A rebuttal to the doublespeak in "Parents, officials struggle over right to refuse vaccines"

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Abstract

A review of a November 11, 2007 *Daily Harold* article by Logan Molyneux. The article, titled, *Parents, officials struggle over right to refuse vaccines*, was located and then downloaded on 12 November 2007 from: http://www.heraldextra.com/content/view/243180/3/ This review addresses each point raised in detail and establishes that factual evidence presented in this review does *not* support most of the issues raised by the writer. Passages in *italics* between opening and closing quote marks are short quotations from the article reviewed.

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1. Just an anecdotal vaccine injury case?

This article begins by briefly recounting the experience of the Dylan Hansen, a child who has apparently suffered serious vaccine-related injury.

Here, this reviewer finds that this anecdotal recounting of the severe harm to this 1-year-old child named Dylan from the simultaneous administration of four live viruses (measles, mumps, rubella, and herpes varicella-zoster) in two Merck vaccines (MMR-II and Varivax) accurately portrays the harm a child may "rarely" experience after getting these two vaccines.

However, this recounting does *not* reflect the reality that vaccine administration can, and does, cause worse injuries and death to some who have been given this combination of vaccines at 12 months of age.

Since administering these two vaccines inoculates the child with "weakened" strains of live viruses for four diseases (measles, mumps, rubella and chicken pox [varicella]), the reader should *not* be surprised that an adverse outcome, such as the one reported, may occur.

The writer's "*Hansen is among a small but growing number of parents who choose not to vaccinate their children …*" is an obvious misstatement of the facts since their child was apparently vaccinated up through the age of 12 months, presuming that the writer's previous account is factually accurate.

Perhaps the writer intended to say:

> "Hansen is among a number of parents who choose to stop vaccinating their children after a given vaccination has resulted in significant harm to one or more of their children."

While the conclusion of the article's "*Hansen is …*" statement, "*… according to the medical community, consequently increase the population's risk of disease,*" captures the orthodoxy of those who religiously believe in vaccination, this reviewer notes that the article fails to cite, or reference, any study that shows that stopping the vaccination of children who have severe adverse reactions to vaccines increases the population's overall risk of disease.

Moreover, many of the proponents of vaccination who appear to hold this belief are the same conflicted pediatricians who derive half, *or more*, of their income from administering vaccines—certainly a group with an innate financial bias towards more vaccinations.

2. Arguments against vaccines?

2.1 Producers are corrupt and greedy

Next, the writer begins his putative discussion about arguments against vaccines by stating obvious facts, "*large pharmaceutical companies … are corrupt*" and "*companies that manufacture the vaccines … lobby for vaccine laws*," as if they were simply thoughts.

Factually, given the spate of incidents involving major pharmaceutical manufacturers, including major vaccine makers, like *Merck, Sanofi-Aventis, SmithKlineBeecham, and Wyeth*, in which they appear to have *knowingly*:

- **a.** Concealed the "side effects" effects of their problematic drugs from the public and
- **b.** Heavily advertised their problematic drugs, even when they knew they were harmful, to increase their revenues,

this reviewer finds there is no argument that the large pharmaceutical companies that make vaccines appear to be corrupt.

Moreover, the writer is stating the obvious when he indicates that pharmaceutical companies are interested in making money.

This is the case because all for-profit corporations, including those that make vaccines are, *as they admit*, driven by the imperative to make money.

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2.2 Vaccine makers lobby for vaccine laws?

Moreover the vaccine firms have not only lobbied "*for vaccine laws*" but also, *given the U.S. laws shielding them from direct suit in vaccine injury cases* (see, *for example*, **42 U.S.C. Part 300aa**), have been successful, *at least in the U.S.*, in obtaining protections that allow them to make their vaccines with little worry of direct litigation even when their vaccines may be, or are, dangerous.

Additionally, they have sought specific protection from being sued for selling for vaccines containing Thimerosal (49.6 weight-% mercury.

Furthermore, to the extent that pharmaceutical companies *knowingly* fail to comply with any applicable federal policy, law or statute governing the manufacture of drugs, *in general*, or vaccines, *in specific*, it is obvious that not only are they corrupt but, *when the federal officials collude with them to allow adulterated drugs* (e.g., vaccines containing a preservative, like Thimerosal, whose toxicological safety has not been proven to the applicable standard "sufficiently nontoxic …" [**21 C.F.R. Sec. 610.15(a)**]) *to be marketed*, they are also apparently operating a "racket" and would seem to be violating the criminal RICO statutes (Racketeering, Influencing, and Corrupt Organizations) statutes set forth in **18 U.S.C.A Sec 1961 et seq**.

Moreover, the federal government "profits" from the current US$ 0.75 tax on each covered vaccine disease dose (currently about US$ 210 million annually and increasing) as long as the payout from the Vaccine Injury Compensation fund is, *as has been the case for more than a decade*, significantly less than the annual interest that accrues to this fund – thus, government officials also have financial incentives to: **a)** approve more vaccines and **b)** minimize the payout from the Vaccine Injury Compensation fund.

Yet, this reviewer is surprised that the writer presents:

- **a.** Only some of the financial incentives for more vaccines and more doses without regard to the true medical cost-effectiveness of each vaccine and
- **b.** These financial incentives as "*Arguments*" rather than the factual realities that they so obviously are.

To see this reality, one need only look at the billions Merck is projecting for its newest vaccine, Gardasil®, and Merck's direct and indirect efforts to widen the vaccine's indicated age range and to expand its indications to include males – all without any proof that vaccinating today will truly protect against cases of cervical cancer, a cancer that:

- **a.** Is life-style related,
- **b.** Will only develop in a small percent of women, and
- **c.** Will not develop for 25 to 50 years after the initial vaccination series.

With respect to this writer's remarks about "*natural health*" and idea that a person can be healthy "*without medicines*," this reviewer first notes that the writer is only stating the obvious and fails to present any evidence that it is not possible for any group to be healthy without medicines.

Moreover, in spite of intense propaganda by the "health-care" establishment, the reality remains that some groups and individuals manage to be healthy and live into their eighties and beyond, with little, or no, vaccinations as well as only minimal, or no, use of prescription drugs.

Perhaps, if more of us followed their examples, we would be as healthy, as a group, as they are.

Moreover, if, *as the writer should have done*, the rhetoric were restricted to vaccines, then there are large groups of people in the United States of America who:

- **a.** Do not vaccinate and
- **b.** Apparently have "no higher" infant, childhood, or lifetime mortality than those who vaccinate their children.

2.3 Coercive vaccination practices?

With respect to this U.K. article's "*the biggest complaint is that vaccines are administered by force,"* this reviewer agrees with the writer to the extent that coercive state laws are used to increase vaccination and, *though medical, religious and, in some States, philosophical exemptions do exist*, health, school and other officials continually discourage Americans from exercising their Constitutional right to exempt themselves and their children.

Moreover, this reviewer is surprised that the writer did not note that the U.S. is one of the few "democratic" nations that have such coercive policies instead of policies of supportive encouragement.

Also, the writer only speaks of the coercive aspects of the laws for our "*school-aged children*," when these laws extend to adults seeking to attend universities and those wishing to be employed in certain jobs.

Moreover, the writer's remark here fails to mention, much less address, the U.S. Constitution's guidance which states that "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof," a prescription that is supposed to guide the various states.

Recognizing the general applicability of these rights, most states include a religious exemption, *as it should in a nation where freedom of religion is guaranteed*, and, *in many states*, there is also a "philosophical" exemption.

3. Are vaccines greatest triumph of public health?

With respect to the article's unsupported generalization concerning "*overwhelming medical evidence and opinion stating that vaccines are not only safe but the greatest triumph of public health in history*," this reviewer simply notes that the writer is parroting the healthcare establishment's views that vaccine apologists proffer instead of presenting scientific evidence to support their views.

The scientific reality is that, *for most vaccines*, there is:

- No proof of long-term safety,
- An increasing body of evidence that the long-term financial, societal and human costs of many vaccines outweigh their claimed benefits, and
- Increasing clarity that the healthcare establishment's propaganda has misled the public concerning the true role of vaccines and vaccination in improving the overall health and the quality of life of the American public.

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4. Fear of being seen as bad parents?

Why is it that this article appears to "subtlety" portray those who choose not to vaccinate as bad parents?

Factually, in the U.S., there are individuals and large groups (e.g., the Amish) who do not favor vaccination and who do not consider themselves to be and are not bad parents.

Finally*, as this article and others show*, there are many good parents who do speak out about the harm that some vaccine has, or vaccines have, caused to one or more of their children.

5. Vaccine teactions unnoticed?

As the article reports here, Marie Hansen, trusting the propaganda incessantly broadcast by those who serve the interests of the healthcare establishment, did not notice any previous adverse reaction to the vaccines given to Dylan Hansen or her other children.

Thus, the article again affirms that Dylan Hansen was vaccinated until the concomitant administration of the Merck MMR-II® and the Varivax® vaccines severely damaged him.

Moreover, had the drug have been an antibiotic and the child experienced a severe anaphylactic reaction, this reviewer, and hopefully the informed reader, recognizes that no one would be writing about that child and/or his mother's decision not to ever again allow that antibiotic to be given to that child or, for that matter, to his siblings.

However, the writer has inadvertently exposed the reality that, with few exceptions, vaccine reactions tend not to be noticed – perhaps because everyone has been indoctrinated and/or brainwashed into believing:

- Vaccine reactions are "rare,"
- Vaccines are safe – even in cases where their long-term safety has not been proven and/or their producers have failed to prove them safe to the standard "sufficiently nontoxic …," and
- Vaccines are effective – though their in-use effectiveness has, in some cases, been shown to be illusory (e.g., the influenza vaccines).

Finally, since neither the producers, nor the government, nor the healthcare providers are conducting on-going monitoring designed to look for the long-term adverse effects that may be vaccine associated, no one should be surprised that most of these go unnoticed by the general public.

Perhaps, if Dylan's parents and those administering his vaccines had been warned to look for adverse reactions, Dylan might have suffered less injury.

6. Growing numbers in Utah?

First, this reviewer wonders why this writer chose to use Utah, whose vaccination uptake rates rank then 25th, above the middle of the list of States, the Commonwealth of Puerto Rico, the District of Columbia, and the U.S. territories but only ranks 34th in population – that is unless the writer was looking for a mostly Mormon (about 62%) population that has historically resisted vaccination.

Moreover, this reviewer is puzzled about this article's concerns about the rise in exemptions in one mostly rural county in Utah, Utah County, and its experience with vaccine exemptions when that experience, even if accurately presented, is not representative of the State of Utah, much less the United States of America.

Tellingly, for example, the overall vaccination rate in State of Utah, already above the median vaccination rate for all the U.S. reporting political units (states, commonwealths, districts, and territories) appears to be increasing regardless of the medical, philosophical, and religious opt-out choices available to the parents and guardians of Utah children.

Given the preceding realities and the lack of more details as to the distributional nature (e.g., medical, religious, or philosophical) of the exemptions requested and/or the reasons for the exemptions (e.g., specific vaccines, general exemption, or exemption following adverse events) and the rate (number divided by population) of the increase in each type of exemption, neither this reviewer nor any other reader can understand the significance, if any, of the writer's remarks here.

7. Vaccine exemptions allowed

This reviewer finds that this article is somewhat misleading in that, while it notes that the current laws in two states only allow a medical exemption, the article fails to mention that about 20 states currently have a philosophical exemption.

In addition, the laws of the States of Mississippi and West Virginia appear to be at odds with spirit of the First Amendment to the U.S. Constitution.

8. Vaccination – a victim of their success or greed?

This reviewer must respectfully disagree with the writer's statements about Dr. Miner's views.

In this reviewer's view, vaccination programs have become victims to greed-driven additions:

- Of vaccines for non-contagious (e.g., hepatitis B and HPV), relative benign (e.g., chickenpox) and non-population-wide (e.g., rotavirus, which is mostly confined to the demographically poor) diseases, where the vaccination programs are not *medically* cost-effective
- Where, *in spite of efficacy claims*, the vaccines are not truly effective in preventing the disease (e.g., human influenza), and
- Where the vaccine does not even provide any protection against one or more of the prevalent virulent strains (serogroups) of the disease (e.g., the current vaccines for *Neisseria meningitidus* do not protect against the "B" strain that, depending upon the age of the child, causes up to 25% (in older children) to 50% (in young children) of the human cases where the strain is identified).

Since the long-term safety of most vaccines has not been proven, in deciding whether or not to deploy a vaccine for which short-term safety and true effectiveness has been established, the decision should be based on its medical cost-effectiveness considering the worst-case costs of the harm that the vaccine is known to, or may, cause.

Today, "societal costs," as reported by studies influenced by those who benefit from the vaccine's being deployed, are being

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used to justify vaccine approval and, *in some cases* (e.g., rotavirus), the lack of even "societal effectiveness" is ignored and the vaccine is licensed and approved for universal use.

Finally, "ill-conceived" vaccines (e.g., the now-withdrawn Lyme disease vaccine) are licensed, approved, deployed and quietly withdrawn without the public's being told the truth about their failure to protect and/or the long-term harm these vaccines caused to those inoculated with them.

