

This document is an attempt by Dick Atlee to respond substantively to each of the points and assertions made in the following *Mount Desert Islander* column, given that those assertions are a fair sampling of those most often made by the pro-mandate side in the ongoing vaccine debate.

Vaccine Benefits Outweigh Risks

March 22, 2019

<https://www.mdislander.com/opinions/state-of-maine-vaccine-benefits-outweigh-risks>

Note: in this document, the column's original text is lightened, the responses are indented.

Before beginning this endeavor, it is hoped there can be general agreement that this debate is not about the elimination of vaccines, but rather about whether exemptions should be allowed. In this debate, it is appropriate to examine the assertions most often cited — i.e., vaccine creation of community ("herd") immunity and protection of immunosuppressed children — and whether there are reasonable grounds upon which the desire for a non-medical vaccine exemption could be based.

For the most part, this response deals with efficacy issues. Safety is only addressed in general terms. A more thorough examination of safety issues is available at http://dickatlee.com/issues/health/vaccines/maine/vaccine_safety_problems_da_190322.pdf

A bill before the Maine Legislature is embroiled in two classic arguments. How do we use science to support political decisions, and how do we balance our individual rights versus those of society?

It should be noted here that this *Mount Desert Islander* column does not actually address *how* we use science in political decisions. It doesn't actually reference science. Rather, it simply presents a set of assertions that are being used to support the policy in question, without reference to competing findings. Because of the space limits of an op-ed piece, no documentation is provided for these assertions. It would be useful to eventually see such documentation. In this response, I have endeavored to document most of the assertions I make, using primarily government and peer-reviewed sources, and to make sure those citations do, in fact, do support the assertions being made.

The issue of rights is dealt with below.

Hundreds of Mainers showed up in Augusta last week to testify on LD 798, An Act to Protect Maine Children from Preventable Diseases by Repealing Certain Exemptions from the Laws Governing Immunization Requirements. The exemptions the bill would repeal are those based on “religious or philosophical beliefs.” The bill does continue to provide exemptions for those with medical conditions that make vaccination contraindicated.

Referring to rational scientific analysis of risks and benefits as a "philosophical belief" is a misnomer. Many in the "vaccine risk awareness" movement who have done thorough research into relevant science have come to their conclusions to avoid vaccination not from "philosophy" but from rational thinking and peer-reviewed science.

Regarding medical exemptions, the DHHS rules governing these (<https://www.maine.gov/dhhs/mecdc/infectious->

[disease/immunization/family/documents/immunization-requirements-for-school-children.pdf](#)) are quite rigid. For instance, they don't take account of the familial risk of a sibling having had an SAE (Serious Adverse Reaction), and, cruelly, a child (or adult) can't get an exemption until s/he has already been injured in some way. Passage of LD 987 (<http://legislature.maine.gov/LawMakerWeb/summary.asp?ID=280072053>) would ameliorate this to some extent, but doesn't resolve the problems created by the absence of the other exemptions for those for whom such exemptions are appropriate.

The impetus behind the bill is outbreaks of childhood diseases thought to be eradicated, or nearly so, in the United States. In 2000, measles was considered eliminated in the United States, but in 2019 in Washington state, more than 60 cases of measles were identified, more than the average number of cases reported in the entire country in a year. Fifty-four of those affected had not been immunized.

Measles wasn't declared "eradicated," only "eliminated", meaning that it's still around but isn't circulating widely (<https://www.historyofvaccines.org/content/articles/disease-eradication>). The average number of measles cases from 2009-2018, per the CDC, was not 60, but rather 218 (see the CDC's graph at <https://www.cdc.gov/measles/cases-outbreaks.html>). The current pace will probably put 2019 high, but the question remains how many of those cases represent fully vaccinated people.

It is also important to note that the measles vaccine's effectiveness wanes, and that additional boosters after the first booster have been found to be ineffective (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5729920/>). This means that, except for those adults who had natural measles and thus are immune for life, there are a lot of adults walking around whose immunity from measles is in question and getting smaller.

At one time, fewer than 20 cases of mumps were reported each year in the United States. In 2006, more than 6,000 cases were reported. A chicken pox outbreak occurred in 2012 in Indiana, sourced to an unvaccinated child. Here in Maine, we have the dubious distinction of the worst pertussis (whooping cough) rate in the nation. Reported cases more than doubled in month-to-month comparisons from last year to this. The greatest number of cases so far this year were in Hancock County.

