

“Vaccine scientists credit Mr. Siri for drilling into
the details of vaccine research...”

— *The New York Times*

VACCINES, Amen



THE RELIGION OF VACCINES

AARON SIRI

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Introduction

Ever hear someone say, “I believe in cars” or “I believe in tools”? I cannot recall ever hearing anyone say they believe in a certain product. But I hear people say, “I believe in vaccines” all the time, especially in response to evidence regarding vaccines.

The expression “I believe in vaccines” carries a truism. The properties often attributed to vaccines require faith. Belief. This is because most claims about vaccines are not grounded in evidence. They are beliefs. It is why challenging claims about vaccines—meaning challenging beliefs—often results in an emotional, not logical, reaction.

This is also why wading into this topic is not for the faint of heart. Nor is it for anyone seeking to avoid controversy. Just the word “vaccines” evokes emotions for many.

Falling Into Vaccine Law

For this reason, among many others, I likely would have laughed if someone had told me eighteen years ago that I would be managing a law firm, with more than 100 professionals, working on vaccine injury, exemptions, and policy. Back then, I was working on high-stakes, multi-billion-dollar lawsuits at one of the country’s premier law firms. Even after starting my own law firm over a decade ago, I continued to handle mostly high-stakes business litigation matters.

Then, one fateful day, I learned something I could not unlearn: of all the corporations I was defending, I would likely never have to defend a pharmaceutical company against claims that children were seriously injured or killed by a vaccine. Why? Because in 1986, Congress granted these companies financial immunity for injuries caused by childhood vaccines in a law titled the National Childhood Vaccine Injury Act (the **1986 Act**).

I learned that, because of the 1986 Act, parents of seriously injured or deceased children must sue the federal government’s health department, instead of the company that profited from the product that harmed their children. From that one data point, my journey regarding vaccines began. What I have uncovered along the way has frequently been unbelievable.

This journey, spanning over a decade of litigating vaccine lawsuits of all stripes across the country, has been unique. This is partly because, unlike doctors, who can appeal to their credentials, I do not get to just say, “trust me.” I need to prove claims I assert with real data. Real proof. Something that will hold up in court. Non-authoritative science will not do. Unreliable data will not do. This means my vaccine litigation work requires me to study the primary sources and carefully review and scrutinize the studies and data that support each claim.

In the course of that legal work, I have worked with well over a hundred immunologists, infectious disease doctors, pediatricians, and other medical professionals. I have deposed these specialists as well, including the world’s leading vaccinologists. This work requires an understanding of vaccinology, immunology, infectious disease, and pediatrics, among other disciplines, with regard to these products. Want to talk about any other drug, medical procedure, etc.? I am not your man. But vaccines, those I know.

Incredibly, most of the information needed to understand vaccine safety is freely available on federal government websites and public databases. Most doctors and parents never bother to look or don’t know it exists. Those who do know and look often learn things they cannot unlearn.

Parents Who Do Not Vaccinate

According to the CDC and public health authorities, parents who choose not to vaccinate their children are typically highly educated. CDC data reflect that half of American children are not fully vaccinated, and at least 1 in 88 toddlers in America are completely unvaccinated. Why would the parents of these children, constituting a large part of the nation’s brain trust, choose not to vaccinate their children?

After all, parents who choose not to vaccinate are, as the CDC laments, typically very highly educated. They are often scientifically literate. Many are medical professionals. Leading scientists. What is it that they have learned or experienced that convinced them to forgo what many believe is the greatest medical achievement of all time?

The answer, I have found, is that they often have had an experience which caused them to scratch below the surface of common conclusory statements about vaccines. They seek the substance that underpins these statements. What they then learn, they cannot unlearn. Cannot unsee.

As an ardent vaccine promoter, Emily K. Brunson, MPH, PhD, explains about those who choose not to vaccinate: “I think we need to avoid the trap of thinking that information or knowledge is enough, because for a lot of the people, and when you look at hesitancy and parental vaccine

hesitancy in the US, the group who is most likely to purposefully choose to not vaccinate are highly educated. **In speaking with them, these are people who have read the primary literature themselves, and they're correctly interpreting it, so it's not a misunderstanding.**"¹

Keep in mind that for those who choose not to vaccinate, that choice often comes with serious consequences. Including expulsion from school. Exclusion from social circles. Being labeled anti-science or worse. It also requires overcoming powerful, almost crushing societal pressure to vaccinate one's child, and rejecting the near-universal advice of public health agencies. Choosing not to vaccinate is not for the faint of heart and, in my experience, is rarely a decision made lightly. Meaning whatever these parents learned, it must have been powerful enough to overcome incredible social pressures and penalties.

This also comports with my experience that in many cases, parents do not choose to *not* vaccinate. They choose to *stop* vaccinating. Their completely unvaccinated children often have an older sibling who is partially vaccinated. But, even among those with a personal experience, it is those who carefully investigate vaccine products who typically reach the conclusion to not vaccinate with sufficient intellectual rigor and confidence to overcome the powerful societal pressures and penalties of not vaccinating.

Other than knowledge and experience, I have found that those choosing to not vaccinate hail from nearly every demographic, race, ethnicity, religion, and walk of life. They are scattered almost haphazardly across all verticals and horizontals of American life, with the only real predictive clustering being around those who use their intellect to research these products.

Vaccine Zealots

There is something else I found surprising in my journey regarding vaccines. The popular conception is that those who do not vaccinate are fanatics. Anti-science. Irrational. Emotional. Zealots. But my experience has generally been the opposite.

To be sure, there are some who take issue with vaccines who meet the foregoing description. They are also the ones who can often be the loudest. But they are, in my experience, the very tiny but vocal tip of the iceberg. The remainder—submerged silently and quietly under the water, not wanting any publicity of any kind, and who do not dare speak their views in mixed company—make up the vast majority of those who choose not to vaccinate. These folks, as a group, are highly knowledgeable and educated about these products. They can speak rationally about them. They are typically science-literate and put that ability to good use

in researching these products. They are far from zealots. They are just parents seeking to make good decisions for their children.

As for parents who *do* vaccinate, almost all such parents I have met appear to have never really thought much about these products, nor have they viewed this as a decision to be made. They just go with the flow. They have never encountered any issue with their children that they have associated with vaccination. They often do what the media typically says good parents are expected to do—trust their doctors. That is not to say they do not hold orthodox views about vaccines, but those views are susceptible to change upon presentation of actual evidence.

Then there is what I call the “Vaccines Amen” crowd. This is the group of parents, doctors, and public health professionals I have dealt with—a small army of them—who have a fervent belief in vaccines. This group is often impervious to reason or data, even when it is provided from their oracle, the CDC. This group attributes properties to one or more vaccines that simply do not exist. They overstate the benefits and cannot accept even official government data showing that many of their core beliefs regarding vaccines are false. When these beliefs are challenged, this crowd gets angry. They often entrench and, instead of addressing the evidence or accepting the clear reality, demand instead that everyone must adopt their beliefs. And for those who refuse to adopt their beliefs, they demand that the refusers be censored, have their rights taken away, and be mandated to be injected. This is the “Vaccines Amen” crowd.

Let me put it this way: the fanatics are not those who choose *not* to vaccinate. The fanatics are those who think *everyone* must be vaccinated whether or not they want to engage in this medical procedure. Let me also state that I think most pediatricians, doctors, and public health authorities mean well. They believe they are engaging in God’s work. And that is often the problem that makes them blind to reality.

The title of this book, *Vaccines, Amen*, comes from this ironic and strange reality I live in every day in which the so-called “antivaxxers” I encounter are often very knowledgeable about the primary sources underpinning the purported safety and efficacy of these products. They often can discuss the literature, pre- and post-licensure, calmly and rationally. They can certainly be upset that their child has been excluded from school, but they are not emotional about the actual products they have chosen not to give their child. Discussing those, these parents are rational.

On the flip side, I have found the opposite to be the case among the Vaccines Amen crowd, including a significant proportion of medical professionals. When challenged about vaccines, they are often emotional about the products themselves. They lack an understanding of the pre- and post-licensure literature and much else about these

products. They regurgitate canned answers they have never researched—essentially mantras. When these mantras are challenged with evidence, it causes cognitive dissonance that often results in anger or a similar emotional response, not a logical response. Most critically, their beliefs in these products persist despite clear, unequivocal evidence to the contrary. This is why I call them “beliefs”—because that is what they are.

Choosing to vaccinate is an important decision that should not be made based on dogma. It should be based on evidence. And you are more likely to receive factual, evidence-based information about vaccines from someone who has been required to litigate and prove or disprove claims made about vaccines with evidence, than you will from someone who just repeats mantras about these products. It is also why the claims in this book are supported by citation to primary sources or reliable evidence.

Parents will spend hours researching before choosing to buy or lease a car or a house. Stress over car seats and stroller purchases. Research which foods are healthiest. It similarly behooves all parents to give the same level of attention to understanding the dozens of products—and they are products—pharmaceutical companies and the CDC seek to inject into their children. Whatever you choose, let me suggest doing so from a place of knowledge.

My Bias

My personal ideological position regarding vaccines is that vaccines should not be mandated. Everyone should be able to get a vaccine, any vaccine, and get as many as they want. But civil and individual rights demand that no one should be coerced into receiving an unwanted medical product or procedure, including a vaccine.

In fact, my rule of thumb is that the more a product needs to be coerced, the more one should be concerned about that product. Parents who make the often socially ostracizing, rights-crushing decision to not vaccinate often have a good reason. Yet, it is these same parents, and their children, who vaccine mandates adversely impact.

Do some vaccines have potential benefits? Yes. Virtually every drug has some benefit. That is even true of most drugs withdrawn from the market due to serious safety or efficacy issues. That does not mean every drug makes sense for every person. It does not mean the potential benefits outweigh the risks. It does not mean that reasonable minds cannot differ on this calculus. They can. Some may choose a speculative benefit even where there is a known harm, and vice versa. The point is that there must be liberty to choose.

The right to choose is certainly my bias, and I tried to keep that bias in mind as I drafted and presented the facts and information in this book. Meaning I sought to be as objective as possible. For that reason, and because there is skepticism regarding any statements made regarding vaccines, as noted, the proof to support each material assertion is included within this book.

Now, I would love to jump into vaccine safety because it is probably the most interesting part of this book, but I know many cannot hear anything about vaccine safety without yelling or wanting to yell, "we must trust the experts!" or "we would all be dead without vaccines!" So, the first three parts of this book will address those claims before we get to vaccine safety in Part IV.

With that—hold on tight. You are about to learn things you can never unlearn.

PART I THE CLERGY

The Ministry of the Clergy

The Ministry of the Clergy is a book by the Rev. Dr. J. H. W. Brown, a well-known English clergyman and author. It is a collection of essays on the history and development of the clergy in England, from the early days of the Christian mission to the present day. The book is written in a clear and concise style, and is suitable for both the general reader and the student of English literature.

As a clergyman, I have often been asked for advice by laymen on the subject of the clergy. This book is a collection of my answers to such questions, and is intended to be a guide to the layman on the subject of the clergy.

Chapter 1

High Priest: Stanley Plotkin

In most systems of belief, there are revered leaders. For vaccines, it is no different. These are the vaccinologists. They are a small group whose words are taken as dogma by the medical community and public health authorities.

The reality is that most doctors, including pediatricians, immunologists, and infectious disease doctors, know almost nothing about vaccines. They rely on the word of vaccinologists, either directly or by following vaccine-related science, policy, and standards molded by vaccinologists.

The vaccinologists, in turn, have developed a self-reinforcing belief system about vaccines that often does not comport with reality. The tiny group of vaccinologists leading this discipline repeat their self-reinforced belief system in their speeches, journal articles, medical textbooks, and to each other. Those who do not reiterate the correct mantras quickly lose their needed patronage from pharma and do not rise in the vaccinology ranks.

I promise to fully support this sacrilegious claim. Let me start with how I came to know this truism. It is the result of directly testing the claims made by vaccinologists in lawsuits wherein they were forced to prove their claims—a forum where repeating dogma is not sufficient.

Let's begin with a deposition I took of the world's leading vaccinologist, effectively the godfather of vaccinology.

The Godfather of Vaccinology

One vaccinologist sits far above all others. Someone whose claims regarding vaccines are treated as fact based on nothing more than utterance from his lips. The world's leading vaccinologist, often referred to as the godfather of vaccinology: Dr. Stanley Plotkin.

As just noted, I had an opportunity to depose Dr. Plotkin as part of a lawsuit. Meaning I got to ask him questions under oath in preparation

for a trial. Unlike his flock of vaccinologists, however, I didn't just take him at his word.

For nine hours, I questioned and pressed him on vaccines and, in particular, vaccine safety. That exchange, while revealing many truths about vaccines, maybe most critically, revealed how Dr. Plotkin views and approaches vaccine safety. And by understanding how Dr. Plotkin thinks about vaccine safety, you will understand how his disciples think about it, whose views then filter into the rest of the medical community, informing vaccine policy by health agencies and medical organizations alike.

While this part of the book (Part I) will touch upon various vaccine safety topics, the purpose is not to cover any particular vaccine safety issue (that will occur in Part IV) but to understand how vaccinologists think about and approach vaccine safety.

The Call to Depose Dr. Plotkin

The story of how I came to depose Dr. Plotkin began on November 29, 2017. On that fateful day for Dr. Plotkin, I was killing time at a coffee shop on the Upper East Side, having arrived early for a meeting in a nearby building.

My cellphone rang. A doctor I knew, Toni Bark, MD, was calling to tell me that there was a once-in-a-lifetime opportunity to depose Dr. Plotkin. She explained she was the expert witness in a family law case in which a mother wanted to keep her daughter unvaccinated, and that Dr. Plotkin had appeared as the expert witness for the father who wanted to start vaccinating the child. Dr. Bark wanted to know if I would take Dr. Plotkin's deposition.

It took a few seconds for it to sink in that we were talking about *the* Stanley Plotkin. The literal namesake of the medical textbook on vaccines—titled *Plotkin's Vaccines*—and the gavel used at CDC's vaccine committee meetings—the "Plotkin Gavel." The man who invented many of the current vaccines, published more studies on vaccines than anyone, and is far and away considered the world's leading authority on vaccines.

After a moment of pause, I told Dr. Bark, "I'll do it." As soon as I hung up, the excitement of the opportunity gave way to the realization, "I need to get to work."

I already knew a decent amount about the primary sources related to vaccine safety, as I had litigated a few vaccine cases by that point, but if I was going to hold the world's leading vaccinologist to the truth, I needed to gather and organize the evidence I had previously reviewed, as well as learn everything possible about Dr. Plotkin. I spent the next six weeks hunkering down in my office preparing.

As I prepared, what kept gnawing at me was the feeling that I must be missing something. I had carefully reviewed the available official government and pharma sources regarding vaccines, and they reflected serious safety gaps. But given Dr. Plotkin's and his kin's confident public statements about vaccine safety, I had to assume he knew something I had missed.

Maybe he had some special inside information. Presumably, he did. Because from my review of the primary sources, there appeared to be, at best, incredible gaps in the trials and data supposedly supporting vaccine safety.

As the date of the deposition arrived, I concluded my research and finalized my outline and exhibits to address the key questions about vaccine safety. As I went to bed the night before the deposition, I felt well prepared, yet I expected surprises. Twists. Unexpected facts. Some special inside information that would throw me for a loop.

However, during my nine-hour exchange with Dr. Plotkin, I was met with none of that. Instead, I was left astonished that the worst fears expressed regarding safety gaps related to childhood vaccines were not only true, they were worse than I could have imagined. This is no doubt why the other side in that family law case made an impassioned motion to the court after the deposition to have the deposition sealed from the world forever, which we succeeded in opposing.¹

The Importance of How Dr. Plotkin Thinks About Vaccine Safety

Understanding how Dr. Plotkin thinks and approaches vaccine safety is critical to understanding vaccines because there truly is almost no area of current vaccinology that Dr. Plotkin's way of thinking did not directly mold.