Together these factors (and not the "*success*" of the polio, DTaP, and MMR-II vaccines) are pushing parents to increasingly question and reject the semi-religious claims made for vaccine safety (e.g., "the safest of medicines") and vaccine effectiveness (e.g., protects "all" those vaccinated from getting the disease) spread by those who profit from increasing the national vaccination programs.

9. An AP study – religious exemptions increase?

Here, this writer is simply reporting the reality that the parents' genuine concern is the real safety of certain vaccines and/or vaccine additives (e.g., Thimerosal, aluminum salts, and gelatin), where they have been told that vaccines are supposedly "the safest of medicines" but their experience or that of their friends and relatives has found that this "the safest of medicines" claim has not been supported by the outcomes observed.

Regarding the stated need for all to be vaccinated, if vaccines truly protected all of those vaccinated from contracting a disease, then the only people at risk would be those who were not vaccinated.

However, accepting the validity of the writer's statement here, it is clear that vaccination does not even protect all those vaccinated from getting the disease the vaccine is supposed to prevent.

Moreover, as the ever-increasing need for one or more subsequent booster doses indicates, the protection from contagious childhood diseases pro-vided by most vaccines for them does not last as long as the protection from disease afforded by having a childhood disease and recovering from it.

As the recent measles outbreak demonstrated, when exposed to measles, some of those who had not had measles but who were "fully" vaccinated still contracted measles – most at ages well-beyond the childhood period, when, *for those children with a healthy immune system and adequate stores and/or intakes of vitamin A and D from Cod-liver oil and vitamin C from fruits and vegetables*, the disease is usually mild.

In contrast, those who have no immunity or incomplete immunity from vaccination, and contract an early childhood disease much later in life have a much more severe case of the disease.

Thus, at best, vaccines are generally protective for some (unknown) period of time for most of those who are vaccinated – regardless of the percentage vaccinated – as the reported outcomes from disease exposure by outside carriers entering the vaccinated population clearly indicate.

10. Re: A disease specialists views on vaccination

First, this reviewer finds the writer's decision to present Dr. Osguthorpe's "speed limit" analogy is appropriate since, since, as all readers know, almost everyone does not drive the speed limit and, for most of us, the ride is still safe.

Moreover, while this reviewer agrees with Dr. Osguthorpe that we "*don't immunize just for fun*" and that some "*children die from preventable diseases*," the article's unspoken realities are: **a)** some children die from being vaccinated and **b)** many more are severely harmed by being vaccinated.

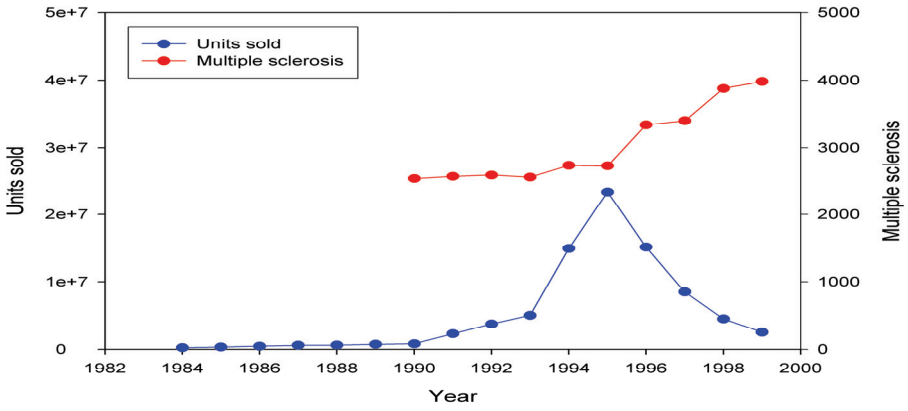
Yet, this reviewer does not hear Dr. Osguthorpe, or others of his ilk, forthrightly address either of these realities.

For example, addressing the hepatitis-B vaccine issues, Dr. Jane Orient, director of The Association of American Physicians and Surgeons, wrote:

> "In 1996, only 54 cases of the disease were reported to the Centers for Disease Control and Prevention (CDC) in the 0 to 1 age group. There were 3.9 million births that year, so the observed incidence of hepatitis B in the 0 to 1 age group was just 0.001 [actually 0.0014] percent. In the Vaccine Adverse Event Reporting System (VAERS) there were 1,080 total reports of adverse reactions from hepatitis B vaccine in 1996 alone in the 0 to 1 age group [raw incidence of 0.028 %], with 47 deaths reported [raw incidence of 0.0012 %].
>
> For most children, the risk of a serious vaccine reaction may be 100 times greater than the risk of hepatitis B. Overall, the incidence of hepatitis B in the U.S. is currently about 4 per 100,000. The risk for most young children is far less; hepatitis B is heavily concentrated in groups at high risk due to occupation, sexual promiscuity, or drug abuse."

Thus, in 1996, for a hepatitis B rate to 0.0014 % (54 cases) "in the 0 to 1 age group," at least 47 children in this age group were reported to have died and 1,033 more were reported to VAERS to have an adverse reaction from being vaccinated with the hepatitis B vaccine.

Thus, the U.S. national hepatitis-B vaccination program appears to be a very poor risk tradeoff especially since most of the reported 54 cases of hepatitis B in infants under 1-year old did not kill the infected infant.



"**Figure 1. Units sold and cases of multiple sclerosis by year.** [Sales of hepatitis B vaccine in France as compared to the frequency of severe multiple sclerosis, 1982-2000 (Data from the French health-insurance system)]"

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In addition, a recent paper, discussing the abuse of evidence-based medicine (EBM) reported the obvious increase in multiple sclerosis (MS) in children that occurred at such an increased rate that, 4 years after hepatitis-B vaccination program for French middle-school children was implemented, the number of cases of MS had increased by about 60%[1] (**see** the quoted text that follows) and **Figure 1** on the preceding page):

> "The incidence of severe MS cases (according to the data from the national health insurance system) and the sales of hepatitis B vaccine doses are depicted in Figure 1, which shows a significant displaced correlation between the two factors.
>
> This increase was so notable that the government of France canceled that national vaccination program for hepatitis B in children as the drop of sales of hepatitis B units after this hepatitis-B program was terminated."

Finally, this increased risk had already been noted in a previous U.S. study of the U.S. Vaccine Adverse Event Reporting System (VAERS) that examined the statistical correlation between the doses of hepatitis-B vaccine used and autoimmune diseases, including MS.[2]

11. Religious/Philosophical exemptions increase disease risk?

First, this reviewer wonders why no data is reported for those who have medical exemptions.

Second, this reviewer notes that no incidence/ prevalence rates were reported for either disease so that neither the incidence/prevalence rates for "vaccinated children" could be assessed nor could the import of the increased rates among those with these exemptions be assessed for measles and whooping cough.

Third, this reviewer notes that there are no outcomes data to assess whether or not the harm caused to the children by the disease in the "exempt" cases was significantly more than the overall vaccine-related harm to the "vaccinated children" as well as the harm to those who, *though they were vaccinated*, still contracted the disease.

In addition, with respect to the anecdotal report about "*an outbreak of whooping cough*" in Utah Valley, it seems as if those cases ("*sick kids*") were unvaccinated children who "*can spread disease even to vaccinated children*," theoretically, but, *from the writer's text*, apparently did not actually do so.

12. Vaccine effectiveness and disease risk?

With respect to the claim that vaccines are "*95 to 99 % effective*," this reviewer would challenge Dr. Miner's blanket, unqualified, effectiveness numbers for vaccines in general, as this reviewer does not know of any effectiveness (not efficacy) studies that have proven the effectiveness of all vaccines when taken as the current vaccination programs recommend.

For example, his blanket assertion concerning vaccine effectiveness seems to be at odds with the claims made by Sanofi-Aventis for its Menactra® meningococcal vaccine, where for the four covered strains, the short-term (3-year) efficacy, not effectiveness, claims are 85% or less, and this vaccine has no efficacy or effectiveness for the "B" serogroup that is the identified strain in up to 50% of the early childhood cases of this disease and up to 25% of the cases in older children.

However, accepting the writer's "*from 1 to 5 percent of kids who for some reason have lost immunity or haven't developed it*" assertion as valid for measles and pertussis, and taking his "*25 percent of other kids not immunized*" assertion to mean those children with "filed religious or philosophical exemptions," the subject of this paragraph, this reviewer finds that, at best, these two well-controlled illnesses can only spread through no more than about 5% of the whole population and, *with appropriate quarantine and other healthcare interventions*, should spread through no more than 1% of the population who has not already had, or been vaccinated against, these diseases.

13. Risks to unvaccinated children and their peers

With respect to the article's assertion that not vaccinating children "*puts them and their peers at risk*," this reviewer finds this assertion is, to say the least, misleading.

When most are vaccinated and, *as the article presumes*, the vaccines are truly long-term effective, the only children put at risk are the non-immunized children and, *presuming the 90 to 95% effectiveness claimed*, a very small percentage (some percent of the 1 to 5%) of those children who have been vaccinated.

However, for everybody's unvaccinated children there is no risk of the known adverse outcomes including death and severe injury associated with the administration of these vaccines.

Since, *as the doctor admits*, vaccination does not guarantee immunity, those making the choice not to vaccinate are accepting the theoretical (theoretical since, absent disease exposure, there is no disease risk) risk of disease and the harm it may cause while rejecting the known risks associated with vaccination, including death and severe injury, and accepting the admitted reality that vaccination may not protect their child from contracting these two diseases.

Section 1 of Amendment XIV, ratified July 9,1868, to the U.S. Constitution states:

> "All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws."

Therefore, it is clear that the right to choose or refuse vaccination is a right that is protected by the constitution of the United States of America and that, *if anything*, given the rise in State laws and regulations mandating vaccines for diseases other than those that are immediately life-threatening to the whole population, the laws should be changed to "opt-in" for all such vaccines – where the person, parent or guardian must be fully informed of the known risks (and their underascertainment-corrected risks) and the theoretical benefits of each vaccine, and then give their affirmative written consent before

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[1] Girard M. When evidence-based medicine (EBM) fuels confusion: multiple sclerosis after hepatitis B vaccine as a case in point Medical Veritas 2007; 4: 1436-1451.

[2] Geier D, Geier M. A case-control study of serious autoimmune adverse events following hepatitis B immunization. ***Autoimmunity*** 2005; **38**: 295-301.

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any of these vaccines may be given to themselves, their child or children or their wards.

14. Vaccination confused with providing immunity

Here this reviewer notes that the writer is obviously confusing immunity with vaccination since no data has been presented concerning the present-day immunity of the entire population of "*Utah Valley*" or, *more importantly*, the breakdown between "natural" and "vaccination acquired" immunity and the "immunity" testing that proves, *contrary to reality*, that both types of immunity are truly protective of all known strains of each disease.

Furthermore, given MRSA and the emerging incidence of variant virulent strains of viruses where the vaccine does not cover all strains, this reviewer wonders why there is no mention of the risk of creating more virulent strains when the virus strains in the live-virus vaccines interact with the "wild"/"natural" disease strains.

Moreover, this reviewer is struck by the writer's failure to state, *much less address*, the biggest risk factor: exposure of the population to a recent non-indigenous immigrants or other travelers, who enter the local population while actively shedding either the measles virus or pertussis.

For we all know that, absent exposures to these disease organisms (unlike some other diseases), there is no disease risk for either pertussis or measles.

Therefore, Dr. Miner's "*the state would have to disallow exemptions to protect the population*" advocates violation of our fundamental Constitutional rights based on a claim that "*the risk would increase*" while ignoring the real disease risk drivers (e.g., illegal immigration, poor hygiene, contaminated water, bad food, poor nutrition, and substandard housing) that far outweigh the increased risk from fewer vaccinations and the reality that nationwide vaccination, *for the newer (approved after 1987) vaccines*, is, *at best*:

- Not medically cost-effective,
- Only marginally cost-effective on a societal basis for some vaccines, or
- For a few of these newer vaccines, not cost-effective even when the projected societal costs are considered and the costs of the harm caused by the vaccines are excluded.

If, as alleged in this article, "*there is little risk of an epidemic*" in Utah Valley, perhaps this would be an ideal area to assess the true costs of vaccination and non-vaccination.

15. Public policy and "informed" consent in vaccination programs

15.1 Informed choice?

While this reviewer agrees that the freedom to make *"an informed choice*" is a major issue concerning vaccines and vaccination programs, this reviewer finds that other major issues are:

- The rigid intransigence on, and propagandization of, the almost religious "savior of mankind" view of vaccines by the healthcare establishment and health officials, and
- The failure of the government and the vaccine makers to provide full and complete scientifically sound and unbiased information:
  - Concerning the theoretical benefits from each vaccine, the apparent efficacy rates and efficacy duration period, and the probable adverse effects, including death, and their incidence rates for healthy children who may contract the disease(s) covered by the vaccine,
  - The real immediate adverse-reaction risks and risk incidences associated with each vaccine or vaccine combination, and
  - The long-term (> 1 year) adverse event risks and their incidence rates for those vaccinated with each vaccine or vaccine combination.