Mumps: the MMR's (measles-mumps-rubella vaccine) mumps component has long been acknowledged to be ineffective (<https://www.ncbi.nlm.nih.gov/pubmed/18403766/>), which is not surprising, given the lawsuit by two of the clinical trials scientists that Merck committed fraud (e.g., putting rabbits' blood into the samples to increase antibody titers) (<https://ahrp.org/former-merck-scientists-sue-merck-alleging-mmr-vaccine-efficacy-fraud/>). It is thus also not surprising that the outbreaks are frequently happening in fully-vaccinated people (<https://www.cdc.gov/mumps/outbreaks.html>). The problem with this is that mumps used to be a relatively minor disease in children, who could handle it well, but now has been transferred to teens and adults, where it can be serious — e.g., male sterility.

Chicken Pox: The disease was so mild in children back when the vaccine was approved in the 90s that the only argument that succeeded in obtaining its approval was a cost-

saving one, eliminating parents lost-work-time staying home with sick children. That argument has now been shown to have been seriously flawed, thanks to the sudden explosion of (expensive) shingles in all age groups. Back in the late 90s, CDC-funded research (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3759842/>) revealed that along with plummeting chickenpox rates came rising shingles rates, not just in the usual elderly population, but at all age levels.

Shingles (re-emerging varicella virus) is normally kept at bay by a "booster" from circulating varicella virus from sick children. The elderly, generally having less child-contact, were thus more susceptible. With the elimination of the circulating virus, shingles was freed from that booster protection to surface in anyone.

Interestingly, after the researcher, Gary Goldman, began collecting shingles data, the CDC shut down that part of the investigation, and did its best to prevent subsequent publication of the information (<https://www.youtube.com/watch?v=9owLjgItcJU>).

Pertussis: Even more than varicella, pertussis is the poster child for a problematic vaccine. The vaccine is designed to control symptoms, not disease. As a result, vaccinated people can and do carry the disease silently and spread it. Thus, vaccinated children may be the greater threat to classroom health, as are grandparents to their grandchildren when they follow the CDC's advise to get vaccinated before visiting.

The classic study on the acellular vaccine (<http://www.pnas.org/content/111/2/787.full.pdf+html>) — which we use now because the whole-cell vaccine in the DTP proved so dangerous — was done using baboons, whose immune systems most closely resemble ours. One group was vaccinated, the other not, and then both were exposed to pertussis virus. In both groups, the virus colonized noses and throats and thus could be shed, infecting others. The unvaccinated group exhibited symptoms, while the vaccinated group did not. However, the unvaccinated group cleared the colonized virus faster than the vaccinated group.

After the virus was cleared, both groups were again exposed to the virus. This time the virus again colonized the vaccinated group (silently), but could not colonize the unvaccinated group (i.e., they were now immune).

This difference was ascribed to the tendency on the many vaccines to fail to emulate natural infection — that is, to focus on stimulating the humeral (antibody) part the immune system known as "TH2" rather than first stimulating the innate cellular ("TH1" _ portion of the immune system before then stimulating the TH2 part.

The result revealed that vaccinated people are capable of infecting others for quite a while after exposure to the pertussis virus, while showing no symptoms. Unvaccinated people, on the other hand, are infectious only during their first —and only — (visible) infection. The relevance of this result to supposed protection of immunocomprised children in the classroom seems clear.

As with mumps, major pertussis outbreaks are occurring in vaccinated populations. In the most recent example, in Los Angeles, all 90 cases had been vaccinated, and, interestingly, in a heavily-hit school, none of the 18 unvaccinated students caught it

(<https://www.latimes.com/local/california/la-me-ln-whooping-cough-vaccine-20190316-story.html>).

The TDaP version for older children and adults appears to lose most of its effectiveness in 2-4 years (<https://pediatrics.aappublications.org/content/135/6/981.abstract>)

Studies show that waning effectiveness may actually not be the main problem, but rather that a different strain is moving in (now around 85%), and that vaccinated people are more susceptible to it than unvaccinated (<https://cid.oxfordjournals.org/content/60/2/223.long> and https://www.cdc.gov/maso/facm/pdfs/BSCOID/2013121112_BSCOID_Minutes.pdf,p.6).