He is listed as an author on over 900 peer-reviewed articles, reviews, abstracts, and letters in medical journals between 1958 and 2025, most regarding vaccines. This is, no doubt, more than anyone else alive or dead. This influence on the development of the "science" of vaccines for decades is alone profound. But it does not stop there. He has been an editor for every major vaccine-related journal, including *Vaccine*, leaving his mark on each, and his endless stream of letters and reviews in these journals have guided how others have conducted vaccine-related studies, leaving his mark even when he is not a listed author.²

He created the standard medical textbook on vaccines, called *Plotkin's Vaccines*, currently in its eighth edition, and is listed as an editor on the front page in each edition.³ A recent CDC Director said Plotkin's textbook has had a "global impact" on vaccinology and this

textbook is often referred to, including by Bill Gates, as “the bible for vaccinologists.”⁴ In reaction, Dr. Plotkin has quipped: “I hope it is more accurate than the Bible.”⁵

Dr. Plotkin also exerted his influence while speaking and lecturing endlessly regarding vaccines to vaccinologists and the broader medical community since the 1950s in nearly every forum imaginable, including when being showered with honors and awards for his vaccine work over the last few decades. Unsurprisingly, these awards include those with his name in them, such as the Stanley A. Plotkin Award for Excellence in Vaccinology awarded by the Pediatric Infectious Diseases Society.⁶

He developed and worked on the development of numerous vaccines, including the rubella vaccine, polio vaccine, chickenpox vaccine, and rotavirus vaccine (just to name a few).

He attended virtually every CDC Advisory Committee on Immunization Practices (ACIP) meeting for six decades, where he was treated as a demigod. Just watch publicly available videos of these hearings.⁷ ACIP is the CDC committee that effectively sets CDC vaccine policy and creates its vaccine schedules.⁸ During these six decades, Dr. Plotkin also participated in ACIP working groups that issue recommendations, which are typically rubber-stamped by ACIP.⁹ But unlike ACIP meetings which are public, these working group meetings are held in secret, with no public transcript or recording available.¹⁰

Dr. Plotkin’s influence on ACIP was so profound that CDC, as noted, named the gavel used at ACIP meetings the “Stanley A. Plotkin ACIP Gavel.”¹¹ In the speech given by the ACIP Executive Director upon the introduction of this gavel into use, he had, among other things, this to say: “Dr. Plotkin has attended ACIP meetings for as long as many of us can remember, and has been a constant source of knowledge and information. After many years of sharing his wisdom and guidance, Dr. Plotkin has announced that he will no longer attend ACIP meetings in person. All of us have been influenced by Dr. Plotkin. Every time Stan approaches the microphone at an ACIP meeting to offer comments, we know that we are about to learn something from his sage advice and massive insight.”¹²

This is why understanding how Dr. Plotkin thinks about vaccine safety is critical to understanding how vaccinologists think about and approach vaccine safety, and the remainder of this chapter will go through various portions of Dr. Plotkin’s deposition to provide insight into how he thinks and approaches vaccine safety.

The Deposition Begins

With that, let’s dive into the deposition. It took place on January 11, 2018, in a small conference room at the Golden Plough Inn in New

Hope, Pennsylvania, near Dr. Plotkin's home. The Golden Plough Inn is a historic inn with plenty of old-world charm. I was there early, and when Dr. Plotkin arrived I offered to take his coat, made sure he had a bottle of water, and directed him to his seat at the head of the table. I sat to his right, just a few feet away. Dr. Plotkin was sworn in by the court reporter. A nine-hour exchange, all caught on video and transcribed by the court reporter, ensued.¹³

I began by establishing that Dr. Plotkin, despite knowing nothing about the child at issue in the lawsuit, held the expert opinion that the child should receive every vaccine on the CDC's vaccine schedule over the mother's objection. A schedule that Dr. Plotkin worked directly with ACIP to create and for which he was instrumental in shaping over the years, including through his articles, textbook, lectures, and vaccine development.

Pharma Insider Wrapped in Scientist Vestment

The next two hours of the deposition were spent going through Dr. Plotkin's long line of incestuous conflicts with the pharma companies that profit from vaccines, including Merck, Pfizer, Sanofi, and GlaxoSmithKline (**GSK**). These are the same four companies that sell and profit from nearly every vaccine on the CDC's childhood schedule. They are also the same four companies whose products, dozens of them, Dr. Plotkin was testifying should be injected into the child at issue over her mother's objections.

Dr. Plotkin consulted for these companies for decades, sat on their corporate boards, and received an undisclosed portion of more than \$182 million in royalties from sales of rubella, rotavirus, and rabies vaccines by one or more of these companies.¹⁴

What is deeply troubling is not that he earned millions of dollars working for and promoting the interests of these pharma companies while sitting on their boards, acting as a consultant or advisor for them, advocating on their behalf in government meetings, and more.¹⁵ No crime in that. What is deeply troubling is that while working at the behest of pharma, Dr. Plotkin ruled the established science of vaccinology for decades as if he was an impartial scientist.

Dr. Plotkin *is* viewed as an impartial scientist and his views on vaccines are accepted as *the* established science of vaccinology, relied upon by the scientific community, typically without question, and in turn by regulators to set public policy, regulations, and mandates concerning these products.

Dr. Plotkin rose to the top of the vaccinology pyramid because his approach and views aligned with the interests of pharma. While Dr.

Plotkin would no doubt strenuously disagree, he *was* curated by pharma, not the other way around, and rose to his rank because of pharma's patronage. Had pharma stopped patronizing him, no doubt his ascent would have come to a screeching halt—more on that in Chapter 6. He is so blind to this that he couldn't even understand why the millions and millions of dollars he received from pharma could possibly influence his views on vaccines, as is evident from his deposition.¹⁶

The following is just a tiny sample of the questions that made Dr. Plotkin bristle at being asked about his financial dealings with pharma and how he could not understand why taking money from these companies could be relevant to his views on vaccines:

Q: Is there a year since 1990 that you've not received any kind of payment or remuneration from Sanofi?

A: Probably not, no.

Q: How much did you receive...

A: Oh, my God. I have no idea. I'm sure it's a sizable amount of money...

Q: Do you anticipate receiving any payments or remuneration from Merck in the future?

A: Sure. ...

Q: ... GSK...?

A: Yes. ...

Q: ...Pfizer?

A: Very likely. ...

Q: And do you continue to receive any payments from the sale ... of the rubella vaccine?

A: Currently, I don't think so.

Q: When did it cease?

A: Oh, Jesus, I couldn't tell you exactly. ...

Q: ...CHOP sold its RotaTeq interest in 2008 for \$182 million ... Did you receive a portion of those proceeds?

A: I believe so, yes.

Q: What was that amount?

A: I could not tell you precisely. ...

Q: You're here today opining that [the child] should receive vaccines that are made by the big four pharmaceutical companies, correct?

A: I am, yes.

- Q:** Okay. And you didn't anticipate that your financial dealings with those companies would be relevant in that issue?
- A:** I guess, no, I did not perceive that that was relevant to my opinion as to whether a child should receive vaccines.¹⁷

This response is incredible. Imagine if he was an expert testifying about the safety of a Boeing airplane. Nobody would question whether asking about how much money he received from Boeing was relevant as to whether he may have a bias in favor of Boeing. That is true of any expert testifying about the safety of any product. Money the expert witness receives from the company profiting from the product would obviously be considered relevant as to whether the expert may have a bias. But when it comes to vaccines, the reverence for and beliefs held about these products by some are blinding—certainly they are to Dr. Plotkin, who cannot see why receiving money (millions, and for decades no less) from the pharma companies that profit from them could bias his views about these products.

After establishing Dr. Plotkin's deep ties with pharma companies, I then read him the following quote from Dr. Marcia Angell, a professor of Global Health and Social Medicine at Harvard Medical School and in its Center for Bioethics, and the former editor-in-chief of the *New England Journal of Medicine*, considered one of the world's most authoritative medical journals:

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

I then told Dr. Plotkin that Dr. Angell "blames ... the issues with truths in medical publishing on individuals that use legitimacy of academia to push pharmaceutical company agendas" and that she said the following about those individuals:

They serve as consultants to the same companies whose products they evaluate, join corporate advisory boards

and speakers bureaus, enter into patent and royalty arrangements, agree to be the listed authors of articles ghostwritten by interested companies, promote drugs and devices at company-sponsored symposia, and allow themselves to be plied with expensive gifts and trips to luxurious settings. Many also have equity interest in sponsoring companies.¹⁹

Dr. Plotkin had not realized that I had spent the prior two hours establishing that he fits this definition. For good measure, I went through this list point-by-point with Dr. Plotkin asking him about each item to see if he indeed fits the definition. At this point, of course, he had no choice but to agree, as his prior answers already established that he does. Here is a portion of that exchange occurring directly after I read the above quote:

Q: You consulted for the big four vaccine manufacturers, correct?

A: Yes.

Q: You're in the corporate advisory board of numerous vaccine developers, correct?

A: Yes.

Q: You've received royalties from the sale of one or more vaccines, correct?

A: Yes. ...

Q: Have any of your co-authors on any of the papers that you've published received compensation from pharmaceutical companies?

A: Presumably, yes.²⁰

Pharma companies kept paying Dr. Plotkin millions of dollars, funding nearly every aspect of his ascendant career, because Dr. Plotkin molded the world of vaccinology in a manner that aligned with their interests. Pharma's interest, of course, is to sell vaccines. This requires, for a product with financial immunity (more on that in Chapter 4), molding the field of vaccinology to studiously avoid adequately studying vaccine safety and otherwise dispelling any claimed vaccine safety issues, and focusing on and exaggerating claims of efficacy. Again, Dr. Plotkin, no doubt, does not see it that way. But pharma obviously would not have continued to support him if his views were not aligned with their interest: maximizing profits.

After the two hours it took to cover all of Dr. Plotkin's funding, roles, and conflicts of interest with pharma companies that earn billions a year in profit from selling vaccines, we finally arrived at the discussion

regarding vaccine safety. Again, the purpose of this discussion is to give insight into how Dr. Plotkin thinks about and approaches vaccine safety. It is not to address vaccine safety itself in any detail, as that will be covered in Part IV.

Importance of Clinical Trials

The exchange with Dr. Plotkin about vaccine safety began with establishing the importance of the clinical trials relied upon to license each childhood vaccine. Those trials are conducted by the pharma company seeking to license the vaccine. They are *not* conducted by the Food and Drug Administration (FDA). The pharma company then submits the data from the clinical trial to the FDA to obtain licensure.

Clinical trials for a new vaccine are critical for assessing safety as they compare a group receiving the unlicensed vaccine with a group that should receive only a placebo (*i.e.*, an inert substance such as a saline injection). The rate of harm between the group receiving the vaccine and the group receiving the placebo is then compared. When making this comparison, researchers should be assessing whether the vaccine group has a higher rate of harm, including immune system issues, neurological disorders, and other adverse outcomes.

Conducting a robust placebo-controlled trial for a vaccine *before* it is licensed is critical because *after* it is licensed it is considered unethical to conduct a trial in which some of the individuals receive a placebo instead of the vaccine. And without a robust placebo-controlled trial, it is extremely difficult to determine whether a vaccine causes a claimed injury. As revealed in my exchange with Dr. Plotkin:

Q: Before vaccines are licensed, they go through clinical trials to confirm their safety, right?

A: Correct.

Q: These clinical trials assess if there are any harms caused by the vaccine, correct?

A: Yes. ...

Q: [I]n order to establish whether it's causal between the vaccine and the condition, you need a ... randomized, placebo-controlled study?

A: Yeah.

Q: But that was not done for this hepatitis B vaccine before licensure, was it?

A: No.

Q: Okay. And given that the vaccine now appears on the CDC's recommended list, isn't it true that it would now be considered unethical to conduct such a study today?

A: It would be, yes, it would be ethically difficult.²¹

This principle gave focus to the incredible importance of the clinical trials relied upon to license a vaccine.

The takeaway point is that Dr. Plotkin agreed that a properly designed placebo-controlled clinical trial is critical for determining whether there is a causal relationship between a childhood vaccine and a claimed injury.

Avoid Pre-Licensure Safety Issues by Conducting Inadequate Clinical Trials

With that foundation, I began to dig deeper, starting with the first vaccine recommended on the CDC schedule, the hepatitis B (**Hep B**) vaccine. Our exchange regarding its licensure gives a window into how Dr. Plotkin, and his disciples, approach vaccine safety in clinical trials: conduct as little safety review as possible to avoid potential safety issues that could prevent licensure.

Remember, the pharma company seeking licensure of the vaccine, and hoping to earn billions if it is licensed, is funding these trials. Because these companies are not concerned about liability after licensure, due to the 1986 Act, it makes financial sense for them to select and pay vaccinologists that will conduct the trial to avoid potential safety issues that could prevent licensure. In contrast, since pharma companies are liable for injuries from their drug products, they often conduct multi-year placebo-controlled trials for their drug products. But again, more on that in Chapter 4.

Back to the deposition, CDC's schedule provides for routine injection of Hep B vaccine at birth. The following exchange was about the first vaccine for Hep B of its kind to ever be licensed: Recombivax HB. You would hope and expect that a new vaccine would be licensed based on a robust multi-year, placebo-controlled trial. Think about it. Many chronic diseases that plague children are not diagnosed until a few years of age, so if the trial is not reviewing safety for at least a few years, it can't possibly determine whether a new vaccine could be a contributing factor in causing these harms.

Before you read the exchange Dr. Plotkin and I had about the clinical trial relied upon to license this Hep B vaccine, please ponder for a moment how long you would assume safety was monitored after

injection in this clinical trial. Again, please keep in mind that this product is being injected into a newborn, often within hours of being born; drugs are often licensed, as discussed later, in multi-year placebo-controlled trials; and this was the very first vaccine of its kind. Really think about it for a moment. Think about how long you think safety was monitored after injection in the clinical trial relied upon to license this novel Hep B vaccine. With that in mind, here is the exchange I had with Dr. Plotkin:

- Q:** Dr. Plotkin, earlier you testified that there are two Hep B vaccines on the market. One by ... GSK, that's Engerix-B; and the other one is by Merck, Recombivax HB, right?
- A:** Yes.
- Q:** For the Recombivax HB, how long was the safety review period in the prelicensure clinical trial for this vaccine?
- A:** I don't know.
- Q:** Dr. Plotkin, I'm going to hand you ... the manufacturer insert for Recombivax HB, correct?
- A:** Yes.
- Q:** And the clinical trial experience would be found in Section 6.1, correct? ...
- A:** Yes.
- Q:** In Section 6.1, when you look at the clinical trials that were done prelicensure for Recombivax HB, how long does it say that safety was monitored after each dose?
- A:** Five days.
- Q:** Is five days long enough to detect adverse reactions that occur after five days?
- A:** No. They would be ... reported separately as observed in the clinic.
- Q:** In Section 6.1 of the manufacturer insert, which under the Code of Federal Regulations are supposed to describe the clinical trial, does it provide for anything other than five days of monitoring after each dose for adverse events?
- A:** It does not specifically say that, no.
- Q:** Okay. Is five days long enough to detect an autoimmune issue that arises after five days?
- A:** No. ...

- Q:** Is five days long enough to detect any neurological disorder that arose from the vaccine after five days?
- A:** No.
- Q:** There's no control group, correct?
- A:** Not—let's see. ... It does not mention any control group, no.²²

It was dumbfounding that Dr. Plotkin did not even know that, according to the FDA documentation, this vaccine was licensed for infants based on a clinical trial that only monitored safety for five days after injection. I assumed when I asked Dr. Plotkin about this, he would point me to another document. Some other clinical trial. Some other report I hadn't been aware of. Instead, he pointed to nothing, other than insinuating that adverse events could be reported after five days. But, after his deposition, when we subpoenaed him for any proof showing safety review went beyond five days after injection, he never provided a shred of proof.²³

Watching the video, it is plain Dr. Plotkin was surprised at the duration of safety monitoring. The fact that he seemed surprised while I had known about this alarming safety gap for years was shocking. This is literally the man whom the CDC and medical community look to as the world's leading authority on vaccines.