15.2 The unfettered right to choose?

Here, this reviewer agrees with Johnston's view that the public wants the right to choose and suggests that the public needs to have the laws governing vaccination rewritten to make them "opt in" laws instead of the current "opt out" laws that are in place today.

If this were to be done, then this major stumbling block would be removed and, *like most of the other elective aspects of American medicine*, "affirmative consent" would be required from each person, parent, or guardian before each and every vaccine could be given.

In this democratic America, vaccination status would no longer be tied to either school attendance or job qualification.

15.3 Mandatory vaccination and law breakers?

Here, the writer is, *at best*, being deceptive.

Because, to comply with the Constitutional mandates regarding "free exercise of religion" and the right to bodily integrity, most States' vaccination laws and regulations provide exemptions that any person may elect.

When the citizen elects to seek an exemption, be that exemption medical, religious, or philosophical, then the citizen is following the law.

Therefore it is disingenuous for any person to even attempt to cast:

- The various States' statutes and regulations governing vaccination as "*mandatory vaccination*" statutes or regulations, or,
- *As the article subsequently does*, portraying citizens who choose a legal exemption from vaccination as if they were law breakers.

As with any permissive laws and/or regulations, the vaccination laws and regulations provide options that a person may *legally* elect.

Thus, *contrary to the writer's distortion of the facts*, the Utah vaccination laws and regulations are not "*rare laws in society that citizens can choose not to follow*."

Again, the writer makes irrelevant and illogical statements here.

Factually, persons can and do legally declare themselves exempt from the posted speed limits when, *for example*, they

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decide that the weather conditions do not permit them to operate their vehicle safely at the posted speed limit and slow down.

For example, when it is raining hard and the posted speed limit is 70 mph, some drivers choose to limit their speed to about 50 mph because they think driving at higher speeds is not safe.

Thus, the writer's:

"*So it's a push for freedom of choice in an area of public policy where adherence is already optional.*"

is a blatant attempt to mislead the reader and portray laws enacted by the legally elected representatives of the people according to the will of the governed as "*public policy*," a term that is usually used for policies decreed by unelected administrative officials without obtaining the affirmative consent of the electorate or their elected representatives.

Hopefully, the citizens of Utah will recognize this attempt to subvert the will of the people and demand that their elected officials purge the State of all those appointed health officials who hold the opinion that their so obviously less-than-objective views should supersede the will of Utah's citizens.

In reality, the reasons for the conditional vaccination rules enacted by the Utah government are that, as they should, they reflect the "will of the people."

Increasingly, the need for these options is supported by the truth that the newer vaccines are apparently not only less than safe and/or less than effective, but also, *in several instances*, these vaccines are not cost-effective.

16. What American value – their personal freedoms and rights

16.1 A BYU "Public Policy" specialist's views

What this reviewer finds sad is that the United States of America, which gave Japan its democratic government – a government that does not mandate vaccines as a general condition for school attendance – continues to deny that same democratic freedom of choice concerning vaccines to all American citizens.

At a minimum, it is clear that this writer, the Utah health officials in this article, and U.S. health officials, *in general*, do not value the personal freedoms and rights of the American public when it comes to the right to choose (freedom of choice) and the right to know all the facts before being asked to choose (informed consent) concerning any aspect of vaccination.

The Japan example is particularly instructive since, *without a mandatory vaccination program*, Japan has a strong vaccination program that has produced an infant mortality rate that is about half of the infant mortality rate in the U.S. today.

Otherwise, this reviewer agrees that laws and regulations on vaccination, *which recommend a given course of action but provide optional choices*, have "*greater influence than guidelines*" because, *in general*, they are *currently* written in a coercive manner or, *when not so written*, are rendered coercive by the administrative practices adopted by State and local "health" officials.

16.2 The views of an advocate for truth in vaccination

First, this reviewer finds it unprincipled to cast those who recommend "*parents do their homework and talk to one or more health professionals and get all the information they can*" about vaccines as "*vaccine skeptics*."

Moreover, this reviewer finds that it is a slander on the good name of the National Vaccine Information Center (NVIC) to refer to it as "*a leading vaccine skeptic group*" simply because the NVIC:

- Tries to provide people with as much information as they can concerning vaccines and
- Focuses on the scientific information that the healthcare establishment and health officials do not routinely provide to the public.

Otherwise, this reviewer agrees that parents should consider taking the actions that Barbara Loe Fisher's group suggests.

17. The need for sticks to coerce vaccination?

This reviewer is bemused not only by the plainly belief-driven views of the health officials concerning vaccines but also by their "*looking for other ways to encourage parents to immunize their children*."

If vaccines truly were: **a)** "the safest of medicines," **b)** "safe and effective," and **c)** "able to immunize almost all those vaccinated" as the healthcare establishment and health officials claim, then why is there any need to "*encourage*" (by obviously coercive means) parents to vaccinate their children or, *as the writer does here*, to use the word "*to immunize*"[3] when "to vaccinate" or "to inoculate" are the verb that should have been used.

In a free market, vaccines that are truly safe and protective need no coercive measures to "*encourage parents*" to accept them for use on their children or themselves.

Thus, the clear message that attempts to "*encourage parents to*" vaccinate their children is sending and, *if these measures are increased*, will increasingly send, *whether or not they should*, is that: **a)** vaccines are not safe and effective and **b)** people should take whatever actions they can, including demanding, *on pain of non-reelection*, that their elected State officials repeal the current "opt out" vaccination laws and regulations and replace them with laws that clearly state that all vaccines are optional and cannot be required as a precondition for access to any school, social program, or job.

As to the plan to tie the ease of getting the WIC food vouchers that mainly the poor receive to vaccination compliance, this reviewer finds that this plan is particularly offensive because it obviously targets the poor (those who receive "WIC food vouchers") and, as stated, it appears to be illegal because it does not treat those with exemptions the same as those "whose child is up on his or her immunizations."

This reviewer is also sad to read that these WIC officials supported this plan, but he is glad that the cost was deemed to be prohibitive.

[3] Given the admitted reality that vaccination does not even provide short-term immunity to some who are vaccinated, it is clear that the use of the verb "*to immunize*" here is, *at best*, inappropriate.]

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18. Medical and public support or unwarranted coercive pressure?

Here, under the guise of medical and public support for vaccines, the writer is clearly attempting to prejudice Barbara Loe Fisher's remarks by explicitly casting her as a "*vaccine skeptic*" and to misrepresent the continual stream of misinformation, propaganda and brainwashing about vaccines as well as the direct "must vaccinate" pressure by health officials and the Establishment to which, as she reports, parents are continually subjected as though this self-serving stream, underwritten by the deep pockets of not only the vaccine makers but also those of the federal government, were simply medical and public support.

Moreover, this reviewer finds that Fisher's remarks that people trying to protect their children are often told that their decisions and/or actions are unpatriotic and selfish accurately reflect the view of reality most parents see.

19. Efforts to educate?

Contrary to the writers remarks, if the goals of Utah public health officials were truly to educate, and not to drive "*those who choose not to vaccinate underground*," then they would not be "*looking for other ways to encourage parents to immunize their children*" as this writer has previously stated in this article that they are.

If, *as this writer states*, Dr. Miner's work were intended to educate, then he would be:

- Actively publishing on-line all of the available peer-reviewed published data on each vaccine so that all might see what all of the benefits and risks are for each vaccine,
- Opposing vaccine administration when a child is ill and/or on any drug treatment regimen for an acute infection,
- Working towards a flexible vaccination schedule where the child's developmental age, immune-system state, and other factors, like breast-feeding, should be used to determine when a child should be vaccinated and not the current rigid schedule that considerers none of these,
- Opposing a statewide vaccination program for any new vaccine where the medical cost-effectiveness has not been established, and
- Supporting the removal of any vaccine that is not cost-effective in terms of its overall costs to society (medical and other) from the Utah list of recommended vaccinations.

However, from the remarks reported in this article that Dr. Miner has made and makes here, it is clear that none of these are a part of his "educational" priorities

20. Like it used to be for infant mortality and disease?

Presuming that the "new" human generations occur about every 20 years, Dr Miner's historical reference frame for how life was seems to be in the about 1950 since that time was roughly three generations ago.

Using this scenario, let us examine the facts about the decline in infant mortality and use another democratic nation, Japan, a nation that, unlike America, was devastated by war in the 1940s and has risen from those ashes to become the de facto low-infant-mortality leader for industrialized nations.

Using the infant mortality rates for the U.S. and Japan as a guide to what it used to be like with infant mortality and preventable diseases in two democratic countries, the first with a coercive vaccine-centric vaccination program and the second with a non-coercive cost-effectiveness-driven vaccination program, it seems clear that we should be adopting a program similar to Japan's.

We should be abandoning the U.S. approach because it obviously has contributed to twice the infant mortality for children born in the U.S. than the infant mortality for children born in Japan.

Moreover, Japan has had a lower infant mortality than the U.S. since the early 1960s (as shown in the following comparative "infant mortality" table).

Moreover, the overall additional 3-plus years of life expectancy seems to confirm that these vaccine-program differences contribute to today's longer life expectancy in Japan.

Infant mortality (deaths/1000 live births) and other information

Year	U.S.	Approx. annual decrease in U.S.	Japan	Approx. annual decrease in Japan	Other Information
1920	86	-----	-----	-----	
1930	65	2.1	-----	-----	
1940	47	1.8	-----	-----	Second World War 1942 – 1945 utterly devastated Japan
1950	29.2	1.78	60.1	-----	Salk vaccine in US mid 1950s
1960	26.0	0.32	30.7	2.94	
1965	-------		18.5	2.50	
1970	20.0	0.60	13.1	1.28	
1980	12.6	0.74	7.5	0.56	
1985	10.6	0.40	5.5	0.40	
1990	9.2	0.28	4.6	0.19	
1995	7.6	0.32	4.3	0.06	
2000	7.0	0.12	3.2	0.22	
2005	~ 6.43	~ 0.11	~ 3.24	~ 0	Life expectancy: US 78.0 years; Japan 81.4 yrs.

Moreover, although the disease reductions from the various U.S. vaccination programs should to be weighed against the harm caused by the vaccines and the program, this reviewer simply notes that, as most vaccines apologists do, this writer does not address the offsetting harm caused by the euphemistically named "adverse events" – including death.

Furthermore, rather than solely speaking of the decline in the diseases caused by organisms for which there is a vaccine, this reviewer understands that there is an ever-growing body of evidence that the epidemic rise in a plethora of chronic childhood diseases, disorders and syndromes (most of which were either not even recognized or, if recognized, were diagnosed at rates below the 1-in-10,000 level in the 1950s [e.g., childhood:

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allergies, asthma, autism spectrum disorders, ADD, ADHD, COPD, diabetes, food intolerances, gastrointestinal disorders like celiac disease, IDCM, MS, obesity, OCD, and SIDS, to name a few]) appears to be linked to some degree to the increases in vaccination and the move to vaccinate young children before their immune systems were intended to independently handle microbial infection.

Moreover, any attempts to get the health establishment to address these concerns are treated as "heresy" because the medical consensus is that vaccines are the safest of medicines and one of the greatest, if not the greatest, medical marvels this world has known.

On balance, this reviewer understands that, to the healthcare establishment's benefit, the current U.S. vaccination programs have been an overwhelming success since they have converted acute diseases from which most recovered with no long-term chronic harm into lifelong chronic conditions from which the children affected do not recover and which require continual medication, tests, follow-ups, and periodic hospitalizations.

Personally, this reviewer thinks that, *at a minimum*, our national vaccination programs should be rolled back to the vaccination programs of the 1970s, use separate vaccines for each live virus, utilize the safest and most effective modern vaccines, while keeping all of the curative advances that we now have.

21. Vaccine preventable tragedies?

Because all those who are vaccinated are not protected by "*a timely vaccination*," how does Dr. Osguthorpe know that all or, *for that matter*, any of the unspecified number of children about whom he is speaking could have avoided the "*tragedies*" as this writer reports them?

Also, why does he fail to mention the children, like Dylan Hansen, who have been, are, and will be tragically damaged by the vaccines that they have been given?

Why is it that the tragedies of the vaccine damaged gets only lip service while the anecdotal tragedies of the non-vaccinated are continually discussed and used to scare people into vaccinating?

Though each reader probably has his own thoughts on the answer to this question, this reviewer understands that the blind worship of vaccination and the on-going efforts to license more vaccines serves the greed of the healthcare establishment that must have an ever-growing customer base for its medicines, interventions, hospitalizations and surgeries if it is to continue to show the profit needed to line the pockets of its managers and shareholders and increase, or at least preserve, its market value.

22. The game of dice and heartache?

This reviewer understands this vaccinologist's point of view and shares his concerns for all those children who are not vaccinated and contract a disease that vaccination may have prevented.

However, this reviewer's concerns are less myopic and extend to those who, *although fully vaccinated for a given disease*, still contract that disease and, *equally importantly*, to those who have been seriously injured by a vaccine or combination of vaccines as well as to the families of those children where vaccination has killed their child.

