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Wednesday, 17 September 2014

On 17 August 2014, Paul G. King, PhD, downloaded an on-line August 13, 2014 article, which was written by "*Gilbert Ross*", titled "**NYC hospitals don't make health workers get vaccinated**", from http://nypost.com/2014/08/13/nyc-hospitals-dont-make-health-worker-get-vaccinated/.

Dr. King's response to that article follows these introductory remarks and two (2) "table of contents" pages.

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This assessment is titled, "**Response to 'NYC hospitals don't make health workers get vaccinated'".**

Introductory Remarks

First, except for the "title", which is quoted in a **bolded** "**inherit**" font, each portion of the article's text is quoted in a grayed "Georgia" font.

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

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

Fourth, when quoting/referencing other sources, the quoted 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 response.

Respectfully,

<s>

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[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.

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Response to
"NYC hospitals don't make health workers get vaccinated"

Dr. King's initial remarks about medical coercion

In a nation where each individual supposedly has inalienable rights that include constitutionally recognized, reinforced rights to "bodily integrity" and "informed consent" in all things including medical decisions, Dr. King understands that this vaccine apologist, "*Gilbert Ross*", "*the medical and executive director of The American Council on Science and Health*"[1], titles his "***OPINION***" as if health workers somehow do <u>not</u> have these inalienable rights.

"As we near the start of flu season, beware: Many of the city's top hospitals pose a serious hazard to your health, because many of their nurses and other care personnel aren't vaccinated — and don't have to be."

Unsubstantiated health hazard: Health-care workers who are implicitly <u>not</u> annually vaccinated with an influenza vaccine

Here, Dr. Ross starts by making a claim that "*hospitals pose a serious risk to your health*".

While this claim has been shown to be true, the reason it is true is that "you" have an increased risk of being exposed to antibiotic-resistant infectious bacteria in hospitals when "you" are there.

Thus, his claim that their "*risk to your health*" arises because their "*personnel aren't vaccinated — and don't have to be*" is an assertion for which, *unlike the resistant-bacterial exposure risk*, there are no recognized peer-reviewed published scientifically sound claim-substantiating studies that Dr. Paul G. King, a PhD Analytical Chemist and independent researcher into vaccination issues, has been able to find[2].

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[1] Based on the information provided at http://acsh.org/about-acsh/meet-the-team/, where Dr. Paul A. Offit of the Children's Hospital of Philadelphia is on the organization's "Board of Trustees"; and the information provided in http://acsh.org/partnerships-alliances/, the "*The American Council on Science and Health*" is a front group for the interests of the medical, pharmaceutical, and biotechnology industries – a front group that solicits funds but provides no list of its major donors or their levels of funding.

[2] Most recently, Thomas RE, Jefferson T, Lasserson TJ. Influenza vaccination for healthcare workers who care for people aged 60 or older living in long-term care institutions. *Cochrane Database Syst Rev*. 2013 Jul 22; 7:CD005187. doi: 10.1002/14651858.CD005187.pub4, reported in the study's "Abstract" (emphasis added),

"AUTHORS' CONCLUSIONS: The results for specific outcomes: laboratory-proven influenza or its complications (lower respiratory tract infection, or hospitalisation or death due to lower respiratory tract illness) did not identify a benefit of healthcare worker vaccination on these key outcomes. This review did not find information on co-interventions with healthcare worker vaccination: hand-washing, face masks, early detection of laboratory-proven influenza, quarantine, avoiding admissions, antivirals and asking healthcare workers with influenza or influenza-like-illness (ILI) not to work. <u>This review does not provide reasonable evidence to support the vaccination of healthcare workers to prevent influenza in those aged 60 years or older resident in LTCIs</u>. High-quality RCTs are required to avoid the risks of bias in methodology and conduct identified by this review and to test further these interventions in combination". This, most-susceptible-population (the elderly) review found <u>no</u> "reasonable evidence to support the vaccination of healthcare workers to prevent influenza in those aged 60 years or older resident in" long-term care institutions.

"To protect both workers and patients, at least 90 percent of health-care personnel should be vaccinated."

Unsubstantiated implicit "herd immunity" claims about vaccination protection from influenza infection

Here Dr. Ross begins by making an unsubstantiated vaccine-seller-favorable claim that "*at least 90 percent of health-care personnel should be vaccinated*" to "*protect both workers and patients*", when, as discussed later in this response, a recent peer-reviewed published randomized double-blind true-placebo-controlled clinical study with extended follow up, and related evidence, *clearly* suggests that vaccinating health-care workers:

1. Increases their risk of infecting others with the "flu"[3];
2. Does <u>not</u> significantly protect other workers and/or the patients from contracting influenza;
3. Increases their risk of contracting the "flu" during the "flu season";
4. Only provides some of those who are vaccinated with at best moderate protection from contracting those strains of influenza covered by the available vaccines; and
5. Causes some of those who are vaccinated to have serious adverse reactions following inoculation that include, *but are <u>not</u> limited to*, vasculitis, Guillain Barré Syndrome, permanent disability, and death.

Given, the preceding facts, *except to sicken its workers*, why would any organization demand that its workers must be vaccinated with a disease-causing influenza vaccine?

"At Mount Sinai, it's just 58 percent; at Maimonides Medical Center, 55 percent; at New York Hospital-Queens, 60 percent."

Focusing on influenza vaccination levels rather than employee and patient health

Given the facts in Dr. King's preceding response, it would seem that, *based on what appear to be last year's levels of influenza vaccination*, these named New York City hospitals care more about the

[3] In this discussion, the "flu" will be considered to be any illness that produces the symptoms of the "flu", defined as fever, runny nose, aching all over, respiratory symptoms, and overall weakness. The "flu" is also referred to using the medical term "influenza-like illness", whose acronym is "ILI".

health of their workers than those with much higher levels of influenza vaccination.

Moreover, given the recent studies showing that influenza vaccination is "flu" disease causing and not "flu" disease protective, hopefully these hospitals will lead the way in not only not mandating any influenza or other vaccine inoculation as a condition of employment but will, *in the light of recent published studies*, also stop what clearly appears to be a worker-disease-promoting medical practice.

Finally, *in light of the "flu"-causing nature of the influenza vaccine inoculations*, Dr. King hopes that they and the other hospitals in New York City and elsewhere that truly care about the health of their workers and patients will lead the way in overturning all federal governmental cost reimbursements based on any mandated level of influenza vaccination for their employees.

"Overall, at the 31 hospitals of the city Health and Hospitals Corp. the rate is just 82 percent — well below the 'herd immunity' [https://health.data.ny.gov/Health/Influenza-Vaccination-Rates-for-Health-Care-Person/vyzr-qxrt] that's needed to prevent a serious flu epidemic."

A "*herd immunity*" myth

As recent publications by Dr. Tetyana Obukhanych, *a PhD Immunologist who has studied the artificial vaccine protections provided by vaccines*, have reported, Dr. Ross' vaccination-derived "*herd-immunity*" claim is, *at best*, a vaccination-promoting myth[4] that, as an increasing body of evidence supports, no vaccine can provide.

Moreover, certainly "*herd immunity*" cannot be provided by a vaccine that needs to be given annually because the claimed "disease protections" provided by influenza vaccine inoculations are moderate *at best* to almost non-existent *at worst,* and these protections are not even represented to last more than a few months.

"Hospital-worker vaccinations are vital, because patients' own immune systems are so often impaired by the illnesses that landed them in the hospital.

It's outrageous for the city's health-care system to so needlessly put the sick and vulnerable at further risk."