This was likely beyond the greatest fears of most vaccine skeptics. I think hardly anyone, absent seeing it with their own eyes, would believe that the FDA licensed a vaccine injected into newborns on the first day of life based on a clinical trial that only monitored safety for five days after injection in a trial with only 147 infants and children. It appears ludicrous and unbelievable. But there it is in the FDA documentation.²⁴

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a vaccine cannot be directly compared to rates in the clinical trials of another vaccine and may not reflect the rates observed in practice.

In three clinical studies, 434 doses of RECOMBIVAX HB, 5 mcg, were administered to 147 healthy infants and children (up to 10 years of age) who were monitored for 5 days after each dose. Injection site reactions and systemic adverse reactions were reported following 0.2% and 10.4% of the injections, respectively. The most frequently reported systemic adverse reactions (>1% injections), in decreasing order of frequency, were irritability, fever ($\geq 101^\circ\text{F}$ oral equivalent), diarrhea, fatigue/weakness, diminished appetite, and rhinitis.

And Dr. Plotkin, the world's leading authority on vaccines, seemingly did not have a clue that this is what was relied upon to license this vaccine.

The next vaccine I asked Dr. Plotkin about is the only other Hep B vaccine given to newborns in the United States, Engerix-B. This time, Dr. Plotkin, realizing the incredible admission he made about

Recombivax HB, insisted that vaccine reactions were collected for more than a few days, despite FDA official documentation showing it was for only four days.

- Q:** So let's take a look at Engerix-B. ... Do you know how long adverse reactions were reviewed after each dose of that vaccine in the prelicensure clinical trial?
- A:** Not offhand, no.
- Q:** I'm going to hand you ... the manufacturer insert for the Engerix-B, correct?
- A:** Yes.
- Q:** Okay. If you turn to Section 6.1, which is clinical trials experience, can you please tell me how long the safety review period was in the prelicensure clinical trials after each dose?
- A:** [reading] "All subjects were monitored for four days post administration." That does not necessarily mean that they didn't collect reactions after four days.
- Q:** Are you claiming they collected reactions after four days but didn't disclose it here in violation of the Code of Federal Regulations?
- A:** I daresay that they collected putative reactions for a longer period. I feel quite positive about that. When they say they were monitored for four days, that means active monitoring as opposed to collecting reports later on. ...
- Q:** And can you provide any proof that there was any reports or follow-up after those four days?
- A:** Well, it doesn't say that here, but I am willing to bet that they did collect reactions after four days. And I imagine that the FDA would not have allowed them not to do that.
- Q:** But as you sit here today, that's just speculation, correct?
- A:** Yes, that's speculation based on experience.
- MR. SIRI:** I'm going to make a request for you to provide proof of what you're claiming, that there was actually, for both hepatitis B vaccines, any safety review that occurred after four days of administration of any dose of these vaccines.²⁵

As noted above, after the deposition, we subpoenaed Dr. Plotkin to provide the data to prove his claims,²⁶ but instead of providing proof, he moved to quash the subpoena.²⁷ He literally took the time to hire a lawyer and file a motion to quash a subpoena that sought just the basic safety data he speculated existed during the deposition.²⁸ Dr. Plotkin never provided a shred of proof that safety was reviewed for more than four days.

While Dr. Plotkin refused to provide any such supposed proof, it still seemed unbelievable. It doesn't take a PhD to realize that if one only reviews safety for a few days after injection, and we are talking about an injection into a newborn, one would have no idea the impact the injection has on that newborn's health weeks, let alone years, later. Again, think about it: numerous serious conditions are simply not even diagnosed until a few years of age, including various immunological, neurological, and related conditions. There are others not diagnosed until a child begins school and various developmental issues become apparent.

Following Plotkin's deposition, we sent a Freedom of Information Act (**FOIA**) request to the FDA on behalf of the Informed Consent Action Network (**ICAN**), the non-profit that funded many of the vaccine policy lawsuits discussed in this book. FOIA is the federal law that allows the public to obtain documents from the government. In this instance, the FOIA request we submitted sought a copy of the clinical trial reports the FDA relied upon to license Recombivax HB. When we got those reports, there it was and remains in black and white: less than a week of safety monitoring after each injection into infants and children. Nothing more. You can review these clinical trial reports yourself.²⁹ And I must say, for a long time thereafter, I still found it hard to believe.

In fact, this disbelief led to another FOIA request regarding Engerix-B, the only other Hep B vaccine given to babies. This time, we asked the FDA to produce *only* those clinical trial reports it relied upon to license this vaccine that reviewed safety for *more* than a week after injection.³⁰ After years of pressing the FDA, including filing a lawsuit against the FDA demanding any such trial reports, the FDA never produced a single clinical trial report or shred of evidence that demonstrated safety was observed for more than a few days after injection in the clinical trial that was relied upon for its licensure. Not one document or shred of proof.

And if you are thinking, as I did, that maybe, just maybe, a clinical trial or some other large robust safety assessment occurred *after* licensure, even though it would be condemned as unethical by the medical community, it also does not exist. Any hope of that was quickly dashed when U.S. Department of Health and Human Services (**HHS**) responded to a

formal request from ICAN to provide such safety data. HHS's response makes plain that no such data exists. HHS pointed to seven studies, none of which could support the safety of injecting this product into babies.³¹ Four of them were not clinical trials and involved adults, and the other three were clinical trials but they, again, did not review safety for more than a few days after injection.³²

Bringing into sharp focus how Dr. Plotkin thinks about vaccine safety (and hence how he taught his disciples to think about vaccine safety), when FDA produced the clinical trial reports for Recombivax HB, guess who was listed as a principal investigator in its trial for children? Yep, Dr. Stanley Plotkin.³³ Meaning, when I asked Dr. Plotkin during the deposition how long safety was monitored in the trial to license Recombivax HB for children, the very man who was the principal investigator for that trial did not know. Incredibly, his memory was not even jogged when reviewing the package insert which explained safety was only monitored for five days after injection. What this reflects is that safety was not just an afterthought, it wasn't even given the minimal attention needed to create a recallable memory for Dr. Plotkin, the principal investigator for the trial. Really pause and think about that for a moment.

The point is not to pick on this clinical trial (though there is a lot to pick on). The point is to show how Dr. Plotkin, the godfather of vaccines, and hence vaccinologists, approach vaccine safety in a clinical trial. The approach, which is precisely what pharma would want, is to conduct as little safety review as possible and pay as little attention to safety as possible to avoid any finding that may prevent licensure of a vaccine. After all, no licensure, no profit.

Avoid Post-Licensure Safety Issues by Declaring Vaccines Do Not Cause Harm Until Proven Otherwise

This brings us to how vaccinologists generally approach vaccine safety after licensure, which is: no matter how many people claim a vaccine caused a given harm, avoid actually studying the harm, and then assure the public that the vaccine does not cause the harm even when there is no proof to support that claim.

It should not be surprising that a pharma product can cause harm. What *is* deeply concerning is that vaccinologists will assert that a vaccine does not cause a claimed harm without any proof to support that claim. Even if millions of parents claim a vaccine caused a certain harm, Dr. Plotkin and his disciples will assert that vaccines do not cause that harm, even if they have no evidence to support that assertion.

Dr. Plotkin has made clear this is how vaccinology works. If you do not look, do not study, and make sure there is no data, you can then

declare that the vaccine does not cause the alleged harm. Sounds crazy, but this is how Dr. Plotkin and his disciples approach vaccine safety.

This incredible claim, and I do admit it is incredible, came into sharp focus during Dr. Plotkin's deposition. Despite the fact that the Institute of Medicine (IOM) conducted a review of the entire universe of vaccine safety literature and concluded that the studies have not been conducted to reach *any* conclusion about whether the vaccines in question caused certain claimed harms, Dr. Plotkin testified that the vaccines in question do *not* cause certain of these claimed harms. In other words, while Dr. Plotkin said the vaccine does not cause the harm, the IOM said the studies have not been conducted to conclude one way or another whether the vaccine causes the claimed harm.

For those unfamiliar with the IOM, which is now known as the National Academy of Medicine, it was established pursuant to a congressional charter with the "explicit purpose ... to provide advice that the government could trust to be free of partisan political influence" and which the legacy media has described as "the nation's most esteemed and authoritative advisors on issues of health and medicine."³⁴

The IOM's review was published in 2012. The IOM was paid by the CDC and the Health Resources and Services Administration (HRSA), a federal agency directly responsible for defending against claims of vaccine injury (more on that in Chapter 5), to review the entire body of science as to what HRSA said were the 158 most commonly claimed vaccine harms. The CDC and HRSA plainly wanted the IOM to find these harms were *not* caused by vaccination.

While I am sure the IOM tried its best to please its paymasters, in the end, the IOM found that for 18 of these harms, the evidence supports causation (meaning, vaccines can cause the harm); for 5, the evidence supports rejecting causation (meaning, vaccines likely do not cause the harm); and for 135, the studies had not been conducted to reach any conclusion regarding causation.³⁵ In other words, for 135 of the 158 most commonly claimed serious harms from vaccines, according to HRSA, the studies had not been conducted to determine whether they are caused by vaccines, let alone studied to determine how these harms could be avoided if they are caused by vaccines.

If that were not disturbing enough, for the last category, Dr. Plotkin and his disciples will still tell you that vaccines do not cause these conditions even though the needed studies (the "science") have not been conducted to make this claim. Meaning, to them, even when the studies to reach any conclusion are lacking, instead of saying "we do not know whether the vaccine causes the harm," they will instead say, "the vaccine does not cause the harm."

For example, I asked Dr. Plotkin: "Can the hepatitis B vaccine cause encephalitis?" His answer was, "No, I would say definitely not."³⁶ Encephalitis means brain swelling. Not something you want to cause in anyone, let alone a newborn.

Now let's look at what the IOM had to say about this same question. After reviewing the entire body of medical literature for any relevant studies, it found a total of three relevant studies, each of which describe neurological issues after Hep B vaccination, and hence, if anything, supported that Hep B vaccine can cause encephalitis. Finding no evidence that Hep B vaccine does not cause brain swelling and some evidence that it does—but not enough to reach a causality conclusion—the IOM concluded: "The evidence is inadequate to accept or reject a causal relationship between hepatitis B vaccine and encephalitis."³⁷ In contrast, Dr. Plotkin's response to this same question of whether Hep B vaccine can cause encephalitis was: "No, I would say definitely not."

Back to the deposition; without bringing up the IOM report, I asked Dr. Plotkin the same question (like I did regarding whether Hep B vaccine can cause encephalitis) for other commonly claimed harms the IOM concluded had yet to be studied to rule out vaccines as the cause. Dr. Plotkin similarly responded that the vaccine does not cause the harm. After setting the table in this manner, I then had this exchange with Dr. Plotkin:

Q: You ... stated that hepatitis B ... doesn't cause encephalitis, right?

A: That's, that's my opinion, yes.

Q: But the IOM, after doing its review, determined it couldn't find science to support a causal determination one way or another [between hepatitis B and encephalitis], correct?

A: Yes. But that means that they don't have evidence for the supposition.

Q: That it either causes or doesn't cause [encephalitis]?

A: Right.

Q: They don't know?

A: They don't know because there aren't enough data. ... In the absence of data, my conclusion is that there are no, there's no proof that causation exists.

Q: So if there's no data to show that it causes or doesn't cause ... your supposition is that ... it doesn't cause it?

- A:** That there's no proof that it does.
- Q:** Okay. That's different than saying it doesn't cause it, correct?
- A:** Correct.
- Q:** So when you were saying earlier when I asked you at the beginning of this whether certain vaccines caused certain conditions and you said, No, they don't, did you just mean that, no, there's not enough evidence to make a decision one way or another?
- A:** I mean that there's no knowledge known to me that they do certain things ... that some may have alleged happen after vaccination.
- Q:** Like, for example, you know, the IOM reviewed whether hepatitis B can cause lupus... They concluded that there's insufficient evidence one way or another to make a determination. ... But [when] you indicated earlier that those vaccines don't cause lupus ... you said "no" because you weren't aware of a mechanism by which it could cause it; is that right?
- A:** Yes. That's correct.³⁸

The admission above is startling because it is about as unscientific as it gets. Lack of evidence is not proof that something does or does not cause a harm. It means we do not know. Yet, going back to the first example, when I first asked Dr. Plotkin, "Can the hepatitis B vaccine cause encephalitis?" he answered, "No, I would say definitely not" but, when confronted with the IOM report, he is forced to admit that there is no support for his conclusion. Instead of backing down, however, he doubled down on that unscientific approach.

When I pressed further, he lamented that, "to prove a negative requires a lot more data than to prove a positive," which is still no excuse for saying a vaccine does not cause a commonly claimed harm without evidence. He maintained this position even after he admitted that a properly designed clinical trial could rule out whether a vaccine causes a claimed harm. That exchange went like this:

- Q:** If ... there was a study that ... had a placebo ... control group, then we could know whether or not these conditions are caused by these vaccines, correct?

- A:** Yes. It would have to be an enormous study and would have to be randomized ideally...
- Q:** It needs to be enormous because you're assuming these conditions are rare, correct?
- A:** Correct.³⁹

So, Dr. Plotkin not only assumes, *without evidence*, that certain commonly claimed harms are not caused by one or more vaccines, he further assumes, *again without evidence*, that these commonly claimed harms are rare. And with those assumptions, he essentially argues there is no point in studying them.

Think about it. Even the IOM, in a report paid for by the CDC and HRSA (who clearly wanted IOM to find that vaccines do not cause these harms), could not find studies ruling out vaccines as the cause of 135 of the 158 commonly claimed injuries listed by the CDC and HRSA.⁴⁰ Yet, Dr. Plotkin's view is that, despite the lack of evidence, he can assert that vaccines do not cause one or more of these harms.

This is not science. It is a belief. Asserting, without supporting studies, that the most commonly claimed injuries from vaccines are not caused by a vaccine requires a leap of faith. It would be akin to declaring a pesticide safe without the necessary safety data to support that conclusion. This approach is the antithesis of the scientific method.

Dr. Plotkin's deposition brought into focus this central article of faith shared among the vaccinologists who decide the so-called science around vaccines: avoid conducting actual safety studies on claimed harms and as long as there is no proof of harm, irrespective of the fact that nobody conducted any such studies, and no matter how many parents claim the harm is caused by the vaccine, assert that the vaccine does not cause the harm. That is indeed a belief. Not science. Examples of this belief in practice fill the remaining pages of this book, so if you need more proof of this reality, it is coming.

It's Fine to Lie to Parents

This belief and approach to vaccine safety is so deeply ingrained, Dr. Plotkin and his disciples have no issue simply lying to parents when making claims about vaccine safety. Dr. Plotkin admitted this when discussing the vaccine safety issue the medical community claims to have most robustly studied: vaccines and autism. If they will lie about this issue, imagine what they would say when it comes to every other vaccine harm – harms which they have not claimed to have as thoroughly studied.

Well over a decade *before* Dr. Andrew Wakefield raised concern in 1998 that measles, mumps, rubella (MMR) vaccine (given after one year

of life) may cause autism,⁴¹ parents were asserting (and continue to assert to this day) that their children developed autism from pertussis vaccines, given three times by six months of age.

These claims were so voluminous that, in 1986, Congress ordered HHS to study the connection between autism and pertussis vaccines.⁴² By 2012, the IOM report we just discussed made clear no such study has *ever* been conducted to support that pertussis vaccine does not cause autism.⁴³ The IOM did, however, find one study which found pertussis vaccines given to infants was associated with an *increased* rate of autism, but the IOM discounted this study.⁴⁴ Aside from the one study that found a connection, the IOM could not identify a single other study looking at the potential connection between pertussis vaccines, including DTaP (diphtheria, tetanus, and acellular pertussis vaccine, given at 2, 4, and 6 months of life) and autism.

With that background, I asked Dr. Plotkin about the IOM's conclusion regarding whether DTaP does not cause autism:

Q: What was the IOM's conclusion in [2012] about whether [DTaP] vaccines can cause autism?

