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

Wednesday, 16 April 2014

On 21 March 2014, Paul G. King, PhD, downloaded an on-line March 20, 2014 article by "Robert Pearl, MD", "**A Doctor s Take On The Anti Vaccine Movement**", from http://www.forbes.com/sites/robertpearl/2014/03/20/a-doctors-take-on-the-anti-vaccine-movement/.

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

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This science-based response is titled, "**An In-depth Review of 'A Doctor's Take On The Anti-Vaccine Movement'**".

## Introductory Remarks

First, each portion of article's text is quoted in a grayed "Georgia" 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 in-depth review.

Respectfully,

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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.

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# An In-depth Review of "A Doctor's Take On The Anti-Vaccine Movement"

# An In-depth Review of "A Doctor's Take On The Anti-Vaccine Movement"

## Introduction

According to his ***Forbes*** biographical sketch, the writer of this article, "Robert Pearl, MD", is the "CEO of The Permanente Medical Group – the largest medical group in the nation – and CEO of the MidAtlantic Permanente Medical Group" and a "a board-certified plastic and reconstructive surgeon", who teaches "courses on strategy, leadership, and health care technology".

Based on Dr. Pearl's background, this reviewer, Paul G. King, PhD[1], observes that this article is being written by someone who is a vaccine/vaccination apologist, given his choosing a title that addresses a movement, "***The Anti-Vaccine Movement***",

- To which he does <u>not</u> belong;
- Which he apparently has either **a)** <u>not</u> studied or **b)** is knowingly misrepresenting; and
- About which Pearl is <u>nonetheless</u> presenting his "***Take***" (his personal impression or opinion).

From the writer's narrative, it is clear that, based on his "exalted" status in the healthcare establishment, Dr. Pearl sees <u>no</u> need to:

- Support his remarks with any cited peer-reviewed published studies or other supporting documentation;
- Provide the factual basis for his pronouncements; or
- Speak with any specificity about the issues that he raises.

## The Review

### Emotion-based Generalizations

"There is nothing more disheartening for a physician than watching a patient die from a preventable cause. And, of course, the loss for the family involved is unimaginable."

While this reviewer is inclined to agree with Dr. Pearl's opening unfocused emotion-based (*ad misericordiam*) musings, Dr. King notes that *most* patients who "*die from a preventable cause*" each year in the United States of America (USA) are the victims of: medical error, intentional medical neglect, or the recognized side effects of the treatments that they have been prescribed by the medical establishment.

[1] Dr. King is an analytical chemist with an MS in inorganic chemistry and more than a decade of intensive study and research into the safety, effectiveness and cost-effectiveness of the vaccines approved by the FDA and recommended by the CDC for population-wide use.

"But it's important, especially for parents, to understand the potential consequences of preventable, infectious diseases."

Here, Dr. Pearl begins by speaking of the "*potential consequences of …*" unspecified "*infectious diseases*", which he broadly claims, but offers no proof to support his claim, are "*preventable*".

Moreover, Dr. Pearl's background does not appear to be in infectious diseases and he does not appear to have spent any significant time in studying infectious diseases and/or their prevention and treatment.

Thus, Dr. Pearl's speaking in vague generalizations is consistent with his medical background, which does not appear to extend to recent patients of his, who have either infectious diseases or chronic medical conditions caused, or exacerbated, by the current increasingly-rigid prescriptive medical "standards of care", which he apparently favors.

## "Whooping Cough" Fear Mongering

"Here's a scenario doctors across the country are witnessing first-hand: A 2-year-old girl develops what seems like a cold. Over the next several days, her breathing rate increases. At times, she stops breathing altogether for several seconds, followed by severe coughing spells and terrifying whooping sounds as she struggles to get air into her lungs. In spite of the best medical care, she experiences an uncomfortable and tragic death."

Here, Dr. Pearl paints an upsetting scenario in which a hypothetical "*2-year-old-girl*" apparently dies from "whooping cough" based on the symptoms provided.

However, Dr. King does not accept that the scenario's unspecified "*medical care*" was even acceptable care, much less, the "*best medical care*" that is claimed.

This is the case because, *instead of giving the child antibiotics, expectorants, fever suppressors and the like*, as allopathic medicine recommends, the truly best medical care would have used both oral and intravenous vitamin C at high levels (to thin the mucous allowing the child to cough it up more easily and to help the immune system suppress the proliferating organism causing the symptoms observed) and adequate doses of vitamin D-3 to attain and maintain a 25-hydroxy vitamin D level in excess of 55 nanogram (ng)/milliliter (mL) in the child's blood [preferably, at the 90–100 ng/mL level] to allow the child's immune system to manufacture its own disease-organism-

specific polypeptide "antibiotics"[2] to suppress the spread of the proliferating organism(s) and assist her body in restoring its health.

Factually, before the "pertussis" vaccines and antibiotics, high-dose vitamin C therapy was successfully used to treat whooping cough cases[3] and, *in general*, instead of the "hundred days" to complete recovery seen in untreated children, the appropriately treated children tended to completely recover in *less than* three weeks.

"A century ago, this experience was common. Pertussis, commonly known as whooping cough, terrified parents and cost children around the world their lives."

Here, Dr. King agrees that, a "*century ago*", "*children around the world*" died from whooping cough, also known as the "100-days disease", before any bacterial organism was associated with the condition and "pertussis" after the organism *Bordetella pertussis* was identified as the apparent causative factor.

However, having talked about this subject with my parents and one of my maternal great uncles, parents were <u>not</u> terrified of whooping cough in the early 1900s and most children, *even without the best medical care available at that time*, survived and were nursed back to health with "home remedies" and a "croup" kettle.

## Next: Unspecified Vaccines Claimed to be Safe and Effective

"Today, there are safe and effective vaccines to prevent these types of diseases in the first place. Yet a growing number of parents choose not to vaccinate their children, resulting in long-term disability and unnecessary deaths."

Here, Dr. Pearl begins by making an unsubstantiated statement,

"*Today, there are safe and effective vaccines to prevent these types of diseases in the first place*",

which makes claims that Dr. King has established are problematic, at best, when it comes to any claim that a particular vaccine is a "*safe*"[4] and "*effective*" vaccine.

Moreover, vaccines are <u>only</u> claimed to provide disease protection and to be efficacious in producing protective levels of antibodies or other indicators of disease protection.

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[2] **a.** Bals R, Wang X, Zasloff M, Wilson JM. The peptide antibiotic LL-37/hCAP-18 is expressed in epithelia of the human lung where it has broad antimicrobial activity at the airway surface. *PNAS* 1998 Aug 4; 95(16): 9541-9546. [http://www.pnas.org/content/95/16/9541.full]

**b.** Gombart AF, Borregaard N, Koeffler HP. Human cathelicidin antimicrobial peptide (CAMP) gene is a direct target of the vitamin D receptor and is strongly up-regulated in myeloid cells by 1,25-dihydroxyvitamin D3. *The FASEB Journal* 2005 Jul; 19(9): 1067-1077. doi: 10.1096/fj.04-3284com. [http://www.fasebj.org/content/19/9/1067.full]

[3] Ormerod MJ, UnKauf BM, White FD. A Further Report on the Ascorbic Acid Treatment of Whooping Cough. *Can Med Assoc J*. 1937; 37: 268-272 [http://www.ncbi.nlm.nih.gov/pmc/articles/PMC536087/pdf/canmedaj00183-0060.pdf].

[4] http://dr-king.com/docs/20130501_Vaccines_The_Safest_of_Medicines_or_the_Biggest_Liequstn_e_b_r1.pdf.

However, today's vaccines have not been proven to be disease-challenge "*effective*" in preventing those who have a "sufficient" level of the protective factors generated by the vaccine from being infected by the disease organisms when some "vaccination protected" inoculee volunteers are subsequently intentionally challenged with the most virulent strains of the wild/naturally occurring disease.

Furthermore, the vaccines' package inserts make no claim that a vaccine is effective in preventing those who have been appropriately inoculated and shown to have "protective" levels of antibodies or other factors from subsequently contracting the disease(s) when those, who are deemed to be protected, are exposed to some infectious non-vaccine strain of each disease covered by a given vaccine.

Why then does Dr. Pearl or any other vaccine apologist make this unsupported claim that vaccines are "*effective*"?

Thus, based on the preceding facts, contrary to Dr. Pearl's claims, vaccines clearly have not been proven "*safe and effective*".

## Another *Ad Misericordiam* Example

"***It Does Not Have To Be This Way***

When my father was a child, his sister died of measles. Her death stayed with him throughout his life. That was before we had a vaccine to prevent measles. If she had been born in the 21st century, she might not have died at age 6."

In contrast to Dr. Pearl's report of his father's experience, when Dr. King's father was a child, though he had measles, mumps, rubella, whooping cough, and chickenpox, neither he nor his 13 older brothers and sisters died from these.

Moreover, in Texas where King's father grew up, "Scarlet fever", a disease that died out without any vaccine, was of much more concern because of the many deaths and serious lifelong injury that some of those who survived it experienced.

As to the "what if" game, if that "*sister*" had been born in the 21st century and were vaccinated with the Merck M-M-R® II or the Merck ProQuad® vaccine, then, she might have died at 12 to 15 months of age from, or have been severely damaged by, the adverse effects of vaccination with either of those vaccines as some are each year based on the reports to VAERS, the Vaccine Adverse-Events Reporting System, jointly maintained by the U.S. Centers for Disease Control and Prevention (CDC) and the U.S. Food and Drug Administration (FDA).

In another alternate universe, like Dr. King, that "*sister*" may have been given daily doses of Cod-liver oil while her fever persisted, eaten

lots of citrus fruit, and recovered with no apparent adverse effects.

## Returning to Vaccines

"Outside of the U.S., approximately 1.5 million children die each year because their families can't afford vaccines.

Here in the United States, we're much more fortunate. Nearly all Americans today have access to a broad range of highly effective and safe vaccines. But a growing number of children aren't getting them.

We need to ask ourselves this: If economics are not the deterrent, why would a parent put their child's life at risk by voluntarily foregoing a life-saving preventive measure? The answer is a combination of false science, outdated anecdotes and fear mongering."

First, Dr. King notes that the link, http://www.chop.edu/service/parents-possessing-accessing-communicating-knowledge-about-vaccines/global-immunization/diseases-and-vaccines-a-world-view.html, that Dr. Pearl provides to the claim,

"*Outside of the U.S., approximately 1.5 million children die each year because their families can't afford vaccines*"

is not to any peer-reviewed publication or to some authoritative CDC document but rather to a posting on a hospital web site, which does not even explicitly make or directly support the causal portion of Dr. Pearl's statement.

Specifically, the linked web site does not claim that the reason the children die is "*because their families can't afford vaccines*".

Next, Dr. Pearl states,

"*Here in the United States, we're much more fortunate. Nearly all Americans today have access to a broad range of highly effective and safe vaccines*"

which, *without any supporting evidence or definition of terms*, now claims that the vaccines available in the USA are more than "*effective*", they are "*highly effective*", and "*safe*".

However, as Dr. King has shown (see footnote "**4**"), today's FDA-approved vaccines are not as "*safe*" as, by law, they are required to be.

In fact, they have not been proven non-carcinogenic and non-mutagenic in humans, a pre-clinical toxicological safety requirement that any prophylactic ("disease preventive") vaccine or other drug product is supposed to be proven to meet before it is given to any human.

Moreover, since the current FDA-approved prophylactic vaccines do not offer any disease protection at all to some who are vaccinated with them and they have not been proven to be effective in protecting all of those vaccinated from subsequently contracting a disease when exposed to the "disease causing" organisms, clearly such prophylactic vaccines cannot be "*highly effective*".

Given the preceding realities, instead of Dr. Pearl's reality denying question,

"*If economics are not the deterrent, why would a parent put their child's life at risk by voluntarily foregoing a life-saving preventive measure?*"

the question Dr. Pearl should be asking himself and the reader is:

"**Since**

- **Today's vaccines have <u>not</u> been proven to be either 'safe' or 'effective';**
- **The protection the vaccines provide, *if any*, is both partial and of relatively short duration;**
- **Each vaccination may severely harm, permanently cripple or kill the child being inoculated;**
- **There are screening tests that could be done to assess a developing child's risk of vaccination harm <u>before</u> any vaccine is given, but the medical profession refuses to routinely conduct these tests; and**
- **The surveys of the current health status of the never-vaccinated children continue to indicate that the never-vaccinated children are two (2) to five (5) times less likely to have a given chronic childhood medical condition than the corresponding age-appropriately vaccinated children in the USA,**

**why would any informed parent in the USA put their child's health at risk by vaccinating that child?**"

The preceding question recognizes that:

- ❑ The risk of contracting vaccine-covered, highly contagious diseases is low in the USA;
- ❑ From birth to at least six (6) months of developmental age or, better, one (1) year of age or, best, until the mother's lactation starts to wane at 2-plus to 5-plus years of age, on-demand breastfeeding by one whose diet is truly healthy is childhood disease protective;
- ❑ IF healthy breastfed children do subsequently contract a vaccine-covered disease, THEN, with appropriate holistic care, almost all those children will have a mild clinical case of that disease and recover to have long-term protection from ever contracting that disease again as well as, in many instances, other benefits that vaccination does <u>not</u> provide; and
- ❑ If by 10 years of age, antibody titer testing indicates that a child still has <u>no</u> immunity to the common viral childhood dis-

eases (e.g., measles, mumps, rubella, chickenpox, fifth disease [a parvovirus] and rotavirus), then, *except for fifth disease, for which there is no vaccine, and rotavirus, which cannot be given to older children*, a parent can still elect to selectively vaccinate his or her child.

## False History Based on False Science

"***The Birth Of Vaccines***

The concept of vaccination was pioneered by Edward Jenner more than two centuries ago.