An article in 1998 linked vaccinations to autism. Even though later discredited, it is still cited as the rationale for significant numbers of parents to opt out of vaccinations for their children, despite a study through the National Institute of Medicine at the National Institutes of Health finding no “causal association between MMR vaccine, or any other vaccine or vaccine constituent, and autism.”

The protagonist of that affair, a co-author of the study, British gastroenterologist Dr. Andrew Wakefield, has had his medical career destroyed and been turned by the press into a bizarre caricature of a callous baby-killer. Because this story is completely false, and has been used to cow countless medical professionals into silence on the vaccine/autism issue, it's worth taking a moment to examine it.

First, and most important, the 1998 *Lancet* article did not, in fact, claim an association between the MMR and autism. Those who take the time to look at the actual article (<https://www.thelancet.com/journals/lancet/article/PIIS0140673697110960/fulltext>) will find that it is a case study describing a novel gastroenterological syndrome with neurodevelopmental aspects. What it said with respect to autism was this:

"We did not prove an association between measles, mumps, and rubella vaccine and the syndrome described. Virological studies are underway that may help to resolve this issue." [Note: measles virus was unexpectedly found in the lesions in the gut of the children; whether it was vaccine-strain had not been determined]. "If there is a causal link between measles, mumps, and rubella vaccine and this syndrome, a rising incidence might be anticipated after the introduction of this vaccine in the UK in 1988. Published evidence is inadequate to show whether there is a change in incidence or a link with measles, mumps, and rubella vaccine."

In other words, the article very definitely *did not* link the two.

What actually happened was that several years later, Brian Deer, a journalist, was asked by the *Sunday Times* (whose owner James Murdoch had just joined the board of vaccine manufacturer Glaxo's board) to "find something big" on the MMR vaccine (<https://www.ageofautism.com/2010/03/brian-deer-hired-to-find-something-big-on-mmr.html>). Deer concocted a completely false story about the study, and particularly Wakefield's role, which he then turned into a complaint to the British General Medical Council, resulting in years of hearings and a retraction of the study by *The Lancet*. Those who wish to fully understand the magnitude of the malfeasance in every aspect of this

case should read an almost-unbelievably detailed and documented examination of it at <http://ahrp.org/laffaire-wakefield-shades-of-dreyfus-bmjs-descent-into-tabloid-science/> .

The result was that Wakefield and his co-defendant, John Walker-Smith, the founder of pediatric gastroenterology, lost their medical licenses. Wakefield was unable to appeal at the time, but Walker-Smith did. The result was a complete exoneration of Walker-Smith in court (<http://www.bailii.org/ew/cases/EWHC/Admin/2012/503.html>). Judge Mitting found "inadequate and superficial reasoning and, in a number of instances, a wrong conclusion." The vast majority of the struck-down charges also applied to Wakefield, and those unique to him have subsequently all been shown to have been false or misleading.

The *British Medical Journal*, which kept up an attack on Wakefield, was ultimately forced to admit serious conflict of interest (<https://www.bmj.com/content/342/bmj.d1678>). However, despite years of protests, *The Lancet* has as yet refused to un-retract the study.

The affair has been widely recognized as having been designed to send a message to every medical researcher and practitioner in the world that their careers and reputations would be destroyed if they stepped across a line raising questions about vaccines, and it has proven to be admirably successful. As internal Merck emails famously said in the 2009 Vioxx case, "We may need to seek them [opposing doctors] out and destroy them where they live" (<https://www.cbsnews.com/news/merck-created-hit-list-to-destroy-neutralize-or-discredit-dissenting-doctors/>).

It also needs to be noted that Wakefield is not, as he is famously accused of, responsible for the drop in measles vaccination. His examination of the records of both the single measles vaccine and the MMR prompted him to publicly recommend using the single vaccine in place of the MMR. He was told by a public health official that that comment "threatened the MMR program," and a couple of months later the U.K. cancelled the import license for the single vaccine. The next year Merck stopped making it. From this, it should be clear where responsibility for the drop in measles vaccination actually lies.