Rather than make blanket statements like the ones that Dr. Osguthorpe makes, this reviewer finds it would be more constructive to limit such comments to those vaccines whose diseases carry a significant risk of death or severe injury at a rate significantly higher than the risk of death or significant permanent injury from the vaccine's being given to other-wise health children.

Unfortunately, most vaccinologists seem unable, or unwilling, to even admit that many vaccines carry some non-zero risk of death and/or severe permanent damage for some who are vaccinated, much less to determine and rationally present the true risks and their true risk incidence rates.

Moreover, this reviewer seeks to help parents steer clear of some of the unnecessary risks borne by young children from vaccines that provide little, or no, protection against diseases they are likely to contract before they are adults.

Thus, this reviewer suggests that the facts clearly support the reality that many of today's childhood vaccines, including the vaccines for hepatitis B, *Haemophilus influenzae* type b (Hib), pneumococcal infections in the ear and nasal cavities, herpes varicella zoster (chickenpox), rotaviruses, *Neisseria meningitidus*, HPV and human influenza, should be reevaluated for continued inclusion in the US national vaccination schedule for children and, unless they are proven to be *medically* cost effective and *truly* safe long-term, their approvals for use in American children under the age of 6 years should be restricted to children who will be traveling to foreign countries where these diseases are presently endemic.

23. Reaction risks?

This reviewer agrees with the opening statements, which the writer attributes to Dr. Osguthorpe, that admit vaccines have risks.

Moreover, with respect to VAERS, the vaccine adverse reports system, created and jointly managed by the CDC and the FDA, this reviewer does not dispute the information from the 2002 CDC surveillance manual for vaccine-preventable diseases, which reports that the number of reports to VAERS:

> "*exceeded the reports of childhood diseases that are preventable by vaccines, with the exception of chickenpox*."

However, this reviewer notes that nowhere in this discussion did the writer report the critical reality that many more "adverse events" occur than are reported.

For example, in 1999, JA Singleton *et al*. from the VAERS Working Group published that the reporting efficiency[4] for the selected vaccine-associated adverse events, which they had evaluated in the VAERS database, ranged from a minimum of <1% to a maximum of 68%.[5]

[4] The term "reporting efficiency" is defined as the reported number of instances for a specific adverse event divided by the number of adverse events expected for that specific adverse event.

[5] Singleton JA, Lloyd JC, Mootrey GT. Salive ME, Chen RT. An overview of the vaccine adverse event reporting system (VAERS) as a surveillance system. VAERS Working Group. ***Vaccine*** 1999; **17**: 2908-2917.

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Moreover, given the reality that most all children have been, and are being, vaccinated for chickenpox, the continued excess of reports of cases of chickenpox in excess of the reports of chickenpox-vaccine-related adverse events to VAERS clearly indicates to this reviewer that the national chickenpox vaccination program should be suspended until its safety and its effectiveness can be independently established.

This is the case because, among other things:

- It is clear that the current chickenpox vaccination program, *originally justified only on its societal cost-effectiveness based on a single dose's providing long-term protection*, does not protect children from getting chickenpox, and
- This program has increased the number of childhood cases of shingles (a much more difficult to treat disease caused by the same herpes varicella-zoster virus that causes chickenpox) from very rare events to common occurrences.

Thus, this is an instance where it is clear that the national "chickenpox" vaccination program has clearly worsened the overall disease outcomes that are being observed in children.

Moreover, when there is no disease, it is obvious that actual reports of vaccine adverse events will overshadow the theoretical benefits of vaccination that a vaccinated person may have from being appropriately inoculated with an ideal vaccine that is truly effective against all strains of a disease in almost all who are fully vaccinated.

However, in the real world, the situation is much more complex because vaccines usually less than ideal and the very act of vaccinating most of a population with a vaccine that is effective against only some strains of the disease will pressure that organism to adapt (mutate), cause the prevalence of the other strains to increase, and open the person vaccinated to being infected by a non-vaccine strain or, in some cases, other organisms.

24. Resurgence of disease?

While this reviewer does not question the accuracy of the writer's quote, he finds that the writer's "*which could result …*" clause to be less than clear because adverse reports linked to a vaccine would seem to indicate that most people are being vaccinated.

Perhaps the writer meant to say something to the effect that stopping vaccination based on the fact that the number of adverse events exceeded the number of diseases case could be problematic and lead to an increased risk for disease resurgence.

In this regard, this reviewer notes that it would take a significant decline in vaccination rates for some period of time before the risk of an outbreak for the contagious diseases for which there should be a vaccine would translate into a significant resurgence in any of these contagious diseases.

Moreover, this reviewer notes that these concerns seem to be misplaced.

This is the case because we have used and are using other effective approaches (e.g., hygiene, sanitation, vector eradication, quarantine, dietary supplements, and anti-infective drugs) to reduce the risk of the spread of diseases that are truly contagious.

For example, although there are FDA-licensed vaccines for "typhoid fever" (Sanofi Pasteur, SA's Typhim Vi and Berna Biotech, Ltd's Vivotif), federal health officials do not recommend that the general public be vaccinated because the general population risk in America is so low that a national vaccination program is not needed.

This is the case in the U.S. because, provided they are used, today's American hygiene and sanitation practices provide more than adequate barriers to the propagation of this disease.

Thus, the only diseases for which resurgence should be a concern are those that are highly contagious and have a high risk of seriously harming the child (e.g., measles) or those whose endemic prevalence results in a significant risk of contracting that disease whenever a person is exposed (e.g., tetanus).

Unfortunately, health officials and the healthcare establishment have misapplied, and are currently attempting to misapply, these valid disease-specific risk concerns to all the diseases for which there recommended nationwide vaccination program exists.

25. Adverse reactions to vaccines—the whole truth?

This reviewer does not disagree with what the writer states here about injected vaccines and injection-site and allergic reactions.

However, this reviewer suggests that this writer should have at least mentioned that, more than causing "*severe allergic reactions*," vaccines can be and, *in some cases*, are lethal to the recipient and/or can permanently damage their health and the quality of the recipient's life.

This reviewer also finds this writer is basically repeating the somewhat disingenuous statements that are routinely made by other vaccine apologists without even defining what the term "*very rare*" means.

For, example, a recent first-providers smallpox vaccination program was rolled out with claims that the risk of death was less than one in a million (perhaps, very rare?) and the risk of a severe adverse reaction was less than 1 in 10,000 (per-haps, "rare"?).

After less than 40,000 people had been inoculated, hundreds had had a severe reaction to the vaccine, and three (3) had died, a not "very rare" less-than-1-in-12, 000 raw incidence rate, the first-providers refused to continue participating (being inoculated).

Based on the fact that these are informed health-knowledgeable citizens who do understand what an acceptable risk is, then vaccines that have a severe adverse effect risk that is greater than 1 in 12,000 are obviously unacceptable to this informed segment of the public.

Thus, *based on this well-monitored program*, it is clear that a claimed risk of dying of "less than 1 in a million" translated into an actual "in use" death-rate of about 1 in 12,000 – a risk about 84 times higher than claimed and one that was unacceptable to the first providers.

Since the childhood vaccination programs are: **a)** not well

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monitored and **b)** rely on voluntary reporting of adverse events, this reviewer finds that, for the typical "1 in 10,000 to 1 in a million" reported risk rates the public would do well to:

- Find out what are the published risks for each specific vaccine,
- Multiply the claimed risk rates they find for a given adverse outcome by at least a factor of 10, *for less than fatal events*, and, *to be safe*, by a factor of at least 100 for death, and
- When multiple vaccines are to be given at the same time, multiply by another factor of 10.

For example, it the published risk for death is 1 in a million (1,000,000) for vaccine "X" and a healthcare provider wants to give vaccine "X" with vaccine "Y", then making the suggested adjustments would result in a more realistic death risk of 1,000 times the reported "1 in 1,000,000" or "1 in 1,000."

These suggestions are based on both the outcomes observed in the well-monitored smallpox vaccination program for first providers, and the rates of voluntary reporting to VAERS, that, *for less than life-threatening adverse events*, are typically no more than 10 % of the actual occurrence rates for most adverse events.

These suggestions are also based on:

- The reality that the health officials, healthcare establishment, and the vaccine makers who profit from, and are championing, vaccination programs are also the sources for the rates for adverse events, and
- The fact that the current vaccine adverse-effect studies:
  - Only last for a few days so that long-term adverse effects are usually neither observed nor reported by these studies,
  - Routinely exclude adverse events, like SIDS (sudden infant death syndrome), that are not "expected" to be vaccine related, and
  - Do not study the interactions with all of the other vaccines that may be injected at the same time.

26. Adverse reactions to vaccines—the truth about the CDC and VAERS?

While this reviewer does not dispute that this article states what the "*CDC's site says*" the risks for seizures were for Dylan Hansen, this reviewer notes that, regardless of the risk, Dylan Hansen has apparently been harmed and questions the accuracy of the adverse-event rates that the CDC, *also charged with promoting vaccination*, publishes.

Using:

- This reviewer's suggested factors and
- The fact that the MMR and chickenpox vaccines were given at the same time and are live-virus vaccines,

the probable incidence rates for a "seizure" in children, such as Dylan Hansen, whose developmental age, as reported in this article, lags behind their physical age, is closer to 1 out of every 30 doses than it is to the reported "*1 out of every 3,000 doses*" apparently for the MMR vaccine and the long-term severe adverse events risks are closer to less than 1 in 1,000 than to the "*less than 1 out of a million*" that the writer reports here.

Moreover, IF the CDC, the FDA, the healthcare establishment, vaccine makers, and health officials were *truly* interested in knowing the true incidence rates or all adverse events, THEN, *contrary to the current voluntary reporting system*:

- The reporting of all adverse events to VAERS would be truly mandatory, and
- The penalties for failure to report any adverse event would be significant.

In addition, the VAERS system was established by legislation (and not by voluntary efforts on the part of the parties involved in vaccination programs as this article suggests) to track the adverse events and their rates.

Furthermore, the National Vaccine Injury Compensation Program (Title 42, Chapter 6A, Subchapter XIX, Part 2; 42 U.S.C. Sec 300aa-11 et seq.) includes the types of neurological injuries reported for Dylan in Sec. 300aa-14. Vaccine Injury Table as recognized reactions to the MMR and other vaccines (e.g., DPT) that occur close to the time of vaccination.

Given the preceding realities, this reviewer finds that the lack of scientifically sound adverse-event incidence rates for each vaccine and vaccine combination is *actually* undermining the credibility of all of the vaccination programs.

Moreover, other scientifically unsound practices being allowed by federal officials in the pre-approval safety studies for the more recent vaccines (such as allowing another approved or, *in some cases*, experimental vaccine to be used as the placebo rather than mandating sterile saline be used as the placebo) are also undermining the credibility of any vaccine pronouncement.

Furthermore, the practice of making a licensed vaccine a nationally recommended vaccine shortly after, *or at the same time as or before*, approval of that vaccine is undermining the credibility of all of the vaccination programs since vaccines are routinely being approved for general use without any significant in-use safety experience and, *in some cases*, in spite of the known adverse risks for doing so.

Finally, the failure to require rigorous vaccine interaction studies for all vaccine combinations that may be given together and making unsubstantiated claims that the developing human immune system can handle hundreds or thousands of vaccines are also undermining the credibility of the national vaccination programs.

27. The Theoretical benefits far outweigh the vaccine's reported risks?

27.1 This article's view of Dylan Hansen's case

Allowing that Dr. Osguthorpe has accepted the CDC's pronouncements as being valid and that he is speaking here about a "*less than 1 out of a million cases*" adverse event, this reviewer finds that the quote: "*But if you have had a bad reaction, even if it was one in a million, it was your child*" seems to be confused since the text states: "*if you have had a bad reaction*" as if this "*you*" were the person given the vaccine and not "your" child.

Moreover, choosing to utter the words, "*it was your child,*" Dr. Osguthorpe appears to be considering Dylan Harman as an "*it*" and, *by speaking in the past tense*, implies that, *after the*

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severe adverse reactions experienced by Dylan Hansen, Dylan is now less than human or should be considered as if he had died ("*was your child*").

Overall, these remarks, *reportedly quotes*, apparently indicate that Dr. Osguthorpe does not really care about the children damaged by the current national vaccination programs – in today's terms, they are simply "collateral damage" in the "vaccines war."

27.2 Influenza risks and influenza vaccine benefits?

Actually, the writer's "*CDC estimates*" statement here is, *at best*, misleading.

Based on a recent (2006) published review[6] of the actual government-reported U.S. population experience for the period from 1979 through 2001:

- On average, about 0.050 (0.023 to 0.103) in 10,000 "*people die each year from causes related to influenza*," and
- Based on a lack of an inverse correlation between vaccine doses administered, influenza cases, hospitalizations or deaths, the current influenza vaccines do not prevent influenza.

Given the actual influenza-related U.S. population experience that has been published, it is clear that:

- The "*CDC estimates*" for influenza-related deaths are a 10- to 40- fold inflation of the reported values and
- Influenza vaccines do not prevent those inoculated from contracting influenza.

27.3 Whooping-cough risks and the benefits of the pertussis vaccine component in the various diphtheria, pertussis, and tetanus combination vaccines?