In the late 1700s, Jenner discovered that individuals who had previously contracted cowpox, a disease with very mild effects on humans, were at little risk for becoming ill with smallpox, a disfiguring and often fatal disease.

He concluded that inoculating individuals with cowpox would prevent children from acquiring smallpox in the future. From that observation, the first vaccine was born."

All that is true about this narrative is that Edward Jenner has been called one of the pioneers of the "*concept of vaccination*", injecting diseased matter from one individual into healthy people to protect them from contracting the disease.

However, the intentional exposure of healthy people to smallpox by introducing fluids thought to contain the disease into the body had been tried in various civilizations before Jenner under the name "variolation" after the medical name for the smallpox, variola[5].

Furthermore, based on the accurate historical records, there is no proof that inoculation with any cowpox-containing solutions ever truly protected those who were inoculated with it from contracting smallpox (variola).

Moreover, the body of unbiased information shows that inoculation with fluids containing "cowpox" against "smallpox" actually increased the incidence of smallpox.

However, the modern live "vaccina" vaccines derived from the repeated manipulation of some strain of smallpox (variola)[6] do appear to provide protection from smallpox that, outside of some "secure" repositories, does not appear to exist in the wild.

Moreover, based on the recent experience in the USA with a "first responders" vaccination program, the live-virus "vaccina" vaccine used

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[5] Vaccine Safety Manual For Concerned Families and Health Practitioners, 2nd Edition, Neil Z. Miller, New Atlantean Press, New Mexico, ISBN: 978-188121737-4, pages "27"-"46" with reference "Notes" on pages "311"-"313".

[6] See, for example, Garcel A, Crance J-M, Drillien R, Garin D, Favier A-L. Genomic sequence of a clonal isolate of the vaccinia virus Lister strain employed for smallpox vaccination in France and its comparison to other orthopoxviruses. *J Gen Virol* 2007 July; 88(7): 1906-1916, which compares the genomic sequence of the particular altered vaccine strain used for inoculation against smallpox in France to that of some other samples.

caused a significant level of harm and, after about 39,000 had been inoculated, three of those inoculated died (about 1 in 13,000) and, because the death rate observed was much higher than the 1 in a million rate that the CDC had "claimed", the other first-responders essentially refused to be inoculated (A Biodefense Failure: The National Smallpox Vaccination Program One Year Later, JANUARY 2004, PREPARED BY THE DEMOCRATIC MEMBERS OF THE HOUSE SELECT COMMITTEE ON HOMELAND SECURITY, JIM TURNER, RANKING MEMBER[7]).

With respect to the FDA-approved viral vaccines exclusively intended for use in preventing childhood diseases, the current live-virus vaccines use an attenuated virus strain (e.g., measles, mumps and rubella) or a bioengineered strain or strains (e.g., GlaxoSmithKline's Rotarix®, attenuated-human-rotavirus vaccine, and Merck's RotaTeq®, a rotavirus vaccine that contains five (5) live bioengineered bovine-human-hybridized rotaviruses for "protection" from rotavirus *re-infection*).

Moreover, smallpox deaths in England and Wales declined only after the people began to refuse the vaccine, from "3708" on average in for the 10-year period ending in "1881" when "96.5" % of the babies were "Vaccinated" to "1", on average, in for the 10-year period ending in "1941" when only "39.5" % of the babies were "Vaccinated" (taken from the data in "Table 2:", page "33" of the reference cited in footnote "**5**").

"Since Jenner's discovery, many other vaccines have been developed, refined and introduced into clinical medicine. Many of these vaccines are mandated for children beginning school, including measles, polio and tetanus."

Here, Dr. Pearl is simply reporting what has happened, "*many other vaccines have been … introduced into clinical medicine*" and was, or is currently being, done in the USA, where the States, not the federal government, have mandated certain childhood vaccination programs, with various exemptions (medical, religious, and philosophical [personal choice]), as a general precondition for the child's attendance in publicly licensed childcare facilities and public and private educational institutions.

However, while these contagious-disease programs have apparently decreased the clinical level of notifiable infectious disease, there is no evidence that, *were the vaccination-related deaths and the noti-*

[7] http://www.hsdl.org/?view&did=443965, last accessed on 2 April 2014. The pertinent information can be found in "Table 1", for the number of first-responders inoculated (on page "5"), and on page "14", in the following paragraph (emphasis added & without internal footnotes), "Again, Congress had to act to develop and pass a compensation plan, the Smallpox Emergency Personnel Protection Act of 2003.[46] By then, warnings of adverse reactions and reports of three deaths linked to the vaccine had already contributed to a growing reluctance among health workers to participate. By the time the Administration established a system to provide compensation eight months later,[47] the vaccination program was stalled."

*fied deaths properly accounted*, the total level of childhood deaths from notified disease cases and vaccination has decreased in the USA.

Moreover, there is a growing body of evidence that the increased vaccine inoculations have been a significant factor in the rise in the number of children with chronic childhood medical conditions in the USA.

Finally, these chronic childhood medical conditions were once uncommon (e.g., childhood asthma [before the 1930s]) or unknown (e.g., childhood type 2 diabetes [before the 1970s), but have increased to epidemic (e.g., childhood asthma and obesity) or near epidemic levels (e.g., childhood gastrointestinal diseases) in the 1990s and later.

"The global impact of these advancements is tremendous. The overall incidence of vaccine-preventable diseases declined dramatically during the 20th century. Smallpox has been eradicated worldwide. And thanks to the efforts of many groups, including the Bill and Melinda Gates Foundation [http://www.gatesfoundation.org/What-We-Do/Global-Development/Polio], polio has been nearly eliminated."

While recognizing the preceding statements are simply versions of the unsubstantiated talking points used by most vaccination apologists and acolytes, Dr. King notes that nowhere does Dr. Pearl disclose, much less discuss, the magnitude of the harm and death that population-wide vaccination programs have caused or are currently causing in the USA.

Those harms and deaths are even more egregious and have been characterized as "genocidal" when those programs have been and are being implemented in regions of the world where the people have serious dietary deficiencies that are not addressed before vaccination, lack access to clean water and/or have primitive sanitation systems[8].

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[8] For example, one need only examine the reality that, before the children of the Australian Aborigines were given adequate supplementation with vitamin C, about half of the infants given the diphtheria, tetanus and pertussis vaccine died shortly after it was administered to them [see EVERY SECOND CHILD by Archie Kalokerinos, MD, Keats Publishing (1981) ISBN 0-87983-250-9, out of print]. Two excerpts and the "INTRODUCTION TO THE AMERICAN EDITION" (emphasis added),

"Nearly three decades of clinical research in the conquest of infant mortality, both before and after the publication of the original Australian edition of this book in 1974, has taught Dr. Archie Kalokerinos what is of value and what is [u]seless in saving the lives of babies. He has a wealth of clinical data, which point to the inevitable conclusion that acute infantile scurvy is the prime cause of the Sudden Infant Death Syndrome (SIDS) and is responsible for these infant deaths. This is a condition that can be so simply, harmlessly and inexpensively corrected, thus preventing these babies from dying. ....

Dr. Klenner found that the best way to fight SIDS is to treat the babies through their mother before they are born, and devised a simple technique for doing this. In hundreds of pregnancies, he gave 5 to 15 grams of ascorbate each day throughout pregnancy and lactation. This corrects the chronic subclinical scurvy existing in the mothers and prevents the scurvy, which otherwise would develop in the fetus, "in utero." Under this megascorbic regime the mother has a much easier time throughout pregnancy and in labor. The neonate is so robust and healthy that there has never been a case of SIDS among these ascorbate-corrected infants, not even a case of respiratory distress during birth. After the infants are weaned they routinely get up to 1 gram of ascorbate daily during their first year. They then receive one gram of ascorbate per day per year of age up to age ten, then ten grams per day thereafter. SIDS is an unknown entity in this population of infants."

Moreover, one cannot logically eliminate a disease, "polio", by orally inoculating millions each year with vaccines that contain strains of one to three types of live poliovirus that those inoculated with them replicate, help mutate, and defecate (and otherwise shed) into the environment orders of magnitude more polio virus, including mutated viruses, than they were given.

Based on the available independent evidence, all that the oral polio vaccine inoculation programs have done is to displace the original strains of the poliovirus with a large number of vaccine-related polioviruses that are, in some instances, apparently more virulent than the original polioviruses.

Moreover, oral polio inoculation continues to cause vaccine-related "polio" cases, though these cases have alternative names, like vaccine-associated paralytic poliomyelitis (VAPP), acute flaccid paralysis (AFP) or, in India, non-polio acute flaccid paralysis (NPAFP).

Perhaps, the interactions between the different polio-vaccine-type strains and viral "mutations" in the multiple campaigns to eradicate polio in India actually created a polio-like virus that sufficiently differs from the original that the paralysis it causes can truly be called NPAFP.

However, it is also possible that NPAFP is a medical label created to justify the claim that "polio" had been eradicated in India, though more than 40,000 developed NPAFP, a severe polio-like paralysis.

"Through the 'Decades of Vaccines Collaboration,' 200 countries have endorsed a shared vision of a world where all individuals and communities enjoy lives free from vaccine-preventable diseases.

Extending the full benefits of immunization to every person worldwide by 2020 would prevent an estimated 20 million deaths – mostly in children – and untold suffering for millions more."

Obviously, Dr. Pearls "*shared vision*" is based on a false foundation. This is the case because, as long as live-virus prophylactic vaccines are being used anywhere in the world, those vaccination programs are intentionally and knowingly infecting, *usually abnormally*, the inoculees with the very diseases from which these vaccines are supposedly freeing the inoculated individuals.

In addition, those who are inoculated are forced to live with many of these diseases for, *in some instances*, the rest of their life and some inoculees do infect others.

Moreover, since Dr. Pearl

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can be found at http://vaclib.org/basic/products/everysecondchild.htm .

- Neither cites nor references any peer-reviewed published studies to support his claimed "*benefits*";
- Uses the disingenuous phrase "*benefits of immunization*" when no vaccine inoculation provides immunity (lifetime protection) from any disease, unless you *ghoulishly* count those for whom vaccination caused death; and
- Refuses to mention, much less address, the annual numbers of disabilities and deaths caused by the current vaccination programs in the USA,

Dr. King is compelled to recognize Pearl's statements as examples of today's unsubstantiated and insubstantial vaccination propaganda.

## The Vaccination Safety and Effectiveness Movement — Knowingly Miscast as the "Anti-Vaccine Movement"

"***The Rise Of The Anti-Vaccine Movement***

In the United States, we are witnessing the scientifically ignorant and sometimes deadly impact of an anti-vaccine movement. Individuals who support the movement continue to question the safety and necessity of vaccines despite extensive medical literature to the contrary.

When laboratory-produced vaccines were first introduced over 50 years ago, there were legitimate concerns about their safety. Many vaccines in their older forms were associated with the risk of rare but dangerous reactions.

The vaccines we use today have minimal risks and an extremely safe track record. They have undergone rigorous testing and scrutiny by the scientific community and have proven their effectiveness in large-scale clinical trials.

As a result, the days of school closures for measles and pertussis outbreaks have become a relic of the past. The side effects from vaccines are almost always mild [http://www.cdc.gov/vaccines/parents/vaccine-decision/side-effects.html]. And even in the extremely rare case of a more serious allergic reaction, physicians and their staff are trained to deal with it.

Simply put, the benefits of vaccination substantially outweigh the risks.

Yet for the last two decades, fear mongers associated with the anti-vaccine movement in the U.S. and other developed countries have convinced some parents to refuse to vaccinate their kids.

The result is an erosion in health gains, both individual and collective. And in some parts of the country, we are witnessing a reversal of what many believe is one of the greatest advances in medical science in the last century."

Here, without citing any source, Dr. Pearl begins by miscasting those who have long been, and are, seeking safe and effective vaccines and cost-effective population vaccination programs as an "*Anti-Vaccine Movement*".

Pearl then starts his rant by implicitly making unsupported claims that those who, like Dr. King, are seeking safe and effective vaccines and cost-effective vaccination programs are "*scientifically ignorant*".

Knowingly, Dr. Pearl asserts,

> "*Individuals who support the movement continue to question the safety and necessity of vaccines despite extensive medical literature to the contrary*",

which tellingly ignores the *scientific* literature that has clearly established that the current vaccines and vaccination programs have serious safety and effectiveness issues, which even the vaccine manufacturers: **a)** recognize and **b)** in the USA, disclose in their FDA-approved package inserts for their FDA-licensed vaccines[9].

Given the preceding realities, Dr. King sees no need to address much of what are obviously the *beliefs* of Dr. Pearl and his fellow vaccine apologists and acolytes.

Moreover, with respect to Dr. Pearl's,

> "*As a result, the days of school closures for measles and pertussis outbreaks have become a relic of the past.*"

Dr. King, who grew up in the late 1940s, 1950s and early 1960s and attended multiple public schools in suburban, metropolitan and semi-rural school districts in Texas, never experienced any school closure for measles, mumps, rubella, pertussis, polio, chickenpox or hepatitis A – though those who were infected did miss some school days.

However, by the mid-1970s, medical and public health officials had begun to support school closure when there was an outbreak of a childhood disease in a school.

Apparently, this was done as a means to reduce the chances that the children would acquire natural disease protection and "encourage" parents to vaccinate their children so that they would not have to miss work to take care of their children, as the schools generally remained open when most had been vaccinated as recommended.

Moreover, as a "reward", those children who were not ill but had not been vaccinated were excluded from attending school.