Misplaced outrage

[4]
a. VACCINE ILLUSION How Vaccination Compromises Our Natural Immunity and What We Can Do to Regain Our Health by Tetyana Obukhanych, which is available for purchase as an e-book on www.Amazon.com or one can visit https://sites.google.com/site/vaccineillusion/measles.

b. Obukhanych, T. Herd Immunity: Myth or Reality?, that can be download from http://www.greenmedinfo.com/blog/herd-immunity-myth-or-reality?utm_source=Master+List&utm_campaign=004c39a42d-Greenmedinfo&utm_medium=email&utm_term=0_af50e1f25a-004c39a42d-87637245, last accessed on 6 July 2014.

Given the facts that Dr. King has provided and the cited published peer-reviewed literature that clearly supports those facts that is cited later in this response, what is "*outrageous*" is that vaccine apologists, like Dr. Ross, are advocating a vaccination program that, overall, is clearly disease causing.

Thus, the current influenza-vaccine inoculation program is <u>not</u> disease protective much less, *as often claimed by vaccine apologists and acolytes*, "disease preventive" for either for the healthcare workers or the patients.

Furthermore, vaccinating healthcare workers with influenza vaccines clearly:

- ❑ Puts the health of some of the workers at risk of serious post-vaccination harm, including death;
- ❑ Increases their risk of getting the "flu", any influenza-like illness [ILI];
- ❑ Provides <u>no</u> protection (when the vaccine is a live-virus influenza vaccine) from being infected with the vaccine-strains of influenza to some moderate level of protection (when the vaccine is an inactivated-influenza vaccine) from being infected by the vaccine-strains of influenza to some who are inoculated with these vaccines;
- ❑ Provides little or no protection from being infected by other strains of the influenza viruses or the parainfluenza viruses; and
- ❑ Overall increases the risk that vaccinated healthcare workers may contract and infect patients with the "flu", any ILI.

"Seasonal influenza is highly communicable and potentially lethal. Vaccinating health-care personnel against it to protect both patients and workers should be a no-brainer."

Seasonal influenza: <u>Not</u> *"highly communicable"*

If the influenza vaccines were genuinely "disease preventive" and provided long-term disease protection from most all strains of influenza without increasing the risk of non-influenza viral respiratory infections (commonly also known as "flu" infections or ILIs), then Dr. Ross' unsubstantiated assertions here might have some merit.

However, the fact are that the current influenza vaccines are directly and/or indirectly disease-("flu")-causing agents that provide no wide "flu" protection or general influenza prevention.

Moreover, the little influenza protection that they may provide to some who are inoculated with them apparently does not last for more than a "year".

Given the preceding facts, the promotion of annual influenza vaccinations for any population is an illogical and irrational action that appears to be driven by other than any true interest in the health of those who are vaccinated or the persons with whom they have contact.

"But the Health and Hospitals Corp., or HHC, doesn't require it — despite the clear benefit to all parties, versus the immeasurably small risk."

Influenza vaccine inoculations: More disease causing than disease preventive

Given the fact that influenza-vaccine inoculations are, *on balance*, more disease causing than they are disease protective to some percentage of those who are inoculated with them, as Dr. King has recently established[5,6], they provide no "*clear benefit to all parties*".

Moreover, the short-term (acute) and long-term (chronic) health risks to those who are inoculated with the current influenza vaccines are anything but "*immeasurably small*".

"Health workers in direct contact with patients are the chief source of infectious outbreaks in health-care facilities. Why won't HHC require vaccination?

False claims about the "*chief source of outbreaks in health-care facilities*"

Based on the cited Cochrane report (see footnote "**2**"), Dr. Ross' claim here is not supported by any unbiased factual study.

If anything, because influenza vaccination was not found to be effective in reducing "flu" cases in long-term care institutions (LTCIs) where, *in general*, patient visitor traffic is much less than it is in most hospitals, it appears that vaccinating health "*workers in direct contact with patients*" does not significantly decrease the risk that the patients will contract the "flu".

Given the established disease-causing nature of influenza vaccination and the very real health threat to some of those who are vaccinated with influenza vaccines, it would seem that the "*HHC*" does not "*require vaccination*" because it has recognized that doing so would be a "flu"-promoting action.

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5 http://dr-king.com/docs/20140122_InfluenzaVaccines_VaccinationPrograms_Unsafe_NotEffective_IllnessCausing_Final_b.pdf.

6 http://dr-king.com/docs/20140205_PGK_sReality-basedResponsesTo_SettingTheRecordStraight_DebunkingALLTheFluVaccineMyths_b1.pdf.

"Two years ago, the public-health nonprofit where I work, The American Council on Science and Health, sent HHC a petition signed by 35 nationally renowned experts in infectious disease, demanding it implement a mandatory vaccination policy.

We got nowhere.

We then appealed to the state Department of Health, which said it had such a policy under consideration. But, sigh, DOH caved to union resistance, and merely adopted an optional 'vaccinate or mask' policy."

Public-health Insanity: Petitioning to mandate a disease-causing vaccination program

Here, Dr. King would begin by asking Dr. Ross to tell us what is "*The American Council on Science and Health*"; for whom does it lobby; how much are each of its employees paid annually; and from where is its funding derived?

Moreover, based on the facts, as Dr. King understands them, influenza vaccination programs are, on balance, disease-causing programs that unnecessarily risk the health of the inoculees for the ongoing profit of the vaccine makers and the providers of the inoculations.

Finally, based on the evidence available to Dr. King, measures that may be effective in preventing "flu" transmission in a hospital include frequent rigorous hand washing with soap and water before having patient contact or contact with items, like food, water and bedding, with which the patients will have contact, and appropriately covering one's mouth when coughing or sneezing[7].

In addition, other virus-exposure-avoidance hygienic practices, and excluding all staff and patient visitors who appear to possibly exhibiting the symptoms of the "flu" from entering the hospital are measures that may be effective in preventing in-hospital "flu" transmission.

However, policies that mandate influenza vaccination or masking are <u>not</u> effective in preventing "flu" transmission in hospitals and long-term care institutions.

"The Centers for Disease Control report that there is no evidence [http://www.cdc.gov/flu/professionals/infectioncontrol/maskguidance.htm] that 'mask use by either infectious patients or health-care personnel prevents influenza transmission.'

In other words, the Department of Health is promoting a flu-prevention policy that doesn't prevent the spread of flu."

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[7] See http://www.cdc.gov/flu/about/qa/vaccineeffect.htm, "Vaccine Effectiveness - How Well Does the Flu Vaccine Work?", page last updated "November 7, 2013", which was last visited on 13 January 2014.

The insanity of promoting policies that spread the "flu"

Dr. King agrees with Dr. Ross that the "*Department of Health*" should not be "*promoting a flu-prevention policy that doesn't prevent the spread of flu*" nor should it be supporting a policy that increases the risk of its employees contracting the "flu"[8].

Unfortunately, the only randomized, double-blind, true-placebo-controlled study of influenza disease protection with nine months of follow up[9] found that vaccination with an inactivated-influenza vaccine offered little protection from contracting influenza to those who were vaccinated with an inactivated-influenza vaccine over the protections from contracting influenza that were observed in those who were given a sterile saline placebo injection.

However, influenza vaccination did result in those who were inoculated having three-plus times the risk of contracting a non-influenza viral respiratory infection (a "flu" [ILI] infection) than those who were given a sterile saline placebo injection.

Thus, in this randomized double-blind clinical trial using healthy 6- to 15-year-old children, influenza vaccination was not highly effective in preventing those who were vaccinated from contracting influenza.

Moreover, it increased the vaccinees' risk of contracting a non-influenza viral respiratory infection by 3-plus times over those children in the double-blinded control arm who were only given a sterile saline placebo injection.

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8 In this discussion, the "flu" will be considered to be any illness that produces the symptoms of the "flu", defined as fever, runny nose, aching all over, respiratory symptoms, and overall weakness.

9 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)".

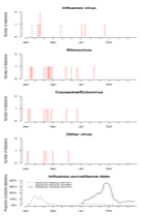

Figure 1. Timing of influenza and other respiratory virus detections in 115 participants aged 6–15 years (A–D), compared with local influenza surveillance data (E). Solid red bars indicate detections in 69 participants who received 2008–2009 trivalent inactivated influenza vaccine, and black dashed bars 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.