First of all, the reader should note that the article makes no mention of the reported risk of death from whooping cough but rather reports an approximate disease incidence rate for annual cases of whooping cough.

While this reviewer lacks the data needed to evaluate accuracy of the CDC's admitted "estimate" (a "guesstimate" based on some unstated model) for whooping cough cases reported in this article, this reviewer simply notes, *in the recent outbreaks of "whooping cough" where pertussis infection was confirmed by a valid lab test*, many of those who were diagnosed with this disease were fully vaccinated.

This finding indicates that one of the undisclosed benefits of being vaccinated against pertussis is a confirmed risk that many of those who are fully vaccinated will subsequently still get the disease.

28. The causal links for severe adverse reactions are difficult to establish?

Given: a) the outcomes observed in the recent fully monitored smallpox "first providers" inoculation program and b) federal officials allowing pre-approval vaccine safety studies to:

- Subjectively exclude certain deaths from being possibly vaccine-related (e.g., SIDS),
- Be conducted for only short periods of time,
- Use non-saline injections as the "placebo," and
- Limit the time period of the study to from a few days to typically no more than six months,

this reviewer understands that, *on some level, conscious or otherwise*, both severe reactions and their incidence are being significantly undercounted and there are not-so-subtle institutional pressures to underreport adverse events and underestimate their incidence rates.

Consequently, the preceding practices and the lack of a strong desire to establish the cause of any serious adverse event combine to make "*such cases are so rare that a causal link is difficult to establish*."

Thus, the innate biases, preconceptions, beliefs and conflicts of interest of "health" officials in the federal and state agencies, the healthcare establishment, academia and the vaccine makers are the underlying drivers that limit the determination of the causal links between a given vaccine, or vaccine combination, and "rare" adverse events.

29. The facts about the rotavirus vaccines?

29.1 The first U.S.-licensed rotavirus vaccine

While the article's initial remarks are roughly accurate, the writer's remarks are technically incorrect because the license for the initial rotavirus, RotaShield®, was only suspended on July 16, 1999 (10.5 months after it was licensed on 31 August 1998) – its license was not revoked.

Moreover, the article failed to report that, *in spite of the fact that the limited pre-licensing safety studies conducted had found a possibly significant increased risk for intussusception, a type of bowel obstruction, which was linked to the vaccine*, the FDA elected to license this vaccine when it should have postponed any such decision and demanded that additional trials be conducted to determine the magnitude of the increased intussusception risk.

This should have been the case because

- Rotavirus infection is, and was, not, in 1998, a population-endemic disease in the U.S.,
- The data from the monitoring of the rotavirus cases was clearly showing the incidence of this disease was already naturally declining, and
- Most American children develop natural immunity to the "native" viruses, which cause this disease, by age five without having a clinical case of rotavirus.

In addition, instead of allowing some time to pass for actual in-use experience data to be collected and evaluated, the CDC compounded the problem by deciding to add the rotavirus vaccine to the national recommend childhood vaccination program before it was approved by the FDA.

Thus, *instead of erring on the side of safety*, the FDA and CDC elected to place other interests, *including those of the vaccine maker*, ahead of the safety of U.S. children and, *since this vaccine is a communicable live-virus vaccine*, the safety of all those adults who will have contact with the live viruses shed

[6] Geier D, Geier M. A case-control study of serious autoimmune adverse events following hepatitis B immunization. ***Autoimmunity*** 2005; **38**: 295-301.

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by those who are inoculated with this vaccine and, *similar to the case for the now-abandoned (in the U.S.) live-virus polio vaccine*, infect some of these exposed adults with a severe case of rotavirus at infection rates that are greater than the current adult disease rates for the "natural" or "wild" rotaviruses.

Moreover, the implication of the writer's "*the vaccine was pulled*" is that all unused doses were recalled from the market, although this was not the case.

29.2 The second U.S.-licensed rotavirus vaccine

With regard to the statement: "*It was later replaced by a more effective vaccine*," this reviewer, *having examined the some of the data generated in the pre-approval process and the post-licensing data from VAERS*, finds this new vaccine, Merck's RotaTeq® (a mixture of bioengineered human-bovine hybridized artificial strains, licensed on February 3, 2006, and approved for nationwide use in August of 2006) is not only no more "effective" than the previous vaccine but also apparently this vaccine has about the same risk[7] of causing intussusception as the previous rotavirus vaccine as well as having other vaccine safety issues that may well be more important than the other issues in the prior rotavirus vaccine.

Additionally, rather than *initially* restricting the vaccine's recommended use to U.S. demographic populations where clinical cases are endemic (like the American Indian reservation used in some of the pre-licensure effectiveness studies conducted), the CDC recommended RotaTeq for all children because, given its high price per dose, there would be little demand for RotaTeq in such areas and the U.S. revenue to Merck would be much less than Merck was projecting based on the CDC's recommending RotaTeq for general use.

However, rather than "pulling" RotaTeq off the market after more than 100 adverse event reports in the first year of approval because it is not safe, *based on VAERS reports* (where, *for the 3 years prior to RotaTeq licensing [2003 – 2005]*, the yearly VAERS rate for intussusception reports was less than 5), the federal officials have elected to:

- Ignore:
  - These safety concerns,
  - The fact that RotaTeq is clearly not preventing cases of intussusception, and
  - The reality that RotaTeq appears to simply be giving many of those inoculated an active clinical case of rotavirus when, *before the vaccine*, a much lower percentage of children had a clinical case of rotavirus (mainly children in the lower socioeconomic groups and, since all appear to have immunity by the time they are 5 years old, most obviously had sub-clinical cases), and
- Allow this vaccine to remain on the market.

All that the FDA did do was to require the RotaTeq package insert to be updated to more accurately reflect the adverse events being reported.

To this reviewer, this is just another in the increasingly self-serving and arrogant actions of those with vested interests in promoting vaccination with little, or no, genuine regard for the safety of the vaccines given to our children or, *for that matter*, to ourselves.

30. The voluntary reporting of adverse events?

First, the writer's "*[d]octors should report cases*" is a tacit admission that doctors do not always report the adverse reactions to vaccines, as they should.

But, the writer's "*they may not always link the problem to the vaccine because they are so rare*," is, at best, hard to accept because, *at a minimum*, the "seizure" that Dylan had happens in at least 1 in every 3,000 doses of vaccine and, *given the admitted underreporting of adverse events to the VAERS monitors*, the true incidence for a "seizure" may be closer to 1 in 30 to 300 doses.[8]

Furthermore, the treating doctors should be reporting all reactions they see as "Adverse Events" because, in general, that is their job and the decision to include the reported event as a Vaccine Adverse Event in VAERS rests with the VAERS monitors who, as a group, are qualified to make such judgments and not the observing healthcare providers who are not generally qualified to make such judgments.

Since the purpose of VAERS is to collect all adverse events that could be linked to any vaccination of any individual, all vaccine providers should: **a)** educate parents to report all reactions to a vaccine that the parent of a child or the inoculee experiences to the vaccine providers, *education that most parents seem not to get*, and **b)** report all reactions they see and or are reported to them as adverse events to VAERS unless an "event" is *unequivocally* proven not to be vaccine related.

Thus, vaccine providers should be required to report any possible vaccination-related event to VAERS.

Given the reality that VAERS gathers adverse event reports and follows up on them, the job of winnowing the reports submitted should be that of those who monitor and follow-up on the reports submitted to VAERS – not the job of the vaccine providers.

Finally, given the reality that even the most serious recognized adverse events, including death, for a given core vaccine (e.g., measles) are significantly underreported, this reviewer sees that it is obvious that many vaccine providers are derelict in reporting even the known vaccine-related adverse events to VAERS.

31. Adverse event trends elicit public-health corrective action?

Based on this reviewer's understanding of the current situation with intussusception and RotaTeq, all that this reviewer can agree is that developing trends are noticed.

[7] In its first 10 months post-licensing, the previous rotavirus generated about 120 intussusception reports in VAERS (about 12 per month). Similarly, in its first 15 months post-licensing, RotaTeq has generated about 165 intussusception reports to VAERS (about 11 per month with an increasing trend from 2006 into 2007).

[8] In a population of about 8 million children being given a dose of the MMR vaccine annually, a "1 in 3,000 doses" risk translates into about 2,700 "seizures" annually while a "1in 300 doses" risk translates into about 27,000 "seizures" annually.

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This reviewer does not find that simply updating the package insert to reflect the reported adverse events has addressed the root cause of the "problem" (the unnecessary harm inflicted on the defenseless children who are *knowingly* given RotaTeq unnecessarily for the benefit of the vaccine maker, the vaccine provider, and those who treat and care for the children by the this vaccine, with no real concern for children or their parents) much less corrected that problem.

32. The "Autism Accusation"

32.1 The views of a Mother of a child diagnosed with autism

First, as any reader would, this reviewer accepts the factual accuracy of the information the writer reports here about Sara, the daughter of Sondra Hurst.

Since the writer does not cite any specific credible medical evidence here that proves that vaccine administered did not contribute to Sara Hurst's diagnosis of autism and the fact that the adverse reactions started shortly after Sara was vaccinated, this reviewer must accept that Sondra Hurst's views are valid.

32.2 Diagnosing vaccine-triggered regressive autism?

Because the general "autism" disorder has been being diagnosed for decades, perhaps the writer intended to address "regressive autism," a condition in which, after some period of normal development, a child begins to regress and lose many, if not all, of abilities that he or she had developed.

If the writer meant to say "regressive autism," then, the ability of parents to accurately diagnose the onset of the symptoms of "regressive autism" in early childhood has been confirmed for several years.

Furthermore, *in cases where the regression is gradual*, then it may be that an issue if the onset's coinciding with a particular "*child's vaccination*."

However, when, as reported here, the child is healthy and within 24 to 48 hours of getting vaccinated has an acute episode (high fever coupled with alterations in eating and fluid intake) followed by a regression in development, as this writer quotes the mother, this reviewer finds that it is very probable that, at a minimum, the unnamed vaccine triggered the events that led to Sara's subsequently being diagnosed with autism.

While coincidence of events (vaccination and the onset of regressive development) does not necessarily link them, approximate coincidence of events does require the researcher to accept the possibility that the causal factor (vaccination) and subsequent effects (developmental regression into a diagnosis of autism) are linked when the timing is appropriate (vaccine first; onset of severe reaction shortly after the vaccine).

Moreover, with respect to the writer's initial "*no evidence*" claim, there is a large and growing body of toxicological and epidemiological evidence that vaccines can cause the set of clinical symptoms used to diagnose "autism" and/or a related "autism spectrum disorder (ASD)."

[**See:** www.mercury-free-drugs.org/docs/070824_CoMeDCitizenPetitionPart2.pdf.]

Thus, contrary to the writer's statement here, there has been and is a large and ever-growing body of evidence that some vaccines can cause the set of symptoms used to diagnose an autism spectrum order.

33. A safety concern—the use of Thimerosal as a preservative in vaccines?

Factually, the safety concern, which is cited by concerned parents and medical and scientific researchers studying vaccine safety, is the use of Thimerosal, 49.55 weight-% mercury, as a preservative in a number of vaccine formulations licensed by the FDA *apparently*, as FDA officials have repeatedly testified before Congress, without proving its safety for use as a preservative to the current applicable legally binding current good manufacturing practice[9] (CGMP) minimum[10] that the vaccine formulation in which Thimerosal is used must be "sufficiently nontoxic so that the amount present in the recommended dose of the product will not be toxic to the recipient, …" (**see**: **21 C.F.R. 610.15(a)**).

At this point, the writer of this article makes provably false assertions about studies showing no adverse effects and the ongoing use of Thimerosal as a preservative in vaccines.

First, with respect to the writer's claim concerning studies showing Thimerosal had no adverse side effects, this reviewer notes that toxicology studies are required to establish that Thimerosal has "*no adverse side effects*."

As far as this reviewer can ascertain, *after studying dozens of the published studies, including some studies where the Thimerosal used was an actual vaccine formulation or formulation equivalent*, all of the published toxicological studies on Thimerosal have shown that Thimerosal has adverse side effects in living systems at levels more than ten thousand times lower than the level of Thimerosal (0.01%; 100 parts-per-million [ppm]) found in the typical Thimerosal-preserved vaccine.

In addition, the writer's claim that Thimerosal has not been used "*in any vaccines for six years*" is a blatant falsehood, as the U.S. FDA CBER's "**Thimerosal in Vaccines**" webpage shows. [**See:** http://www.fda.gov/cber/ vaccine/thimerosal.htm, last visited on 28 January 2008.]

Factually, as that site's Table 3, "**Thimerosal and Expanded List of Vaccines - (updated 9/6/2007) — Thimerosal Content in Currently Manufactured U.S. Licensed Vaccines**," and the extracted updated listing on the following page clearly show, several U.S.-licensed vaccines still contain a preservative level of Thimerosal and others contain a lower level of Thimerosal.