This approach created a proverbial "carrot and stick", *which the Establishment continues to use*, designed to "encourage" families to

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[9] The package inserts are accessible at http://www.fda.gov/biologicsbloodvaccines/vaccines/approvedproducts/ucm093830.htm, last accessed on 23 March 2014. For those in the current format, safety issues can be found in section "8 USE IN SPECIFIC POPULATIONS" at "8.1 Pregnancy" and section "13 NONCLINICAL TOXICOLOGY" at "13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility"; the lack of effectiveness can be found by studying the package insert's section "14 CLINICAL STUDIES", which only assess the apparent efficacy of the vaccine but do not include disease-challenge studies to prove that the vaccine is effective in preventing disease in all those who were inoculated and developed antibody levels that the manufacturer deemed to be disease protective.

vaccinate especially where, *as was increasingly the case*, both parents had to work to support the family, and the extended family was no longer as readily available to step in to provide childcare.

Moreover, Dr. Pearl's unsupported claims,

> "*The side effects from vaccines are almost always mild. And even in the extremely rare case of a more serious allergic reaction, physicians and their staff are trained to deal with it*",

are of little comfort to the parents of the thousands of children in the USA who are permanently disabled each year and of no comfort to the parents of the hundreds of children each year who die shortly after being vaccinated.

Simply put, for those hundreds of children, and adults, whose inoculations precipitate their deaths, Dr. Pearl's claim that "*the benefits of vaccination substantially outweigh the risks*" is obviously false as it is for most all the thousands who are permanently harmed by their inoculations.

Moreover, although post-natal immune system evaluations could be used to identify many of the children who should not be vaccinated, medical and public health officials have resisted, and are resisting, requiring such assessments before any child could be vaccinated on an increased-cost basis in the USA.

However, the lifetime costs of caring for one severely vaccine-injured child in the USA run into the millions.

Moreover, *except for the* National Vaccine Injury Compensation Program[10], few measure the costs to a family who suddenly loses a previously healthy baby because of a vaccination that a healthy child was given to "protect" that child from the future risk of possibly contracting some disease or, for combination vaccines, diseases.

Furthermore, though touted as "the safest of medicines" and "safe and effective", vaccines are known to cause serious adverse reactions, including death, in some who are vaccinated.

However, *unlike notifiable diseases*, there is no rigorous system for ensuring that almost all serious adverse reactions are reported and, in the full-scale clinical trials, the number of vaccinated participants is not sufficient to guarantee that the risk of all serious adverse events that occur at an average frequency of "1 in 10,000" or higher is rigorously quantified.

This lack of knowledge is the case even though a verified risk of "1 in 10,000" currently translates into about 330 affected babies annually

[10] Title 42 of the United States Code (**42 U.S.C.**) in Sections 300aa-10 through 300aa-34 (42 U.S.C. §§ 300aa-10 – 300aa-34).

for each such adverse event in the USA.

Instead of a rigorous adverse-event reporting system, the USA has opted for a *de facto* voluntary reporting system (VAERS) where, *depending on the specific adverse event and year*, *less than* 1% to about 10% of the adverse events that occur are reported to VAERS[11].

Furthermore, Dr Pearl's closing paragraphs,

> "*Yet for the last two decades, fear mongers associated with the anti-vaccine movement in the U.S. and other developed countries have convinced some parents to refuse to vaccinate their kids.*
>
> *The result is an erosion in health gains, both individual and collective. And in some parts of the country, we are witnessing a reversal of what many believe is one of the greatest advances in medical science in the last century.*"

are obviously unsubstantiated assertions based not on science, but rather on, *as Pearl so succinctly puts it*, "*what many believe*".

Unfortunately, Pearl's belief-based assertions are not supported by the unbiased factual historical record for smallpox and polio.

Factually, smallpox was not wiped out by inoculating about 10% of the world's population with various "vaccina" vaccines, where the vaccina viruses seem to have been created by the repeated manipulation of some smallpox strain (see footnote "**6**"), but rather mainly by relative peace, improved sanitation; improved hygiene that washed bedding and undergarments with soap and hot water; clean drinking water; improved housing and clothing; and safer foodstuffs.

Moreover, *like polio*, the smallpox virus was apparently displaced by the less deadly manufactured vaccina-virus strains that were generated from the smallpox strains used to develop those "smallpox" vaccines (the "vaccina" virus strains), which were then employed in various "smallpox"-vaccination campaigns.

Moreover, recent genetic sequencing[12] has established that the genome for smallpox is also highly similar to the genome of monkeypox, a disease that still infects humans in some parts of the world.

Thus, outside of some samples stored in "secure" viral repositories around the world, today the "wild" viruses related to smallpox are predominantly the vaccina-virus strains used in the "smallpox" vaccines, which still infect humans when they are inoculated with it; the

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[11] 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.

[12] Kugelman JR, Johnston SC, Mulembakani PM, Kisalu N, Lee MS, Koroleva G, et al. Genomic variability of monkeypox virus among humans, Democratic Republic of the Congo. *Emerg Infect Dis* [Internet]. 2014 Feb 2. http://dx.doi.org/10.3201/eid2002.130118.

cowpox virus, which infects some humans; and the monkeypox virus, which also infects some humans who are exposed to it.

Thus, rather than being eradicated ("wiped out") in the 1940s, vaccine-strain-ascribed "smallpox" deaths continued to occur[13] and, *much as the native wild polioviruses have been*, the smallpox viruses were simply displaced, by the derived man-made vaccine strains of "vaccina" (see footnote "**6**"), which were derived by man-made manipulation of viral replication conditions starting with the certain strains of the smallpox virus.

For polio, the unbiased historical record clearly reveals:

- Polio viruses, "Simian virus 40" (SV40), and other primate-native viruses were spread by the early Salk "inactivated virus" vaccines;
- The initial Sabin live-attenuated polio vaccines also spread polio viruses, the SV40 virus, and other viruses;
- The SV-40 virus, which has been shown to be a causal factor in certain human cancers, has become incorporated into the human genome of many of those infected with it and/or live SV-40 continues to be present in some of the current viral seed stocks used to produce the current polio vaccines;
- The hyped "polio epidemic" in the USA was actually stopped by changing polio-related definitions and diagnostic criteria which, in the mid-1950s, reclassified most of what would have previously been "polio" cases as cases of Coxackie virus or aseptic meningitis, leaving only a small percentage of the "polio" cases to be diagnosed as "paralytic poliomyelitis" cases, but only when the paralysis persisted for 60 days or more, and only when the CDC made that diagnosis; and
- The original native/wild strains of the three (3) types of polio have been displaced by the vaccine-derived strains in campaigns that saturated the environment with vaccine strains of the polioviruses, which are continuing to be: **a)** modified by

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**13** Kempe CH. SMALLPOX VACCINATION OF ECZEMA PATIENTS WITH ATTENUATED LIVE VACCINIA VIRUS. *The Yale journal of biology and medicine*, 1968 August; 41: 1-12, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2591438/pdf/yjbm00179-0005.pdf, last accessed on 5 March 2014, See page "10", referencing the period from 1948 through 1967,

"The last smallpox death in the United States following an importation occurred in 1948, but since that time there have probably been 200 to 300 deaths from smallpox vaccination. Assuming a mortality rate of 30% from variola major, the number of smallpox cases in the United States would have had to be between 600 and 900 during this period to equal the mortality from vaccination".

See also, page "3", which speaks about the declining protection from smallpox (emphasis added),

"Actually, the United States is no better protected than Sweden, Poland, Great Britain, or the rest of Western Europe, where in 1963, the importation of four cases resulted in 141 secondary cases with eleven deaths.[3] As a nation, we can be said to be well vaccinated but not well immunized. While it is true that fatalities from smallpox are less common in anyone who has ever been vaccinated, it is also true that within one year after primary vaccination the chance of an attack of smallpox is reduced to 1/1,000 of that in the unvaccinated, within three years to 1/200, within ten years to 1/8, within twenty years to 1/2, and after twenty years there is little protection from clinical infection".

mutation and **b)** displaced by yet other man-made strains of polioviruses that are currently being administered in many developing countries.

Thus, diagnostic substitution, and not vaccination, "wiped out" the "polio epidemic".

That preceding account is factually accurate is supported by the reality that the incidence of "polio" declined in developed countries in Europe, *which did not implement a polio vaccination program in the 1950s*, as much as it did in the USA, *which did*.

Moreover, when it comes to the polioviruses, we are continuing to spread them wherever live-virus polio vaccines continue to be used.

Thus, the two (2) purportedly greatest achievements of human vaccination appear to be, *at best*, illusory.

## Measles and Whooping Cough — Dr. Pearl's Fear Mongering

***"The Fear Mongering Behind Measles And Whooping Cough***

Measles and whooping cough are very serious, highly contagious respiratory diseases spread through the air by breathing, coughing or sneezing.

Although their clinical symptoms are different, both carry risks of long-term problems and even death."

Under a "***Fear Mongering***" banner, Dr. Pearl begins by stating some truths about the diseases "measles" and "whooping cough".

However, Dr. King notes that, though they are different vaccines, the current vaccines for measles are live-virus vaccines (Merck's M-M-R® II and ProQuad® in the USA) that may be contaminated with some adventitious viruses and possibly bioactive human and other-source DNA-related materials as well as contain live mumps and rubella viruses and, for ProQuad, a live "chickenpox" virus.

In contrast, the current FDA-approved early childhood vaccines for whooping cough contain both pertussis-related endotoxin (at levels higher than are permitted in most other vaccines) and isolated toxic components, including the pertussis toxin, from killed *Bordetella pertussis* [*B. pertussis*] bacteria, as well as tetanus toxoid, diphtheria toxoid, non-specific immune-system activators (i.e., "polymeric aluminum salt" adjuvants) and, in many instances, components to provide protection from other diseases (e.g., components for Haemophilis influenza type B, hepatitis B, and three inactivated polio viruses).

In addition, though the basis vaccines are different, both of these classes of vaccines, live-virus and bacterial-component, also "*carry risks of long-term problems and even death*".

Furthermore, because the "measles"-containing vaccines are live-virus vaccines, they abnormally (by injection rather than inhalation) infect every person inoculated with them and, in some inoculees, actually cause cases of measles and, worse, cases of atypical measles.

In addition, the "measles"-containing vaccines also cause some to develop the serious adverse effects that a natural measles infection may cause, including death, as well as some serious adverse effects that contracting natural measles does not cause because of the other live viruses and/or other bioactive components in them.

Likewise, in young children, the pertussis-related toxins, including endotoxin, in the vaccines that are used to protect against whooping cough can trigger significant adverse reactions, including death, in the inoculees.

Moreover, to avoid having to identify these deaths as vaccination-related deaths, many are mislabeled as post-inoculation "SIDS"[14] and post-vaccination "SBS" (shaken baby syndrome, where a parent or another childcare provider is blamed for the death of a baby who exhibits evidence of bruising and trauma[15]).

Thus, for measles and whooping cough, both natural disease and vaccination are known to cause harm and death.

However, while both natural measles and whooping cough (pertussis) cases and natural measles-related and pertussis-related deaths are "notifiable" occurrences, where there are legal penalties for a healthcare provider's failure to report them, the more than 8-million cases of abnormal "measles"-containing-vaccine infections annually from vaccination and their outcomes, are generally ignored.

For vaccination-related outcomes, in the USA, VAERS, a *de facto* voluntary adverse-events reporting system[16] is used to assess vaccination outcomes.

Thus, VAERS is used to monitor the voluntarily reported adverse post-inoculation reactions to the live measles, mumps and rubella vaccine, the measles mumps, rubella and alphaherpes varicella zoster

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[14] SIDS is the medical acronym for sudden infant death syndrome, generally characterized by the sudden cessation of breathing, which is claimed by mainstream medicine and vaccine-protective apologists to have no known cause, although these cases frequently occur shortly after a DPT- or DTaP-containing vaccine inoculation.

[15] Here, the SBS diagnosis is used to cover up the healthcare provider's failure to ensure that the child's vitamin C and insulin levels are in the proper ranges before vaccination and/or to properly correct the child's vitamin C deficiency when the vaccinated child's health first starts to deteriorate shortly after a pertussis-containing vaccination as well as to protect the vaccination itself from being recognized as a causal (triggering) factor for such deaths.

[16] VAERS is a voluntary reporting system because there is no penalty for a healthcare provider's failure to report a post-vaccination adverse event

virus (chickenpox) vaccine, any of the pertussis-components-containing vaccines, and any other vaccine.

Clearly, in such a biased system, it is difficult to assess whether the theoretical benefits of vaccination outweigh the mostly unreported harm from vaccination.

However, except for chickenpox, the protections provided by having the highly contagious childhood diseases for which there is a vaccine and recovering from them provides natural disease-recurrence protections that last much longer than the disease protection provided by repeated vaccination.

Worse, in most all instances, the proportion of those who are vaccinated that have any significant disease protection after being multiply vaccinated is, in most instances, *not more than* about 95%, best case (e.g., measles), and can be *less than* 10% (e.g., influenza).

Moreover, the typical duration of disease protection for the majority of those who are age-appropriately vaccinated ranges from *less than* one (1) year (e.g., influenza) to *not more than* three (3) years (e.g., whooping cough) to *not more than* 10 years (e.g., measles) after the last dose was administered.

In contrast, having whooping cough naturally and recovering from it provides protection from whooping cough caused by any human-infective *Bordetella* species[17] that, *on average*, lasts for more than 30 years[18] and having measles naturally provides essentially lifetime (*greater than 60* years) protection from measles re-infection.

"Measles begins with fever, runny nose, cough and a rash all over the body. Before the introduction of a measles vaccine in 1963, hundreds of thousands of people in the U.S. contracted the disease annually. Thousands were permanently disabled and between 400 and 500 people died. But since 1963, reported cases fell to less than a thousand a year."