On a normalized group size basis, there were 3 influenza cases in the vaccinated group versus the equivalent of 4 influenza cases in the control group given a placebo injection.

Furthermore, there were 15 non-influenza viral respiratory infections in the inactivated-influenza-vaccine inoculated group versus the equivalent of four (4) non-influenza viral respiratory infections in the control group who received a sterile saline inoculation.

Considering that all of the above cases were "flu" cases, *on a normalized group size basis*, non-vaccination (sterile-saline injection) resulted in the equivalent of 8 "flu" cases and influenza vaccination resulted in 18 "flu" cases, resulting in non-vaccination's being 2.25 times more effective than inactivated-influenza vaccination in preventing "flu" cases.

Backing the preceding study up are two other studies[10,11] which, *respectively*,

a. Showed increased non-influenza viral illnesses in those vaccinated with an inactivated-influenza vaccine and

b. Revealed that, on average, less than 18% of all "flu" cases reported by the Centers for Disease Control and Prevention (CDC) were proven influenza cases.

Turning to the current live-virus influenza vaccine, AstraZenaca (MedImmune) FluMist® Quadrivalent, containing four (4) genetically

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10 Kelly H, Jacoby P, Dixon GA, Carcione D, et al. Vaccine Effectiveness against laboratory-confirmed influenza in healthy young children: a case-control study. *Pediatr Infect Dis J* 2011; 30: 107–111. This study also found that those who were vaccinated and did not get a laboratory-confirmed case of influenza had a higher than expected levels of noninfluenza respiratory infections and, in this 2011 publication, reported (emphasis added), "We concluded that the use of ILI controls without influenza virus being identified is the appropriate choice of comparison group for the influenza cases in this study design. However, within the control group, we found that there was significantly higher vaccination coverage among those who tested positive for other respiratory viruses than among those who tested negative for all viruses. This could be interpreted to mean that influenza vaccination increases the risk of being infected by viruses other than influenza, but we believe that this explanation is biologically implausible."

11 As stated earlier, "flu" is any influenza-like illness (ILI), including but not limited to, influenza, a bad cold, an RSV infection, and pneumonia, which produces influenza-like symptoms. In a recent paper, Doshi P, Influenza: marketing vaccine by marketing disease. BMJ 2013; 346 doi: http://dx.doi.org/10.1136/bmj.f3037 (Published 16 May 2013), the author found that, on average, less than 18% of all ILI cases were confirmed influenza cases as shown in "Fig.2",

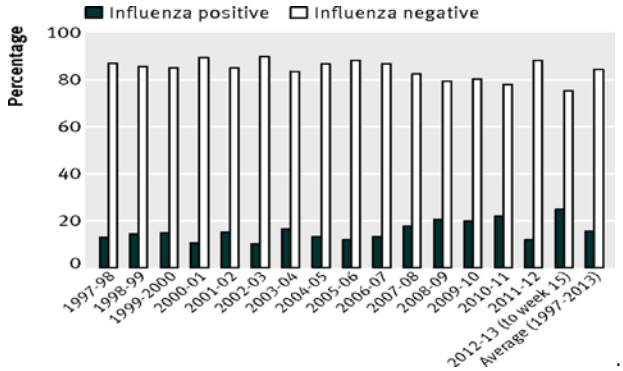

Fig 2 Proportion of specimens testing positive for influenza at World Health Organization (WHO) Collaborating Laboratories and National Respiratory and Enteric Virus Surveillance System (NREVSS) laboratories through the United States. Data are compiled and published by CDC.[28-43].

engineered "cold-adapted" influenza virus strains (two [2] influenza A strains and two [2] influenza B strains), as Dr. King has previously discussed (see footnotes "**5**" and "**6**"), these vaccines only provide antibody protections from subsequent influenza infections for those specific strains when they infect those who are inoculated with them.

Moreover, the live-virus influenza vaccines infect about 80%[12] of those inoculated with at least one (1) of those now four (4) live strains of the influenza virus, which those who are inoculated can shed for at least 21 days and, *while shedding these live viruses*, inoculees can infect others with whom they have close contact with the vaccine's live viruses or mutated viruses derived from the vaccine's live viruses.

Thus, the disease protections provided by the live-virus influenza vaccine depend upon the inoculees' being infected by the vaccine strains of influenza to the point that the innate immune system's defenses are breached, and the adaptive immune system recognizes these viruses as foreign and begins producing antibodies to them.

Given all of the preceding realities, since no influenza-vaccine inoculation program prevents the spread of the "flu", then why are Dr. Ross, "*The American Council on Science and Health*", and the CDC clearly "*promoting a flu-prevention policy that doesn't prevent the spread of flu*"?

"Influenza is highly contagious; each year it infects about 20 percent of Americans [http://www.cdc.gov/flu/about/disease/us_flu-related_deaths.htm], leading to 200,000 hospitalizations and 5,000 to 50,000 deaths.

And some of those deaths are preventable — people who caught the flu while hospitalized for something else. Hospital patients are among the most vulnerable to the severe (even lethal) complications of influenza."

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12 From 2009 Package Insert for MedImmune's FluMist (emphasis added),

"14.5 Transmission Study

FluMist contains live attenuated influenza viruses that must infect and replicate in cells lining the nasopharynx of the recipient to induce immunity. Vaccine viruses capable of infection and replication can be cultured from nasal secretions obtained from vaccine recipients. The relationship of viral replication in a vaccine recipient and transmission of vaccine viruses to other individuals has not been established.

Using the frozen formulation, a prospective, randomized, double-blind, placebo-controlled trial was performed in a daycare setting in children <3 years of age to assess the transmission of vaccine viruses from a vaccinated individual to a non-vaccinated individual. A total of 197 children 8-36 months of age were randomized to receive one dose of FluMist (n=98) or placebo (n=99). Virus shedding was evaluated for 21 days by culture of nasal swab specimens. Wild-type A (H3N2) influenza virus was documented to have circulated in the community and in the study population during the trial, whereas Type A (H1N1) and Type B strains did not.

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

Assuming a single transmission event (isolation of the Type B vaccine strain), the probability of a young child acquiring vaccine virus following close contact with a single FluMist vaccinee in this daycare setting was 0.58% (95% CI: 0, 1.7) based on the Reed-Frost model. With documented transmission of one Type B in one placebo subject and possible transmission of Type A viruses in four placebo subjects, the probability of acquiring a transmitted vaccine virus was estimated to be 2.4% (95% CI: 0.13, 4.6), using the Reed-Frost model.

The duration of FluMist vaccine virus replication and shedding have not been established."

Factual distortions about annual influenza cases in the USA

Here, Dr. King finds that Dr. Ross' assertions are more propaganda than fact.

First, while the influenza is a contagious disease, because no valid secondary "sick to well" attack rate has been established, influenza does not appear to be "*highly contagious*" in the normal manner in which viral diseases such as measles are contagious.

In addition, the source of the contagion may well be from a few "highly infectious – but generally symptomless – latent carriers, briefly called into contagiousness by the 'seasonal stimulus'"[13] and not those who are overtly sick with the "flu", any ILI.

Moreover, *at least with respect to influenza A*, it is important to ensure that a person's circulating blood vitamin D level (measured as one's 25-hydroxy vitamin D blood level) is adequate[14].

Furthermore, the target level for 25-hydroxy vitamin D in human blood is between 55 and 80 ng/mL even though the upper limit on the normal range is 100 ng/mL and having a level of up to 200 ng/mL for extended periods has not been found to be toxic.

