Care, 19: 109-115, 2007.

Wong, FY,
Campsmith ML, Nakmura GV, Crepaz N, Begley E

HIV testing and care-related services among a group of HIV-positive Asian Americans and Pacific Islanders in the United States: Findings from a Supplemental HIV/AIDS Surveillance (SHAS) Project

AIDS Education and Prevention, 16: 440-447, 2004.

Chng CL,
Wong, FY, Park RJ, Edberg MC, Lai DS

A conceptual model for understanding sexual health among Asian American/Pacific Islander (AAPI) men who have sex with men (MSM) in the United States

AIDS Education and Prevention, 15: 21-28, 2003.

Nehl EJ,
Wong, FY, He N, Nakayama, Huang ZJ, Zheng

Substance use and sexual risks among a sample of MSM in Shanghai, China

Journal of Drug Issues, in press:

Yu F, Nehl EJ, Lin C-S, Tran A, Zheng T, He N, Berg CJ, Lemieux AF, Sullian PS,
Wong, FY (corresponding author)

A syndemic including cigarette smoking and sexual risk behaviors among a sample of MSM in Shanghai, China

Drug and Alcohol Dependence, in press: .

Luo X, Duan S, Pu Y, Yang Y,
Wong, FY, He N

Prevalence and correlates of alcohol use and subsequent sex among male adults in a rural ethnic minority community of Yunna Province, China

BioScience Trends, in press: .

Link to this page: http://www.sph.emory.edu/faculty/FWONG3

About Paul G. King, PhD, Author of this Fact-based Assessment

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

Furthermore, 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, which 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 diabetes), or nearing (peanut allergy), epidemic childhood levels in the USA.

More recently, Dr. King was the co-author of a review paper in the journal ***Vaccine*** with Gary S. Goldman, PhD, which evaluated the CDC-recommended universal varicella vaccination program[23].

That paper established that the current CDC-recommended two-dose vaccination program was not effective in preventing all those who have been fully vaccinated from subsequently contracting chickenpox.

Since that program has greatly increased the public's risk of having clinical cases of shingles, it is also not societally cost-effective for universal use.

In addition, Dr. King was a co-author of a follow-up paper[24] published by the journal *Human & Experimental Toxicology* with Gary S. Goldman, PhD, that provided more evidence that the U.S. "universal varicella vaccination program is neither effective nor cost-effective".

Moreover, Dr. King was also one of the authors of a paper in the journal *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[25].

---

23 Goldman GS, King PG. Review of the United States universal varicella vaccination program: Herpes zoster incidence rates, cost effectiveness, and vaccine efficacy based primarily on the Antelope Valley Varicella Active Surveillance Project data. *Vaccine* 2013 March 25; 31(13): 1680-1684 (open access). [See, http://www.sciencedirect.com/science/journal/0264410X/31/13, article "6".]

24 Goldman GS, King PG. Vaccination to prevent varicella: Goldman and King's response to Myers' interpretation of Varicella Active Surveillance Project data . *Hum Exp Toxicol*. 2013 Dec. 10. [http://het.sagepub.com/content/early/2013/12/10/0960327113512340.full.pdf+html.] .

25 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. OPEN ACCESS

Furthermore, Dr. King was one of the authors in a review chapter, "Mercury Induced Autism"[26] (pages 1411-1432), in Comprehensive Guide to Autism Editors: Vinood B. Patel, Victor R. Preedy, Colin R. Martin. Springer New York (2014), where the lead author was Mark R. Geier, MD, PhD. This chapter presented updated evidence that mercury, including the bolus doses delivered when certain preserved vaccines and preserved serum products are given to pregnant women and young children, is a significant causal factor in "autism" and other developmental disorders, dysfunctions, and syndromes.

Finally, Dr. King was one of the authors of the paper, "A two-phase study evaluating the relationship between Thimerosal-containing vaccine administration and the risk for an autism spectrum disorder diagnosis in the United States", in the journal, *Translational Neurodegeneration*, where the lead author was David A. Geier. This open-access paper contributed more evidence to the actuality that there is a causal relationship between Thimerosal-preserved vaccine administration and the subsequent risk of a child's being diagnosed with "autism" in the USA[27].

###

[26] See, http://www.researchgate.net/publication/258009647_Mercury_Induced_Autism/file/60b7d526955a643330.pdf for the complete chapter.

[27] Geier DA, Hooker BS, Kern JK, King PG, Sykes LK, Geier MR. A two-phase study evaluating the relationship between Thimerosal-containing vaccine administration and the risk for an autism spectrum disorder diagnosis in the United States. *Translational Neurodegeneration* 2013 Dec. 16; 2:25 (12 pages). In the first month after publication, it was accessed more than 10,500 times.