While Dr. Pearl's statements about the measles disease seem reasonably accurate, his statements about the measles cases appear to be generalizations that do not specify the year or range of years in which the claimed numbers of cases, disabilities and deaths occurred.

In addition, Dr. Pearl neglected to mention that, *in response to a spike in measles cases in 1986*, a second dose of the Merck Attenu-

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[17] The human infective **B. species** are *B. pertussis*, *B. parapertussis*, *B. bronchiseptica* and *B. holmesii*. When it provides any protection, the pertussis-containing vaccines only provide limited-duration protection from *B. pertussis*, but no protection from infection by the other human-infective *B. species*.

[18] Wearing HJ, Rohini P. Estimating the Duration of Pertussis Immunity Using Epidemiological Sciences. *PLoS Pathol*. 2009 Oct: 5(10): e1000647 (11pgs). See, http://www.plospathogens.org/article/info%3Adoi%2F10.1371%2Fjournal.ppat.1000647, last accessed on 25 March 2014

vax® live measles vaccine, or the combination live measles, mumps and rubella vaccine (M-M-R II) was recommended.

Moreover, although the CDC's stated justification for the second dose was to provide measles protection to those up-to 5% who did not develop protective antibodies to measles after the first dose, the real reason was to boost the waning antibody levels in most of those who were initially protected but, after ten (10) or more years, had lost their protective level of antibodies.

In "recognition of" the limited-duration protection following the second vaccination for "measles", in 2013, the CDC started to recommend that certain "higher exposure risk" groups get a third or a third and a fourth vaccination for measles[19] when the only available FDA-licensed "measles" vaccines are Merck's M-M-R II and ProQuad vaccines.

Clearly, these CDC recommendations are seeking to boost/extend the inoculees' antibody protections for several viral diseases (i.e., measles, mumps and rubella) for which it is clear that such antibody boosting seems to be required.

Based on the preceding realities, the CDC has recognized that even double inoculation (abnormal infection twice) with these live-virus measles-containing vaccines does not provide long-term protection to being re-infected with measles when the inoculee is subsequently exposed to wild/natural measles.

However, the CDC has failed to actively disclose in the vaccination schedule's notes for whom, *including those who previously had an adverse reaction to the vaccine*, each such additional vaccination represents a risky re-challenge to the inoculee's immune system that increases the risk that the inoculee will have a serious, potentially life threatening, or fatal reaction to that additional vaccination.

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19 http://www.cdc.gov/mmwr/preview/mmwrhtml/su6201a3.htm, Advisory Committee on Immunization Practices (ACIP) Recommended Immunization Schedule for Adults Aged 19 Years and Older — United States, 2013. *MMWR* 2013 Feb 1; 62(01): 9-19, last visited on 25 Mar 2014. See Schedule's footnote "7. Measles, mumps, rubella (MMR) vaccination" (emphasis added),

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

*Measles component:*

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

….

HCP born before 1957:

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

## Misrepresentation of the Factual Record about a 1998 Study

"Things started changing in 1998 when a British physician published a study in "The Lancet" medical journal that falsely asserted a connection between autism and the combined measles-mumps-rubella (MMR) vaccine.

An investigation into the work revealed the research was unethical and rife with conflicts of interest. The article was filled with false and fraudulent data, and the health care risks described have been completely discredited. In 2010, the paper was fully retracted from 'The Lancet,' a remarkable event in the world of peer-reviewed journals."

Here, Dr. Pearl begins by attempting to rewrite history, apparently to suit his personal views, as he provides no peer-reviewed published citations to support his statements.

First, the 1998 article[20] in question was a case study in which the dozen authors did not assert a "*connection between autism and the combined measles-mumps-rubella (MMR) vaccine*" but rather concluded,

> "We have identified a chronic enterocolitis in children that may be related to neuropsychiatric dysfunction. In most cases, onset of symptoms was after measles, mumps, and rubella immunisation. Further investigations are needed to examine this syndrome and its possible relation to this vaccine",

where the "symptoms" alluded to were the symptoms of "chronic enterocolitis".

Furthermore the paper's "Findings" simply reported (emphasis added),

> "Onset of behavioural symptoms was associated, by the parents, with measles, mumps, and rubella vaccination in eight of the 12 children, with measles infection in one child, and otitis media in another. All 12 children had intestinal abnormalities, ranging from lymphoid nodular hyperplasia to aphthoid ulceration. Histology showed patchy chronic inflammation in the colon in 11 children and reactive ileal lymphoid hyperplasia in seven, but no granulomas. Behavioural disorders included autism (nine), disintegrative psychosis (one), and possible postviral or vaccinal encephalitis (two). There were no focal neurological abnormalities and MRI and EEG tests were normal. ...".

With respect to Dr. Pearls' next statement,

> "*An investigation into the work revealed the research was unethical and rife with conflicts of interest*",

Dr. King notes that, though some of the actions taken by the lead author AJ Wakefield and the senior clinician, Professor J.A. Walker-Smith were found to be "*unethical*" by a UK General Medical Council and that council found both to have an apparent conflict of interest, a

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[20] Wakefield AJ, Murch SH, Anthony A, Linnell J, Casson DM, Malik M, Berelowitz M, Dhillon AP, Thomson MA, Harvey P, Valentine A, Davies SE, Walker-Smith JA. Ileal-lymphoid-nodular hyperplasia, non-specific colitis, and pervasive developmental disorder in children. *The Lancet* 1998 Feb 28; 351: 637-641 [retracted in 2010].

subsequent legal review[21] of Professor Walker-Smith's actions found that Walker-Smith was not guilty of any unethical behavior or conflict of interest; quashed the General Medical Council's relevant findings; and restored Walker-Smith's medical license.

Moreover, nowhere was the research conducted or the results reported in the now-withdrawn study proven to have been falsified.

The actions taken against those researchers was simply an industry-organized attack to discredit the "messengers" because they had dared to expose the lack of safety testing for the UK-licensed combination measles, mumps and rubella vaccines and, by drawing the hearings out over several years, to send a chilling message to other researchers who might want to pursue that issue.

The tactics used by the pharmaceutical industry are similar to those used to discredit a November 2012 published study challenging the safety of Monsanto's glyposate herbicide, its Roundup® formulation, and one of its varieties of GMO-modified corn[22], which was withdrawn on the pretext that the effects were not significant enough because too few rats had been used in each group studied.

However, since an earlier Monsanto study using the same design and numbers of rats in each study group with an unsupportable, short, follow-up period published earlier in the self-same journal, which found no evidence of harm, was not withdrawn, it is clear to Dr. King, that a witch hunt was created and the authors' integrity attacked in both instances to create a pretext for withdrawing a paper that spoke incon-

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21 http://childhealthsafety.wordpress.com/2012/03/07/english-court-exonerates-mmrautism-doctor-uk-general-medical-given-sound-thrashing/, last accessed on 25 March 2013,

"Neutral Citation Number: [2012] EWHC 503 (Admin) Case No: CO/7039/2010

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL
07/03/2012

Before:
MR JUSTICE MITTING

Between:

| | |
|---|---|
| PROFESSOR JOHN WALKER-SMITH | Appellant |
| - and - | |
| GENERAL MEDICAL COUNCIL | Respondent |

MR STEPHEN MILLER QC AND MS ANDREA LINDSAY-STRUGO (instructed by EASTWOODS SOLICITORS) for the Appellant

MISS JOANNA GLYNN QC AND MR CHRISTOPHER MELLOR (instructed by FIELD FISHER WATERHOUSE LLP) for the Respondent

Hearing dates: 13th. 14th, 15th, 16th & 17th February 2012".

22 Gilles-Eric Séralini G-E, Clair E, Mesnage R, Gress S, Defarge N, Malatesta M, Hennequin D, Spiroux de Vendômois J. Long term toxicity of a Roundup herbicide and a Roundup-tolerant genetically modified maize. *Food Chen Toxicol.* 2012 Nov; 50(11): 4221–4231.

venient truth to those manufacturers of the MMR vaccines and the governmental agencies that approved these MMR combination vaccines in the United Kingdom (UK) and elsewhere without the requisite clinical studies that unequivocally established that the combination vaccines were no less safe and no less effective than giving the individual vaccines used to make the combination vaccines separately at the same time.

Furthermore, to ensure that the requisite safety studies could not be conducted, the UK regulators withdrew the licenses for the single-component vaccines and, *in the USA*, Merck stopped supplying the single-component vaccines to the market.

Turning to Dr. Pearl's next claim,

> "*The article was filled with false and fraudulent data, and the health care risks described have been completely discredited*"

Dr. King simply asks that Dr. Pearl provide those independent published peer-reviewed studies where the same children and their records were independently studied and any of the reported "*data*" has been proven to be "*false and fraudulent*"?

Also, Dr. Pearl please provide Dr. King with: **a)** any independent peer-reviewed published study or studies for which all of the complete anonymized datasets and ancillary information necessary to verify the findings are readily available and **b)** copies of those datasets and their ancillary information, which supports your unsubstantiated claim that "*the health care risks described have been completely discredited*".

Dr. King respectfully makes these requests because, to date, he has been unable to find any such independent studies.

Turning to Dr. Pearl's closing statement,

> "*In 2010, the paper was fully retracted from 'The Lancet,' a remarkable event in the world of peer-reviewed journals*",

Dr. King can only agree that this article was withdrawn in 2010 and, if this event was "*remarkable*", it was but another black mark against that journal – a mark no less black than the one created by the pretextual withdrawal of Séralini G-E et al. (2012) in 2013.

## Measles in What Alternate Universe?

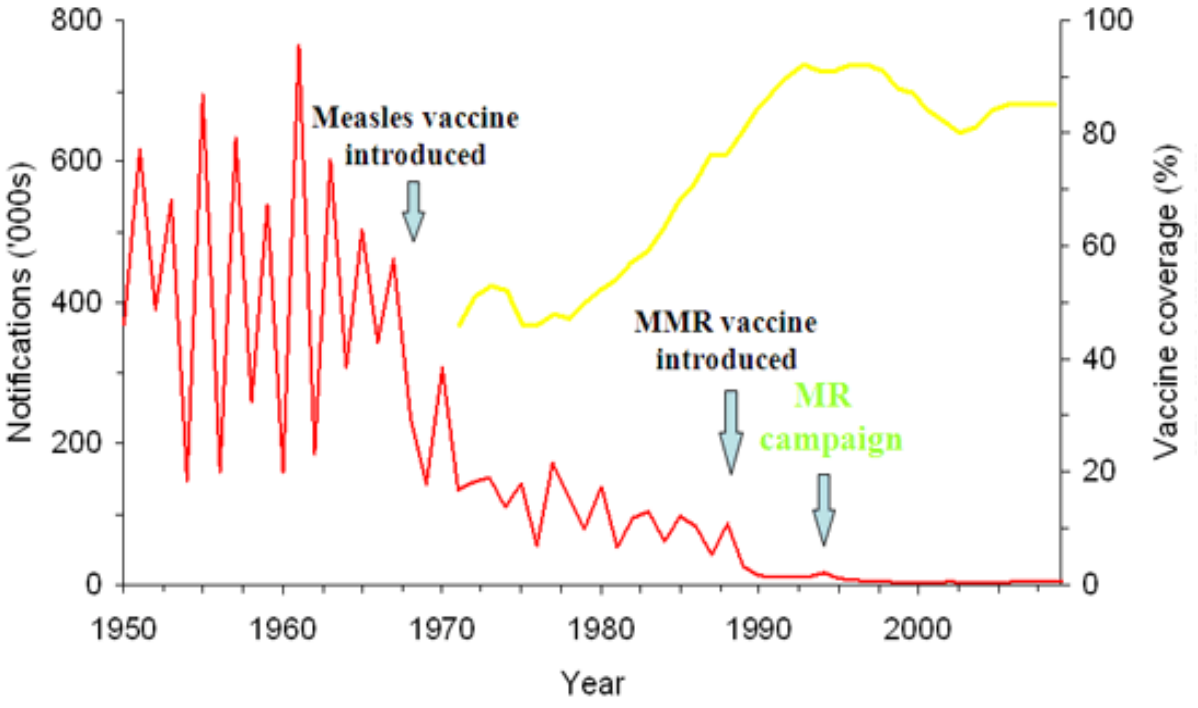
"But the damage was done. Vaccination rates in the UK plummeted and reported cases of measles soared. In the U.S., new measles cases have tripled as of 2013, with reported outbreaks in eight American communities. The recent outbreak in New York City has sickened at least a dozen people."

First, although vaccination levels for measles did decline after the

cited 1998 paper was published, a significant part of the reason for the decline was that the UK withdrew the licenses for the single vaccines for measles that many parents had been using.

Turning to a recognized factual UK source, http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/Measles/EpidemiologicalData/measNotVaccCoverage/,

Annual measles notifications and vaccine coverage, England and Wales 1950-2009




Source: Office for National Statistics and Department of Health

Dr. King found a graphical illustration, included above, that shows that the level of MMR vaccination coverage, *already declining before 1998*, continued to decline to about 80% in 2004 from a level of about 92% in 1997, a decline of about 12% over a "7"-plus-year period or a decline of less than 2% per year.

Clearly, the inoculation level did not "plummet"[23].

Moreover, Dr. Perl's assertion that "*reported cases of measles soared*" is obviously false as the figure clearly shows that there was no significant

[23] http://www.merriam-webster.com/dictionary/plummet, emphasis added, "Full Definition of PLUMMET
1 to fall perpendicularly <birds plummeted down>
2 to drop sharply and abruptly <prices plummeted>
Examples of PLUMMET
The acrobat plummeted into the net.
The car plummeted to the bottom of the canyon.
The satellite plummeted into the ocean.
Stock prices plummeted 40 percent during the scandal".

increase in notified measles cases.