A: I'd have to look that up, but I feel confident that they do not cause autism.⁴⁵

But then after seeing the IOM report from 2012, Dr. Plotkin changed his tune:

Q: So the IOM reviewed the available evidence with regard to whether Tdap or DTaP can cause autism, and their conclusion was the evidence doesn't exist to show whether DTaP or Tdap do or do not cause autism, correct?

A: Yes. ...

Q: Dr. Plotkin ... was the IOM able to identify a single study supporting that DTaP or Tdap do not cause autism?

A: No, they did not identify a study. ...

Q: [S]tudies are possible to determine whether or not a vaccine does or does not cause, does not cause autism, correct?

A: They are possible, yes.⁴⁶

And when pressed whether he would tell a parent that “vaccines do not cause autism” even though the proof needed to support that claim does not exist, here is what he said:

Q: If you don’t know whether DTaP or Tdap cause autism, shouldn’t you wait until you do know, until you have the science to support it to then say that vaccines do not cause autism?

A: Do I wait? No, I do not wait because I have to take into account the health of the child.

Q: And so for that reason, you’re okay with telling the parent that DTaP/Tdap does not cause autism even though the science isn’t there yet to support that claim?

A: Absolutely.⁴⁷

Please read this last exchange one more time. Really think about it. Dr. Plotkin is saying that absent any proof a vaccine does not cause autism, he will still tell parents that vaccine does not cause autism. Again, he will do so despite having zero proof to support this claim. That is simply lying.

To be sure, this exchange does not mean that DTaP causes autism. But it does mean that when Dr. Plotkin or any other doctor tells you, “vaccines do not cause autism,” it is not a data-supported claim. It is a belief.

This belief is not limited to DTaP vaccine and autism. In fact, there is not a single study of the vaccines given to babies in the first six months of life per the CDC schedule that supports the claim they do not cause autism. Not a single study. That, again, may sound incredible, but that is what the CDC was forced to admit in a federal lawsuit. On behalf of ICAN, I sued the CDC for any such studies, and the CDC could not produce a single study supporting the claim that these vaccines do not cause autism. Not one study. This is covered in detail in Chapter 11.

Again, to be clear: this alone does not mean that vaccines cause autism. But it does mean that the claim “vaccines do not cause autism” is not science. It is a belief. A mantra. What makes this belief even more incredible, as will be discussed in Chapter 11, is that the only studies that have looked at these vaccines given to infants and autism have found that infants receiving one or more of them have multiple times the rate of autism compared to those who do not. Again, more on this later.

Also, consider that autism is the injury the medical community says they have most carefully studied. Just imagine the state of the “science” for the over one hundred serious harms, aside from autism, commonly reported as being caused by vaccines. These are harms my firm regularly

gets phone calls about from parents. These are also harms listed on vaccine package inserts by pharma companies because federal law requires that they list harms they have a basis to believe are *causally related* to their vaccine (and *only* ones they have a basis to believe are causally related). Again, more on that in Chapter 11.⁴⁸

Plotkin's Approach to Vaccine Safety Is Disturbing

This approach to vaccine safety is disturbing. Consider this: chronic disease among children has exploded from less than 10% of children in the 1980s to over 40% in 2025, and many of these chronic diseases are disclosed in vaccine package inserts.⁴⁹ They are also typically related to some form of immune dysregulation.⁵⁰ What could cause the immune system of children to dysregulate en masse? Well, maybe start by looking at the products specifically intended to modify the immune system, vaccines, which have gone from 3 injections in 1986 to 29 injections in 2025 by just one year of age per the CDC pregnancy and childhood schedule.⁵¹

But given how Dr. Plotkin and his flock of vaccinologists approach vaccine safety, they will studiously avoid studying this issue and, at the same time, claim this rise in chronic disease is *not* caused by vaccines. As we have seen, their approach is that a lack of proof means vaccines do *not* cause the harm—a stance equivalent to lying, as seen from Dr. Plotkin's approach regarding vaccines and autism.

The unbelievable gaps in safety pre-licensure and post-licensure continued to be confirmed for hours during the deposition, each hour further burying my hope that there was a valid explanation for it all. It got worse with each issue discussed.⁵² But it did let me clearly see how Dr. Plotkin viewed and approached vaccine safety.

The most disturbing takeaway, which has only been reinforced in the years since I took this deposition, is that most of what vaccinologists, public “health” officials, and doctors say about vaccines is dogma. It is believed through repetition. Not facts. Not reality. Not data. Just repetition. It is often contrary to the data. The hard facts. This is no doubt why they tried to have the court seal Dr. Plotkin's deposition so that it would never see the light of day. Thankfully, their motion failed.⁵³

In sum, Dr. Plotkin's approach—and, as discussed in the next chapter, the approach of his disciples—regarding vaccines is often indistinguishable from the realm of life which demands blind trust and belief: religion.

Chapter 2

Disciples: Vaccinologists

The same dogma just discussed in the prior chapter is repeated like a cacophony by the small group of vaccinologists upon whom the rest of the medical community relies. And who are these vaccinologists? They are Dr. Plotkin's disciples.

I mean this literally. They are disciples of Dr. Plotkin, the ultimate pharma insider wrapped in scientist vestments. As Paul Offit, MD, who may be the world's most well-known vaccinologist, explains about Dr. Plotkin: "He trained a generation of scientists, including myself, to think like he thinks."¹ Yes, he did.

Vaccinologists Work in an Echo Chamber

Scientists who did not adopt the beliefs taught by Dr. Plotkin lost the patronage of pharma and did not rise into the inner vaccinology sanctum, as discussed in greater detail in Chapter 4.

The tight-knit group of vaccinologists, a number of whom I have deposed, live in an insulated world where their vaccine dogma is constantly repeated and reinforced, letting it guide the trials, research, textbooks, and recommendations on vaccines. They then cite each other's dogma to reinforce their own.

One of my favorite dogmatic claims they make regarding vaccines is: "With the exception of safe water, no other intervention, not even antibiotics, has had such a major effect on mortality reduction and population growth."² That is a serious claim. So, one would expect it to be well supported, especially since this claim is made *ad nauseam* by the small group that runs the world of vaccinology, and it is then repeated by the broader medical community and amplified by the media.

Incredibly, when one traces this claim back, all roads lead to the same source: Dr. Plotkin's own textbook, *Plotkin's Vaccines*.³ And what does Dr. Plotkin cite for this claim? Nothing. This is but one example

of dogma repeated by vaccinologists in their echo chamber without any data to support the claim. Worse, as will be seen in Chapter 7, this claim is easily disproven based on official government data.

Driving home the point that Dr. Plotkin's words are viewed like those of a high priest sharing the word of God, guess who Dr. Plotkin cites when he makes this claim in his own writings? Yep, he cites himself. Let's be very clear about that. When Dr. Plotkin writes that only clean water saved more lives than vaccines, he cites his own prior statement from his own textbook.⁴ But, as noted, the claim in his textbook is unsupported—it cites nothing.

Effectively, Dr. Plotkin's textbook is treated like the Bible, even by Dr. Plotkin himself. It becomes a "fact" simply by having been written in his textbook. And that is precisely how his disciples treat what Dr. Plotkin says and how he has taught them to think about vaccinology.

Vaccinology's Core Beliefs

Here are the core beliefs of vaccinologists in a nutshell that have become clear to me after nearly a decade of deposing them, meeting them, and carefully reviewing their published works, statements, and speeches. They are well-trained to think that if efficacy can be inferred from the data, then get the vaccine on the market. Never infer a vaccine causes harm, no matter how many report that it does. Instead, if no studies clearly prove a claimed harm (and we will review later the nearly impossible bar they set for proving a vaccine causes a claimed harm), then without any doubt—even without studies—repeat to the public over and over that the vaccine does not cause the harm.

That the world's leading vaccinologists have been well trained in this approach by pharma's ultimate insider, Dr. Plotkin, is plain. Here are but a few examples. As you will see, their statements about vaccines are often not those of scientists, but rather of religious adherents repeating *a priori* conclusions that are easily refuted.

Dr. Offit, one of the four editors of *Plotkin's Vaccines*, is probably the world's most well-known vaccinologist. He is a prolific vaccine proponent who has earned millions from pharma and also sits on government vaccine committees, and, as we quoted earlier, said Dr. Plotkin "trained a generation of scientists, including myself, to think like he thinks."⁵ With that background, Dr. Offit is widely reported as saying: "I think we should be proud of vaccines as arguably the safest, best tested things we put in our body."⁶ Really? The "safest, best tested things we put in our body"? Someone should give Dr. Offit a copy of the clinical trials for Hep B vaccines (or for any other routine childhood vaccine as reviewed in Chapter 10) as well as copies of post-licensure vaccine safety reviews

(as reviewed in Chapter 11).⁷ But the IOM report and Hep B vaccine trial we previously reviewed alone make clear that claiming vaccines are the best tested things we put in our body requires closing one's mind very tightly to reality while repeating the mantra "safest, best tested things we put in our body." Perhaps Dr. Offit should also be reminded about purified water; then again, he probably wouldn't agree that purified water is safer than vaccines.

Dr. Offit also learned from Dr. Plotkin that when you make vaccine safety claims, no matter how ridiculous they are, you hold yourself out to be an impartial scientist. Yet Dr. Offit, like Dr. Plotkin, is far from impartial. He consulted for Merck, received Merck research grants, and was paid roughly \$6 million from Merck's vaccine sales for a vaccine he co-invented.⁸ Since 2005, he has also held a \$1.5 million research chair endowed by Merck.⁹ He is nonetheless regularly quoted and interviewed by news outlets as if he is an impartial voice on vaccine safety. Dr. Offit, no doubt, believes he is an impartial scientist and rose on his own merit; the reality is that if his views did not align with pharma's interests, he would not have had its support. And without that support, he would not have ascended the vaccinology ranks.

Another example is when Tina Tan, MD, FIDSA, FPIDS, FAAP, another Plotkin disciple and the author of *The Vaccine Handbook: A Practitioner's Guide*, did not even bother to mince words when telling the public in November 2020, before the first Covid-19 vaccine was even authorized (that happened in December 2020), that: "Safety should not be a legitimate concern."¹⁰ Dr. Tan apparently knew, before a Covid-19 vaccine was ever even authorized, let alone used in the United States, that, "Safety should not be a legitimate concern." She knew this because this conclusion is not based on evidence, but rather, like other conclusions reached by a true religious adherent, is based on belief.

Dr. Tan also learned from Dr. Plotkin that when you make vaccine safety claims, no matter how ridiculous they are, you hold yourself out to be an impartial scientist. Yet Dr. Tan is, as you likely already guessed, anything but an impartial scientist. She has been: a consultant for Sanofi, Merck, GSK, and Pfizer; a member of committees for Sanofi and Merck; a member of the advisory board for GSK and Pfizer; the recipient of research funding from Sanofi, Merck, and Pfizer; on trips to cities around the world paid for by Sanofi; and on the speakers' bureaus of Sanofi, Merck, GSK, and Pfizer.¹¹ For those who don't know what a speakers' bureau is, Pew explains, "Faculty who participate in speakers' bureaus are de facto 'marketers in academic robes,'"¹² or as a Tufts University School of Medicine ethics article explains, "physicians who participate in Speakers' Bureaus are essentially just paid marketers or spokespersons

for industry who use, indeed exploit, their roles as physician leaders to influence their colleagues to prescribe the sponsor's product."¹³

Yet, Dr. Tan—like Dr. Offit, Dr. Plotkin, and others in the small gaggle of vaccinologists—is regularly quoted in the media as if she were an impartial scientist. She also, like Dr. Plotkin and Dr. Offit, no doubt believes she *is* an impartial scientist and rose on her own merit. But the reality is that absent pharma's patronage—which would have ceased the moment she stopped expressing views that served pharma's interests—she never would have ascended the vaccinology ranks.

Injured Vaccinologist Remains Faithful

One final story drives this point home: the story of what happened when Gregory Poland, MD, MATH, MACP, FIDSA, FRCP—considered a world leading vaccinologist, and director of the Mayo Clinic's Vaccine Research Group—was injured by a vaccine.

Dr. Poland developed life-altering tinnitus, which many experience as torturous ringing in the ears, soon after he received his second dose of a Covid-19 vaccine.¹⁴ He explains that it “was like someone suddenly blew a dog whistle in my ear” and “has been pretty much unrelenting.”¹⁵ He explained that he “can only begin to estimate the number of times I just want to scream because I can't get rid of the noise or how many hours of sleep I've lost.”¹⁶

When Dr. Poland finally went public with this life-altering vaccine injury, he received emails from across the country and the world from others who described suffering from the same vaccine injury. He explained: “What has been heartbreaking about this, as a seasoned physician, are the emails I get from people that, this has affected their life so badly, they have told me they are going to take their own life.”¹⁷ Dr. Poland estimated that there may be tens of thousands of people affected in the United States and potentially millions worldwide with this serious and debilitating condition.¹⁸

Because this injury affected one of the world's leading vaccinologists, one would think it would be taken seriously. You would think that vaccinologists, and in turn the CDC, would recognize that the vaccine is causing this injury and address this harm. Nope. That is not how the religion of vaccines works.

Instead, the same medical publication reporting Dr. Poland's injury and the findings above, says that there are “ongoing research efforts to understand if COVID-19 vaccines may be related to various auditory complaints, including hearing loss and tinnitus” and that there are “no definitive studies on the subject.”¹⁹ Of course not. Who would pay to conduct that study? Certainly not pharma companies, as they have a

negative incentive to study this harm, nor federal health authorities because it could undermine their authority and reputation if they proved it caused this chronic debilitating harm after they had already licensed, recommended, promoted, and mandated this product.

The CDC's Vaccine Adverse Event Reporting System (**VAERS**) has over 28,000 reports of tinnitus following Covid-19 vaccines,²⁰ but because the CDC insists that VAERS can never prove causation (more on that in Chapter 11), the CDC says that "the data from safety monitoring are not sufficient to conclude that a causal relationship exists between vaccination and tinnitus."²¹ And what does Pfizer have to say about its Covid-19 vaccine causing tinnitus? "Tinnitus cases have been reviewed and no causal association to the Covid-19 vaccine has been established."²²

The dogma is so strong that even Dr. Poland, despite knowing the Covid-19 vaccine caused his tinnitus and that of many others around the world, says that "[t]emporality is not causality" and that (here it comes): "Rather, it forms a hypothesis, and then what you do is carefully collect information to determine [whether] this potential syndrome or side effect [is] above and beyond the background rate before there was COVID or a COVID vaccine, and is the rate different in people who got the vaccine and people who didn't."²³

And who will do this study properly? Nobody.

Meaning, you must wait for the study that will never be conducted. Pfizer won't do the study. The CDC sure as hell won't conduct a study that shows the vaccine widely causes this harm. And until that study is conducted, as Dr. Plotkin has taught his disciples, the conclusion is that the vaccine does not cause the harm.

As for all the people whose lives are ruined, including the many who have taken or have wanted to take their own lives because of their debilitating, torturous, and relentless condition, they are told it is just a coincidence. Correlation. Temporal relation. Not causation. Never causation. Nothing to see here, folks. So much "nothing to see" that, despite suffering a debilitating adverse event following vaccination, Dr. Poland says about his first grandchild, "I'd encourage him to get the vaccine."²⁴ Belief runs deep among vaccinologists.

When Pinned, Demand Mechanistic Studies

If the foregoing were not bad enough, except for a limited number of harms vaccinologists are forced and/or willing to recognize, even when confronted with virtually irrefutable evidence, vaccinologists will argue it is effectively impossible to establish that a vaccine causes a claimed serious harm by demanding mechanistic studies that they know nobody will conduct. On the other hand, they will rely on virtually any study

or data, often laughably poor in design and quality, to *rule out* that a vaccine causes a claimed serious harm.