The irony is that long before Deer began his fraudulent campaign of defamation against Wakefield, the CDC had already in 2001 discovered a significant link between the MMR and autism in a study of school children in Atlanta. However, the study team was ordered to destroy that incriminating data. They massaged the data for three years until they finally succeeded in removing its statistical significance, and the resulting fraudulent paper (mentioned in the op-ed paragraph above) that they published via the Institute of Medicine has been used ever since by vaccine proponents as "proof" of the lack of an association. Worse, this claim is generally stretched into the even more inappropriate generality that "Vaccines don't cause autism." This whole affair was described in detail in the movie *Vaxxed*, by a whistleblower — the study's chief data scientist — who had secretly retained all the data to avoid committing a federal crime.

The link between vaccinations and autism, particularly with the MMR (measles, mumps, rubella) vaccine, is labeled "critically flawed" by Children's Hospital of Pennsylvania (CHOP). In a vaccine safety publication, CHOP distinguishes between the terms "safe" and "harmless." The latter, taken literally, is a test few life activities could pass. "Having been preserved from a real

danger” is the safety definition CHOP finds most applicable, in that “a vaccine’s benefits must clearly and definitively outweigh its risks.”

Unfortunately, studies in recent years of the aluminum adjuvants used in many vaccines (though not in the MMR) have elucidated a mechanism by which the adjuvant nanoparticles are carried by macrophages directly to the brain and deposited in the glial cells, where they create an ongoing cycle of neuro-destructive inflammation. This type of inflammation in mice generates behaviors characteristic of autism. The sequence of international studies that have elucidated this mechanism and its effects are described at <https://web.archive.org/web/20180313132231/https://healthcareinamerica.us/did-chinese-scientists-find-autisms-missing-puzzle-piece-2d50be5b9122>, and in <https://www.youtube.com/watch?v=ZeORYSHoRUc>.

CHOP's safe/harmless distinction is in one sense a fair one. The problem is that it is a technical distinction of which most of the general public is likely unaware. To the public, "safe" does not include the possibility of SAEs (Serious Adverse Events) on the order of chronic disability or death. Those in industry and government who use the term are certainly aware of this potential misunderstanding, though many in the media may not be.

Justice Antonin Scalia perhaps had a more accurate rendition of the situation in his acknowledgement in the majority decision in the 2011 *Bruesewitz v. Wyeth LLC* (<https://www.supremecourt.gov/opinions/10pdf/09-152.pdf>) that vaccines fall into the category of "unavoidably unsafe."

Side note on CHOP: Consider the source being cited here. The director of CHOP's Vaccine Education Center is Dr. Paul Offit (<https://www.chop.edu/centers-programs/vaccine-education-center/our-team>), the industry's primary public spokesperson. Merck funds his research and buys copies of his book and distributes it to doctors. (<https://www.upi.com/UPI-Investigates-The-vaccine-conflict/44221058841736/>).

Dr. Offit was on the CDC's Advisory Committee on Immunization Practices (ACIP) during votes to add rotavirus vaccines to the childhood schedule, one of which he and CHOP had patents on. CHOP sold the vaccine's future royalties for \$182M, of which Dr. Offit received at least \$29 million (he and CHOP refuse to disclose the actual amount. (<https://www.ageofautism.com/2009/02/voting-himself-rich-cdc-vaccine-adviser-made-29-million-or-more-after-using-role-to-create-market.html>)). But his comment is telling: "I am a co-holder of a patent for a (rotavirus) vaccine. If this vaccine were to become a routinely recommended vaccine, I would make money off of that. When I review safety data, am I biased? That answer is really easy: absolutely not." Interesting. . .

One has to wonder about Dr. Offit's advice when, in 2005, CHOP's October 2005 newsletter (apparently subsequently removed from the web) famously said "In fact, Dr. Offit's studies show that in theory, healthy infants could safely get up to 100,000 vaccines at once" (<https://web.archive.org/web/20060907100428/http://www.chop.edu/consumer/jsp/division/generic.jsp?id=81553>).

Vaccines cannot be called 100 percent harmless, as there are certainly documented, untoward effects for those vaccinated. However, most are mild and innocuous, especially as compared to the effects of the diseases they prevent. Risks inherent in those diseases are far greater.