If anything, the average number of notified measles cases in the UK also declined during this period.

In the context of a society that

- Intentionally infects more than eight (8) million children and adults annually with a live measles virus contained in a "disease preventive" vaccine that is given twice to most all children and an additional one or more times to some groups of children and adults, and
- As far as Dr. King can estimate from the limited measles and MMR adverse-reaction data, which he has found[24],
  - Thereby creates more than 300 cases of vaccine-strain measles each year (footnote "**24**", page "7" [text]);
  - Apparently annually causes the deaths of up to 300 to 800 children each year (footnote "**24**", page "7" [Table 1. Death Reports 2003 – 2012 in Children to 6 Years of Age]); and
  - Otherwise permanently damages many times the number of children and adults than it annually kills,

why, *except to misdirect the reader*, is Dr. Pearl speaking of the about 50 to *less than* 300 cases of wild/natural measles, which, on average, causes the death of less than one (1) child each year in the USA (see, footnote "**24**", page "5" ["TABLE 12. Number of deaths from selected nationally notifiable infectious diseases — United States, 2003–2009", "0.57" measles death per year])?

## Realities about Whooping Cough, a Highly Contagious Disease

"Meanwhile, whooping cough, a highly contagious bacterial infection, has seen a huge increase in the number of people infected each year."

Here, Dr. Pearl begins with a statement that is partly true.

However, since whooping cough is a disease that is diagnosed by the characteristic cough that it causes in infected children and, to a lesser extent in adults, in children certain viral infections, like an RSV (Respiratory Syncytial Virus) infection, can cause a child to be diagnosed with whooping cough.

In addition, even though there has been a steady increase in the average number of cases over time since the 1970s, on average, the

[24] http://dr-king.com/docs/130906_Mealses_MeaslesVaccinationRealities_AFormlRespnseToEndangeringTheHerd_final_br1.pdf.

increase has not been "*a huge increase in the number of people infected each year*".

Factually, from 1944-2011, as shown in the following table, the notified "pertussis" cases did change.

After World War II, the notified pertussis cases declined from the 100,000 to 150,000 level in 1946-1947 to roughly the 1010 to 2,180 level in 1976-1979, and the general trend was for a declining level of disease over time[25].

However, from 1979 onwards, the general 4-year trend segments show an upward trend[26].

| Pertussis Cases (Deaths) by Year 1944-2011 (from various "Summary of Notifiable Diseases" reports in the *MMWR*) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | | |
| *25,827* | *25,616* | *15,632* | *10,454* | *13,278* | *16,858* | *27,550* | *18,719* | | |
| (16) | (31) | (9) | (9) | (20) | (15) | | | | |
| 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 |
| 4,617 | 5,137 | 7,796 | 6,564 | 7,405 | 7,388 | 7,867 | 7,580 | 9,771 | 11,647 |
| | | | | | | | | | (11) |
| 1984 | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 |
| 2,276 | 3,589 | 4,195 | 2,823 | 3,450 | 4,157 | 4,570 | 2,719 | 4,083 | 6,586 |
| (7) | (4) | (6) | (1) | (4) | (12) | (12) | | | |
| 1974 | 1975 | 1976 | 1977 | 1978 | 1979 | 1980 | 1981 | 1982 | 1983 |
| 2,402 | 1,738 | 1,010 | 2,177 | 2,063 | 1,623 | 1,730 | 1,248 | 1,897 | 2,463 |
| | | | | | | | | (4) | (5) |
| 1964 | 1965 | 1966 | 1967 | 1968 | 1969 | 1970 | 1971 | 1972 | 1973 |
| *13,005* | 6,799 | 7,717 | 9,718 | 4,810 | 3,285 | 4,249 | 3,036 | 3,287 | 1,759 |
| | | | | | | | | | |
| 1954 | 1955 | 1956 | 1957 | 1958 | 1959 | 1960 | 1961 | 1962 | 1963 |
| 60,886 | 62,786 | 31,732 | *28,295* | *32,148* | *40,005* | *14,809* | *11,468* | *17,749* | *17,135* |
| | | | | | | | | | |
| 1944 | 1945 | 1946 | 1947 | 1948 | 1949 "effective pertussis vaccines introduced" | 1950 | 1951 | 1952 | 1953 |
| 109,873 | 133,792 | 109,860 | 156,517 | 74,715 | 69,479 | 120,718 | 68,687 | 45,030 | 37,129 |
| | | | | | | | | | |

This trend is apparent in spite of the increase from three (3) to now up-to five (5) doses of a DTap-containing vaccine for children under 7 years of age and, after aluminum-adjuvanted tetanus, reduced diphtheria and reduced acellular pertussis components (Tdap) vaccines were approved in the USA, a Tdap vaccination was recommended for children at -

[25] The general trend segments, in terms of notified cases, were: for 1948-1951, roughly 68,700 to 120,700; for 1952-1955, roughly 37,100 to 62,800; for 1960-1963, roughly, 11,470 to 17,750; for 1964-1967, roughly 6,800 to 13,000; for 1968-1971, roughly 3,040 to 4820; and, for 1972-1975, roughly 1,740 to 3,290.

[26] The general trend segments, in terms of notified cases, were: for 1980-1983, roughly 1,250-2,460; for 1984-1987, roughly 2,280-4,200; for 1988-1991, roughly 2,720-4,570; for 1992-1995, roughly 4,080-6,590; for 1996-1999, roughly 6,560-7,800); for 2000-2003, roughly 7,580-11,650; for 2004-2007, roughly 10,450-25,830; and, for 2008-2011, 13,280-27,550.

10 to 11 years of age as well as for pregnant adolescents and pregnant women during each pregnancy.

Clearly, Dr. Pearl's is mistaken about the nature of the timing and nature of the increases in whooping cough ("pertussis") cases and is ignoring the reality that the increasing number of required pertussis-components-containing-vaccine doses was, and is, a significant causal factor for the increasing number of whooping-cough cases in the USA[27].

"The incidence of whooping cough was relatively low in the U.S. – around 5,000 cases annually – when vaccination was the unchallenged standard of care. But the impact of the anti-vaccine rhetoric and associated fear has contributed to several outbreaks across the United States and Europe, resulting in multiple infant deaths.

Here, Dr. Pearl begins by misrepresenting the number of cases of whooping cough ("pertussis") in the USA as if it were "*around 5,000 cases annually*", when, from 1951 to the late 1970s, a period when vaccination was increasingly pushed as the "*standard of care*" for whooping cough and generally "*unchallenged*", the number of cases decreased

- From about 70,000 cases in 1951 (when the population of the USA was about 152 million; or 1 case in 21,714 residents)
- To about 1,000 in 1976 (when the population of the USA was about 216 million; or about 1 case per 216,000 residents).

Furthermore, since 1976, in spite of the CDC's adding recommendations for additional doses of the "pertussis"-component-containing vaccines to the original three (3) doses, the notified instances of clinical "pertussis" cases has generally increased:

- To 4,570 cases in 1990 (when the population of the USA was about 249 million or about 1 case per 54,486 residents [about four (4) times the level in 1976]) and, most recently,
- To 13,278 to 27, 550 cases annually (with a mean of 19,101 ± 6,068 [standard deviation], when the population of the USA was 300 to 310 million; or about 1 case per 16,000 residents on average [more than three (3) times the 1990 incidence level and greater than the incidence level in 1951]) from 2008 through 2011.

Additionally, the scientific studies have clearly established that the failures[28] of the "pertussis"-component-containing vaccines to:

**a.** Stop the spread of pertussis in the population;

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

28 http://dr-king.com/docs/130816_RespnseTo_AsWhoopingCoughReturns_TrustScience_NotOpinion_finl_b.pdf.

**b.** Protect against the other organisms that can cause clinical cases of whooping cough, including the three (3) other species of *Bordetella* that are human infective;

**c.** Prevent the creation of persons who are "pertussis" carriers who can spread the infection though they do not exhibit the disease's clinical symptoms;

**d.** Thwart the mutation of *Bordetella pertussis* to more virulent strains; and

**e.** Provide protection that lasts *more than* three (3) years from the date of their last inoculation from whooping cough infection caused by *B. pertussis* to a significant portion of those who are multiply inoculated according to the current inoculation schedule in the USA.

"In 2010, three [sic; there] were 9,000 cases of whooping cough reported in California alone, causing the deaths of 10 infants under the age of 1 – the most in the state since 1947. The first whooping cough vaccine was developed in the mid-1920s. By the mid-1940s, it was used widely and often administered in combination with the diphtheria and tetanus vaccines."

First, in 1947, California had a population of about 9.83 million residents[29], which had grown to about 37.2 million in 2010[30] – a 3.78-fold increase.

Thus, to put Dr. Pearl's deaths assertion,

"*causing the deaths of 10 infants under the age of 1 – the most in the state since 1947*"

into perspective, *on a per capita basis*, presuming his assertion is valid, the incidence of death from whooping cough in 2010 was less than one-fourth of the incidence of death from whooping cough in 1947.

Moreover, since the 9,000 cases in California were about [9,000 divided by 27,550 cases in the USA times 100%] or 32.67% of all "pertussis" cases in 2010, while California residents made up about 12% of the population, clearly many other states had a much lower incidence of "notified pertussis" cases in 2010.

With respect to Dr. Pearl's next assertions,

"*The first whooping cough vaccine was developed in the mid-1920s. By the mid-1940s, it was used widely and often administered in combination with the diphtheria and tetanus vaccines*",

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29 http://www.dof.ca.gov/HTML/FS_DATA/STAT-ABS/documents/B1.pdf, last accessed on 28 March 2014.

30 https://www.census.gov/1940census/pdf/infographic1_text_version.pdf, last accessed on 28 March 2014.

Dr. Pearl seems to be intentionally misleading the reader.

This is the case because **a)** the first "*whooping cough*" vaccines were highly problematic; **b)** the first reasonably reproducible pertussis-components-containing vaccines were not developed until the late 1930s; **c)** those whole-cell-derived pertussis-components-containing vaccines were combined with diphtheria toxoid and tetanus toxoid components to make "DTP" (diphtheria-tetanus-pertussis combination vaccines that were mostly preserved with Thimerosal and adjuvanted by absorbing the components onto suitable polymeric hydrated aluminum salts; and **d)** their "*use*" did not become wide spread until the late 1940s.

Furthermore, Dr. Pearl conveniently leaves out the reality that: **a)** these vaccines: carried deadly risks to the health of many of the young children given them; and **b)** because of their lethality, they could not be given to children older than seven (7) years of age or to adults.

In addition, there was, and still is, no direct "antibody" measurement that could be proven to be correlated with the apparent protection from the disease caused by *B. pertussis* that was provided by these mostly Thimerosal-preserved and, *in almost all instances*, polymeric-hydroxy-aluminum-salt-adjuvanted DTP vaccines.

To hide many of the deaths caused by those vaccines, new diagnostic terms were introduced.

In the USA, that diagnostic term was "sudden infant death syndrome" (SIDS) while, in Australia, the diagnosis was "cot death" and, elsewhere, the term "crib death" was used.

Moreover, the cause of those deaths was claimed to be "unknown" (idiopathic) even though studies[31,32] using the monitoring of the infant breathing patterns of DPT vaccinated children had clearly established that, *in many instances*, the DPT vaccination was a causal factor for many, *if not most*, of those deaths that occurred shortly (within 30 days) after a DPT inoculation.

In addition, many more children were seriously harmed and, in the 1980s, their parents were increasingly successful in suing the vaccine's manufacturer for the costs of the harm and the lifetime care these DTP-vaccination-damaged children would require.

Successful vaccine-damage civil lawsuits, mainly for harm caused by the DTP and live polio vaccines, became so frequent that, *by the*

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31 Scheibner V (1993). Vaccination: 100 years of orthodox research shows that vaccines represent an assault on the immune system. Australian Print Group. ISBN 0-646-15124-X.

32 Scheibner V (April 1999). ""Vaccinations: Part I - Medical Research On Sids And Epidemics"". *"Consumer Health" - Consumer Health Organization of Canada* 22 (4), last accessed on 3 April 2014.

*mid-1980s*, the vaccine-makers' lobbyists were threatening that their firms would stop making these vaccines unless the federal government indemnified them from being sued[33].

However, rather than

- Pointing out that the providing vaccines that were "safe" was the absolute nondischargeable duty of the manufacturer;
- Noting safer vaccines were being developed and/or had been marketed in at least one other developed country to replace the DTP vaccine (e.g., the diphtheria, pertussis, and acellular pertussis [DTaP] vaccine in Japan), which was apparently as, or more, effective and caused *less than* 10% of the deaths and serious injuries than the corresponding DPT vaccines seemed to be causing; and
- Rebuffing the vaccine manufacturers' demands,

on November 14, 1986, "Section 323 of title III of Pub. L. 99-660", was enacted into law and codified under 42 U.S.C. Section 300-aa (as amended) with effective dates as follows (emphasis added),

> "Subtitle 1 of title XXI of the Public Health Service Act [part 1 of this subchapter (42 U.S.C. 300aa-1 to 300aa-6)] shall take effect on the date of the enactment of this Act [Nov. 14, 1986] and parts A and B of subtitle 2 of such title [subparts A and B of part 2 of this subchapter (42 U.S.C. 300aa-10 to 300aa-23)] shall take effect on October 1, 1988 and parts C and D of such title [subparts C and D of part 2 of this subchapter (42 U.S.C. 300aa-25 to 300aa-33)] and this title [probably means provisions of title III of Pub. L. 99-660 other than those that enacted this subchapter and redesignated former sections 300aa to 300aa-15 of this title as sections 300cc to 300cc-15 of this title; these other provisions amended sections 218, 242c, 262, 286, and 289f of this title and enacted provisions set out as notes under sections 201, 300aa-1, and 300aa-4 of this title] shall take effect on the date of the enactment of the Vaccine Compensation Amendments of 1987 [Dec. 22, 1987]."