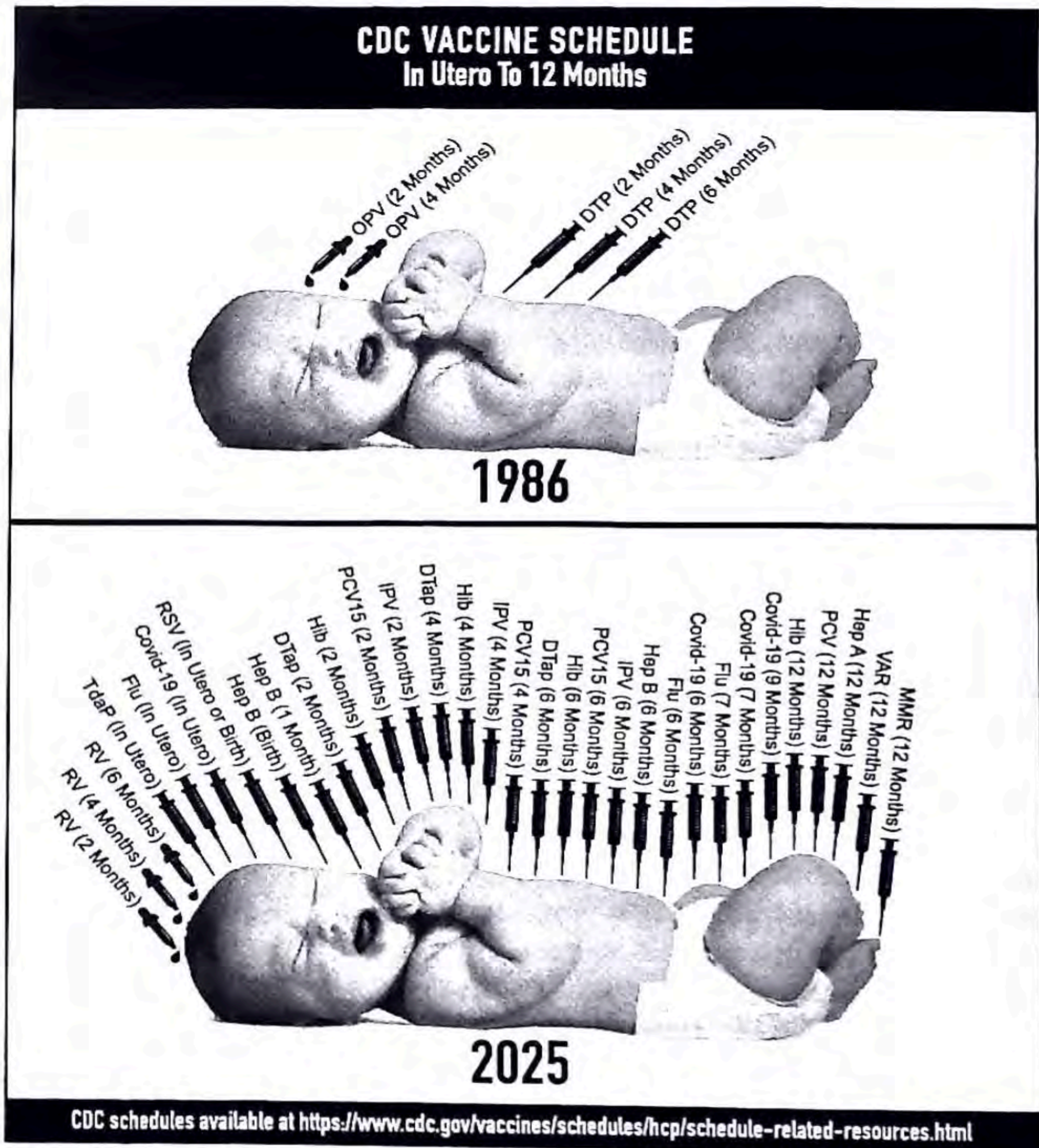
For example, Dr. Plotkin was asked the following regarding Dr. Poland's vaccine injury, "Based on your years of experience does this sound like it was 'caused' by the vaccine, or 'coincidental'?" and his response was, "I am sorry for Dr. Poland, but there is no way to know if it was caused by the vaccine."²⁵ He says that "mechanistic studies are needed" to prove that the vaccine can cause tinnitus. As their name suggests, mechanistic studies seek to find a specific underlying biological mechanism that explains precisely how harm is caused.

What Dr. Plotkin is effectively saying is, "tough luck, you can never prove the vaccine causes tinnitus" because, as I am sure he knows, nobody will conduct the mechanistic studies he suggests. With that, he and his vaccinologist disciples, along with CDC and pharma, can and will claim the vaccine does not cause tinnitus. Case closed.

Let me put it this way. While Dr. Plotkin and his disciples require mechanistic studies to *prove* a vaccine causes a given harm, when it comes to *disproving* that a vaccine causes a given harm, they don't require any studies (let alone mechanistic studies). Instead, to disprove a claimed harm, they rely on the fact that no studies exist or may point to epidemiological studies, which are studies using historical health data and are known to be easily manipulated.²⁶ Yet they will not accept even extremely robust epidemiological studies which show a vaccine can cause widespread serious harm, instead demanding mechanistic studies which nobody will do. Such is the cult of vaccinology, and all you need to do is take Dr. Plotkin at his word to understand the foregoing.

These Beliefs Guide Licensure & Mandates of Vaccines

Stepping back to take a wider view, this small gaggle of vaccinologists is the reason that almost all vaccines injected into children today were licensed and are mandated. They were principal investigators for the clinical trials for most of the current vaccines on the CDC's childhood schedule;²⁷ were members of the FDA's vaccine advisory committee, VRBPAC, that voted to license these vaccines;²⁸ and were members of the CDC's vaccine advisory committee, ACIP, that voted to add these vaccines to CDC's childhood vaccine schedule.²⁹ That schedule, in turn, is what states look to when deciding which vaccines to mandate for school enrollment; and the Plotkin disciples have grown this schedule from 3 injections by one year of age in 1986, to 29 injections by one year of age in 2025.³⁰



Not only do Plotkin's disciples conduct clinical trials for these vaccines and sit on the FDA and CDC vaccine committees that vote on FDA licensure and the CDC schedule, but they also work for the very pharma companies that earn billions of dollars from these vaccines.³¹

In doing so, they are walking in Plotkin's footsteps. He, too, had guided CDC's vaccine committee while working for, or sitting on, the boards of nearly all pharma companies that are involved in vaccines.³² Just watch his deposition—it took almost two hours to get through these conflicts.³³

To give but one example of pharma insiders sitting on CDC and FDA vaccine committees as though they were impartial scientists, we turn to Dr. Kathryn Edwards, a Plotkin disciple often referred to as

the godmother of vaccines. She conducted many of the clinical trials relied upon to license many of the vaccines currently on the market, and during the same period of time, sat on FDA and CDC's vaccine committees voting on licensure and recommendations.³⁴ I know this from deposing and cross-examining her on the stand.

Here are the details. From 1991 to 2000, Dr. Edwards was a principal investigator for clinical trials of Hib (Haemophilus influenzae type b), DTaP (diphtheria, tetanus, and acellular pertussis), IPV (inactivated poliovirus vaccine), and other childhood vaccines. Dr. Edwards, however, was all but in bed with these same pharma companies that profit from these products.³⁵ Here is a list of just a few of the conflicts identified in the fine print of some of Dr. Edwards' peer-reviewed studies from this same time period: "received funding for vaccine studies from Wyeth Lederle, Aventis, SmithKline Beecham, and Merck,"³⁶ "consultant for and has vaccine trial contracts with Pasteur Mérieux Connaught, SmithKline Beecham, and Wyeth Lederle Vaccines,"³⁷ "gives lectures sponsored by Pasteur Mérieux Connaught and Wyeth Lederle,"³⁸ "consultant for Smith-Kline Beecham,"³⁹ and "funding for research from Connaught and Lederle-Praxis and is on their speaker's bureaus."⁴⁰

These are *serious* conflicts. Simply put, receiving funding from, consulting, giving lectures, and being on the speakers' bureaus for these companies will have a corrupting effect, whether conscious or unconscious, on impartiality and objectivity. And as a reminder of what a speakers' bureau is, Pew explains that, "[f]aculty who participate in speakers' bureaus are de facto 'marketers in academic robes,'"⁴¹ or as a Tufts University School of Medicine ethics article explains, "physicians who participate in Speakers' Bureaus are essentially just paid marketers or spokespersons for industry who use, indeed exploit, their roles as physician leaders to influence their colleagues to prescribe the sponsor's product."⁴²

It gets worse because during the same time period that Dr. Edwards was disclosing pharma patronage and conducting their clinical trials, she was also sitting on the CDC's vaccine committee and FDA's vaccine committees, and it was during this same time period that these committees voted to add the Hep B, DTaP, Hib, IPV, Varicella, and Hep A vaccines to the CDC's childhood vaccine schedule. And each of these products was made and sold by the same four companies from which Dr. Edwards was disclosing patronage from: Merck, Smith Kline Beecham, Wyeth Lederle, and Connaught.

Think about that. During the same years that most childhood vaccines on the schedule today were licensed and added to the CDC's childhood schedule, Dr. Edwards was a voting member of the CDC or FDA vaccine committee. Yet, she had also received funding from, consulted for, gave lectures for, and was on the speakers' bureau of the

very pharma companies whose vaccines were being voted upon. Let that sink in for a minute.

And if you are hoping that Dr. Edwards is an exception, get ready to be disappointed. An investigation by Congress regarding these committees, resulting in a 2000 report titled "Conflicts of Interest in Vaccine Policy Making," found with regard to FDA's vaccine committee that the "overwhelming majority of members, both voting members and consultants, have substantial ties to the pharmaceutical industry."⁴³ The report's condemnation of the CDC's vaccine committee was equally stinging and scathing.

I can also tell you that this Congressional report only identified a small fraction of the actual conflicts the members of the CDC and FDA vaccine committees had with pharma. For example, with regard to Dr. Edwards, here is the only direct conflict with pharma the report identified: "Dr. Edwards received a contract from Wyeth Lederle for \$255,023 per year from 1996 to 1998 for the study of pneumococcal vaccines."⁴⁴ The report entirely missed the extensive and far more concerning list of her conflicts with pharma, including Dr. Edwards' funding, consulting, giving lectures for, and/or being on the speakers' bureaus for Merck, Wyeth Lederle, Aventis, SmithKline Beecham, and Connaught.

But even the limited conflicts the Congressional investigation uncovered—shocking in and of themselves—were enough to reach its damning conclusions: "loose standards," that "significant conflicts of interest are not deemed to be conflicts," and that certain policies even encourage "a system where government officials make crucial decisions affecting American children without the advice and consent of the governed."⁴⁵ Imagine its conclusion had the Congressional investigation uncovered all of these voting members' conflicts.

Let's put this Congressional report, issued on June 15, 2000, into context. During the few years leading up to this report, a large portion of the vaccines on the current CDC childhood vaccine schedule were voted upon by FDA and CDC's vaccine committees and then added to the childhood schedule. This included four vaccines (Hep B, DTaP, Hib, and IPV) each administered three times in the first six months of life and two vaccines (Varivax and Hep A) given in the first year of life.⁴⁶ These medical products, given to healthy babies, are injected during critical phases of immunologic and neurological development.⁴⁷ This should have demanded the most impartial committee possible to evaluate whether they should be injected universally into every baby numerous times in the first few months of life. Licensing and recommending these vaccines should *not* have been decided by pharma-conflicted vaccinologists who followed the creed for avoiding safety issues at almost any cost

and who had incestuous ties to the very pharma companies that stood to earn billions of dollars from the sales of these products.⁴⁸

While the next part of this book will get into pharma's role in more detail, the takeaway point of this chapter is that the impact that Dr. Plotkin and his disciples have had on vaccines, vaccinology, and vaccine policy is almost without measure. Their fingerprints are on everything that the medical community and public believes it "knows" about vaccines. Much of what is said at the CDC and FDA vaccine committee meetings stems from Dr. Plotkin and his disciples. This information then filters into journals, textbooks, and the broader medical literature regarding vaccines, and becomes policy, is repeated by doctors, and is then broadcast by those pushing so-called "public health," which is where we turn next: to those who are effectively viewed as public "health" authorities but are in reality simply people pushing the dogma promulgated by the vaccinologists.

Chapter 3

Priests: Medical Profession

This brings us to the outer circle of vaccinology's religious hierarchy. These are the public-facing "health" officials, such as Anthony Fauci, MD, and the other heads and deputies of the federal, state, and local public "health" agencies. Like priests, they repeat the words of the high priest and his disciples. In the world of vaccinology, as you now know, the high priest is Dr. Plotkin, and his disciples include those who worked with him or are the product of his influence on vaccinology.

Public "Health" Officials

Let's begin with Dr. Fauci, the infectious disease doctor who is viewed by many as the most knowledgeable person in the world when it comes to infectious diseases and vaccines. The reality? Much of what he says about vaccines is merely a repetition of what is conveyed to him by the disciples through direct conversations, speeches, journal articles, medical textbooks, etc.

For example, when Dr. Fauci, the U.S. Surgeon General, and the heads of National Institutes of Health (NIH) and the CDC wanted to know whether those with natural immunity after Covid-19 infection should be afforded the same rights as those who had been vaccinated, they turned to Plotkin's disciples. That's right; you would think the heads of four U.S. federal "health" agencies, with the full resources of their agencies behind them, that collectively have an annual budget of over \$50 billion and over 30,000 employees, could answer this question internally. But that is not how the religion of vaccines works.

Instead, they convened a closed-door meeting.¹ In attendance were Dr. Fauci, the heads of NIH and the CDC, the U.S. Surgeon General, and four vaccinologists: Dr. Peter Hotez; Dr. Paul Offit; Michael Osterholm, PhD, MPH; and Akiko Iwasaki, PhD. This meeting was incredibly consequential to the lives of millions of Americans and

everyone else around the globe whose health authorities take their lead from U.S. federal “health” agencies.

It was incredibly consequential because the agenda included determining whether the CDC should, as it was already doing for vaccine immunity, recognize natural immunity as sufficient to keep one’s job, go to school, and otherwise participate in civil society without a Covid-19 vaccine. In other words, the civil and individual rights of millions of Americans—and millions more around the globe—hung in the balance of what these vaccinologists thought. Putting aside that civil and individual rights should never be conditioned on the opinions or beliefs of any public “health” official, the government did not turn inward to the over 30,000 individuals in its agencies to answer this question. They turned instead to the Plotkin disciples.²

Their advice? You guessed it: vaccinate. These disciples all agreed that natural immunity was not enough to let people retain their rights. The only difference among them was that Dr. Offit asserted that those with natural immunity must receive one dose of vaccine to retain their rights, Dr. Osterholm asserted two doses were needed, and Dr. Hotez and Dr. Iwasaki asserted three doses were needed.³

Of these four disciples, Dr. Hotez may be the most aggressive and petulant. You may have seen him on television wearing his bowtie, and if you have, you may already know his near-universal advice on vaccines which he often delivers with a crazed look in his eyes: *More. More. More.* Dr. Hotez has stayed truly faithful to the religion.

Returning to the closed-door meeting, Plotkin’s disciples simply denied the immunity humans have relied upon for eons in favor of the immunity created by the disciples’ true gods—vaccines. After all, in their religion, only vaccines can save humanity.

Think about it. Despite having copious resources at their disposal, especially during the pandemic, the heads of the federal public health apparatus could not figure out that immunity conferred from natural infection is *at least as good* as immunity conferred from vaccination. Keep in mind, vaccines try, at best, to achieve the immunity generated by natural infection. These health officials instead needed the blessing of vaccinologists on the issue of whether immunity after infection, produced by a person’s own immune system, which the vaccine is trying its best to emulate, provided protection sufficient to give the previously infected the same rights as the vaccinated. Only a zealot or someone truly uninformed would insist that prior infection does not provide sufficient immunity, yet a product from Pfizer or Moderna *does*.

The point is that almost all those in the federal and state public health apparatus, as well as almost all immunologists, virologists, pediatricians, and the larger medical community, know almost nothing about

vaccines. They all just peddle and repeat the mantras and incantations taught to them by the vaccinologists, who were, in turn, curated by pharma, as we will discuss in detail in Part II.