These generalities are not statements based on scientific evidence. Death and permanent disability are the risks certain vaccines pose to certain people, making those vaccines far more dangerous to those people than the risks in, say, childhood mumps or chickenpox. The vaccine package inserts (<http://www.immunize.org/fda/>) and the Department of Health and Human Services's (HHS) Vaccine Injury Table (<https://www.hrsa.gov/sites/default/files/vaccinecompensation/vaccineinjurytable.pdf>) contain extensive lists of such adverse events.

On three separate occasions, the CDC has asked the Institute of Medicine to investigate and increasing number of adverse events commonly associated with certain vaccines, in order to ascertain whether those events are caused by the vaccines. In each of these reports, the IOM has decried the lack of research that would make such judgments possible:

- a. 1991 — vaccine=DTP
result: 6 causal, 4 non-causal, 12 insufficient research to judge
- b. 1994 — vaccines=diphtheria, tetanus, measles, mumps, polio, hepatitis-b, hib
result: 12 causal, 4 non-causal, 38 insufficient research to judge
(also insufficient research to judge risks of multi-antigen vaccine)
- c. 2011 — vaccines=varicella, hepatitis-b, tetanus, measles, mumps, rubella
result: 18 causal, 5 non-causal, 135 insufficient research to judge

In 1994 the IOM called for the CDC to research which children are at risk of vaccine injury. As of the latest report, the CDC had so far failed to do so.

The weighing of risks and benefits can only be done when the risks factors are actually known, and it is clear that at this point, the risks are largely unknown. Even if they were known, doing such a calculation in a medically appropriate and ethical way requires taking into account the factors characterizing both the individual recipient and the particular vaccine. This has no place in a one-size-fits-all mandatory policy.

The 1986 National Vaccine Injury Compensation Act, which freed manufacturers from liability from death and injury caused by their vaccines, also filled this liability gap by requiring HHS to foster research into improving the safety of vaccines, and to report biennially to Congress on its progress. Last year it was forced to acknowledge it had done neither in the intervening three decades ([https://icandecide.org/wp-content/uploads/whitepapers/Stipulated Order copy.pdf](https://icandecide.org/wp-content/uploads/whitepapers/Stipulated_Order_copy.pdf)).

It must also be understood that because the FDA treats vaccines as "biologicals" rather than "pharmaceuticals," vaccine safety studies don't follow the familiar standards for drug safety testing — multiyear double blind inert-placebo controlled trials:

- Trials are short (sometimes only a few days, as with both Hepatitis B vaccines)
- Inert saline placebos are not used. Instead, an earlier equally untested vaccine or the vaccine adjuvant or the vaccine minus the antigen is used. Any safety problems inherent in these cover up any danger signal in the trial vaccine. The only saline placebo used was in a small part of the HPV trials, and the results were so striking (0

adverse affects) that the saline-placebo group's data was bundled with another non-inert placebo group's to hide that result. (FDA 2006 *Gardasil Clinical Review Tables 229 and 295*, referenced in Holland, Rosenberg, Iorio, [The HPV Vaccine on Trial](#), p. 58

- Only healthy children are enrolled in these studies, but the ultimate intention is for the vaccine to be given to *all* children, including children with specific health issues that may predispose them to vaccine injury.

Despite the increasing awareness, and admission by high-up Federal health officials – e.g. former NIH head Bernadine Healy

(<https://www.youtube.com/watch?v=UZFPpHBNp2M>, <https://www.cbsnews.com/news/leading-dr-vaccines-autism-worth-study/>) that there are subgroups of children who are predisposed to injury, there has been virtually no research done to identify these groups.

The other part of the vaccination debate is whether government has a right to intervene in a parent's decision not to vaccinate his child. Parental rights are among the most protected in our society, but what about the rights of the rest of our kids to attend a school where the students are least likely to transmit childhood diseases by virtue of having been vaccinated?

One of the forms of the Doctrine of Utility (<https://en.wikipedia.org/wiki/Utilitarianism>) is the statement that what is most desirable is that which does the most good for the most people. While it has a nice ring, it has been used by such diverse individuals as Germany's Dr. Mengele in his experimenting on a few "undesirables" in order to further the health/eugenic needs of a much larger group, and the public health officials who ran the well-known Tuskegee experiment (https://en.wikipedia.org/wiki/Tuskegee_syphilis_experiment),.