After the preceding laws, the National Vaccine Act (42 U.S.C. Sections 300aa-1 through 300aa-6) and the National Vaccine Injury Compensation Program (42 U.S.C. Sections 300aa-10 through 300aa-34) were enacted in 1986, the vaccine makers immediately began pushing for the population-wide use in young children of the hepatitis B (hep B) vaccines (first licensed in 1981) and for the population-wide use of the *Haemophilis influenza* type B (Hib) vaccines (first licensed in 1985) as well as began incorporating these vaccine components, along with the inactivated polio vaccine (IPV) component, into combination vaccines.

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[33] These threats were an obvious form of extortion and, under the governing statutes in Title 42 of the United States Code [42 U.S.C.], an empty threat because, for those vaccines licensed under 42 U.S.C., the government had, and has, the legal right to step in and, using the existing facilities, takeover the manufacturer of vaccines.

However, given the legal protection afforded by the federal law, it was not until the early 1990s that the safer DTaP vaccines began to be introduced and, subsequently, combination vaccines based on the approved DTaP vaccines were introduced to replace most of the DTP-containing vaccines.

Based on a search in VAERS using MedAlert (http://www.medalerts.org/), though the first DTaP vaccine was introduced in 1991, it took until 1999 before the adverse events attributed to any DTP-containing vaccines dropped from the 3900-reports level seen in 1991 and 1992 to below 300 reports annually.

Moreover, as of 2013, about 40 VAERS reports were still being attributed to some DTP-containing vaccine annually.

However, given the rise in recommended/mandated doses and the increase in the population segments being recommended to receive these vaccines, the level of DTaP/Tdap-containing adverse-event-related reports increased to the 4,000 to 5,000 level between 2002 and 2008.

Since that time, *for reasons apparently related to reduced reporting*, the level of adverse-event reports, where a DTaP/Tdap-containing vaccine was administered in 2012 or 2013, has dropped to below 2900 annual reports.

Similarly, the increasing incidence of paralytic polio cases attributed to one of the three (3) live-polio-viruses in the live-virus vaccine caused the federal government, which, as of 1988, was responsible for compensating those with vaccination-related injuries, to phase out the use of the live-virus vaccines and re-introduce polio vaccines containing inactivated polioviruses.

"In 1991, a combination vaccine called DTaP reduced the frequency of side effects and eliminated nearly all major adverse reactions from whooping cough immunization."

Here, Dr. Pearl generalizes about the reduction "*in the frequency side effects*"; rather than portraying the frequency of the "*major adverse reactions*" as a reduction; chooses to state, "*eliminated nearly all major adverse reactions*"; and does not mention that the remaining "*major adverse reactions*" still included vaccination-related death.

"Unfortunately, California is now one of 19 states that allow 'personal belief' exemptions for parents before their children enter school. As a result, non-medical exemptions in California have tripled between 2000 and 2010 with some schools in affluent communities reporting rates as high as 84 percent.

And as the 2010 outbreak demonstrated, clusters of whooping cough appear most frequently in these communities with higher than average non-medical exemptions."

Here, ignoring the significant outbreaks of whooping cough in Washington State in 2012, Dr. Pearl returns to the 2010 California outbreaks and attempts to blame the rise in pertussis cases on those who choose not to vaccinate their children even though, as the CDC stated (emphasis added),

> "Causes
>
> Pertussis, a respiratory illness commonly known as whooping cough, is a very contagious disease caused by a type of bacteria called *Bordetella pertussis*. These bacteria attach to the cilia (tiny, hair-like extensions) that line part of the upper respiratory system. The bacteria release toxins, which damage the cilia and cause inflammation (swelling).
>
> Transmission
>
> Pertussis is a very contagious disease only found in humans and is spread from person to person. People with pertussis usually spread the disease by coughing or sneezing while in close contact with others, who then breathe in the pertussis bacteria. Many infants who get pertussis are infected by older siblings, parents or caregivers who might not even know they have the disease (Bisgard, 2004 & Wendelboe, 2007). Symptoms of pertussis usually develop within 7–10 days after being exposed, but sometimes not for as long as 6 weeks. …"[34].

clearly the "cause" of whooping cough is exposure to any whooping-cough-causing organism shed by any person, vaccinated or unvaccinated, symptomatic or asymptomatic.

Moreover, since:

**a.** More than 70% of the cases occurred in individuals who had been age appropriately vaccinated with multiple DTaP vaccine doses as well as, in some instances, at least one Tdap vaccine dose and

**b.** Vaccination with these vaccines has been proven to create asymptomatic carriers who, though not clinically infected and generally asymptomatic, can and do infect those who with whom they have contact,

clearly a major source of the clinical whooping cough infections was, and is, those who were vaccinated and developed a case of whooping cough and those asymptomatic vaccinated carriers who were shedding live human-infective *B. species*.

Therefore, the unvaccinated were not the principle source for the 9,000 cases in 2010 (in a population of 37.2 million residence; or 1 case per 4133 residents) since most (> 70%) of those who contracted whooping cough had been previously age-appropriately vaccinated.

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[34] http://www.cdc.gov/pertussis/about/causes-transmission.html, "Pertussis (Whooping Cough) Causes & Transmission", last accessed on 30 March 2014.

Furthermore, an analysis of the reported deaths[35] 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[36].

While Dr. Pearl portrays the problem as if it were somehow being caused by allowing "*'personal belief' exemptions*", he presents no data that supports his claim.

Moreover, in 2010 in Texas, another state that allows "*'personal belief' exemptions*", there were 2,848 cases of "pertussis" in a population of about 25.146 million or about 1 case per 8,829 residents – a rate less than half of the California rate – even though it is also a populous "border" state in which about 8.1% of the residents of the USA dwelt

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[35] 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:

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[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 [sic] 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

[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."

[36] For a more in-depth discussion of the realities concerning the use of vaccines containing "pertussis"-derived components, see the tables and discussion that are contained in pages "7" – "10" of http://dr-king.com/docs/20140326_PGK_sDrftResponseTo_Blind%20eye%20to%20scientific%20fraud%20is%20dangerous_final_b1.pdf.

in 2010[37].

Moreover, from the historical trends and the CDC's ineffective actions to counter the steady increase in cases of whooping cough in the vaccinated, it is clear that the current "pertussis"-components-containing vaccines are not effective in preventing most of those who were age-appropriately vaccinated from subsequently contracting whooping cough when exposed to any human-infective *B. species* or certain other organisms that can cause some to exhibit the symptoms used to diagnose whooping cough (see the applicable passages in footnotes "**27**" and "**28**").

Turning to Dr. Pearl's next claim,

> "*As a result, non-medical exemptions in California have tripled between 2000 and 2010 with some schools in affluent communities reporting rates as high as 84 percent*",

Dr. King simply observes:

- "*non-medical exemptions*" are the sum of both "'*personal belief' exemptions*" and "religious" exemptions;
- in general, the overall percentage for both exemptions for children in a state is less than 2%; and
- "*affluent communities*" are generally where the better-educated parents:
  - **a.** raise their families and
  - **b.** have the time and the ability to educate themselves about the theoretical benefits and the actual risks associated with a given vaccination recommendation.

Thus, if the "*non-medical exemptions*" levels are higher in "*affluent communities*", where the better educated parents tend to reside, it would seem to Dr. King that those who live in *less* "*affluent communities*" might want to learn from the example set by those better informed parents who live in those "*affluent communities*" or, *at a minimum*, want to understand the reasons for the parents' in "*affluent communities*" seeking "*non-medical exemptions*".

Turning to Dr. Pearl's next unsupported assertion,

> "*And as the 2010 outbreak demonstrated, clusters of whooping cough appear most frequently in these communities with higher than average non-medical exemptions*",

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[37] Taken from the Census web page http://quickfacts.census.gov/qfd/states/48000.html, last accessed on 30 March 2014.

Dr. King observes that, *based on the information presented and the facts surrounding the problematic nature of the "pertussis"-components-containing vaccines (see the applicable passages in footnotes "**27**" and "**28**")*, Pearl's claim does not appear to be supported by the evidence presented and is at odds with the reality that most clinical cases of whooping cough do not occur in "*affluent communities*".

"Even if this exemption did not exist, there will always be some individuals who will not be vaccinated and others who will lose their immunity decades after the vaccine is given. Protecting these folks requires what health experts call 'herd immunity.'"

Here, presuming that he is referring to the "*personal belief*" exemption, Dr. Pearl begins with a factual assertion,

"*Even if this exemption did not exist, there will always be some individuals who will not be vaccinated*".

However, Pearl's claim,

"*others who will lose their immunity decades after the vaccine is given*",

is at odds with the facts:

- The current vaccines do not provide whooping cough "*immunity*" but provide only limited-duration and incomplete protection from "pertussis" infection to some inoculees (see the applicable passages in footnotes "**27**" and "**28**");
- A significant percentage of those who are vaccinated will develop no protection from contracting: **a)** whooping cough in general, or **b)** *B. pertussis* infection in specific[38];
- For those to whom the vaccination provides some protection after receiving the initial three (3) doses of a DTaP-containing vaccine, many of those children will not be protected for even three (3) years[39,40,41] after their last dose of a "pertussis"-components-containing vaccine;

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38 Based on the information provided in the "CLINICAL STUDIES" section of the vaccine producer's self-serving package inserts for each of the DTaP/Tdap vaccines that have been approved by the U.S. Food and Drug Administration (FDA).

39 http://news.discovery.com/human/whooping-cough-vaccine-110920.htm, "Whooping Cough Vaccine Fades After Three Years" last visited on 30 March 2014, emphasis added, "'Older kids and younger kids seemed to be pretty well protected but the age of eight to 12 was the vast bulk of the cases. And when we examined that, it was correlated to being more than three years from the last vaccine booster dose.'"

40 http://www.nejm.org/doi/full/10.1056/NEJMoa1200850#Top=&t=articleTop, Klein NP, Bartlett J, Rowhani-Rahbar A, Fireman B, Baxter R. Waning Protection after Fifth Dose of Acellular Pertussis Vaccine in Children. *N Engl J Med* 2012 Sept 13; 367:1012-1019, emphasis added,

"Waning of DTaP Effectiveness

In the primary analysis comparing PCR-positive children with PCR-negative controls, with adjustment for calendar time, age, sex, race or ethnic group, and medical service area, the odds ratio for pertussis was 1.42 per year (95% CI, 1.21 to 1.66), indicating that each year after the fifth dose of DTaP was associated with a 42% increased odds of acquiring pertussis. A secondary analysis comparing PCR-positive cases with matched controls yielded similar results".

- For young children, starting DTP vaccination when the child is two (2) months of age will significantly increase the child's risk of developing childhood asthma as compared to that risk when a parent elects to delay starting vaccination with a DTP-containing vaccine until his or her child is older than four (4) months of age[42];
- For children who get their first DTP-containing vaccine dose before they are one (1) years of age, they have an increased risk for their developing chronic diseases (e.g., asthma[43]); and
- In Japan, where the start of DTP vaccination was, and still is, often delayed until after the child is two years of age, infant mortality (2.78 per 1,000 as of 2011[44]) is less than half (45.7%) of the infant mortality rate in the USA (6.08 per 1,000 as of 2011[45])[46].

Clearly, Dr. Pearl's has inflated the duration of the limited protection from whooping cough provided by the current "pertussis"-components-containing vaccines from the factual years after the first/last inoculation to "*decades after the vaccine is given*" – a roughly ten-fold inflation in the duration of the vaccine-provided protection afforded to some of those who have been age-appropriately vaccinated with the existing "pertussis"-components-containing vaccines.

In contrast, in the pre-vaccination era, children under one year of age seldom had whooping cough and having a case of whooping cough and recovering from it conservatively provided 10 to 50 years of protection from a re-infection that resulted in a clinical case of whooping

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41 http://pediatrics.aappublications.org/content/133/3/e513, Quinn HE, Snelling TL, Macartney KK, McIntyre PB. Duration of Protection After First Dose of Acellular Pertussis Vaccine in Infants. Pediatrics 2014 Mar. 1; 133(3): e513 -e519, from the abstract, where "VE" was the abbreviation for "vaccination effectiveness", "RESULTS: VE against hospitalization increased from 55.3% (95% confidence interval [CI], 42.7%–65.1%) for 1 dose before 4 months of age to 83.0% (95% CI, 70.2%–90.3%) for 2 doses before 6 months. The VE of 3 doses of DTaP against all reported pertussis was 83.5% (95% CI, 79.1%–87.8%) between 6 and 11 months, declining to 70.7% (95% CI, 64.5%–75.8%) between 2 and 3 years of age and 59.2% (95% CI, 51.0%–66.0%) between 3 and 4 years of age.".

42 http://www.sciencedirect.com/science/article/pii/S0091674907023792. McDonald KL, Huq SI, Lix LM, Becker AB, Kozyrskyj AL. Delay in diphtheria, pertussis, tetanus vaccination is associated with a reduced risk of childhood asthma. *J Allergy Clinical Immunol* 2008; 121: 626-631.

43 Halvorsen, R. Vaccines, Atopy & allergy: Problems & Solutions. The Health Hazards of Disease Prevention BSEM 2011 March,

44 http://www.indexmundi.com/g/g.aspx?c=ja&v=29, last visited on 24 July 2012.

45 http://www.indexmundi.com/g/g.aspx?c=us&v=29, last visited on 24 July 2012.