Repeating Plainly False Beliefs

I will give one more example of how public “health” officials repeat the claims of vaccinologists like mantras. ICAN sent a formal legal demand on behalf of more than 55 groups in the United States, comprising more than 5 million Americans, asking HHS why clinical trials for childhood vaccines do not include a placebo control group.⁴ True to its religious beliefs, HHS’s response began by repeating a false mantra about vaccines, stating: “Contrary to statements made on page two of your letter, many pediatric vaccines have been investigated in clinical trials that included a placebo.”⁵

That would be a decent rebuttal (and at least some welcome news) if it were true. As you can read for yourself in ICAN’s response, which comprehensively cited FDA’s official documentation, it is categorically false to claim that many of the childhood vaccines on the CDC schedule were licensed based on placebo-controlled trials.⁶ The reality is that none of the routine injected vaccines on CDC’s childhood schedule were licensed by FDA for children based on a placebo-controlled trial—as we will cover in detail in Chapter 10.

How could HHS, which wrote its response in conjunction with the CDC, FDA, and NIH, get this fact wrong? Believe it or not, even though the clinical trial data on FDA’s own website and in its possession make clear it is false to claim that routine childhood vaccines on the CDC schedule were licensed based on placebo-controlled trials, I do not think the “health” officials at these agencies knew it was false. This is because the disciples have told them otherwise, either directly or through their published works, and these “health” officials were, as is their normal practice, just repeating that mantra like a prayer.

Follow the Evidence

Those looking to blindly follow a religion can follow what public “health” authorities and most doctors say about vaccines. For those looking to make an informed decision regarding these products, there are objective facts. For instance, whether a placebo (*i.e.*, an inert substance) was used in a clinical trial is an objective fact that can be determined from the clinical trial documents and reports for each vaccine. More on that in Chapter 10.

The above alone may sound unbelievable. I assure you, however, that as we review the primary sources and evidence related to vaccines in Parts III and IV, any disbelief should quickly melt away. But before we do, it is also essential that you understand the truly unique, one-of-a-kind, economic and regulatory structure of vaccines, as doing so will help prevent cognitive dissonance. Understanding this structure will give clarity as to why the market, courts, and regulators allow both the harms caused by these products and the false claims by “health” authorities about these products to continue unabated. And it is to that we turn next.

PART II

THE CHURCH

Chapter 4

Original Sin: 1986 Act

Overview of the Church of Vaccines

The clergy in most religions operate within a defined power and financial structure. The religion of vaccines is no different. The vaccinologists we've discussed also operate within a larger power structure and need funding and resources. Where does that funding come from? It comes in large part from the pharma companies profiting from the sales of vaccines, either directly or from third parties within the sphere of pharma's influence in the form of grants and other support.

The four primary companies that make and sell vaccines are Merck, Pfizer, GSK, and Sanofi. I have found that the more influential the vaccinologist, the more intertwined that person will typically be with these pharma companies and with the federal "health" agencies that make decisions and fund research that benefit these companies.

For example, Dr. Plotkin, the godfather of vaccinology, worked with or sat on the board of virtually every pharma company profiting or seeking to profit from vaccines. I am not sure anyone will ever compete with his list of conflicts. His disciples similarly have extensive entanglements with pharma, which are typically directly related to their influence and standing as vaccinologists. As a rule of thumb: the more entangled with pharma, the greater their influence and standing in the world of vaccinology.

Pharma's extensive influence over vaccinology is not a conspiracy—it's just business. Pharma generates tens of billions of dollars in vaccine sales every year, and part of keeping that business healthy is to annually sink huge sums back into leading vaccinologists, directly and indirectly, as well as into extending their control over vaccinology, journals that publish about vaccines, medical textbooks, the conferences designed to "teach" doctors, etc.¹ Pharma even funds activities in

federal agencies through the CDC Foundation, an organization created by Congress to allow pharma and others to fund personnel and activities within the CDC.²

Simply stated, pharma is the real power behind the religion of vaccinology. It is the hand behind-the-scenes that effectively selects who will fill the critical public-facing roles held by vaccinologists and others to whom the medical profession and public look for the "truth" regarding vaccines. Its power comes primarily from the ability to fund or withdraw funding, invitations, access, etc., to those it wants to see ascend or descend, respectively.

As we will review over the next three short chapters, this power structure is fairly simple. Pharma supports the vaccinologists who carry its message. That message is published in medical journals and similar apocryphal medical literature, also supported by pharma. These publications are then relied upon as gospel by the "health" agencies to set policies, as well as by the CDC and FDA vaccine committees whose members include individuals funded and supported by pharma. And if all that were not bad enough, employees of these "health" agencies, especially top-level employees, hope to get a job in pharma after leaving government which discourages them from displeasing pharma lest they harm their future lucrative prospects.

Pharma is omnipresent in every aspect of the religion of vaccinology. Critically, it is able to extend its reach and power without the normal detractors since it is immune from financial liability for injuries caused by its holy vaccines, as we are about to discuss in detail in this chapter. Pharma has also gotten Congress to turn the U.S. federal "health" agencies into essentially the funding, marketing, promoting, and defending arm of pharma's vaccine business, all of which work essentially at the behest of pharma's interests, as we will discuss in the next chapter.

That brings the power structure into complete alignment. Every powerful, influential, or monied entity relating to vaccines is marching to pharma's incantations. The vaccinologists supported by pharma inscribe their dogma into the medical literature, trial reports, and journals, which are also supported by pharma. This "science" is then relied upon by CDC and FDA vaccine committees, filled with members beholden to or aligned with pharma, to license vaccines and create the vaccine schedules used like a bible by the entire medical profession, including pediatricians, OB-GYNs, immunologists, infectious disease doctors, etc., almost all of whom know nothing about vaccines otherwise.

Understanding this power structure, laid out over the next three chapters, is critical to understanding vaccine safety. The good news is it is not very complicated. With that we begin with the immunity given to pharma for vaccine injuries.

The 1986 Act

Companies can generally be sued and held liable for injuries caused by their products, with one exception: vaccines. If a drug, car, toy, etc., sold by a company kills or seriously injures your child, you can sue the company to claim the product could have been made safer; but if a vaccine kills or seriously injures your child, you can never sue the pharma company selling this product to claim it could have been made safer. This unique financial immunity, not enjoyed by any other product manufacturer, is the original sin that has wrought many of the issues with vaccines that have followed.

Let's start with why you generally cannot sue pharma for vaccine injuries. The answer is not comforting. Into the 1980s, there were only three routine childhood vaccines on the CDC vaccine schedule: diphtheria, tetanus, pertussis (**DTP**); measles, mumps, rubella (**MMR**); and oral polio (**OPV**).³ That's it, just three.

As uptake of these products increased in the 1960s and 1970s, so did the number of children they injured; with that, so did the number of lawsuits brought by parents who alleged that one or more of these vaccines caused chronic illness, developmental delays, and/or disabilities in their children, or the death of their child. Faced with crippling liabilities, pharma companies began to exit the vaccine business in droves. It is reported that the number of companies selling a pertussis vaccine dropped from seven to one, measles vaccine from six to one, and polio vaccine from three to one. This should not be surprising since companies sell products to make money. Not to lose money.

By 1986, only one company remained that sold DTP, one that sold MMR, and one that sold OPV. The liabilities they faced for harms caused by these products were so great that the last remaining company selling these products also threatened to exit the vaccine business. For example, the only remaining manufacturer of DTP was facing liability more than 200 times its annual sales.⁴ That is a lot of harm.

Now, every kind of consumer product—and vaccines are a consumer product—can eventually reach this fork in the road. A point at which liability from harms or potential harms might exceed revenue. When a company faces this type of liability, the company's economic self-interest drives it to make a safer, better product. Meaning, the solution is to make a safer product!

But when it comes to vaccines, and only vaccines, Congress, in its infinite wisdom, decided that instead of forcing these companies to make safer and better products, it instead granted these companies immunity from liability for injuries caused by these products. It did so as part of the National Childhood Vaccine Injury Act of 1986 (the **1986 Act**).

Meaning, Congress' solution was to effectively say to these companies: "We see you are facing liability because your products are causing serious harms and deaths, and these liabilities greatly exceed your sales. However, you don't need to worry about making a safer or better product. What we will do instead is pass a law to make sure you can keep selling your vaccine products, no matter how harmful, no matter how many children are seriously injured, no matter how many children are killed. The law will prevent those injured from suing you."

Congress did not stop there. It did not just give these companies immunity for the harms caused by the three vaccine products that drove the passage of the 1986 Act, but it extended the immunity to *any other routine childhood vaccine developed thereafter*.⁵

It was a terrible decision. This financial immunity given to pharma for vaccine injuries is the original sin that created the profound moral hazard we live with today.

Let me put this into sharp focus. Of all the products used by Americans every day—from electrical outlets, foods, motorcycles, cars, surgical tools, drugs, power tools, etc.—none are granted immunity for injuries they cause. Yet, families cannot sue the manufacturer of a product injected into perfectly healthy babies—a product the public is repeatedly assured is "safe"?!

With the legal right to profit from vaccines without concern for the financial downside of causing harms, the vaccine market that was on the verge of collapse in 1986 is valued at over \$56 billion today as the CDC's schedule has grown from 3 injections by age one in 1986 to 29 injections by age one in 2025.⁶ Each additional vaccine adds hundreds of millions or billions in revenue to the pharma company's annual income statement.⁷

Economic Self-Interest Drives Safety

To truly appreciate the incredible harm this decision has caused, it is essential to understand how economic self-interest works when it comes to publicly held companies, including all major pharma companies.

Public companies seek to maximize profit for their shareholders. Maximizing profits typically goes hand-in-hand with ensuring the safety of products. That's because the safer a company's product, the less money the company will lose paying for harms.

This means a company's drive to maximize profits typically drives innovation and avoids the introduction into the market of unsafe products that could cause financial losses.

For example, if a pharma drug causes harm, the company selling it will lose money paying damages to those harmed. That is why pharma

companies have a financial incentive to ensure they sell the safest drugs possible and an incentive to timely monitor and address safety issues after licensure. Meaning, with drugs, maximizing profit is aligned with assuring the drug's safety.

But what if a pharma company never had to pay any damages for harms caused by a certain product? In that case, the economic incentive would be reversed. The company would have a *disincentive* to identify any safety issue that would prevent licensure, and similarly a *disincentive* to identify any safety issue after licensure.

Let me put it this way. Companies that are financially liable for injuries want robust pre-licensure studies to avoid post-licensure liability. In contrast, companies *not* financially liable for injuries caused by their products have no financial interest in identifying safety issues pre-licensure; and that disincentive continues post-licensure.

With vaccines, there is *no* motivation for the company to identify safety issues that would avoid licensure, and similarly *no* motivation to identify and address safety issues after licensure. Why would it? It only stands to lose money, not make money, should it take any extra steps before or after licensure to identify any safety issues.

This is why decoupling a company's profit motive from its responsibility for safety introduces an incredible hazard for consumers.

Let me give you a concrete example by comparing the clinical trials that Pfizer conducted to license its four most profitable drugs, as of 2019, with the clinical trials conducted to license four infant vaccines.⁸ As the following chart reflects, Pfizer's drug products were licensed based on multi-year, placebo-controlled trials, whereas the childhood vaccines were licensed based on trials with no placebo control and only days or weeks of safety review after injection. If the data in this chart regarding vaccines seems unbelievable, and it should seem unbelievable, hold tight, as we will carefully review, with supporting FDA sources, the clinical trial relied upon to license each childhood vaccine in Chapter 10.

Pfizer's Top 4 Most Profitable Drugs			Vaccines Given in First 6 Months of Life		
DRUG	SAFETY REVIEW	CONTROL	VACCINE	SAFETY REVIEW	CONTROL
Elilquis	7.4 Years	Placebo	DTaP	28 Days	DTP vaccine
Enbrel	6.6 Years	Placebo	Hep-B	5 Days	None
Lipitor	4.9 Years	Placebo	Hib	3 Days	Hib vaccine
Lyrica	2 Years	Placebo	IPV	3 Days	None

After reviewing this chart, you should be wondering how products injected into babies could have such short periods of safety monitoring after injection.

Of course, as you know from the above discussion, the answer is that because Pfizer is liable for the injuries caused by its drug products, it really wanted to know the safety of its drug products before licensure to avoid losing money on these products. In contrast, because it is not liable for injuries caused by its vaccine products, it has no economic interest in knowing, and in fact had a financial disincentive to determine whether its vaccine products cause harm either before or after licensure. For vaccines, the company's financial interest is to get its vaccine products licensed with as little safety review as possible.

Think about it this way: when it comes to cars, planes, drugs, chainsaws, and every other consumer product, it is the mere *potential* of liability that drives companies to carefully evaluate product safety before going to market and then to actively monitor and improve the product's safety thereafter. This is *the* reason products are typically safe—or continually improved for safety. But that is not the case for vaccines.

Vaccine Makers Can Kill with Impunity

I also want to make clear that the immunity enjoyed by vaccines is unique. There is no other consumer product that has the immunity enjoyed by pharma companies for vaccine harms.⁹

The only other products sometimes claimed to have immunity for harms are guns. But that immunity only comes into play in a limited way: when a gun is used in an illegal act. So, unlike the near complete lack of recourse against a pharma company for vaccine harms, you can still sue gun companies for a claim that the gun could have been made or designed in a manner that would have avoided the harm.¹⁰ Also, no one mandates that you purchase or use a gun.

If you did not know about pharma's immunity for vaccine injuries and deaths before reading this book, you may find it shocking and unbelievable, especially given the endless assurances that these products, injected into healthy babies, are safe. But it is precisely the reality Congress created when passing the 1986 Act.¹¹ As that law provides: "No person may bring a civil action for damages in an amount greater than \$1,000 ... against a vaccine administrator or manufacturer ... for damages arising from a vaccine-related injury or death ..."¹²

Instead, the 1986 Act requires that claims for vaccine injuries be brought in the Vaccine Injury Compensation Program (VICP) against the Secretary of Health and Human Services (HHS).¹³ Meaning, someone injured by a vaccine needs to sue the federal government, not the pharma company that profited from selling the product. We will discuss the VICP in greater depth in the next chapter.

Technically, after going through the VICP, an individual injured by a vaccine can bring a claim in court against the pharma company selling the vaccine. However, there is typically little to assert unless the injured person has proof of fraud. This is because the United States Supreme Court has made clear that you can never, ever, sue a pharma company on the basis that the vaccine that injured you could have been made safer.

Such claims are called “design defect” claims and nobody is permitted to ever bring such a claim against a pharma company for a vaccine product. As explained by the Supreme Court, “*we hold that the National Childhood Vaccine Injury Act preempts all design-defect claims against vaccine manufacturers brought by plaintiffs who seek compensation for injury or death caused by vaccine side effects.*”¹⁴

The dissent by Justice Sonia Sotomayor and Justice Ruth Bader Ginsburg in this Supreme Court decision rightly points out:

The majority’s decision leaves a regulatory vacuum in which no one—neither the FDA nor any other federal agency, nor state and federal juries—ensures that vaccine manufacturers adequately take account of scientific and technological advancements. This concern is especially acute with respect to vaccines that have already been released and marketed to the public. Manufacturers, given the lack of robust competition in the vaccine market, will often have little or no incentive to improve the designs of vaccines that are already generating significant profit margins.¹⁵

What this effectively means is that pharma can keep profiting from a harmful vaccine no matter how easy, cheap, or inexpensive it would be to make it safer, and no matter how much technology or science advances. This is why virtually nobody even tries to sue pharma companies for harms caused by routine childhood vaccines since the passage of the 1986 Act; there is almost no claim that can be asserted. Vaccines really are the only consumer product where a company can harm or kill you or your child with near-complete impunity.

The Need for Immunity Is Disturbing

Here is what makes pharma’s immunity for vaccine injury particularly disturbing. If this immunity was repealed, all pharma companies would need to do to avoid liability is precisely what they already do to avoid liability for drug injuries. They would need to make vaccines as safe

as technologically feasible (hence, avoiding design defect claims) and adequately disclose their risks (hence, avoiding failure to warn claims). That's basically it – with these two adjustments, pharma could generally avoid liability for most vaccine injuries.