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[9] 21 U.S.C. "Sec. 351. Adulterated drugs and devices
A drug or device shall be deemed to be adulterated -
(a) Poisonous, insanitary, etc., ingredients; adequate controls in manufacture
(1) ...; or
(2) (A) ... ; or
(B) if it is a drug and the methods used in, or the facilities or controls used for, its manufacture, processing, packing, or holding do not conform to or are not operated or administered in conformity with current good manufacturing practice to assure that such drug meets the requirements of this chapter as to safety and has the identity and strength, and meets the quality and purity characteristics, which it purports or is represented to possess;"

[10] See 21 C.F.R. "§ 210.1 Status of current good manufacturing practice regulations" and 21 C.F.R. "§ 211.1 Scope."

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Specifically, nine (9) for the vaccines listed have a preservative level (nominally, 0.001 % [10 ppm] to 0.01 % [100 ppm]) of Thimerosal and eight (8) others contain a lower level (< 0.00012% to < 0.0004 % [< 4 ppm]) of Thimerosal.

Thus, it is clear that, *contrary to the writer's misstatement here*, U.S.-licensed vaccines still contain Thimerosal.

34. The National Vaccine Injury Compensation Program

Current FDA-listed vaccines that contain Thimerosal

Vaccine	Trade Name	Manufacturer	Thimerosal Concentration[1]
DTaP	Tripedia	Sanofi Pasteur, Inc	≤ 0.00012%
DT	No Trade Name	Sanofi Pasteur, Inc	< 0.00012% (single dose
		Sanofi Pasteur, Ltd	**0.01%**
Td	No Trade Name	Mass Public Health	**0.0033%**
	Decavac	Sanofi Pasteur, Inc	≤ 0.00012%
TT	No Trade Name	Sanofi Pasteur, Inc	**0.01%**
Hepatitis B	Engerix-B Pediatric/adolescent Adult	GlaxoSmithKline Biologicals	< 0.0002 %
HepA/ HepB	Twinrix	GlaxoSmithKline Biologicals	< 0.0002 %
Influenza	Fluzone	Sanofi Pasteur, Inc	**0.01%**
	Fluvirin	Novartis Vaccines and Diagnostics Ltd	**0.01%**
	Fluvirin (Preservative Free)	Novartis Vaccines and Diagnostics Ltd	< 0.0004 %
	Fluarix	GlaxoSmithKline Biologicals	< 0.0004 %
	FluLaval	ID Biomedical Corporation of Quebec	**0.01%**
	Afluria	CSL Ltd, (Approved 28 Sept. 2007)[2]	**0.01%**
Japanese Encephalitis	JE-VAX	Research Foundation for Microbial Diseases of Osaka University	**0.007%**
Meningococcal	Menomune A, C, AC and A/C/Y/W-135	Sanofi Pasteur, Inc	**0.01%** (multidose)

[1] The values in bold are levels of Thimerosal that are considered to be preservative levels.

[2] Added by this reviewer since it was licensed after the FDA last updated Table 3 on 6 Sept. 2007.

Factually, the **42 U.S.C. Sec. 300aa-11 Part 2 - National Vaccine Injury Compensation Program**, Pub. L. 99-660, title III, Sec. 311(a), Nov. 14, 1986, 100 Stat. 3758, established the vaccine injury program at the end of 1986.

In general, except for misidentifying the name of the program by leaving off the first word, "National" in the enabling statute and substituting "*Immunization*" for the correct word "Injury" as well as characterizing the usual decider of each case as a group of attorneys rather than as an individual "special master" who normally makes and/or oversees administrative determination of petitions (cases) filed with a division of the United States Court of Federal Claims, commonly referred to as the "Vaccine Court," and handled by United States Court of Federal Claims special masters, this reviewer accepts the validity of the writer's statements about the number of cases where there was a ruling in favor of the petitioners.

However, the reader should note that the writer's minimalistic "*only about 2,300 cases*" translates into an overall cost of almost two billion (US$ 2,000,000,000.00) taxpayer dollars.

With respect to the increases in claims filed, this reviewer notices that the increases reported in this article have occurred in spite of the apparent failure of the Secretary of Health and Human Services (HHS) to "undertake reasonable efforts to inform the public of the availability of the Program" (**see: 42 U.S.C. Sec. 300aa-10(c)**).

Additionally, this reviewer finds that the writer is *knowingly* misrepresenting reality concerning the evidence (toxicological, epidemiological and case-study) that has clearly established a causal link between certain "*vaccines and neurological disorders, including autism and many others*" in children from the injection of Thimerosal-containing vaccines, which does cause sub-acute mercury poisoning.

In some cases, this sub-acute mercury poisoning by vaccines containing Thimerosal manifests as the clinical neurological symptoms that are used to diagnose various neurodevelopmental disorders, including autism and the other autism spectrum disorders.

Hopefully, after reviewing the toxicological, epidemiological and case-study evidence provided in the text portion of the FDA citizen petition assigned FDA Docket # 2007P-0331[11], this writer and those who read this citizen petition and check the published studies referenced therein will understand that at least one causal linkage between some "*vaccines and neurological disorders*" has been proven.

Moreover, case studies[12] published after this FDA citizen petition was filed on 24 August 2007 have strengthened the causal link between Thimerosal (49.55 weight-% mercury), mercury poisoning and childhood neurodevelopmental disorders.

Finally, on November 9, 2007, the government conceded one of the vaccine injury cases scheduled to be heard as an Autism Omnibus test case for the theory, "Thimerosal causes autism" (**see: *Hannah Poling v. Sec. HHS***, case: 02-1466V).

[11] This FDA citizen petition, titled "Citizen Petition to Ban Use of Mercury in Medicine, UNLESS Proven Toxicologically Safe to the CGMP Standard 'Sufficiently Nontoxic …'" by the FDA, was filed by CoMeD, Coalition for Mercury-free Drugs, with the FDA Division of Dockets Management on 24 August 2007 and, on that day, was assigned FDA Docket # 2007P-0331 by the FDA. (**see**:http://www.mercury-free-drugs.org/docs/070824_CoMeDCitizenPetitionPart2.pdf).

[12] **a.** Geier DA, Geier MR. A case series of children with apparent mercury toxic encephalopathies manifesting with clinical symptoms of regressive autistic disorders. ***J Toxicol Environ Health A*** 2007; **70**: 837–51.

b. DeSoto MC, Hitlan RT. Blood Levels of Mercury Are Related to Diagnosis of Autism: A Reanalysis of an Important Data Set. ***J Child Neuro*** 2007 November; **22**(11): 1308–11.

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35. Parental concerns about The National Vaccination Program For Children

First of all, the article's assertion that the current national vaccination program only requires "*15 vaccine doses*" grossly understates the actual number of vaccine doses in the national vaccination program currently in effect[13] and about the same as the program that was in effect when this article was written.

That national program recommended 36-38 (or, *for certain risk groups*, more) vaccine doses (when the recommended 3-dose rotavirus and annual-plus influenza vaccines are included) be administered to children from birth through 6 years of age.

From age 7 to 18, *for females*, six more vaccine doses (including the 3-dose HPV vaccine) and, *for males*, only three vaccine doses (one each of a Tdap, an MCV4 and an MPSV4 vaccine).

Thus, since:

- The 2007 schedule has been available in its current form since March of 2007 and, even in the first "seven" months, a child fully vaccinated under this schedule would receive 19 to 21 vaccines, and
- As the tables' titles reflect, the national program only recommends vaccines – neither it nor the laws and regulations of Utah require giving these vaccines,

this reviewer does not understand how this writer can justify the "*requires 15 vaccine doses*" language used unless this writer was actually speaking about some program other than the current recommended U.S. national program.

With respect to the quotes attributed to Sondra Hurst about splitting vaccines up, this reviewer agrees with, and finds that the scientific evidence clearly supports, her views.

Furthermore, this reviewer supports a program that allows the parents to choose both when they vaccinate and which vaccines they allow to be given to their children.

36. Rationale for the childhood vaccination program?

This reviewer has difficulty accepting that any journalist who has done any study of the vaccination programs would believe that the current "Recommended" childhood vaccination schedules in the U.S. have been developed for reasons other than the convenience of the vaccinators and vaccine manufacturers.

Returning to the example set by Japan, a democratic nation that has a vaccination program that was also "*developed for everyone*," this reviewer offers an example 2005 vaccination schedule, *shown in the adjacent column*, to demonstrate how a vaccination program that was truly developed for everyone can be designed to provide sufficient flexibility for individuals.

Moreover, *unlike the U.S. program*, the Japan's program uses "carrots," *coupons for free vaccines*, instead of "sticks," *regulations and laws pressuring people to vaccinate in order to obtain access to education and jobs*, to encourage its citizens to vaccinate their children.

With respect to the second "reason" where the article states that the national vaccination program "*was developed based on the times children are vulnerable to each disease,*" does this writer think that anyone will believe that, *for example*, the U.S. childhood hepatitis B vaccination program "*was developed based on the times children are vulnerable to*" contracting hepatitis B, a "lifestyle" disease, whose exposure risk is confined to those who are intravenous-drug users and those who engage in high-risk sexual practices with multiple partners?

Example 2005 Japanese vaccination schedule [1]

Vaccine	Vaccination period (after receiving the vaccination coupon)	Child's age (Born:)	Delivery of vaccination coupon
BCG	Any day prior to the child's 6th month	From Dec 16th 2004 to Dec 15th 2005	3 to 4 months old
Polio	Any day before the child reaches 7.5 years of age	July to November/2004	May/2005
		December/2004 to March/2005	August/2005
DPT (1st term: 3 doses + 1)		Dec./2004 to Nov./2005	After 4 months old
DT (1st term: 2 doses + 1)		If your child had contracted whooping cough (pertussis) in the past do not need to receive the DPT vaccination.	Contact the Infectious Disease Prevention Division to apply for the DT vaccination
Measles	Any day before the child reaches 7.5 years of age	Born from Mar. 16, 2004 to March 15, 2005	12 to 13 months old
Rubella		Born from March/2004 to February/2005	13 months old
Japanese Encephalitis (1st term: 2 doses + 1)		Born from March/2002 to February/2003	At the following month of child's 3rd birthday
Japanese Encephalitis (2nd term: 1 dose)	Any day prior to the child's 13th birthday	Elementary school: 4th grade students	May/2005
DT (2nd term: 1 dose)	Any day prior to the child's 13th birthday	Students of 6th grade of Elementary school (born from April/1994 to Feb./1995)	May/2005 (at the following month of child's 11th birthday)
Japanese Encephalitis (3rd term: 1 dose)	Any day prior to the child's 16th birthday	Elementary school: 3rd grade students	June/2005

[1] Reviewer corrected Table's "dosis" to doses" and "7,5" to "7.5"

Additionally, *if the writer's assertion were true*, then the vaccination program would delay the vaccination of all nursing babies until after nursing stopped since human breast milk continually transfers protective immune factors from the mother to the nursing child.

[13] http://www.cdc.gov/vaccines/recs/schedules/child-schedule.htm#printable

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37. A timely immunization program or not?

37.1 An immunization program?

First, this reviewer notes that Dr. Osguthorpe's statement here is, *at best*, misleading, because inoculating a child with a vaccine for a given disease only "vaccinates" that child, it does not, *as earlier statements in this article clearly acknowledge*, *necessarily* "*immunize babies*" against that disease.

Moreover, a more honest, statement would have been::

"The reason we vaccinate children when we do is: it is convenient for us to do so."

37.2 The proper timing of vaccination for various diseases?

This reviewer simply notes that these statements are feeble attempts to justify a U.S. recommended vaccination schedule that, *for most vaccines*, is actually more about convenience than it is about the "*for everyone*" and the "*times children are vulnerable to each disease*" reasons that the writer declares.

Moreover, this reviewer notes that nowhere does the doctor or the writer address the issue of natural maturation of the human immune, where based on the available studies, the natural time that the child's immune system is expected to handle diseases on its own is between 2 and 3 years of age when the child's mother or, in some cases, wet nurse would naturally stop nursing that child.

Furthermore, in an in-press paper[14] researchers from the University of Manitoba studying the effect of delayed DPT vaccination in Canadian children on asthma found that at least a 2-month delay for the first dose of DPT roughly halved the asthma rates in those children compared to children who received their first DPT on schedule (at 2 months) – indicating, at least, in this instance, that delaying the initial DPT vaccination by at least 2 months is a net positive for the health of the children vaccinated.

Clearly, these findings point to a need to rethink the U.S. program because the U.S. program uses the same timing for the DTaP shots given as was used in 1995 in Canada.

38. The need for a more flexible vaccination program?

First, this reviewer accepts and agrees with the views Marie Hansen expressed is quoted as expressing here.

As someone who works with other researchers, physicians, parents, and healthcare providers, this reviewer not only agrees with Marie Hansen but also has the research to back up at least one of the reasons "*some kids are having problems with the vaccines*."

Based on a careful review of the published toxicological, epidemiological, and, most importantly, case studies, this reviewer understands that the neurodevelopmental and many other childhood disorders, syndromes, and diseases have been, and are still being, caused by sub-acute poisoning by mercury from the administered vaccine-derived Thimerosal (49.55 weight-% mercury) as well as the Thimerosal in some other medicines routinely given to children and, *to a lesser extent*, mercury from Thimerosal and other organic mercury compounds that added to other drugs as well as from *in utero* mercury exposures.