Based on several studies[15], it appears that vitamin D-3 supplementation is more effective in preventing influenza A infections than vaccination and, *when the person's vitamin D levels are optimal*,

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13 Cannell JJ, Zaslov M, Garland CF, Scragg R, Giovannucci E. On the Epidemiology of Influenza. *Virology* 2008 Feb 25; 5: 29 (12pgs). [Open Access]. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2279112/ and http://www.virologyj.com/content/5/1/29. While this review of the epidemiology of influenza confirms that influenza is a "contagious" disease, the failure of any study to establish a scientifically sound "secondary attack" rate precludes influenza from being a highly contagious disease, like measles, where the secondary attack rate has been found to be about 70%. Tellingly, the cited article also states (emphasis added),

> "Subjects that sicken do so two to four days after being iatrogenically infected; that is, the incubation period is about three days. *However, it is crucial to remember that the incubation period only tells us what the serial interval should be, not what it is. Furthermore, induction of human infection in the laboratory only tells us such infection is possible; it does not tell us who is infecting the well in nature*.
>
> The obvious candidate is the sick. However, Edgar Hope-Simpson contended that the extant literature on serial interval, secondary attack rates, and other epidemiological aspects of influenza are not compatible with sick-to-well transmission as the usual mode of contagion. In his 1992 book, after considering all known epidemiological factors, he presented a comprehensive, parsimonious – and radically different – model for the transmission of influenza, one heavily dependent on a profound, even controlling, effect of solar radiation. Furthermore, while agreeing the sick could infect the well, Hope-Simpson's principal hypothesis was that epidemic influenza often propagates itself by a series of transmissions from a small number of highly infectious – but generally symptomless – latent carriers, briefly called into contagiousness by the 'seasonal stimulus'".

14 Generally, a level that is greater than 50 ng/mL is considered adequately protective for preventing someone from contracting influenza.

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a. Li-Ng M, Aloia JF, Pollack S, et al. A randomized controlled trial of vitamin D3 supplementation for the prevention of symptomatic upper respiratory tract infections. *Epidemiol Infect* 2009; 137: 1396–1404.

b. Ginde AA, Mansbach JM, Camargo CA Jr. Association between serum 25-hydroxyvitamin D level and upper respiratory tract infection in the Third National Health and Nutrition Examination Survey. *Arch Intern Med* 2009; 169: 384–390.

c. Yamshchikov AV, Desai NS, Blumberg HM, Ziegler TR, Tangpricha V. Vitamin D for treatment and prevention of infectious diseases: a systematic review of randomized controlled trials. *Endocr Pract* 2009; 15: 438–449.

d. Urashima M, Segawa T, Okazaki M, Kurihara M, Wada Y, Ida H. Randomized trial of vitamin D supplementation to prevent seasonal influenza A in schoolchildren *Am J Clin Nutr* 2010; 91:1255–1260.

e. Bergman P, Lindh ÅU, Björkhem-Bergman L, Lindh JD. Vitamin D and Respiratory Tract Infections: A Systematic Review and Meta-Analysis of Randomized Controlled Trials. *PLoS ONE* 2012 Jun 19; 8(6): e65835.. DOI: 10.1371/journal.pone.0065835. Article available at: http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0065835.

probably at least as effective as vaccination in preventing influenza B infections.

Turning to the claimed, "*each year it infects about 20 percent of Americans, leading to 200,000 hospitalizations and 5,000 to 50,000 deaths*", these are claims that are apparently not supported by fact.

Based on "Table 1" in a 2006 retrospective study spanning the period from 1979 through 2000[16], the data for 1990 through 2000 indicated that 13,000 to 44,000 were hospitalized for influenza for the years where data was available during that period with an average of 25, 667 hospitalizations for influenza (roughly 12.8-plus percent of the CDC's "*200,000*" claim).

Furthermore, for the years where data were available, 604 to 3,006 influenza-related deaths were reported making the CDC's estimates 21.5-plus times higher at the low end and 14.6-plus times higher at the upper end of its estimated range.

Thus, *on average*, the CDC's estimates for hospitalizations should be divided eight (8).

Moreover, *if more accurate average estimates are sought*, the CDC's influenza-related death estimates should probably be divided by 12.4.

Based on what has been found and what is being claimed, the CDC's stated "*hospitalizations*" are, on average, being inflated by more than 8-fold of the average annual number and the CDC's influenza-related "*deaths*" are being inflated by 8.3- to 16.6-fold.

Therefore, it appears that the CDC, *whose estimates are based on an adjustable mathematical model*, is inflating the numbers of hospitalizations and deaths that are related to "influenza" in order to stoke the public's fear of their risk for getting the "flu".

Thus, the CDC is using the fear mongering effects of its inflated numbers to promote influenza vaccination when increased vitamin D-3 supplementation is probably a more effective disease-prevention strategy.

Moreover, vitamin D-3 supplementation is a less costly intervention and one that, *unlike vaccination*, does not increase the supplement takers risk of non-influenza viral respiratory infections.

Furthermore, in adults, greatly increased vitamin C supplementation using oral liposomal vitamin C at 5 to 25 grams per day and/or vitamin C at 10 grams to 50 grams per day for most non-life-threatening cases and, for life-threatening "flu"-related infections, adding intrave-

[16] Geier DA, King PG, Geier MR. Influenza Vaccine: Review of Effectiveness of the U.S. Immunization Program and Policy Considerations. *J Am Phys Surg* 2006Fall; 1(3): 69-74.

nous vitamin C at initial levels of 50 to 100 grams per day is probably much more effective in curing influenza infections with minimal risk of follow-on bacterial infections.

Turning to Dr. Ross' final statements,

> "*And some of those deaths are preventable — people who caught the flu while hospitalized for something else. Hospital patients are among the most vulnerable to the severe (even lethal) complications of influenza*",

Dr. King notes that the increased risk of death in hospitals comes from the increased risk of infection by the antibiotic-resistant bacteria that proliferate in most hospitals after the patient's contraction of an ILI has weakened the body's immune system by depleting the body's vitamin D, vitamin C, zinc and magnesium stores.

Were these ILI-induced depletions to be assessed and adequate replacement levels provided, then, *provided these were given initially*, the need for giving antibiotics when bacterial infections subsequently developed would be virtually eliminated and the risk of death should be reduced by at least an order of magnitude, if not more.

Unfortunately, the orthomolecular medical approach to "flu" (ILI) treatment and cure is generally rejected by most of allopathic medicine.

This is apparently the case because adopting that approach would be less lucrative for the healthcare providers and facilities.

Furthermore, it would significantly reduce the revenues of the pharmaceutical industry.

Finally, this approach would further expose the falsity of the current influenza vaccination program with respect to what is claimed that influenza vaccine inoculation provides as compared to the facts about what influenza vaccine inoculation actually provides the inoculees.

"Widespread immunization campaigns can reduce this frightful toll. Seasonal flu vaccines can reduce morbidity by 60 to 90 percent; they're easily the most effective method to prevent transmission of the virus."

False claims: The "benefits" of annual influenza vaccination?

Since, as Dr. King has established, widespread influenza vaccination campaigns have been shown to increase "flu" (ILI) morbidity (illness).

They have not reduced "flu" "*morbidity by 60 to 90 percent*".

Moreover, Dr. Ross tellingly makes no claim that the current influenza vaccination campaigns can reduce what is crucial, influenza-related mortality (death).

Furthermore, in the 2006 study (see footnote "**16**"), there was no significant correlation between the level of influenza vaccination and "flu"-related "cases", "hospitalizations" or "deaths"

Those non-correlations occurred even though, during the period studied, the number of doses of influenza vaccine distributed generally increased from 12-plus million in 1980 to 65-plus million in 2000.

Moreover, even though the population of those over 65 years of age, the principal population segment targeted for influenza vaccination at the start of this period, only increased from 25,550,000 in 1980 [where more than 45% of those over 65 were vaccinated] to about 34,992,000 in 2000 [where more than 90% of those over 65 were vaccinated and other population segments, including pregnant women starting in 1997, were being vaccinated].