This is because these two claims, design defect claims and failure to warn claims, are typically how a product manufacturer is held liable for harm from its products. This is why, again, a company that makes its product as safe as technologically feasible (for example, adding a protective cover on a saw blade) and discloses its risks (for example, listing all risks in the product's package insert) will limit its liability. This is how drugs, even those with a troubling safety profile and limited market, can be profitable.

There is no reason that pharma cannot do the same with vaccines. If the immunity under the 1986 Act did not exist, pharma companies could limit their liability for vaccine harms by making vaccines as safe as technologically feasible and disclosing their risks. By doing those two things, pharma companies could profitably sell vaccines, just as pharma does with drugs – even drugs that have a very limited market.

It's not as though there's an insufficient market for vaccines that would deter pharma companies from making and selling them. The market for childhood vaccines in the United States alone includes 74 million children. Each childhood vaccine is typically a multi-dose series given annually to each new birth cohort. All fifty states mandate vaccines for school enrollment. The federal government spends billions annually in taxpayer money to purchase vaccines from pharma companies and market them to the public. Meaning, pharma literally has a guaranteed, captive market to which it sells its vaccines with the bonus of free marketing. Yet pharma still needs liability protection for injuries to turn a profit?!

Really think about it: why do mandated products with free marketing and guaranteed sales need immunity from liability for vaccine harms to turn a profit, especially when the public is repeatedly assured that they are "safe"?

After you have really considered this question, to beat this point just a bit more, imagine I presented you with the following business idea: we are going to make a product (potentially even using government money); the government is going to market it (using taxpayer dollars); the government is going to guarantee us payment (using taxpayer dollars); the government is going to mandate it for every American (including under threat of expulsion from school); and the government is going to grant us immunity from liability for harms (no matter how bad the injuries). How would you react to this? You would likely say it was nuts and that this business model cannot be real.

Yet that is the current reality in which pharma companies profit from vaccines.

In 2019 alone, Pfizer generated \$5.95 billion from just one childhood vaccine, Prevnar-13.¹⁶ By 2028, the vaccine market is expected to exceed \$153 billion.¹⁷ If these revenues are not sufficient to pay damages for vaccine injuries, there is indeed good cause for concern.

In the face of the foregoing, a pediatrician once argued with me that the financial immunity pharma enjoys for vaccine injuries is a good thing because it incentivizes pharma companies to develop and sell more vaccines. My response was that there is no reason pharma companies cannot be incentivized to sell more vaccines *and* assure they are safe without immunity.

Again, pharma does not have immunity for injuries caused by its drug products and is still able to turn a profit—even drugs for rare conditions with a limited customer base. They even turn a profit on drug products that have serious known risks and have caused widespread harm among those who use them. This is because, as discussed, if it's not feasible to make the drug safer *and* the company discloses the risks, the injured consumer typically cannot successfully sue.

There is no reason this couldn't also work for vaccines. Pharma companies could make vaccines as safe as technologically feasible *and* disclose the risks. If pharma companies did that, they would generally be protected from liability. But they don't. The reasonable conclusion, then, is that the immunity is needed because vaccines *could* be made safer and risks are *not* being fully disclosed.

Product Liability Attorneys Neutered

Consider that drugs are regularly withdrawn from the market because class action and product liability attorneys can sue for harms. These lawsuits involve experts, from both sides, carefully examining the safety of the drugs at issue and reviewing the company's internal documents, studies, and data. The plaintiffs in these lawsuits are typically trying to prove that it was feasible to make the product safer or that the company failed to disclose one or more risks. As you now know, this will almost never happen with a vaccine.

Let me put it this way: drugs so dangerous they were pulled from the market would likely still be on the market, and considered safe and effective, if classified as vaccines.

It is an incredible state of affairs. The one and only product for which a company can literally get away with killing someone—even if the company knows how to make the product less lethal but chooses not to—is a product we inject into millions of babies every year. For many

parents, the analysis of whether to vaccinate their children begins and ends with this fact.

After all, if vaccines are so safe, why do pharmaceutical companies—almost all of whom have been forced to pay out billions of dollars for misconduct related to drug products—need legal protection for injuries that vaccines will supposedly not cause?

Even more telling is the question of why, decades after vaccines have been purportedly thoroughly tested and declared safe, they still need this protection. You now know the legal reason, and as we review the science of vaccines in Section IV, the full answer will become crystal clear.

Chapter 5

The Public Face: Regulators

After Congress granted pharma companies financial immunity for vaccine injuries, parents and government regulators remained the only line of defense to protect children from vaccine injury. Putting parents aside, regulators are a far and away weaker potential safeguard for product safety than economic self-interest, but federal regulators who seriously seek to improve vaccine safety could play a limited role. Unfortunately, when it comes to regulating vaccine safety, our country's federal agencies have, to put it mildly, not honored this duty.

Hopelessly Conflicted: Promotion v. Safety

When a federal agency is responsible for promoting a product or service, Congress has typically created an entirely independent agency to ensure that product or service's safety. This is because after an agency has promoted a product, it will rarely if ever admit that it promoted a product which harmed the public. History has shown that when an agency has the conflicting duties of promoting a product/service *and* of assuring its safety, one of these duties will overwhelm the other.

This is why, for example, when Congress made the U.S. Department of Transportation responsible for promoting transportation, it made a completely separate and independent agency responsible for transportation safety, the National Transportation Safety Board.¹ Similarly, to avoid conflicts in having the Atomic Energy Commission both promote nuclear energy and assure its safety, this agency was abolished and Congress transferred the promotion function to the Energy Research and Development Administration and transferred the safety function to the completely independent Nuclear Regulatory Commission.²

These two examples reflect common sense and highlight the critical importance of separating promotion duties from safety duties. Think about it: nobody should want the agency responsible for avoiding plane

crashes or nuclear radiation leaks to have competing interests. In the case of nuclear energy, for example, the separation of promotion and safety occurred after an “increasing number of critics ... charged that the” Atomic Energy Commission’s focus on “growth of the industry” resulted in its being “insufficiently rigorous in several important areas [of safety], including radiation protection standards, reactor safety, plant siting, and environmental protection.”³

Yet, when it comes to assuring the safety of products injected into healthy babies and toddlers, Congress made HHS – within which are the CDC, FDA, NIH, and all other health subagencies – responsible for the conflicting duties of promoting vaccines *and* assuring their safety. HHS’s focus on growth of the vaccine industry has not only resulted in it being insufficiently rigorous about vaccine safety, but over time abandoning and, as you will read later, even working against vaccine safety.

The result of making HHS responsible for both promotion and safety of vaccines is a serious and dangerous structural conflict that should never have been created. At the very least, it should have been quickly corrected after repeated demands, spanning decades, to members of Congress by vaccine safety advocates to create an independent board or agency to oversee vaccine safety. These groups, often filled with parents of vaccine injured children, however, have plainly been no match for the one thousand-plus highly paid pharma lobbyists.

Hopelessly Conflicted: Defense + Promotion v. Safety

Sadly, the conflict HHS has in assuring vaccine safety is far worse than its promotion duties overtaking its safety duties, as was occurring in the areas of transportation and nuclear energy. In addition to this already damning conflict, HHS is also responsible for defending against legal claims that a vaccine caused an injury. I mean that literally – HHS is literally legally responsible to defend against claims brought by citizens that a vaccine caused them harm.

This is because Congress, when it gave pharma companies immunity for vaccine injuries, created the Vaccine Injury Compensation Program (**VICP** or **vaccine court**) where individuals can file claims against HHS for certain limited compensation for vaccine injuries.⁴ And Congress made the Secretary of HHS the respondent (the defendant) in vaccine court. Meaning, the very same agency responsible for vaccine safety, HHS—which is already conflicted in having to also promote vaccines—is *literally* responsible for defending against vaccine injury claims.

Pause and really think about this incredible conflict. If HHS, including any of its subagencies, were to publish a study showing a vaccine causes a certain injury or illness, the public could use that study

against HHS in vaccine court. This, of course, makes it highly unlikely that HHS and its subagencies would publish such studies because those studies could then be used to successfully sue HHS for vaccine injuries. It is hard to imagine a more insidious and corrupting conflict.

The normal role of government has been inverted. Regulatory agencies usually exist to protect consumers—its citizens—from industry. With vaccines, however, HHS is required by law to defend whom? Not American citizens injured by vaccines, but rather products sold by pharma companies. Incredibly, the government protects the financial interests of Pfizer, Merck, Sanofi, GSK, and other pharma giants by aggressively battling against everyday American citizens harmed by their vaccine products.⁵

If that sounds crazy, that's because it is. Vaccines are the only consumer product I am aware of where the federal government defends *corporate interests* against claims brought by everyday Americans for harms caused by these companies. Please pause and think about that fact for a moment.

Hopelessly Conflicted: A Recap

So, let's do a quick recap. The primary safeguard for product safety—a company's own economic self-interest—has not only been eliminated, but inverted by creating a financial *disincentive* for pharma companies to identify vaccine harms either before or after licensure.

Setting parents aside, this leaves vaccine safety solely in the hands of the far weaker safeguard: regulatory agencies. But the federal agency responsible for vaccines, HHS, is hopelessly conflicted. It is legally mandated to both vigorously promote these products and to defend against any claims that they cause harm.⁶ These promotion and defense roles entirely crowd out HHS's safety function.

Outside of the Vaccines Amen crowd, it is difficult to see how anyone can rationalize these conflicts as a good thing—or as anything other than extremely concerning—especially given that these products are injected dozens of times into healthy babies.

Abandoned Safety

If you are thinking maybe, just maybe, even with these fundamental and irreconcilable conflicts HHS and its agencies have nonetheless done the hard work to assure vaccine safety, brace yourself. This will be a painful Band-Aid to rip off.

When Congress passed the 1986 Act, it clearly recognized that it was removing the economic self-interest that incentivizes pharma

companies to ensure the safety of their vaccine products. Congress therefore made HHS responsible for vaccine safety in a section of law titled the Mandate for Safer Childhood Vaccines (the **Mandate** or **Vaccine Safety Mandate**).⁷ The Vaccine Safety Mandate effectively transferred all vaccine safety duties to HHS because pharma companies no longer had an economic self-interest to fulfill these duties.

The Vaccine Safety Mandate is *the* section of law that underpins all of vaccine safety in this country. This is it. Everything else is derivative of these responsibilities. Therefore, it's important to understand what this Mandate requires and what HHS has, or hasn't, done to fulfill its requirements. It is roughly half a page of text and consists of three simple parts.⁸

The *first* part of the Mandate (titled "General Rule") requires HHS to make vaccines safer in every possible manner—something a pharma company would normally be responsible for (since they develop, make, and profit from these products) and would ordinarily have a financial self-interest in doing as part of its business operations. However, since these companies no longer have any such economic self-interest—and, in fact, now have a financial disincentive to ensure safety—Congress transferred these safety responsibilities to HHS. This included making HHS responsible for "the licensing, manufacturing, processing, testing, labeling, warning, use instructions, distribution, storage, administration, field surveillance, adverse reaction reporting, and recall of reactogenic lots or batches, of vaccines, and research on vaccines, in order to reduce the risks of adverse reactions to vaccines."⁹

The *second* part of the Mandate (titled "Task Force") created a Task Force on Safer Childhood Vaccines, comprising the heads of NIH, the CDC, and the FDA, to recommend how HHS should fulfill its safety responsibilities listed in the first part of the Mandate—very important and simple enough.

The *third* part of the Mandate (titled "Report") required HHS to submit a report to Congress every two years detailing what has been done to improve vaccine safety pursuant to the first part of the Mandate—again, important and simple enough.

So, let's see whether the critical safety requirements of the Vaccine Safety Mandate have been fulfilled. The logical place to start is with the biennial vaccine safety reports HHS is required to submit to Congress pursuant to part three of the Mandate. When our firm first began representing ICAN,¹⁰ it wanted to see these reports. So, in August 2017, on behalf of ICAN, we requested them from HHS pursuant to FOIA.¹¹ When HHS failed to produce any reports, we sued HHS in federal court to obtain them.¹² In that lawsuit, HHS eventually capitulated and admitted that, in the thirty years since the 1986 Act took effect, it had

never produced or submitted even one report to Congress as required by the Mandate.¹³ Not a single report.

Years later, in 2021, we again requested from HHS any reports submitted to Congress as required by part three of the Mandate.¹⁴ We assumed HHS would have finally taken this obligation seriously after its earlier embarrassing admission in our federal lawsuit from 2017. But in 2023, HHS again admitted it *still* never once produced or submitted any such report to Congress.¹⁵

It was and remains extremely disturbing that HHS has not completed the simple task, per part three of the Vaccine Safety Mandate, of preparing and submitting a biennial report to Congress detailing what it has done to improve vaccine safety. I can already hear the Vaccines Amen crowd saying that maybe HHS failed to submit these reports because it was so busy assuring vaccine safety!

To test that theory, let's review the recommendations to improve vaccine safety made by the Task Force on Safer Childhood Vaccines since 1986 pursuant to part two of the Mandate. To see what recommendations were made, we again needed to take legal action. In the end, HHS admitted that the only recommendations ever made occurred on April 19, 1996,¹⁶ and that "the Task Force on Safer Childhood Vaccines was disbanded in 1998."¹⁷

Meaning, since 1986, our federal health authorities did not submit a single biennial report to Congress on what they have done to improve vaccine safety and have not, apart from one instance, made any recommendations on how to improve vaccine safety as required by the Vaccine Safety Mandate. And remember: making recommendations on how to improve safety (part 2 of the Mandate) and submitting a biennial report to Congress on what improvements were made (part 3 of the Mandate) are the two *easy* parts of the Vaccine Safety Mandate.

If HHS is not fulfilling the easy parts of the Mandate, do you really think it is fulfilling the first part, the hard part, of stepping into the shoes of the pharma companies and actually *assuring* safety?

Logic would dictate the answer is "no," and that indeed *is* the reality. Our hopelessly conflicted federal health agency has failed to do its job even by the most generous of interpretations. Part IV of this book describes these failures in detail. But we don't have to dig that deep to get a sense of the depth to which HHS has utterly failed to fulfill its vaccine safety duties. This is because instead of keeping watch *over* pharma companies to ensure vaccine safety, we discovered that the CDC has instead been setting policy *with* pharma companies. Sounds unbelievable, but by examining just the CDC's Immunization Safety Office (ISO)—which we are about to do—you will see this is the reality. And,

as noted, the full proof of HHS's utter disregard and even undermining of vaccine safety will be covered in Part IV.

CDC's Safety Office Sets Policy with Pharma

In 2025, the CDC spent billions of dollars promoting, purchasing, and distributing vaccines—including over \$8 billion paid to pharma companies for vaccines.¹⁸ That is billions, not millions. Yet, the CDC's ISO has a miserly budget of only roughly \$20 million.¹⁹

Incredibly, even the ISO's measly budget is not directed toward actual vaccine safety. Instead, the longtime head of the ISO, Frank DeStefano, MD, MPH, who ran ISO from 2004 until 2022, spent his time making policy decisions with pharma companies that profited from vaccines, including Merck, Sanofi, GSK, and Pfizer. This *is* what the CDC itself admitted he was doing.

When my firm, on behalf of ICAN, requested Dr. DeStefano's emails with these companies, we received numerous pages redacted by the CDC on the basis that these communications involved setting CDC policy.²⁰ Meaning, instead of regulating these companies, Dr. DeStefano was making policy with them. Again, that is not my claim; it is what the CDC itself claimed by redacting Dr. DeStefano's communications with pharma companies on this basis.²¹

We fought in federal court to lift these redactions and successfully removed many of them. A review of just a sample of these emails shows Dr. DeStefano's cozy relationship with these pharma companies.²² But guess who Dr. DeStefano—the head of CDC's ISO—refused to work with? Groups concerned about vaccine safety, like ICAN, which seek to hold pharma companies accountable regarding vaccine safety.