Furthermore, based on the proper interpretation[15] of the Danish epidemiological data for the introduction of the MMR vaccine and its delayed acceptance by the Danes, it is clear that, *in some cases*, the MMR vaccine is a causal factor in some cases where the child is diagnosed with a neuro-developmental disorder.

Thus, in 2007, the science has established two vaccine-related causal factors:

1. Mercury poisoning from Thimerosal in some vaccines and, to a lesser degree, other sources, and, to a lesser extent,
2. The MMR vaccine,

as reasons that "*some kids are having problems with the vaccines*."

Moreover, this reviewer again notes that the government's conceding Hannah Poling v. Sec. HHS seems to indicate that, at least in this one vaccine injury case, Thimerosal was a probable causal factor in the vaccine-related injuries that Hannah Poling sustained.

39. The exercise of the permitted vaccine exemptions in Utah to delay vaccination—not immunization

First, while this reviewer does not dispute: a) the fact pattern that Margie Golden states, b) the legality of the parental practices described, which indicate thoughtful parenting, or c) that many of the children in question are eventually vaccinated when they approach adulthood and either enter college or as many do serve a mission as the Church of the Latter Day Saints expects of its members, the reviewer again notes that Margie Golden, *as many do*, uses the word "*immunized*" as if it were medically synonymous with the word "vaccinated," when it is not.

This is an error that vaccinologists have made so frequently that the public and most thesauri have accepted this inaccurate and misleading juxtaposition of terms.

Furthermore, this reviewer notes that:

- Children who have a clinical case of a given communicable childhood disease (e.g., measles, mumps, rubella, chickenpox, whooping cough) once, *generally, except for chickenpox*, develop an immunity to that disease that lasts much longer than the immunity provided to only some percentage, *hopefully, greater than 80%*, of those who are fully vaccinated and
- Some of those who are fully vaccinated against a given disease subsequently may contract that disease when exposed to it because the vaccine provided them with incomplete, little, or no immunity at all to the disease.

[14] McDonald KL, Huq SI, Lix LM, Becker AB, Kozyrskyj AL. Delay in diphtheria, pertussis, tetanus vaccination is associated with a reduced risk of childhood asthma. J Allergy Clin Immunol. 2008 Jan 17 [Epub ahead of print]

[15] Goldman GS, Yazbak FE. An Investigation of the Association Between MMR Vaccination and Autism in Denmark. ***J Am Physicians and Surgeons*** 2002 Fall; **9**(3):70–5.

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However, this reviewer does not understand why Margie Golden apparently believes that her views are more valid than those of the parents who have considered:

- The disease risks of not getting a vaccine as the U.S. schedule recommends,
- The risks of harm from getting a vaccine as the U.S. schedule recommends,
- How they are raising their children and the environment in which those children are being raised, and
- Their understanding that, for healthy children, the childhood diseases are usually not life threatening and, *for the "lifestyle" diseases*, their children have almost no risk of exposure, and

decided that exempting their children from the rigid recommended vaccination program for some period of time was, *on balance*, safer for their children than following this program.

Thus, though these children have theoretically been "*at unnecessary risk for years*" of contracting a disease, these children have most certainly avoided all of the known risks of harm, including death, that come with vaccination according to the recommended national vaccination schedule – real risks that Golden does not even mention.

Finally, this reviewer notes that Golden fails to address the reality that vaccination does not necessarily provide immunity or to mention the reality that some vaccines do not provide complete disease immunity for anyone who is vaccinated (e.g., the vaccines for *Neisseria meningitidis*, Sanofi-Pasteur's Menomune® and Menactra®, which provide no immunity for the "B strain" [serogroup B] of this disease that causes anywhere from about 50 % [in very young children] to roughly 20% – 25 % [in pre-teens, teens and young adults] of the identified cases of this disease).

40. Natural childrearing and immunization?

This reviewer is struck by the fact that, though the vaccine apologists in this article speak to giving children immunity from disease, they push vaccination in an abstract "aseptic" environment that ignores the lessons of natural child rearing that have preserved and nourished the human race for centuries.

In a healthy natural society, where most all children are breastfed (by their mothers or a "wet nurse") for two to three-plus years, we know that human breast milk provides the antibodies and many other immune factors necessary to maintain the children's immunity to endemic diseases.

In addition, we understand that, during the time from birth to natural weaning, each infant's immune systems are rapidly developing.

Given these two realities, it is obvious that there is no disease-related need to vaccinate a child that is being breastfed and, *if possible*, all vaccinations should generally be postponed until after the child is two years of age.

This is the case because "beyond two years" is the time at which a naturally raised child's immune system would "start" to fight disease on their own (without the immune factors continually provided by the human breast milk they have been ingesting).

Thus, this reviewer must oppose those who recommend early vaccination because it is obvious that there is a significant risk that early vaccination will, *as the study cited[14] that found positive effects for delaying the initial DPT shot*, do more harm than good to the child's developing immune systems.

Likewise, this reviewer: **a)** is opposed to vaccination while a child is being breastfed, **b)** advocates for breastfeeding for a minimum of two years, **c)** suggests, as long as the risk of disease is low, that parents may want to withhold vaccination until their child is two years of age, and **d)** thinks that vaccination should be restricted to those diseases where there is proof of long-term effectiveness and, with appropriate vitamin supplementation, minimum risk of a severe adverse reaction.

The preceding suggestions are based on this reviewer's current science-based understanding of the development of the human immune system.

Thus, this reviewer finds it unconscionable that anyone would recommend vaccinating children at birth for hepatitis B, *a lifestyle disease with near zero risk at birth*, or, *for that matter*, any other disease unless: **a)** the disease is endemic in the population and highly contagious, **b)** there is proof that the human breast milk available for feeding the child provides no immunity for that disease, and **c)** the available vaccine has been proven to be safe, provides long-term immunity – not just to produce antibodies, and is provably *medically* cost effective.

Hopefully, all who read these remarks will understand the realities presented and adopt a similar stance toward what health officials should be doing to promote post-partum health and a rational vaccination program designed to minimize the risks of damage to the children's developing immune systems – something that today's recommended vaccination programs obviously ignore.

Returning to Margie Golden's words, this reviewer finds that her obtuse "*diseases hit the younger kids too, and maybe more so*" remark seems to imply that, in general, childhood diseases are more severe in younger children than they are in older children and adults – when, *for most childhood diseases*, the reality is these diseases are less severe in all but the youngest (those developmentally under 1 year of age) children than they are in older children and adults.

For example, when a male child has mumps as a pre-schooler, the disease is usually very mild and recovery rapid.

However, when that male does not have mumps until after puberty, the disease is much more severe and renders some infected males sterile.

When pre-schoolers first have chickenpox the disease is also mild and, *in many*, there are few, if any pox, and recovery is rapid; for children older than ten, chickenpox becomes an increasingly more virulent disease (wide spread pox and severe itching) and recovery times are more protracted.

Thus, based on this reviewer's understanding of medical reality, this reviewer finds that Margie Golden's remarks would have been more accurate if she had said something like:

"The diseases infect the younger kids too, though, except for the very young, the younger kids general have milder cases and recover faster, …".

In addition, if truly Golden truly believes that "*immunizing the younger kids is important*," then, *since having a childhood disease provides a higher level of immunity and, in general, a*

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longer period of immunity than vaccination does, Margie Golden should be opposing vaccination for any of the communicable childhood diseases.

Moreover, while this reviewer does accept that Margie Golden lives in a vaccine-centric reality where the imperatives are to push for up-to-date vaccination on a rigid schedule an concern is myopically focused only on the vaccine preventable disease so that the epidemic increase in the diseases, disorders, and syndromes that exist outside of the vaccines' sphere are not even noticed, this reviewer is driven by other imperatives.

This reviewer is opposed to vaccines that:

- Are not really effective (e.g., the influenza vaccines),
- Are not cost-effective (e.g., the rotavirus vaccines),
- Provide a false sense of protection (e.g., the meningococcal vaccines),
- Cause more long-term harm (e.g., the now-withdrawn Lyme-disease vaccine),
- Create more disease overall than "immunity" (e.g., the varicella vaccines for chickenpox),
- Lead to worsening of the prevailing disease (pneumococcal-conjugate vaccine),
- Introduce new diseases into humans (e.g., the polio vaccines, which have introduced, *among other viruses*, SV-40 and RSV into humans, and the new rotavirus vaccine that has introduced bioengineered human-bovine hybrid viruses into humans [and the environment] without any long-term proof of safety), or
- Contain Thimerosal (49.55 weight-% mercury), any other added or residual mercury compound, or any other bioaccumulative toxin, at any level.

Unfortunately none of the vaccine apologists quoted here or the writer of this article appear to share these concerns.

Finally, *even for "safe" vaccines, which do pro-vide protection for the majority who are vaccinated and do not contain bioaccumulative poisons*, this reviewer understands that the decision to vaccinate, or not to vaccinate, is one that parents and guardians should *carefully* consider and *affirmatively* make because, *as even the article being reviewed reports*, no vaccine is completely free of adverse-event risks.

41. Relevance of Utah's history of opposing vaccination?

41.1 Smallpox and the vaccine for smallpox

Although this reviewer has a slightly different view of the history of the cowpox vaccine and smallpox in Utah and elsewhere and the recent "first providers" smallpox vaccination program obviously proves there are, and, were people with no immunity to the smallpox vaccine's "cowpox" virus, this reviewer accepts that, *absent widespread exposure to a smallpox virus*, the smallpox "*disease has been all but eradicated*."

41.2 Polio and the polio vaccines?

In discussing the polio disease, this reviewer finds that the writer is significantly distorting history.

Actually, the "last case of wild (naturally occurring) polio in the U.S. was reported in 1979."[16]

However, since the U.S. used a live-virus vaccine to inoculate people with live polio viruses from the early 1960s until 2000, many people inoculated as well as some of those who came into contact with these children, or another adult shedding polio virus, have been infected with a vaccine or vaccine-related strain of polio.

By 1979, this practice had displaced the prevailing wild polio viruses and replaced them with vaccine strains and vaccine-related strains.

However, since, *in humans*, the polio virus typically rarely causes persistent long-term (lasting 30 days or longer) paralysis, the revised [in1956] definition of clinical polio,[17] the reported U.S. annual risk for clinical polio was reduced to "on the order of one in 2.4 million"[16] or, for a population of 200 to 300 million citizens, about "500" annual clinical polio cases.

Accepting that vaccine-related paralytic polio "occurs in about one in 200 infections,"[16] this means that about 2,000 people a year would be infected and experience some polio symptoms.

In 2000, "the use of the oral vaccine in the U.S. was discontinued in 2000, and all vaccination is now done with the injected inactivated virus."[16]

However, in 2005, 4 non-paralytic polio cases were reported in Minnesota.

All were non-paralytic polio cases from an oral-live-vaccine-related strain.

The first case, the first reported case nationally since 2001, was found in an infant who had been diagnosed with immune system problems, and the other cases were three children in another family that had had contact with that infant.

The source of the infection was reported to be a person "who recently received an oral form of the vaccine containing live attenuated virus."[16]

Thus, the last reported cases of polio clearly occurred in 2005.

These polio cases underscored the reality that some of the persons entering the U.S. from other countries where the oral live virus is still being administered are introducing mutated strains of the vaccine strain they have received into America.

Moreover, *as the figure on the next page shows*, the reality of paralytic polio is much more complex than the information provided in this article portrayed it and, *as is the case currently with Thimerosal and neurodevelopmental and other childhood developmental disorders*, man-made environmental factors, polychlorinated compounds (labeled as "DDT-like chemicals," and "DDT" in the figure), seem to have been significant causal cofactors in the rise (1912–1953) and the fall (1953–1970) of "Poliomyelitis" in the U.S.[18]

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[16] http://www.medpagetoday.com/PublicHealthPolicy/PublicHealth/tb1/1935 last visited 14 November 2007

[17] Miller NZ. The polio vaccine: a critical assessment of its arcane history, efficacy, and long-term health-related consequences. ***Medical Veritas*** 2004; **1** (2): 239–251.

[18] http://www.geocities.com/harpub/pol_all.htm last accessed 24 November 2007.

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Thus, this reviewer finds that, *among other factors* (like the change in the definition of polio in 1956), the introduction and the wide-spread use of chlorinated chemicals appear to have been significant cofactors in the incidence of clinical cases of "Poliomyelitis" in the U.S. during the period from 1912 through 1970.

42. The success of vaccines?

If the preceding examples are the basis for Osguthorpe's statements, it is clear that reality is very different than he and other vaccine apologists have painted it.

Furthermore, the "*success stories*" (repeatedly used as the "poster children" for the current national vaccination programs) are for vaccines where everyone is, or was, inoculated with a disease or a disease related to the disease of interest and contracted that disease—with, *based on the stated views of the vaccine apologists*, very-rare (< 1 in a million) deadly consequences, unlike the recent actual experience of those who participated in the recent "first providers" smallpox inoculation program, where about 1 in 12,000 died.