46 Ironically, though the clinical cases of whooping cough in children increased when the majority of the children were vaccinated beginning at two (2) years of age, the cases of whooping cough in Japan in those children under one (1) year of age, those most at risk of serious infection and death from contracting whooping cough, virtually disappeared. See 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.

cough caused by *B. pertussis*, or *B. parapertussis*, and, probably, *B. bronchiseptica*, and *B. holmesii* [47].

Finally, Dr. King notes that no vaccination program has been proven to provide "*herd immunity*" or even "herd protection" in schools where virtually 100% of the school-aged children had been age-appropriately vaccinated with a measles vaccine[48,49].

Thus, Dr. Pearl's,

"*Protecting these folks requires what health experts call 'herd immunity'*",

simply reflects a misleading vaccination claim made by "*health experts*", who continually misrepresent vaccination as if it could provide disease protections which are as, or nearly as, good as the protections that are provided to healthy, initially breastfed children who age-appropriately develop natural immune-system protection from the contagious childhood diseases for which there is a childhood vaccine.

"If a single parent does not immunize a child, the risk to that individual is low. But as the number of unvaccinated children grows, the risk of numerous people contracting and spreading the disease multiplies, creating a public health risk for a large segment of the population."

First, Dr. Pearl's scenario is only accurate for human populations who are largely inoculated with vaccines, where:

- Some percentage of the vaccinated never develop any effective protection from disease and, *as the vaccines' protections wear off*,
- The percentage of those who have some protection declines over time after their last dose of each vaccine;
- In many instances, the protection provided is only briefly boosted when they are given vaccine doses beyond the initial early childhood doses; and
- Each additional vaccine dose that is administered unavoidably increases the number of inoculees who will subsequently develop an autoimmune-related chronic medical condition[50].

In populations where healthy, well-nourished young children were age-appropriately allowed to contract those childhood diseases for

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47 Wearing HJ, Rohini P. Estimating the Duration of Pertussis Immunity Using Epidemiological Sciences. PLoS Pathol. 2009 Oct: 5(10): e1000647 (11pgs).

48 *MMWR* 1989 Dec 29; 38(S-9): 1-18, "Measles Prevention: Recommendations of the Immunization Practices Advisory Committee (ACIP)".

49 Davis RM, Whitman ED, Orenstein WA. A persistent outbreak of measles despite appropriate prevention and control measures. *Am J Epidemiol*. 1987; 126(3): 438-449.

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

which there is a FDA-licensed vaccine and recover, "*herd immunity*" was probably achieved when *more than* about 68% contracted the disease.

This is the case because most children (usually, *more than* 90%) are exposed to those contagious childhood diseases and recover to, *in contrast to the short-term and incomplete protection provided by vaccine administration*, have long-term and complete protection from re-infection for most of the childhood diseases other than chicken-pox[51,52].

Thus, unlike vaccination, there is no significant build up of the percentage of the people over time who are at risk of contracting these diseases when re-exposed to the causative organism and the annual cases of disease that do occur in the young children who have not yet had one or more of those diseases provide exogenous boosts to the immune systems of those who have had the natural disease thereby actually strengthening the immune system of those who had previously had the disease.

Moreover, using the natural system, those females who are exposed to a given contagious childhood disease acquire a broader range of immune factors and higher levels of those immune factors, which they can then pass to their offspring provided they breastfeed those offspring for *not less than* six (6) months, than the range and levels of immune factors acquired by vaccination.

"For highly contagious diseases like whooping cough and measles, herd immunity is dependent on having 95 percent of the population in a community immunized. When the immunization rate falls, the danger to both the young and elderly increases dramatically."

First, as Dr. King has stated, for the highly contagious infectious childhood diseases (e.g., measles), there is no such thing as "*herd immunity*" even in settings where essentially 100% of the children have been age-appropriately vaccinated (see footnotes "**48**" and "**49**").

Second, since vaccination neither provides essentially lifetime protection from infection when the vaccine is not a live-organism vaccine nor lifetime protection from re-infection when a live-organism (typical-

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51 Chickenpox is caused by some strain of alphaherpes varicella zoster virus (commonly referred to as varicella zoster virus [VZV]), which, absent periodic exogenous (external) boosting by exposure the live VZV being shed by others, can subsequently recur as "shingles", which causes serious and life-threatening symptoms at a much higher frequency than caused by having chickenpox in childhood.

52 Since injection with the live VZV strain in the chickenpox vaccine (Merck's Varivax® in the USA) causes much less viral shedding than having chickenpox naturally, the implementation of a now two-dose chickenpox vaccination program has essentially doubled the incidence of shingles in older children and adults of all ages, who now have much lower exogenous boosting exposure opportunities that are mainly limited to exposures to those shedding VZV just prior to and during the initial days of a shingles episode.

ly, a live-virus) vaccine is used to infect those inoculated with it, vaccination cannot provide disease "*immunity*" (lifetime protection).

Thus, as Dr. Pearl does in this article, vaccine apologists who use the terms "*immunity*", "*immunized*" and "*immunization*" are *knowingly* using deceptive terminology to implicitly suggest that vaccination can provide lifetime protection from the claimed covered disease(s) when vaccination, at best, only provides limited-duration protection from those diseases to some percent of those multiply inoculated with vaccines.

Therefore, if vaccine apologists and acolytes wanted to be honest about what vaccination does, they would cease using such terms.

If Dr. Pearl and other vaccine/vaccination proponents wanted to continue to use accurate "i"-word descriptors, they would replace the terms "*immunized*" and "*immunization*" with "inoculated" and "inoculation".

Finally, Dr. Pearl's closing statement in this paragraph,

> "*When the immunization rate falls, the danger to both the young and elderly increases dramatically*",

is clearly at odds with the experience in the UK with measles (see the figure titled "Annual measles notifications and vaccine coverage, England and Wales 1950-2009" on page "***23***"), where, *though the vaccination coverage level dropped from about 92% in 1997 to about 80% in 2004*, a 12 percentage-point drop, the level of measles cases did not significantly increase (but rather appeared to, *on average*, decline through 2009) while the inoculation coverage level slowly increased from roughly 82% to about 85%.

However, as the sudden increase in imported measles cases when there was a large outbreak of measles cases in Europe more recently indicates, many, if not most, of the age-appropriately vaccinated children and adults and all the unvaccinated, who have not developed natural protection from measles infection, have no effective protection from contracting measles when exposed to someone who is shedding an infectious measles virus[53].

Thus, in the USA,

- Low instances of initial-case generation by individuals from or going to areas where measles infections are endemic and then entering or re-entering the USA;
- The efficiency of the interception and identification of the initial measles cases;

[53] For a detailed discussion of measles/measles vaccination realities, see pages "16" – "33" of http://dr-king.com/docs/120127_RevisdDrft_RevuOfAutsmControvrsyNeedForResponsbleScienceJournlsm_b.pdf.

- The effectiveness of the identification of the initial cases' contacts; and
- The appropriate quarantine of those who are or may be infected by and are shedding or may shed live measles virus

make up the real "disease-prevention program" for measles that is currently effectively preventing the spread of measles in the USA (see footnote "**53**") — not the "measles" vaccination program.

In fact, since a multi-component vaccine containing live measles, mumps and rubella viruses is administered, more than eight (8) million people in the USA are infected with measles, mumps and rubella annually.

Finally, if the goal were to provide our children with lifetime protection from measles, mumps and rubella, the mandatory "MMR" vaccination program would have to be abandoned and, with appropriate breastfeeding and other nutritional disease-severity-mitigation and disease-recovery strategies, our children would again be allowed to naturally contract and recover from measles, mumps and rubella.

In this "lifetime protection from re-infection" approach, pre-teens who had not had a diagnosed clinical case of these disease would be screened for their disease-protective antibody titer levels and, if they had no evidence of a disease-protective titer, their parents would have the option of having them inoculated with the appropriate vaccine for the disease(s) for which they had no evidence of protection.

Of course, the suggested "lifetime protection from re-infection" approach would significantly reduce the need for vaccine doses for measles, mumps and rubella; curtail the vaccine makers' and the providers' profits from the administration of those doses; and reduce the federal government's tax revenues that are derived from a tax on each dose administered (currently, $ 2.25 per dose of M-M-R II and $ 3.00 per dose of ProQuad).

However, based on the substantiated information presented by Dr. King in this review and the other applicable documents in the "Publications (by year)" portion of his web site[54], if the Establishment were truly interested in protecting the health of our children and, *by doing so*, the health of the people in the USA, then the Establishment would, *at a minimum*, be adopting and implementing the suggested "lifetime protection from re-infection" approach for the management of measles, mumps, rubella, and chickenpox infections in the USA.

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[54] http://dr-king.com, "Documents" web page, "Publications (by year)" section.

## Realities about the Current FDA-approved Vaccines and the CDC-recommended Vaccination Programs

### *"A Plea To Parents*

We have highly safe and effective vaccines readily available to prevent many of the most dangerous childhood diseases. Yet despite decades of research that demonstrate their overwhelming positive impact on the health of our children, we are losing ground."

Contrary to Dr. Pearl's unsubstantiated assertions, the current FDA-approved prophylactic ("disease preventive") vaccines have not been proven to be "safe"[55] much less "*highly safe*" as Pearl asserts here.

Moreover, *as a result of the issues surrounding the safety of vaccines raised in oral arguments before the Supreme Court on the issue of suing a vaccine manufacturer for a design defect in its vaccine*[56], vaccines have been described by the Supreme Court of the USA as "unavoidably unsafe" in recognition of the reality that all vaccines cause harm, including permanent disability and death, to a few of those who are vaccinated with any particular vaccine.

Furthermore, with respect to Dr. Pearl's inflated claim that "*effective vaccines*" are "*readily available to prevent many of the most dangerous childhood diseases*", Dr. King again respectfully points out that the package inserts for the FDA-approved prophylactic vaccines make no claim that those vaccines are "*effective*" in preventing the diseases for which the manufacturers only claim that the vaccines may provide some protection from subsequently contracting the natural/wild disease(s) covered by a given vaccine.

Instead, a given package makes claims of usually antibody-titer-based efficacy, *not disease-challenge-established effectiveness protection*, in protecting some stated percentage of the healthy subjects who are appropriately inoculated with usually two (2) or more doses of a given vaccine from subsequently contracting a covered disease if subsequently exposed to a causative organism.

Turning to Dr. Pearl's next statement,

> "*Yet despite decades of research that demonstrate their overwhelming positive impact on the health of our children, we are losing ground*",

Dr. King first observes that, for prophylactic vaccines, most of the "*research*" to which Pearl refers should be classified as "tobacco science"

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

56 http://www.supremecourt.gov/oral_arguments/argument_transcripts/09-152.pdf. The transcript of oral arguments on 12 Oct. 2010 in "RUSSELL BRUESEWITZ, ET AL., : Petitioners v. WYETH, INC., FKA WYETH LABORATORIES, ET AL"; case "No. 09-152".

or "pseudoscience" because it has repeatedly failed to even prove that the formulation of the vaccines used are not carcinogenic, mutagenic, and reproductively toxic in any manner to the target populations, developing humans and/or human adults, before being given to any human in a clinical trial.

Moreover, the clinical trials of each new vaccine for "safety" are currently scientifically unsound because they have *not* used a "placebo"[57] that produces no adverse effects when administered to humans (e.g., sterile, pH-balanced, isotonic saline) as the control in all of the vaccine's safety assessments.

In addition, clinical vaccine trials designed to assess the "effectiveness" of a given vaccine do not establish that it prevents those who are appropriately vaccinated and appear to be protected from a given disease are actually protected from contracting that disease after being naturally exposed to some currently circulating wild/native species or strain of that disease.

Instead, the development of certain levels of certain antibodies in a certain period or other protection indicators are claimed to be proof of vaccine efficacy, a surrogate for vaccine effectiveness, because the pro-vaccine crowd claims it would be unethical to perform such evaluations in volunteers who would have given their informed consent for such testing.

However, the pro-vaccination crowd apparently has no problem with giving prophylactic vaccines that may cause cancer, mutations, or reproductive toxicity to our children and ourselves without telling the parents or us about those risks as a part of obtaining informed consent before administering any vaccine.

As a scientist, Dr. King has no ethical problem with informed-consent-based disease-challenge studies using "volunteers" who have been vaccinated in the clinical trials for effectiveness and, after developing the indicators thought to indicate protection from infection, are then selectively and appropriately sequentially exposed to "wild", "circulating" or "endemic" strains of each of those diseases in the vaccine that was previously administered to them.

Dr. King holds this view because the diseases for which we currently have a vaccine that is claimed to be "disease preventive" (pro-

[57] Instead of requiring the use of a true placebo in all clinical safety evaluations, the vaccine's developers have been allowed to use: **a)** another approved vaccine, **b)** some other experimental vaccine, or **c)** a "similar" formulation as the vaccine's formulation without the putatively disease-protection-generating antigens in the vaccine being evaluated for safety.

phylactic) do not generally cause life-threatening clinical symptoms in the initially healthy people who contract any of those diseases.

Similarly, Dr. King finds that it is unethical to give prophylactic vaccines to our children and ourselves while concealing the reality that none of the current FDA-approved vaccines has been proven to be free from the risk of causing cancer, mutation or reproductive harm in those inoculated with them.

Thus, *based on the carefully worded results of those industry-conducted clinical trials currently used as surrogates*[58] *for proof of "safety" and "effectiveness"*, the public has been required to "believe"/ "accept" that the published results of the pseudoscientific vaccine safety and efficacy surrogate research assessments conducted by the vaccine's developers in formal clinical trials constitute "proof" that a given vaccine is "*safe*" and "*effective*".

Moreover, as written, Dr. Pearl's statement is focused on the claimed "*decades … that demonstrate their overwhelming positive impact on the health of our children*".

However, when the overall "*health of our children*" has been repeatedly assessed since the 1980s in NHANES (National Health and Nutrition Examination Survey) studies[59], the overall "*health of our children*" has been found to be declining[60].