Thus, the administration of the ever increasing number of influenza vaccination doses, estimated to be between 140 and 150-plus million for the upcoming "flu season", has *definitely* benefited

- The vaccine makers;
- Those who administer the vaccines;
- The health-care providers who treat the post-vaccination-related adverse effects and the vaccine-induced chronic diseases,
- The health-insurance providers who profit from selling more "health" insurance, and
- The federal government who collects a $ 0.75 tax for every dose "given".

However, as the number of influenza-vaccine doses administered has increased, the recipients have paid, *directly or indirectly*, the ever-increasing costs of the vaccine doses; the ever-rising levels of post-vaccination adverse events, including permanent disability and death; and the increasing levels of chronic medical conditions associated with those increased doses of influenza vaccine.

Dr. King wonders how much longer will an obviously failed influenza vaccination program continue before the residents of the USA wake up and demand that this failed program be stopped.

Hopefully, they will also stridently demand that all the involved responsible individuals and corporations who have been and are abetting and promoting any aspect of this disease-causing influenza-vaccine inoculation program must be criminally prosecuted to the full

extent of the law under the federal RICO (Racketeer Influenced and Corrupt Organizations) Act of 1970, as amended.

"The Infectious Disease Society of America, The Society for Healthcare Epidemiology of America, The American Academy of Pediatrics and other major medical groups all endorse mandatory vaccination of health-care personnel."

To the extent that Dr. Ross' statement here is true for influenza vaccination, all of these groups should obviously be included in any criminal RICO prosecution.

"After all, it does three key things:

- Prevents the virus from spreading to patients, including those with weakened immune systems.
- Promotes "herd immunity," [http://www.vaccines.gov/basics/protection/] making it less likely that the virus can spread to those who can't be vaccinated or for whom the vaccine doesn't "take."
- Ensures that the health-care workforce remains functional even in the event of a massive flu outbreak."

False claims about the current influenza vaccination program

Presuming that Dr. Ross is speaking of the influenza vaccination program, Dr. King observes that, contrary to the assertions made in those statements, the current influenza vaccine inoculation programs do not meet any of the three claims made.

First, as Dr. King has established and the manufacturers' package inserts support, the influenza vaccines do not prevent: **a)** influenza infection or **b)** the spread of influenza infection *per se*.

All the vaccine makers *only* claim that inoculation with any of their influenza vaccines does is to provide some levels of antibody titers that are purported to provide some level of very short-term disease protection (not prevention) to some percentage of those appropriately inoculated with them from subsequently contracting, or in the case of the live-virus influenza vaccine, being re-infected by, only a few strains of the influenza A and influenza B viruses.

Second, as Dr. King has established, no vaccine has been proven to provide "*herd immunity*" (see footnote "**4**") because to do so, that vaccine would generally have to provide lifetime disease-protection from disease infection or, *in the case of the live-virus vaccines*, re-infection.

Moreover, because they do not even provide durable (long-term) protection from "flu" to most of those who are inoculated with them,

the influenza vaccines are particular deficient in their ability to provide "*herd immunity*".

Third, as Dr. King has established, because:

- Inactivated-influenza vaccine inoculation causes more "flu" (ILI) cases than it prevents cases of influenza;
- Live-virus influenza vaccine inoculation infects most who are inoculated with them and, *through the inoculees' shedding*, can infect the recent inoculees' contacts for up to 28 days
- Influenza vaccination causes a significant level of serious post-inoculation adverse events, including temporary and permanent disability and death in some of those who are given either type of influenza vaccines; and
- The annual injection of influenza vaccines that contain the same or similar antigens significantly increases the risk of debilitating autoimmune-induced chronic disease[17] in the vaccinees,

influenza vaccination obviously cannot ensure that "*the health-care workforce remains functional even in the event of a massive flu outbreak*"[18].

"In short, this is a core safety practice for public health. It's obscene that HHC refuses to mandate annual flu vaccination as a condition of initial and continued employment and/or professional privileges. (The only permitted exemptions should be for documented medical conditions.)"

More obscenity: Recommending disease-causing influenza vaccination

Here, Dr. Ross is cravenly advocating that a proven disease-causing, serious-harm-inducing, chronic-disease-promoting medical practice, annual influenza vaccination, should be considered a "*core safety practice for public health*".

Thus, given the preceding realities, what is "*obscene*" is that any employer or agency in the USA would mandate, or consider mandating, "*annual flu vaccination as a condition of initial and continued employment and/or professional privileges*"

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[17] Tsumiyama K, Miyazaki Y, Shiozawa S. Self-Organized Criticality Theory of Autoimmunity. *PLoS ONE* 2012 Dec 31; 4(12): e8382 (9 pages).

[18] Since: **a)** a "*massive flu outbreak*" can be caused by an influenza strain that is not covered by the available influenza vaccine or by some virulent non-influenza viral respiratory pathogen, and **b)** less than 18% of the cases of "flu" that occur annually are vaccine-strain-covered influenza cases, clearly the current influenza vaccines are not likely to stem any "*massive flu outbreak*" and may actually exacerbate the cases of "flu" when they are being caused by a non-influenza viral respiratory pathogen.

Furthermore, Ross' parenthetical comment "*(The only permitted exemptions should be for documented medical conditions.)*" clearly indicates that he has no regard for each individual's inalienable and constitutionally affirmed rights to "bodily integrity" and "informed consent".

Moreover, Ross appears to have no concern about a failed inactivated-influenza-vaccine-inoculation program that clearly causes more disease (ILI cases) in, and harm to, the coerced inoculees ("*the healthcare workforce*") than it prevents cases of influenza infection by the three(3) or four (4) strains of influenza viruses in a given vaccine.

"Yet the unions for nurses and other hospital workers resist, citing reasons from 'freedom of choice' to religious objections to fear of side-effects."

The cogent protected rights of individuals in today's USA & recognized serious post-influenza-vaccination adverse reactions

Here Dr. King simply notes that:

- The inalienable rights including the rights to life, liberty and happiness that are recognized as being given by the Creator to all mankind and the Constitution of the United States of America, as amended, which guarantees "freedom of choice" when it comes to any prophylactic medical practice, including vaccination, offered to "healthy individuals" to supposedly prevent some possible future illness that, if exposed, they may or may not contract.
- In addition, when it comes to religion, the First Amendment of the Constitution of the United States of America (emphasis added),

  > "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances",

  which the U.S. Supreme Court has established as personal right, subject to the individual rights retained by the residents in each State, is an individual right for each person to exercise his or her religion as he or she sees fit and,
- Furthermore, Title VII of the Civil Rights Act of 1963 clearly provides that the employers must make accommodation for the sincerely held "religious" beliefs of the employee absent a compelling employer safety or religious, not monetary or

other, interest that precludes accommodating an employee's beliefs.

Moreover, the serious adverse reactions to influenza vaccination are well known and include disability, permanent disability and death, effects that are much more than merely a "*fear of side-effects*",

Furthermore, these serious adverse effects collectively occur more often than very rarely.

For example, Dr. King was able to derive the data shown **Table 1** from various CDC and FDA sources, including the Vaccine Adverse Events Reporting System (VAERS) database, which is publically searchable.

The information that Dr. King located indicated that the death rate from influenza vaccination of workers in the population of the USA appears to be somewhere between 1 and 53 worker-age deaths per million doses with the most probable estimate of post-influenza-vaccination-associated deaths being between 27 and 53 deaths per million doses given to that population.