Based on the facts (not the claims made by the writer) and the increasing incidence of immune and autoimmune diseases, and the increasing incidence of allergies in our children today, the reality is that the current recommended national vaccination programs are apparently one of the greatest successes for programs that seem to be designed by the healthcare establishment and drug providers to:

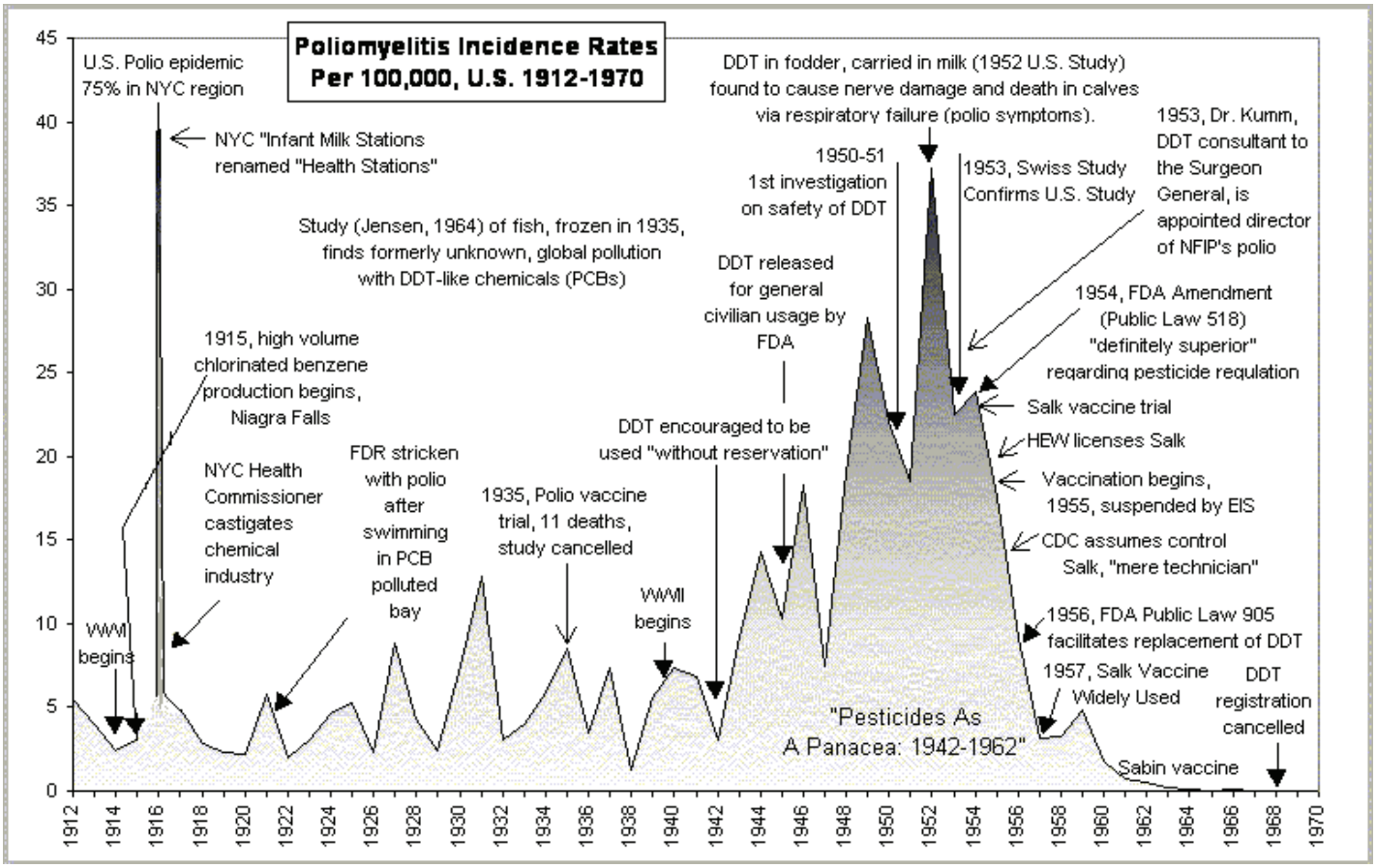
- Significantly increase their customer base and
- Increase the number of customers requiring long-term treatments for chronic conditions for which the healthcare providers and the drug firms could charge increasingly higher prices with little, or no regard, for the long-term health and welfare of the public.

43. How vaccines work?

Because the explanation provided here as to how vaccines work does not address pathogens other than viruses and fails to even address the separate immune systems within the human body, much less the current understanding of how the various immune systems in the human body function and communicate, all that this reviewer can do is recommend that this writer refrain from writing about matters that this writer not only clearly does not understand[19] but also about which he is either apparently not willing to do even rudimentary research or, *if this portion of the text was provided by someone else*, simple fact checking.

[19] **See Appendix I** for a general overview of this reviewer's journeyman's view of the human immune system.

Poliomyelitis: "Graphic Timeline: U.S. 1912-1970"



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Reviewer's concluding remarks

Lest anyone attempt to paint this reviewer as "anti-vaccine," a label often used by those who are fervent proponents of the current national vaccination programs, this reviewer reminds the readers that those who attempt to attack the credibility of the messenger (instead of defending their positions with scientifically sound published studies that support their positions and undermine those of this reviewer) should simply be ignored.

Actually, *as this reviewer has repeatedly stated*, this reviewer in not "anti-vaccine."

If an animal that might be rabid bit this reviewer, he would immediately seek to be vaccinated with the rabies vaccine.

In addition, when this reviewer was raising a child in the 1970s, he did not oppose that child's being given the DPT, polio and MMR vaccines.

However, if this reviewer were to be facing parenthood today, he would oppose giving that child the hepatitis B, pneumococcal, Hib, rotavirus, influenza, hepatitis A, chickenpox, meningitis, and HPV vaccines, because these vaccines have more real short-term and/or long-term risks than they may, *if there is an exposure*, provide protection against these diseases in today's America.

Also, this reviewer would, *as he did then*, support a child's mother in breastfeeding her child until natural weaning and in appropriately supplementing her lactation diet with added magnesium, potassium, selenium, silicates, and vitamins (e.g., A, the Bs, C and D-3), and see to it that the child received appropriate supplementary foods (home-puréed fresh and steamed vegetables and most fruits, and, in limited amounts, meats) after the child's first teeth began to erupt.

As a scientist, this reviewer understands that we should follow natural practices whenever we can and only add allopathic medicines or other alternative medicines when the natural practices and natural remedies truly fail to rapidly "cure" the child's discomfort.

Hopefully, after reading this review, all who do read it will carefully consider and verify the validity of the reviewer's statements, and, *to the extent you all can*, appropriately incorporate this reviewer's substantiated understanding into your views.

Since Logan Molyneux did not provide his credentials, this reviewer would strongly encourage all who read this review to visit http://loganmolyneux.com/ and read the applicable information provided there.

Similarly, this reviewer encourages the readers to visit http://www.dr-king.com/ and read the applicable information posted in this website.

Further, *in addition to being sent to various others*, the original detailed draft from which this shortened review constructed was emailed to Logan Molyneux on 25 November 2007 at his website's contact address:

logan@loganmolyneux .com.

As of 28 January 2008, more than 2 months later, this reviewer has received no response to or direct feedback on that original draft.

Also, this reviewer understands that the major problems with the current vaccines and vaccination programs have been self-inflicted by those who are the proponents of these and, unless these problems are openly and honestly addressed, these proponents are risking the complete loss of the confidence of the American people not only in the information that these proponents publish but also in any national vaccination program.

Moreover, the current realities (long case delays and miserly awards) for the U.S. National Vaccine Injury Compensation Program (NVIC) are also undermining the U.S. vaccination programs.

Furthermore, the unintended consequences of the National Vaccine Injury Compensation Program, that was created to: **a)** protect the vaccine makers and providers from being sued for the "rare" harm caused, **b)** provide rapid compensation for the families whose children who were harmed, **c)** require accurate records, **d)** track the adverse events that could be or are vaccine linked, and **e)** mandate safer vaccines, this reviewer finds:

- Though the vaccine makers are being protected, the families with vaccine-injured children are not being:
  - Rapidly heard (cases can take 10 years to resolve and some types of cases have been repeatedly delayed from being heard by the government) or
  - Fairly compensated (the original 1987 cost-of-living-adjustment (COLA) provisions were repealed in 1988), and
- Based on an ever-increasing body of evidence, the federal government and vaccine makers have:
  - Ignored and are ignoring the mandate to make vaccines safer and
  - Instead, elected to:
    - Market ever riskier vaccines and
    - Ignore the statutes and laws that mandate:
      - Proof of safety for vaccines to the applicable biological-drug standard "sufficiently nontoxic …,"
      - Proof of effectiveness (not efficacy), and
      - The safening of all vaccines.

Lastly, the greatest example of the Establishment's vaccine hubris is the broken 1999 promise that Thimerosal would be **removed** from all vaccines that could be given to children, including *implicitly* all those vaccines that may be given to pregnant women.

Though this writer and most vaccine apologists write as if this promise to the American people has been kept, they are *knowingly* lying to the people of America.

Hopefully, **Americans who read this review will**, *at a minimum*, ***continually*** (at least weekly) **contact the offices of their elected federal officials** (and the campaigns of all those running for federal office) **until:**

a. **The 1999 promise to remove Thimerosal from "all" vaccines is kept,**
b. **All unexpired Thimerosal-containing vaccines and any other drugs containing any added mercury compound are recalled and destroyed,**
c. **The use of Thimerosal or of any other mercury compound is *permanently* banned from medicine, and**
d. ***After appropriate investigations*, the appropriate legal actions are taken against those firms and individuals who were or are responsible for illegally using, or permitting the illegal use of, Thimerosal and any other mercury compounds in medicine without the required proofs of safety.**

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Appendix I. A journeyman's 2007 view of the human immune system

The Immune System is the name of a collection of compounds, cells, and organs whose complex interactions form an efficient system that is usually able to protect an individual from both outside invaders and its own abnormal cells, which, when *not* properly handled, can lead to cancer.

The immune system is a multi-layer wide-area network of subsystems distributed in the lymphoid tissues and organs of the body. Although the lymphoid tissues are widely distributed, they are concentrated in bone marrow, lymph nodes, spleen, liver, thymus, and Peyer's patches scattered in the linings of the GI tract.

The lymphoid system is encompassed by the system of mononuclear phagocytes (equivalent to a reticuloendothelial system [RES]). Lymphocytes are the predominant cells, but macrophages and plasma cells are present also. Lymphocytes are cells, which are continually circulating—alternating between the circulatory blood stream and the body's lymphatic channels.

The immune system's components can also be viewed as belonging to one of two general categories, non-specific (also known as innate immunity or non-adaptive immunity) and specific (also known as acquired or adaptive immunity). The breakdown of the immune system into non-specific and specific components is only valid for classification purposes because there is a constant and complex interaction, coordination and communication among all the components of the immune system. The non-specific components provide the majority of the body's immune resistance to outside invaders and altered internal cells.

The outermost layer of the immune system's defenses are the non-specific physical barriers (e.g., the skin, mucosal membrane, tears, ciliary elevators, and urine) and the chemical barriers (e.g., sebum, sweat, stomach acid, mucosal secretions, metallothioneins, and lysozymes).

The second layer of the immune system is also a non-specific defense layer that includes the macrophage system, complement, fever, interferon and inflammation.

The macrophage system attacks and consumes pathogens by engulfing them, a process known as phagocytosis. Complement cooperates with macrophages by attaching to foreign cells and initiating the ingestion of the cells in phagocytosis. Interferons are a class of proteins; activated by fever, which prevent viral replication in surrounding cells and also inhibit the growth of cancer cells. Fever is a powerful part of the immune system, as it interferes with pathogen growth, inactivates many pathogen toxins, and facilitates a more intense immune system response.

Whether caused by bacteria, viruses, or by physical means, when any tissue injury occurs, the injured tissues respond by releasing "inflammatory" substances such as bradykinins, complement, and histamines. This process is called inflammation and it strongly activates the macrophage system to remove damaged cell tissue. Inflammation is a vital part of the healing and repair process of the immune system and, whenever it is delayed or inhibited, healing and repair are generally incomplete and/or abnormal.

The immune system's third defense layer, the specific immune subsystems (also known as acquired or adaptive immunity), consists of B cells (for humoral immunity), and T cells (for cell-mediated immunity). The B and T cells have mechanisms for selecting a precisely defined target and for developing memory for a targeted antigen, so that the immune response to subsequent exposures to this antigen will be more efficient and effective. In a healthy immune system, these two branches of the specific immune subsystem are "balanced."

Every standard definition of immunity depends on the overall competence of both the non-specific and specific components of the immune system to recognize, isolate and eliminate foreign pathogens. This competence also involves the ability of the immune system to properly distinguish between self and non-self. Thus, at its foundation, immunity is the body's ability to establish and maintain its biological identity.

Consequently, *given the preceding realities*, there is a vast difference between true immunity, a prerequisite for bodily health, and the absence of any disease symptoms.

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