Out of such excesses came a number of international agreements, including:

- The Nuremberg Code (<https://history.nih.gov/research/downloads/nuremberg.pdf>)
- The U.N. Universal Declaration on Bioethics and Human Rights (<https://unesdoc.unesco.org/ark:/48223/pf0000142825.page=80>)

to which the U.S. is a signatory, and which specify Informed Consent as a human right.

Sadly, the information given out by the CDC with respect to vaccines is insufficient for making an informed decision, and a mandatory policy by definition eliminates consent.

As mentioned above, the precedent for mandatory vaccination in the U.S. was the 1905 *Jacobson v. Massachusetts* case (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1449224/pdf/0950581.pdf>). At the time, living conditions were poor for the majority of people, there were no antibiotics, and only relatively primitive medicines, so communicable diseases were the major cause of death, against which the as-yet-underdeveloped concept of legal or human "rights" was no match. In the 100+ years since then, the relative importance of these two potentially conflicting concepts has reversed. It is no longer clear how relevant the *Jacobson* case is in today's world, particularly considering the questions about "safety and effectiveness" raised here.

Does a child with a known communicable disease have the “right” to go to school, putting all the other students at risk? Most often, symptoms become obvious only after a child has actually contracted the disease. They are exposing their friends, babysitters and schoolmates in the early days, already contagious but without the cough, fever or spots to make it apparent.

Some of this is addressed in the next response. But the true irony of this train of thought is that children are not exposed to each other only in school. There are pick-up sports, Scouts, community drama, community centers, YM/WCAs, malls, restaurants, etc. where children interact with each other. Are unvaccinated children to be denied access to every group activity and public space society has to offer? This is already beginning (<https://www.cnn.com/2019/03/26/health/rockland-new-york-measles-unvaccinated-ban-bn/>) and where it will ultimately end up is of great concern.

For the public hearing last week, 527 items were filed in testimony. All the testimony is posted online. There were pleas to require broad vaccination to protect those who, for medical reasons, cannot receive certain vaccines, as well as parents who felt that vaccination would adversely affect their children and opposed the bill.

In a document I compiled for legislators called "Analysis of vaccine effectiveness with respect to the removal of unvaccinated children from classrooms" (https://dickatlee.com/vaccines/maine/limits_of_vaccine_effectiveness.pdf), I brought together the science of the efficacy of each of the childhood vaccines in terms of whether or not each one can play a role in protecting immunocompromised children in a classroom. This is also partially covered in comments above. The fact is that "vaccines" (as a whole) do not offer that protection, though a few might to some degree:

- some vaccines are for noncommunicable or non-childhood diseases,
- others have high primary failure (produce no antibody titers in some) and secondary failure (ineffective due to waning or antigen-strain replacement) rates, making such children the equivalent of unvaccinated children (or worse), and
- others actually increase the risk of transmission by hiding symptoms (esp. pertussis).

Most Maine medical leaders were fully supportive. They are worth naming: The Maine Hospital Association, the public health director for the city of Portland, the Maine Children’s Alliance, the pediatric hospitalist at Maine Medical Center, the Maine Nurse Practitioner Association, the Maine Primary Care Association, the American Nurses Association, the American Medical Association, the American Academy of Pediatrics, the Maine Medical Association and other medical, educational and civic organizations.

There are many reasons why this is not surprising, and why such endorsements should not be considered as validating LD 798 or any other related effort (such as mandating the HPV vaccine):

- Numerous medical professionals have commented on the absence of serious vaccine education in medical schools. For the most part, they describe it as consisting of simply "safe and effective" and "follow the CDC schedule on time." Much of the independent and international research that is raising serious questions about both of these dicta has occurred in the last decade or so, and doctors — particularly in the

current forced-rush atmosphere of healthcare — don't have time to do in-depth examination into that research, and it is not made readily available to them, especially in the current atmosphere of censorship of such information. This dynamic applies to public officials as well.