Table 1 Death reports, influenza vaccine data and derived data for those ≥ 18 -Years Olds

Year [2004 –2013]	Death Reports for Those ≥ 18-Years Old In VAERS			Difference [ALL – Influenza-Vaccine-Related]	Million Doses of 'Flu' Vaccine Distributed [1,2,3,4]	≈ 'Flu' Death Reports/ $10^{\wedge 6}$ doses distributed[5,6]	At presumed 1% reporting rate, Estimated Death Incidence/$10^{\wedge 6}$ doses distributed[5,6]	At a presumed 10% to 1% reporting rate, Estimated Death Incidence/$10^{\wedge 6}$ people inoculated[6]
	ALL	'Flu' Vaccine	'Flu' % of All					
2004	32	27	77.1	5	≈ 60-66 (recall)	**0.5_6–0.5_1**	**≈ 53**	**≈ 5** – ≈ 53
2005	17	**10**	**58.8**	7	≈ 86.0	**0.14**	**14**	**1** – 14
2006	34	**19**	**55.9**	15	> 100.0	**0.23**	**≤ 23**	2 – ≤ 23
2007	45	**23**	**51.1**	22	≈ 113.0	**0.25**	**25**	3 – 25
2008	32	**12**	**37.5**	20	≈ 113.0	**0.13**	**13**	1 – 13
2009	*..76*	***67***	***88.2***	*9*	≈ 114 (seasonal) ≈ 125 (pamdemic)	**0.35**	**35**	3 – 35
2010	45	**30**	**66.7**	15	≈ 163.0	**0.23**	**23**	2 – 23
2011	36	**23**	**63.9**	13	≈ 134.9	**0.21**	**21**	2 – 21
2012	30	**19**	**63.3**	11	≈ 141.5	**0.17**	**17**	2 – 17
2013	29	**20**	**68.5**	9	≈ 134.5	**0.18**	**18**	2 – 18
					Average [SD]	**0.2425 [0.1206]**	**24.20** [11.92]	

1 Data for 1990-1991 through 2000-2001 flu seasons were from a CDC report http://wonder.cdc.gov/wonder/help/vaers/ss5201.pdf

2 Data for 2001-2002 through 2009-2010 flu seasons were from the CDC "Vaccine Supply" sections in the ACIP"s recommendations for the next influenza season as found in the CDC's ***Morbidity and Mortality Weekly Report*** (***MMWR***).

3 Data for 2010-2011 through 2013-2014 flu seasons were from CDC reports of doses distributed. [See, http://www.cdc.gov/flu/professionals/vaccination/vaccinesupply.htm]

4 Data for 2009-2010 pandemic influenza vaccine was from wwwnc.**cdc**.gov/eid/article/19/3/12-0394.htm.

5. Presumes all doses distributed in the year in question although, typically, about 3% are distributed at the beginning of the following year.

6 Presumes that, on average, only 90% of distributed doses were used and about 90% of those doses were given to those of working age (or 81% overall).

Similar estimates for permanent disability (as shown in **Table 2** on the next page) indicate that the incidence of permanent disability to workers from influenza vaccination appears to be somewhere between 3 and 63 instances per million doses of influenza vaccines administered, with the more probable incidence being somewhere

between 15 and 63 permanent disability instances per million health-care workers inoculated with an influenza vaccine.

Clearly, for influenza vaccines that cause and spread the "flu" and that do not protect the vaccinees from contracting the "flu" (any ILI), such risks are not acceptable.

Moreover, for Guillian Barré Syndrome (GBS), Dr. King has previously determined (see the paper cited in footnote "**6**", circa pages "*17*"-"*19*") that the probable overall population GBS risk for all influenza vaccinees is on the order of 4 to 200-plus GBS cases per million doses of vaccine administered (2 to 100-plus times the CDC's claimed 1 to 2 cases per million doses).

In addition, based on the industries reporting that about 1 in 50 (2%) of all serious adverse events following vaccination are submitted to VAERS and the estimate of the U.S. Food and Drug Administration (FDA) that no more than 1% of all serious adverse drug reactions are reported[19,20], the probable range for post-vaccination adverse GBS reactions appears to fall roughly between 18 GBS cases and 200 GBS cases per million doses of influenza vaccine dispensed where the level of the GBS cases seems to depend upon the nature of the specific vaccine formulations being marketed in a given year.

However, in no case are levels of influenza-vaccination-associated GBS cases near or below the level of 1 to 2 GBS cases per million (1,000,000) influenza inoculations reported by the CDC.

Moreover, these levels of GBS are unacceptable because the current studies have shown that influenza vaccines cause the "flu" at levels more than twice the levels of protection from the influenza-strain viruses in the inactivated-influenza vaccines (see page "*7*" of this response).

Furthermore, when the live-virus influenza vaccine is used, it infects almost all of those who are inoculated with it with live influenza viruses which can be shed and infect others for more than 21 days after the most recent inoculation with that vaccine as well as, *if*

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19 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.

20 http://www.cdc.gov/vaccines/pubs/surv-manual/chpt21-surv-adverse-events.html, last updated "April 1, 2014". Web page last accessed on 24 August 2014. This CDC document shows < 10 % reporting for serious rare events that should be reported to VAERS – tellingly, permanent disability and death were not studied.

"Table 3. Reporting efficiency To VAERS for various adverse events ..."

Event*	Reporting efficiency %
...	...
MMR and thrombocytopenia	4%
DTP and hypotonic hyporesponsive episodes	3%
MMR and rash	<1%

susceptible, those who are administering the live-virus vaccine to others.

Thus, the informed health-care workforce is more than justified in rejecting these disease-causing influenza vaccines.

Table 2 Perm. Disability reports, influenza vaccine data & derived data for≥ 18 -Years Olds

Year [2004 –2013]	Disability Reports for Those ≥ 18-Years Old In VAERS			Difference [ALL – Influenza-Vaccine-Related]	Million Doses of 'Flu' Vaccine Distributed [1,2,3,4]	≈ Perm. Disability (PDis.) Reports/ $10^{\wedge 6}$ doses distributed[5,6]	At presumed 1% reporting rate, Estimated P. Dis. Incidence/$10^{\wedge 6}$ doses distributed[5,6]	At a presumed 10% to 1% reporting rate, Estimated P. Dis. Incidence/$10^{\wedge 6}$ people inoculated[6]
	ALL	'Flu' Vaccine	'Flu' % of All					
2004	49	16	35.3	33	≈ 60-66 (recall)	**0.3_3–0.3_0**	**≈ 32**	**≈3 – ≈32**
2005	58	**22**	**37.9**	36	≈ 86.0	**0.32**	**32**	**3** – 32
2006	103	**26**	**25.2**	77	> 100.0	**0.32**	**≤ 32**	3 – ≤ 32
2007	204	**58**	**28.4**	146	≈ 113.0	**0.63**	**63**	6 – 63
2008	150	**44**	**29.3**	106	≈ 113.0	**0.48**	**48**	5 – 48
2009	*188*	***105***	***55.9***	*83*	≈ 114 (seasonal) ≈ 125 (pamdemic)	**0.54**	**54**	5 – 54
2010	124	**61**	**49.2**	63	≈ 163.0	**0.46**	**46**	5 – 46
2011	133	**69**	**51.9**	64	≈ 134.9	**0.63**	**63**	6 – 63
2012	120	**66**	**55.0**	54	≈ 141.5	**0.58**	**58**	6 – 58
2013	73	**49**	**67.1**	24	≈ 134.5	**0.45**	**45**	4 – 45
					Average [SD]	**0.47$_{25}$ [0.12$_{37}$]**	**47.$_{30}$** [12.30]	

[1] Data for 1990-1991 through 2000-2001 flu seasons were from a CDC report http://wonder.cdc.gov/wonder/help/vaers/ss5201.pdf

[2] Data for 2001-2002 through 2009-2010 flu seasons were from the CDC "Vaccine Supply" sections in the ACIP"s recommendations for the next influenza season as found in the CDC's ***Morbidity and Mortatlity Weekly Report*** (***MMWR***).

[3] Data for 2010-2011 through 2013-2014 flu seasons were from CDC reports of doses distributed. [See, http://www.cdc.gov/flu/professionals/vaccination/vaccinesupply.htm]

[4] Data for 2009-2010 pandemic influenza vaccine was from wwwnc.**cdc**.gov/eid/article/19/3/12-0394.htm.