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58 In this context, these "surrogates" are clinical trial studies that are used as substitutes for the research studies that would unequivocally prove that a vaccine is "safe" relative to the use of sterile, isotonic, pH-balanced saline or, for proof of protection (vaccine effectiveness), clinical studies that would establish the percentage, hopefully near or at 100%, of those who were appropriately vaccinated who, after a period to allow the vaccine's claimed protection to develop, did not subsequently contract a clinical case of the disease(s) for which the vaccine is supposedly protective after appropriately vaccine-inoculated participants were intentionally exposed to the native/wild strain or species of the disease(s) for which protection is claimed.

59 For more details on the findings, the CDC's NCHS (National Center for Health Statistics provides some database access to the NHANES datasets through http://wwwn.cdc.gov/nchs/nhanes/bibliography/key_statistics.aspx.

60 Lowry F. Prevalence of Chronic Illness in US Kids Has Increased. *MedScape Today*, 2010 Feb 16; 2010, which, for those who have, or set up an account, can, after logging in, be accessed at http://www.medscape.com/viewarticle/717030,

"The rate of chronic health conditions among children in the United States increased from 12.8% in 1994 to 26.6% in 2006, particularly for asthma, obesity, and behavior and learning problems, according to results of a new prospective study published in the February 17 issue of the Journal of the American Medical Association.

'Understanding prevalence and dynamics of chronic conditions on a national scale is important when designing health policy, making accurate clinical predictions, and targeting interventions to prevent chronic conditions,' write Jeanne Van Cleave, MD, from MassGeneral Hospital for Children, Boston, Massachusetts, and colleagues.

Patterns of how these health conditions have changed have not been widely examined, the authors note. The aim of this study was to examine fluctuations in the prevalence of obesity and other chronic conditions over time.

The investigators used data from the National Longitudinal Survey of Youth-Child (NLSY) Cohort (1988 - 2006) to estimate changes in prevalence, incidence, and rates of remission of obesity, asthma, other physical conditions, and behavior and learning problems in 3 consecutive cohorts of children in the United States.

The children were 2 through 8 years old at the beginning of each study period, and each cohort was followed up for 6 years. Cohort 1, followed up from 1988 to 1994, consisted of 2337 children, cohort 2 consisted of 1759 children and was followed up from 1994 to 2000, and cohort 3 consisted of 905 children and was followed up from 2000 to 2006.

Health conditions were reported by the parents and included any condition that limited activities or schooling or required medicine, special equipment, or specialized health services and that lasted at least 12 months.

Moreover, this decline has not been caused by the effects of any acute disease but rather because of the near epidemic or epidemic increases in the levels of chronic childhood medical conditions that, in the 1970s, were either unknown (e.g., childhood type 2 diabetes) or rare (e.g., children with severe regressive neurodevelopmental [e.g., autism spectrum disorder]; behavioral disorders [e.g., children with attention-deficit hyperactivity disorder {ADHD}]; and metabolic disorders [e.g., obesity]).

Increasingly, parents and independent researchers have become aware that the increasing level of vaccination, in terms of both the diseases covered and doses of "disease protective" components in the vaccines that are administered, is a significant factor in the decline in the overall "*health of our children*".

Thus, if, as Dr. Pearl suggests, the overall "*health of our children*" should be the measure upon which we should focus, then it is increasingly clear, *by that criterion*, our vaccination program has had an overwhelmingly negative impact on the overall "*health of our children*".

"Before parents decide not to vaccinate their son or daughter, they need to consider the scientific evidence. They need to imagine how they will feel should their child die or experience long-term disability from an easily preventable disease."

Here, Dr. King agrees with Dr. Pearl's first statement,

"*Before parents decide not to vaccinate their son or daughter, they need to consider the scientific evidence*".

However, Dr. King suggests that, *at a minimum*, everyone who has that choice should study and understand the information provided

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Prevalence Increased With Time

The investigators report that the prevalence of any chronic condition increased with subsequent cohorts. The baseline prevalence for cohort 1 was 11.2% (95% confidence interval [CI], 9.7% - 12.8%; P < .001), for cohort 2 it was 16.6% (95% CI, 14.6% - 18.8%), and for cohort 3 it was 25.2% (95% CI, 22.0% - 28.7%).

The end-study prevalence of any chronic health condition was 12.8% (95% CI, 11.2% - 14.5%) for cohort 1 in 1994, 25.1% (95% CI, 22.7% - 27.6%) for cohort 2 in 2000, and 26.6% (95% CI, 23.5% - 29.9%) for cohort 3 in 2006.

The investigators also report substantial turnover in chronic conditions. At the beginning of the study, 7.4% (95% CI, 6.5% - 8.3%) of children in all cohorts had a chronic condition that persisted to the end, 9.3% (95% CI, 8.3% - 10.3%) reported conditions at the beginning that resolved within 6 years, and 13.4% (95% CI, 12.3% - 14.6%) had new conditions that arose during the 6-year study period.

Cohort 3 had the highest prevalence of having a chronic condition at any time of the study period — 51.5% (95% CI, 47.3% - 55.0%) — and there were higher rates among boys (adjusted odds ratio [AOR], 1.24; 95% CI, 1.07 - 1.42), Hispanic children (AOR, 1.36; 95% CI, 1.11 - 1.67), and black children (AOR, 1.60; 95% CI, 1.35 - 1.90).

The authors cite limitations of their study, including that information about children's health was parent-reported and subject to recall bias. With the exception of obesity, the NLSY did not use objective criteria for diagnoses. Some children may have been over-diagnosed, they point out. In their conclusion, the authors write that chronic conditions in childhood are common and dynamic. This emphasizes the benefits of continuous and comprehensive health services for all children 'to adjust treatment of chronic conditions, promote remission, and prevent onset of new conditions. Further research should examine etiological differences between persistent and remitted cases.'

... Source: Van Cleave J, Gortmaker SL, Perrin JM. Dynamics of Obesity and Chronic Health Conditions among Children and Youth. *JAMA* 2010 Feb 17; 303(7): 623-630. [http://jama.jamanetwork.com/article.aspx?articleid=185391]". This article was last accessed on 31 March 2014.

in the package insert for each vaccine that is being proposed or recommended for administration.

In addition, they should study:

- The theoretical risk(s) that the persons, who are to be inoculated with these vaccines, have for contracting the disease(s) covered by the proposed vaccine inoculation;
- The possible serious adverse reactions the persons who are to be inoculated may incur and their population occurrence risks; and
- *Where possible*, the approximate risks for serious adverse reactions, including death, for each individual who is scheduled to be vaccinated may incur, not the irrelevant population risks.

However, Dr. Pearl abandons his "*need to consider the scientific evidence*" and makes a biased, emotional (*ad misericordiam*) argument when he next states,

> "*They need to imagine how they will feel should their child die or experience long-term disability from an easily preventable disease*".

Moreover, even here, Dr. Pearl's pro-vaccination bias is clearly apparent when he fails to ask parents "*to imagine how they will feel should their child die or experience long-term disability from*" a vaccine inoculation.

Furthermore, Dr. Pearl does not inform the reader that, *based on a presumed high (10%) reporting level for serious adverse events and deaths to VAERS for the vaccines that Dr. King has accessed in depth in his peer-reviewed articles or peer-reviewed published studies* (e.g., the childhood vaccines for influenza, tetanus, diphtheria, pertussis [whooping cough], measles, mumps, rubella, chickenpox and shingles), probably many more children die each year in the USA from a serious reaction to a vaccination they received than from the disease or diseases for which that vaccination is purported to provide protection.

Additionally, Dr. Pearl fails to inform the reader that, *at the multiple dosing levels currently recommended (typically, two [2] to five [5] or more doses*, several of the current vaccine inoculation programs are neither medically cost-effective nor societally cost-effective when all of the vaccine/vaccination costs are independently accessed.

Moreover, *ignoring the cost-effectiveness aspects of the CDC's recommendations*, Dr. Pearl joins the Establishment, the manufacturers and their minions, and other vaccine/vaccination apologists and acolytes in condemning the residents of the USA to a healthcare sys-

tem that wastes billions of dollars annually in promoting vaccination programs that are not truly cost-effective.

Finally, Dr. Pearl neglects to inform the reader that, *except for directly lining the pockets of the vaccine makers and the vaccination providers*, the childhood vaccination programs in the USA for whooping cough and chickenpox, which can be deadly to some, have been repeatedly shown to be ineffective in protecting the population from being infected by, and suffering from, the adverse health effects related to the occurrence/recurrence of these diseases in the USA.

"And as a society, before we allow misinformation to threaten public health, we must recognize that vaccines today are safe and effective. Anything less is irresponsible. We owe it to our children and our communities to make vaccination universal."

First, Dr. King cannot agree with Dr. Pearl's first statement in his closing remarks,

"*And as a society, before we allow misinformation to threaten public health, we must recognize that vaccines today are safe and effective*"

because the standards for prophylactic vaccines, which require that they must be proven to be "*safe*" and "*effective*", have not been met.

Thus, Dr. Pearl and his fellow vaccine apologists, including the Establishment, vaccination providers and governmental officials, are, in Dr. King's view, those who are principally guilty of allowing "*misinformation to threaten public health*".

Clearly, to the extent that the decline in the overall health of our children is linked to the rise in chronic childhood diseases that are plainly linked to one or more aspects of our past and current vaccination programs, we must more stridently press for abandoning those vaccines and vaccination programs that have been independently proven to be less safe than required by law, less effective than their proponents claim, and/or not cost-effective when all of the costs, including vaccination-related damage to the recipients are considered.

In Dr. King's view, anything less than prophylactic vaccines/ vaccination programs that have been *independently* proven to be:

- As safe as currently required by law from carcinogenicity, mutagenicity, reproductive toxicity;
- Free from serious adverse effects that occur more frequently in those who are vaccinated than in those who naturally contract the disease(s) covered by the vaccine/vaccination; and
- Free from the exacerbation of the risks for long-term chronic diseases triggered by the non-reversible damage to the

immune system that repeated vaccine inoculation has been shown to cause

should be challenged; and those vaccination programs that are neither effective nor cost-effective when all costs are properly considered should be abandoned.

Until the preceding actions are implemented, what truly "*is irresponsible*" in our society are the CDC-supported vaccination recommendations and State-supported vaccination mandates for vaccines that have independently been proven to be ineffective (e.g., the pertussis components in the current FDA-approved vaccines that contain them) and/or cost-ineffective (e.g., the current two-dose chickenpox vaccination program.

In a world where the current FDA-approved vaccines have essentially been recognized as "unavoidably unsafe" by the U.S. Supreme Court and none of the prophylactic vaccines given to our children and ourselves have been proven to be *incapable* of causing cancer, mutations and/or reproductive harm, what we owe "*our children and our communities*" is freedom from any and all mandates for prophylactic vaccination that do not provide us with the option to decline any prophylactic vaccination for any reason (i.e., a medical, religious, or "personal choice" [philosophical] exemption).

Moreover, in a "free society", after

- The current or future FDA-approved prophylactic vaccines have been proven to be incapable of causing cancer, mutations and/or reproductive harm and those without these proofs of safety have been withdrawn
- The remaining vaccines have been proven to be reasonably safe in randomized double-blind placebo-controlled studies where the control is a true placebo,
- Those vaccines that have been proven to be safe are also proven to be effective in disease-challenge studies using fully informed volunteers and
- The remaining vaccination programs have been proven to be medically cost effective when all of the costs for the maximum permitted doses have been appropriately included,

any prophylactic vaccination mandate should still allow the individual to decide whether that vaccination is appropriate for that individual or those minor children or wards for which that individual cares by continuing to provide medical, religious and personal-belief exemptions for all who currently want to be excluded from a given mandate.

## Dr. King's Closing Remarks

Recognizing that individual freedom of choice and bodily integrity that are inherent rights in the Declaration of Independence and explicitly recognized rights reserved to the individual by the Constitution of the United States of America, which cannot legally be infringed by any prophylactic vaccination program, Dr. King makes the preceding recommendations with the realization that, when proven to be truly as "safe" as required by law and truly "effective" in providing protection from disease without significantly increasing the level of chronic disease, and truly medically cost-effective, many may elect to participate in the vaccination programs that meet the criteria that Dr. King has proposed.

However, until the requisite independent proofs of "safety", "effectiveness" and "cost-effectiveness" have been established, Dr. King cannot recommend, and Dr. Pearl should not be recommending, any universal vaccination program.

## Acknowledgments

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## About Robert Pearl, MD, Author of the Article Reviewed

Source: http://www.forbes.com/sites/robertpearl/

"As a CEO, practicing physician and business school professor, I have a unique perspective on the business of health care and the culture of medicine. My passion is helping people understand the interactions and consequences of these powerful forces. I am the CEO of The Permanente Medical Group – the largest medical group in the nation – and CEO of the MidAtlantic Permanente Medical Group. In these roles, I am responsible for 9,000 physicians, 35,000 staff and the medical care of 4 million Americans living on both the west and east coasts. I am chair of the Council of Accountable Physician Practices (CAPP), a board-certified plastic and reconstructive surgeon, a clinical professor of surgery at Stanford University, and on the faculty of the Stanford Graduate School of Business where I teach courses on strategy, leadership, and health care technology. I received my M.D. from the Yale University School of Medicine and completed my residency in Plastic and Reconstructive Surgery at Stanford. Follow me on Twitter @RobertPearlMD."

## About Paul G. King, PhD, Author of this In-depth Review

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[61].

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.

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[61] 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".]

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[62].

Furthermore, Dr. King was one of the authors in a review chapter, "Mercury Induced Autism"[63] (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[64].

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62 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

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

64 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.