- The role of funding in medical industry can't be ignored. Hospitals get better government reimbursements if a higher proportion of their patients have both flu and pneumonia shots. A major portion of pediatric practice income is from vaccines. Medical practices in some states also have financial incentives from insurance companies to have a certain percentage of their clients up-to-date. Medical associations refuse to reveal their sources of funding, but the potential role of the pharmaceutical industry in this area is something to be considered.
- The Appeal to Authority that is inherent in lists of supporting agencies is part of why we are in this quandry. The CDC, the FDA, and the EPA have each been found on numerous occasions to have provided fraudulent and/or conflict-of-interest-ridden information and policies, but virtually all the other national health agencies in the world take their cue from these three, as do the next-eschelon state agencies and medical associations. Just one example: the FDA's 1992 designation of GMO foods as "generally recognized as safe" was a political decision that overruled the strong opposition of its own scientists.

Several health care providers, including a few physicians, did oppose the bill. Some opined that it is the pharmaceutical companies and the health care industry that promote vaccinations to enhance their bottom lines. The Maine Pharmacy Association was among those testifying in support.

It would be surprising if a business association whose principal reason for being is pharmaceuticals, and whose members in recent years have increasingly become advertised injectors of vaccines, wouldn't support increasing the demand for vaccines. This speaks to business sense, but isn't a cogent medical argument.

As for the incentives of the pharmaceutical industry, the industry has been quite publicly frank in its view that vaccines are key to its future financial viability. Unlike all of its other products, vaccines have

- no liability
- no advertising costs
- a guaranteed customer base (particularly in mandate areas)

The increase in a wide variety of chronic diseases nationwide in the U.S. has tracked the increasing vaccine schedule (and several other ubiquitous environmental influences such as GMOs and glyphosate herbicides). The potential for vaccines to be contributing to this increase in chronic diseases would naturally make them highly desirable to an industry whose profits are based on selling ever more drugs for treating chronic diseases.

Whether or not this large increase in childhood chronic disease can be laid at the feet of vaccines will only be settled when a large-scale "vaxxed-vs-unvaxxed" study is finally carried out. The CDC has persistently refused to do such a study, but a first pilot study *has* been done (<https://www.oatext.com/pdf/JTS-3-186.pdf>). Though the study has been subject to criticism, some justified, some not, as a pilot it has provided a "signal" — a

finding that warrants further research. In the study, unvaccinated children got the vaccine-targeted diseases, as expected. However, the vaccinated children were significantly sicker, with:

- more than a doubling of chronic illness
- a tripling of eczema
- a quadrupling of neurodevelopmental disorders, autism and ADHD
- a quintupling of learning disabilities
- a thirty-fold increase in allergic rhinitis

It is difficult, if not impossible, for the average citizen to follow the detailed arguments and statistics presented by both sides. Most parents want nothing but what is best for their children, and most have decided that the benefits of immunization outweigh the risks. Unvaccinated children are also protected by those children who are vaccinated. The weight of the argument is in favor of vaccinating our kids for a healthier society.

One would wish that in our democratic republic, where freedom of the press has been considered the mainstay of democracy from the very beginning, that members of the press would follow those "detailed arguments and statistics" and present a balanced picture to a public that supposedly can't follow them. However, for a variety of reasons — primarily originating from the financial incentives of an industry that pays for the bulk of advertising and has captured the regulatory agencies and much of the focus of medical education — this isn't happening, and is, in fact, moving in the opposite direction: suppression of solid scientific information.

It is agreed by all that most parents want nothing but what is best for their children. Most have accepted the claim that the benefits outweigh the risks. For many, if not most, that decision is based on a one-sided narrative that ignores much of what recent science is telling us, and doesn't consider the risk/benefit analysis of each of the vaccines with respect to their own particular children, yet no one in this LD 798 debate is saying that those mothers shouldn't follow that narrative and choose to vaccinate their children.

The only issue here is whether that *other* group of mothers that *also* want to do best for their children — and who are far more likely to know whether their particular children are at risk from any one or all the vaccines than are state legislators or bureaucrats — should also be allowed to make their own decision: to not vaccinate or to use a different schedule.

Finally, the issue of who is protecting whom is far from simple. If, as may be the case judging from all the information cited above, unvaccinated children as a whole turn out to have stronger immune systems than vaccinated children, and vaccinated children have weakening immunity with respect to some of the vaccine-targeted diseases, the unvaccinated children may to some extent be protecting the vaccinated children.