[5.] Presumes all doses distributed in the year in question although, typically, about 3% are distributed at the beginning of the following year.

[6] Presumes that, on average, only 90% of distributed doses were used and only about 90% of those doses were given to those of working age (or 81% overall).

"Sorry:

- No religion gives you the right to put the sick at added risk of disease.
- Freedom of choice means the freedom to find other work if you won't be vaccinated to protect yourself and others — not the freedom to threaten others' health.
- If you can't see that the benefits of vaccination outweigh the tiny risk of side-effects, you don't belong working in a hospital."

Willful ignorance of our constitutional and legal freedoms and of the fact that the influenza vaccination program is a failed disease-causing, inoculee-health-damaging program

Here, Dr. Ross again attempts to ignore the inalienable rights and religious freedoms guaranteed to Americans by the Constitution and, in employment, by Title VII of the Civil Rights Act of 1963.

In addition, as Dr. King has established, influenza vaccination clearly provides net negative benefits to: **a)** the inoculees; **b)** those with whom they interact (patient, co-worker, family member or friend); and **c)** maintaining a healthy workforce.

As the studies by Cowling et al. (footnote "**9**") and Kelly et al. (footnote "**10**") have established being inoculated with an inactivated-influenza vaccine can cause the inoculees to contract the "flu" (any ILI).

Similarly, being inoculated with a live-virus influenza vaccine infects the hospital employees with live influenza viruses which, *unless quarantined from work (on paid medical leave) for not less than 28 days*, may be shed and infect any other person with whom they have contact including patients.

Given all of the preceding facts, not only should be there be no mandates for influenza vaccination but also the current influenza vaccination programs clearly should be scrapped and replaced by appropriate dietary supplementation, which has been shown to be effective in preventing or minimizing the risk of contracting influenza.

"Union opposition is potent."

While in States where there are strong unions or associations of workers, their opposition is not only "*potent*" but, *in this instance*, is also science-supported.

"It took vaccine expert (and ACSH trustee) Dr. Paul Offit and his team a full six years to finally implement the Children's Hospital of Philadelphia's 'Get vaccinated or get out' policy, ultimately firing only nine out of 9,300 CHOP employees.

But it can be done, and must be done.

Physicians and other health-care providers are bound by three key ethical duties: 'To do good or to do no harm,' 'To put patient interests first' and 'To protect the vulnerable.'

To avoid or ignore these clear duties is unprofessional and worse, is detrimental to public health."

Physicians and health-care providers: Heal yourselves

Here, Dr. King notes that:

IF physicians and other health-care providers are truly bound by "*three key ethical duties*" as Dr. Ross describes them, "*To do good or to do no harm*", "*To put patient interests first*" and "*To protect the vulnerable*",

THEN, those physicians and other health-care providers need to unite and demand that "*vaccine expert (and ACSH trustee) Dr. Paul Offit and his team*"

who have supported a coercive ***disease-causing*** influenza vaccination program should, at a minimum, be dismissed immediately from "*Children's Hospital of Philadelphia*" (or CHOP) with prejudice for violating all three (3) of these key ethical duties and its disease-causing "*Get vaccinated or get out*" influenza-vaccination policy.

In addition, if it has one, CHOP should immediately stop its patient-damaging policy of vaccinating all patients for influenza on intake before surgery.

This is the case because that policy has apparently increased the surgical patients' risks of pre- and post-surgical complications and death since it has been adopted in some hospitals.

Moreover, *if this were the case*, this policy would seem to be knowing medical malpractice given the published studies that clearly indicate that inactivated-influenza vaccination is not only a disease-causing practice but also one that carries with it a known risk of cardiovascular inflammation (vasculitis).

When given pre-operatively or post-operatively to surgical patients, especially those who are undergoing cardiovascular surgical procedures, influenza vaccination can obviously have serious negative health consequences for such patients.

"Yes, a mandatory-vaccination is coercive. So what? Voluntary approaches don't work, and protecting the public health justifies such coercion.

Every hospital should tell its workers: 'You may choose not to be vaccinated — or to work in this hospital with sick patients. Not both.'"

Were the current influenza vaccination programs, on balance, disease protective, Dr. Ross might have some basis for his argument in some nation where bodily integrity and the right of informed consent are <u>not</u> guaranteed by that nation's constitution.

However, since:

- The current influenza vaccination program has clearly been shown to be disease-causing program and <u>not</u> a disease-preventive program,
- The influenza vaccines have been shown to provide little or <u>no</u> protection against the "flu", and
- We live in a nation where the rights to bodily integrity and informed consent are constitutionally recognized personal rights,

there is <u>no</u> longer any "public health" justification for maintaining the current influenza vaccination program.

IF:

- Dr. Ross truly believes that the "*three key ethical duties*" are, "*To do good or to do no harm*", "*To put patient interests first*" and "*To protect the vulnerable*",

THEN:

- *After reading the referenced studies that Dr. King has cited and verifying the facts they reveal*, Dr. Ross will be at the forefront of the efforts to stop all of the current disease-causing influenza vaccination programs.

OTHERWISE:

- Dr. Ross will remain just another vaccine apologist who apparently makes his living by, *among other things*, touting vaccination programs, *like the current influenza vaccination program*, which clearly do more harm than good.

Summary of Dr. King's position on safe and effective vaccines and cost-effective vaccination programs

Dr. Paul G. King is a researcher into the issues surrounding the current vaccination programs in the USA and elsewhere as well as a strong proponent of:

- Those vaccines that are as safe as required by law and are truly effective in providing long-term disease protection to most of those inoculated with them without serious risks of harm, death or permanent disability at levels that are significantly higher than the corresponding levels of risk for those adverse outcomes when a person age-appropriately, or otherwise, naturally contracts a disease for which a vaccine he or she would have received is claimed to provide disease-protective levels of antibodies; and
- When suggested for universal use, those vaccination programs that are truly medically cost-effective when all of the costs are properly considered including: **a)** the harm from adverse reactions; **b)** the development of chronic diseases, and **c)** the loss of those additional disease protections that are provided by age-appropriately contracting a contagious vaccine-covered childhood disease, naturally neutralizing that infection, and returning to pre-infection health with the lifetime or long-term (> 30 year) natural disease "immunity" from re-infection.

Acknowledgments

For contributing valuable insights and providing their personal experience-based knowledge in various areas, Dr. King thanks Tetyana Obukhanych, PhD; 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 Gary S. Goldman, Eileen Dannemann, and Jennifer S. K. Toland for their support, suggestions, corrections and alternate wordings that helped him to finalize this response.

About Dr. Gilbert Ross, Author of the Article Being Reviewed

Source: This article

"Dr. Gilbert Ross is the medical and executive director of The American Council on Science and Health."

Source: http://www.motherjones.com/politics/2005/11/paging-dr-ross

"Paging Dr. Ross

A doctor who defends corporations from "inconvenient" science has a secret of his own.

—By ***Bill Hogan*** | November 2005 Issue

When American corporations come up against inconvenient science, say, a study showing that mercury in fish can damage a developing fetus, or that a blockbuster drug has nasty side effects, they call in the American Council on Science and Health (ACSH). Industry-funded ACSH is the most aggressive debunker of pesky research reports emanating from government and academia. Its medical/executive director's calm, soothing voice can be heard on television and radio, quelling public fears about the latest bad news about health and the environment.

That man is Dr. Gilbert Ross. It was Ross who defended the Wood Preservative Science Council, saying that, contrary to reams of scientific evidence, the arsenic in pressure-treated wood poses "no risk to human health"; Ross who wrote on behalf of the farmed-salmon industry that the PCBs in fish "are not a cause of any health risk, including cancer"; and Ross whose organization once asserted that the jury's still out on whether environmental cigarette smoke really is hazardous to your health. Much of his time is spent tarnishing noncorporate-sponsored work as junk science of questionable motive.

But Ross may not be ACSH's most prudent choice to question the credibility of other doctors, scientists, and researchers. Although the biography posted on the organization's website doesn't mention it, Ross actually had to abandon medicine on July 24, 1995, when his license to practice as a physician in New York was revoked by the unanimous vote of a state administrative review board for professional misconduct.

Instead of tending to patients, Ross spent all of 1996 at a federal prison camp in Schuylkill, Pennsylvania, having being sentenced to 46 months in prison for his participation in a scheme that ultimately defrauded New York's Medicaid program of approximately $8 million. During a three-and-a-half-week jury trial, federal prosecutors laid bare Ross' participation in an enterprise, headed by one Mohammed Sohail Khan, to operate four sham medical clinics in New York City. For his scam to work, Khan needed doctors who could qualify as Medicaid providers, and Ross responded to an ad in the New York Times promising 'Very, very good $$.'

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After his release from prison, Ross answered another ad in the *New York Times*, this one for a "staff assistant" at ACSH. Ross told president Elizabeth Whelan that he'd been convicted of a crime, done time in prison, and no longer possessed a medical license. She hired him anyway, and in 1999 he was promoted to medical/executive director.

In 2000, while admitting his 'unethical and criminal activity,' which he said was motivated by 'greed,' Ross asked a state review panel to reinstate his medical license. The panel ruled against him. Ross finally got his license back in 2004, though he faces three years of probation should he ever choose to practice medicine again. Last year, in filling out a form for *nydoctorprofile.com*, an official state website, Ross faced a field titled 'Criminal Convictions.' He left it blank."

Source: http://acsh.org/about-acsh/meet-the-team/gilbert-ross-m-d/

"Gilbert Ross, M.D.
Medical/Executive Director

Dr. Gilbert Ross is the Executive Director and Medical Director of the American Council on Science and Health (ACSH), a consumer education-public health organization. He received his undergraduate degree in Chemistry from Cornell University's School of Arts and Sciences in 1968, and received his M.D. from the N.Y.U. School of Medicine in 1972.

He did his postgraduate training in Internal Medicine at the Bronx Municipal Hospital Center and N.Y.U.-Bellevue Hospitals in New York, and completed a fellowship in Rheumatology at Montefiore Hospital in the Bronx, N.Y. He is a Diplomate of the American Board of Internal Medicine, board-certified in both Internal Medicine and Rheumatology.

He practiced medicine on Long Island from 1977 through 1996. He was a member of the faculty of Cornell University Medical School, Stony Brook Medical School, and the Albert Einstein College of Medicine. He was a member of the attending staff at North Shore University Hospital and Long Island Jewish Hospital, as well as the New York Hospital Medical Center of Queens.

He became the Coordinator of Medical Projects for the American Council on Science and Health in February 1998, and subsequently became the organization's Medical Director, then Executive Director in 1999. In this capacity, he is in charge of all scientific projects and publications, as well as personnel issues involving the scientific staff.

He has authored many letters to editors of various publications, including the New York Times, the Wall Street Journal, Business Week, AMA News, and various news services. He has authored letters published in The Lancet and the New England Journal of Medicine. He is co-author of studies published in the Journal of Rheumatology, the Journal of Health Communication, Oncology Times and Clinical Therapeutics. He has appeared on many TV and radio shows, including segments on the Good Morning America, the Fox News show, "The Seven Deadly Threats" (bioterrorism), and Aaron Brown (CNN). He has had published op-eds in the Wall Street Journal (on the FDA), and in the Los Angeles Times (on smoking), USA Today, and the San Francisco Chronicle, as well as National Review Online (on drug importation). His editorial on medical errors appeared in Oncology Times.

As medical director of ACSH, he has written, co-written, or edited approximately one-hundred publications over the past several years, covering a spectrum of public-health topics too varied to describe here.

Dr. Ross is married and resides in New York City. He has three children."

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About Paul G. King, PhD, Author of this Review

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

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[21].

Moreover, Dr. King was also one of the authors of a paper in *Int. J. Environ. Res. Public Health*, where the lead author was Janet K. Kern, PhD.

That peer-reviewed paper reviewed Thimerosal exposure and the roles of sulfation chemistry and thiol availability in autism[22].

Also, Dr. King was one of the authors in a review chapter, "Mercury Induced Autism"[23] (pages 1411-1432), in Comprehensive Guide to Autism Editors: Vinood B. Patel, Victor R. Preedy and Colin R. Martin. Springer New York (2014), where the lead author was Mark R. Geier, MD, PhD.

Additionally, 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. That open-access paper contributed more evidence to the actuality of a causal relationship between the level of Thimerosal-preserved vaccine exposure and the subsequent risk of the inoculated children's receiving a diagnosis of "autism" in the USA[24].

Moreover, Dr. King is one of the authors of a paper titled, "Methodological Issues and Evidence of Malfeasance in Research Purporting to Show Thimerosal in Vaccines Is Safe"[25], where Dr. Brian Hooker was the lead author. That open-access paper established that the six (6) key epidemiological studies, which the CDC uses to support its assertion that Thimerosal-containing vaccines are safe to give to pregnant women and developing children, have significant methodological issues and evidence of intentional malfeasance that renders them scientifically unreliable.

Furthermore, Dr. King is the co-author of a paper with Dr. Gary S. Goldman that is titled, "Vaccination to prevent varicella: Goldman and King's response to Myers' interpretation of Varicella Active

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21 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".]

22 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

23 See, http://www.researchgate.net/publication/258009647_Mercury_Induced_Autism/file/60b7d526955a643330.pdf for the chapter.

24 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). [http://www.biomedcentral.com/content/pdf/2047-9158-2-25.pdf.] In the first month after publication, it was accessed more than 10,500 times.

25 Hooker B, Kern J, Geier D, Haley B, Sykes L, King P, Geier M. Methodological Issues and Evidence of Malfeasance in Research Purporting to Show Thimerosal in Vaccines Is Safe. *Biomed Res Int*. 2014; 2014: 247218 (8 pages). http://www.hindawi.com/journals/bmri/2014/247218/.

Surveillance Project data"[26], which, as the abstract's "Summary" states, clearly established that "[w]hen the costs of the booster dose for varicella and the increased shingles recurrences are included, the universal varicella vaccination program is neither effective nor cost-effective" in the USA.

Finally, Dr. King is one of the authors of an in-press paper titled, "Thimerosal as discrimination: vaccine disparity in the UN Minamata Convention on mercury"[27], where Lisa K. Sykes was the lead author. That article addresses the discriminatory nature of the now internationally condoned disparity between the early childhood vaccination programs in the developed countries, where the use of Thimerosal-preserved vaccines has mostly been abandoned, and the developing countries, where several of the early childhood vaccines remain Thimerosal-preserved vaccines. Underscoring this dichotomy, the article's "Abstract" closes with,

> "Ultimately, the Minamata Convention on Hg has sanctioned the inequitable distribution of thimerosal by specifically exempting TCVs from regulation, condoning a two-tier standard of vaccine safety: a predominantly no-thimerosal and reduced-thimerosal standard for developed nations and a predominantly thimerosal-containing one for developing nations. This disparity must now be evaluated urgently as a potential form of institutionalised discrimination."

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[26] 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* 2014 Aug; 33(8): 886-893. Abstract: http://het.sagepub.com/content/33/8/886.abstract.

[27] Sykes LK, Geier DA, King PG, Kern JK, Haley BE, Chaigneau CG, Megson MN, Love JM, Reeves RE, Geier MR. Thimerosal as discrimination: vaccine disparity in the UN Minamata Convention on mercury. *Indian J Med Ethics*. 2014 Apr 11. [Epub ahead of print.] The article's abstract is available at http://www.ncbi.nlm.nih.gov/pubmed/25101548.