But when pharma insiders wanted to use Dr. DeStefano's position to lend credibility to their beliefs, mantras, and conclusory assertions regarding vaccine safety, he readily obliged, routinely co-authoring studies with them. These pharma insiders, of course, only publish studies affirming the mantra that vaccines are "safe and effective." For example, in a study assessing whether a GSK influenza vaccine could cause narcolepsy, Frank DeStefano's co-authors included an author who "receives consultancy honoraria from GSK," another who "received honorarium from GSK," another who "received research funding from GSK, Merck, Pfizer, Roche and Sanofi Pasteur and speaking and consulting fees from GSK and Sanofi," and another who "reports contracts from ... GSK."²³

Similarly—and this may sound unbelievable—the CDC itself will only publish studies that support its policy that vaccines are safe and effective. Most of the studies the CDC relies upon to make claims about vaccines and set national vaccine policy are self-generated and published

in the CDC's Morbidity and Mortality Weekly Report (**MMWR**). Putting aside the broader issues with the peer review process for medical journal articles, the MMWR is not peer reviewed at all. Instead, its studies go through an internal clearance process within the CDC. That clearance process ensures that only studies supporting CDC's policy that vaccines are "safe and effective" get published.

As explained by the CDC, "MMWR publishes only reports that have been cleared according to CDC and MMWR clearance policies" which includes "clearance from ... CDC offices that have a programmatic interest in the report's topic."²⁴ The result? As the CDC makes clear: "By the time a report appears in MMWR, it reflects, or is consistent with, CDC policy."²⁵ And the CDC's policy is that vaccines are safe and effective, which is why it will not publish any study that undermines this policy.

For those surprised at how federal health agencies handled Covid-19 vaccines, understanding this framework for how vaccines have been and are handled within our federal health agency should help alleviate some of that cognitive dissonance. Full relief will need to wait until you make it through the rest of this book.

To sum up the last two chapters: nothing is driving vaccine safety. Not market forces, not economic self-interest, not the threat of liability, not lawsuits, and not even the very last—far weaker—line of defense: federal regulators. That is the hard truth. The unfortunate reality this has wrought will become clear in later chapters, especially when we review pre- and post-licensure vaccine safety literature. But first, there is one last major player in the religion of vaccines whose role it is essential to understand. That is where we turn next.

Chapter 6

The Real Power: Pharma

With the windfall of financial immunity granted by the 1986 Act, and with hopelessly conflicted federal regulators, pharma set out to do precisely what companies seek to do: maximize profits. And pharma excels at maximizing profits.

Pharma Controls Vaccinology

As noted above, Merck, Sanofi, GSK, and Pfizer are the biggest players in the vaccine market. Scratch the surface, and you will find that these companies are the benefactors of virtually every player in the vaccine universe, including the small group of vaccinologists who conduct vaccine studies and clinical trials and direct national vaccine policy; the journals and peer-reviewers that publish the science; and the medical schools, organizations, and institutions that gatekeep the medical profession.

In the religion of vaccinology, vaccines are the center of worship, but these pharma companies are the patrons and real power running the religion behind the scenes.

Pharma has been so effective in marketing to the public, lobbying the government, and co-opting regulators and the medical community to believe that vaccines are *to be worshiped*, that many people don't even think of vaccines as a consumer product. But they are. Vaccines *are* consumer products sold by pharma companies just as other companies sell other products. They are, I promise, consumer products sold by large corporations for profit and not articles of worship given to Moses at Mount Sinai.

Car companies, for example, promote their cars, have excellent marketing and public relations campaigns, and work to constantly reinforce a positive image of their products. But they must also consider potential safety-related liability and deal with actual liability, lawsuits, and

regulators, including when these cause negative news cycles about their products in the legacy media.

Unlike every other consumer product, for the past forty years, pharma has enjoyed free rein to promote its vaccine products without any real pushback on safety. No class action lawsuits. No consumer product lawsuits. No negative news cycles reporting on settlements or verdicts for harm caused. And no regulators pushing back—only regulators spending billions in taxpayer dollars to promote these products.

Pharma's grip on the establishment structures that endlessly reinforce its vaccine products as objects of worship remained unbroken even during the Covid era, despite concerted efforts to give serious push back against its reign. Even though the safety issues with Covid-19 vaccines could not be clearer, the mainstream media still carried the messaging that emanates from pharma. While pharma could not control certain alternative media, its grip, if anything, tightened during Covid-19 on nearly all legacy media and traditional institutions surrounding vaccines. Incredibly, pharma maintained this grip even though a Rasmussen Reports survey found that 24% of American adults said they personally knew someone who had died from side effects of a Covid-19 vaccine.¹

Pharma's approach—branding vaccines as being infallible while exerting control over vaccinology, clinical trials, journals, medical institutions, and the surrounding “science”—is not a conspiracy. It is just business and effective salesmanship. Pharma puts to use the billions it earns annually from vaccines to cement those profits and generate more. Exactly as their shareholders expect. That is capitalism. The problem, as discussed, is that it has no financial self-interest to assure safety.

Let's go through the ways pharma is in control.

Pharma Control Over Vaccinologists

We begin with the vaccinologists. As reviewed in earlier chapters, pharma funds the small group of vaccinologists who conduct the clinical trials relied upon to license vaccines, sit on the FDA and CDC committees that decide whether to license and recommend vaccines, run the scientific journals focused on vaccines, and otherwise set the policy for vaccines nationally.

This relatively small group of vaccinologists, many of whom we visited with earlier, are almost all hand-selected by pharma through a process of elimination.

Vaccinologists who deviate from accepted dogma don't receive funding for research by pharma, don't receive invitations to participate or speak at pharma-funded events, don't get selected to conduct clinical trials, and get excluded from coveted positions on journals and

institutions which rely on support from pharma. Without such funding, invitations, and participation, they do not advance in their careers.

The remaining vaccinologists, akin to “natural selection” but in this case “pharma selection,” continue to receive patronage from pharma and rise in the ranks. These vaccinologists are the anointed.

This alone does not make them sinister. In my experience, the vaccinologists who are setting policy for millions of Americans believe they are doing God’s work and view the patronage from pharma as something that does not affect their judgment.

These vaccinologists, however, would not have risen to their high positions of authority *without* pharma’s patronage, and they would not have received pharma’s patronage if their beliefs were not acceptable to pharma. On what basis does pharma select the anointed? The answer is simple. For a *liability-free product*, it patronizes those who have an *a priori* belief these products are so safe that there is little need for almost any pre- and post-licensure safety review, and that the products should get onto the market as soon as any efficacy can be shown.

You’ve got to hand it to pharma. These companies are brilliant. They handpick and support vaccinologists who serve their purposes while letting these vaccinologists believe they have ascended the ranks on their own merit. The reality, however, is that they have risen *because* pharma supports them. And pharma supports them *as long as their beliefs maximize profits*. No vaccinologist, except the most introspective, will likely be able to come to terms with this reality. But it is the reality.

Dr. Edwards, for example, as we reviewed, was a voting member of the CDC and FDA vaccine committees and had also received funding, provided consulting, gave lectures for, and sat on the speakers’ bureau of the very pharma companies whose vaccines were voted upon. Do you think pharma would have kept patronizing her if her views did not align with their interests? Of course not.

And as the Congressional investigation and report published in 2000, *Conflicts of Interest in Vaccine Policy Making*, made plain, Dr. Edwards was the rule and not the exception, finding that the “overwhelming majority of members, both voting members and consultants, have substantial ties to the pharmaceutical industry.”² And, recall, during the period of time leading up to when this report found conflicts were rampant, a large portion of the vaccines on the current CDC childhood schedule were licensed by the FDA and added to the CDC’s schedule.³

Decisions by these committees should have been made by individuals who are skeptical of these products or at least neutral about them.⁴ Instead, these decisions were made by individuals with incestuous ties to the very pharma companies that stood to earn billions from their sales.⁵ What makes this incredibly troubling is that the normal backstop to this

type of corruption, holding the company accountable for harms, doesn't exist for vaccines because of the 1986 Act.

Now, you would hope things would change after the scathing Congressional report in 2000. But, as you already know, that is not how this religion works. In 2008, the Inspector General of HHS *again* found an incredible level of conflicts of interest and even more pervasive problems, including that "CDC had a systemic lack of oversight of the ethics program" including finding that "58 percent of [committee members] had potential conflicts of interest that CDC did not identify" and "32 percent ... had potential conflicts of interest that CDC identified but did not resolve."⁶

Conflicts have deepened over time to the point that even blatantly obvious conflicts are no longer recognized as such by the Vaccines Amen crowd. That was obvious from Dr. Plotkin's deposition and is also painfully obvious from the following exchange I had with Dr. Edwards in 2020, when I cross-examined her on the stand before a jury. To provide context, Dr. Edwards was one of the five members of the independent data safety monitoring board for Pfizer's Covid-19 vaccine. Critically, she was *the* vaccinologist on that independent safety board. This board was responsible for reviewing and determining whether there were any safety issues with Pfizer's Covid-19 vaccine during the clinical trial. This role was incredibly important because it involved assuring the safety of a product slated to be injected into billions of people. It was therefore critical that the members of this independent safety board be *independent* of Pfizer. With that background, here is the exchange:

Q: Isn't it true that you've also been an advisor to Pfizer?

A: Yes, sir. I have been an advisor to Pfizer, and I've been working very, very closely with Pfizer, particularly their COVID vaccines, and going over lots of reactions and adverse events. So yes, I am working and being paid by Pfizer for my assessment of vaccine safety.

Q: You're part of the Data Safety Monitoring Board ... for the Pfizer COVID vaccine? ...

A: That's correct.

Q: You're one of the only five members of that Data Safety Monitoring Board for the Pfizer COVID-19 vaccine, right?

A: Yes, sir, I am.

Q: And that's supposed to be an independent Data Safety Monitoring Board, correct?

A: It is an independent Data Safety Monitoring Board.

Q: That's the board that all of us in America are hoping on and relying upon is going to independently make sure that safety is properly assessed as the clinical trial for that Pfizer COVID-19 vaccine is ongoing, correct?

A: That's true. And let me tell you that we have worked very hard to go over this. It's very, very hard to do that as comprehensively as we possibly can.

Q: And since it's supposed to be independent, it's critical that the members of that independent Data Safety Monitoring Board are in fact independent of the pharmaceutical company whose product is being evaluated, correct?

A: That's correct.

Q: But isn't it true that directly before becoming a member of the independent Data Safety Monitoring Board of the Pfizer COVID-19 vaccine, you were an advisor to Pfizer?

A: Pfizer pays me to evaluate the safety of their vaccines because I'm an expert. So I do get paid to do the work that I've been doing, but I've been doing the work conscientiously and comprehensively.

Q: My question was, before you became a member of the independent Data Safety Monitoring Board of the Pfizer COVID-19 vaccine, isn't it true that you were separately, before you held that independent position, you were an advisor to Pfizer?

A: Yes, sir. But I think what you're presuming is that because I've been an advisor makes me on their dole or makes me point to say what they want me to say. That is not and has never been a part of my being. I say what I believe based on my expertise.

Q: So you don't think that financial incentives can sway people's judgments at all?

A: It does not sway my judgments, sir.

- Q:** Why bother having an independent Data Safety Monitoring Board? Why doesn't Pfizer just have some of its employees on it?
- A:** Because we are independent.
- Q:** Meaning folks who were never advisors to Pfizer?
- A:** We are independent from Pfizer in this assessment.

After reading this exchange, it should be deeply disturbing to most people that the premier vaccinologist that was supposed to be "independent" on Pfizer's Covid-19 vaccine's independent vaccine safety board was not even independent of Pfizer.⁸ But this is nothing new for the small cabal of vaccinologists who think they are independent but only rose due to pharma patronage, including when they are paid to conduct those companies' trials.

Pharma's omnipresence does not end there. The patronage it uses to maintain tight control over those who conduct its clinical trials and, by extension, the vaccine committees at the FDA and CDC, also extends to medical journals, the tool for publishing science. We turn to that next.

Pharma Control Over Science Itself

Pharma's control over medical journals is critical to its business model. This is because trial results and studies that support vaccine policies, which in turn increase vaccine sales, are published in medical journals such as *The Lancet*, *The New England Journal of Medicine*, and *The Journal of the American Medical Association*. And who do you think effectively guides and funds these medical journals? Pharma.

But don't take my word for it. In 2004, the editor of *The Lancet*, Richard Horton, explained that: "Journals have devolved into information laundering operations for the pharmaceutical industry."⁹ A year later, Richard Smith, who served as editor of *The British Medical Journal* for twenty-five years, wrote, "medical journals are an extension of the marketing arm of pharmaceutical companies."¹⁰ And, Marcia Angell, the former editor of *The New England Journal of Medicine*, lambasted the pharmaceutical industry for becoming "primarily a marketing machine" and co-opting "every institution that might stand in its way."¹¹

Dr. Angell also explained that: "It is no longer possible to believe much of the clinical research that is published, or to rely on the judgment of trusted physicians or authoritative medical guidelines. I take no pleasure in this conclusion, which I reached slowly and reluctantly over my two decades as an editor of the *New England Journal of Medicine*."¹²

So, you have the clinical trials and studies, *i.e.*, the “science,” of vaccines being paid for by pharma, run by pharma-funded vaccinologists, and then published in pharma-funded journals. Our federal health agencies then rely on the pharma-funded and pharma-curated data and studies to make critical decisions, including the licensure, recommendation, mandate, etc., of vaccine products, which will impact pharma’s bottom line as well as the rights and lives of countless people in America and worldwide. It is to that we turn next.

Pharma Control Over Regulatory Agency Decisions

Pharma’s influence stretches through and beyond the doors of the FDA and CDC, including, as we have already extensively reviewed, those voting upon whether the government should license, recommend, and pay pharma billions for a given vaccine product. This should not be surprising, since pharma is very good at pushing its business interests and there is nobody standing in its way as it does so.

While pharma uses consultancies, advisories, lavish trips, awards, contracts, speakers’ bureaus, etc., to select who it wants to ascend in the world of vaccinology, it has another tool to influence those in government. That is to reward government employees who do their bidding while in government with lucrative positions within pharma after government. In this manner, pharma directly influences government employees while they are employed by the government.

For example, Julie Gerberding, MD served as the CDC Director from 2002 to 2009. During her tenure at the CDC, she oversaw several controversial studies and recommendations regarding vaccines produced by Merck – including its recommendation related to Merck’s Gardasil vaccine and studies related to Merck’s MMR vaccine and autism. Unsurprisingly, after a tenure that aggressively protected Merck’s products, and hence Merck’s profits, Dr. Gerberding joined Merck in 2010 as the president of vaccines, where she has raked in millions of dollars, including cashing in over \$22 million in Merck stock.¹³

In 2023, a Pfizer Director of Research and Development, while being secretly recorded by a Project Veritas journalist, put words to what many people already knew: “In the pharma industry, all the government officials who, like you know, review our drugs, eventually come work for pharma companies,” this Pfizer Director said.¹⁴

“How do you feel about that revolving door?” the journalist asked.

“It’s pretty good for the industry to be honest. It’s bad for everyone else in America,” he replied.

“Why is it bad for everybody else?” the journalist responded.

“Because if the regulators who review our drugs, you know that once they stop being a regulator they want to go work for the company, they are not going to be as harsh on the company where they’re getting their job,” the Pfizer Director said.¹⁵

Wrap-Up

Putting it all together, the religion of vaccinology is funded, structured, curated, designed, and run by pharma. It is like a centralized religion in that each of the main pharma companies selling vaccines—Pfizer, Merck, Sanofi, and GSK—all have the same approach, and they coordinate and direct their efforts through their trade group, Pharmaceutical Research and Manufacturers of America (PhRMA), where the CEOs of all four of these companies sit on its board.¹⁶

Medical professionals fall in line with what is licensed by the FDA and placed on the CDC’s vaccine schedules. Pharma, through its anointed vaccinologists, guides this process—driving the licensure of liability-free products, creating the vaccine schedules that lead to mandates, controlling the published science, and setting vaccination policies across medical institutions.

The result is that vaccines exist in an economic and regulatory framework unlike any other product on the market. Nothing else even comes close. After forty years of nearly unchecked inroads, pharma—through funding, marketing, public relations, and promoting its liability-free products—now dominates every step of the process, from generating the “science” and “data” around vaccines, to co-opting regulators, vaccinologists, and the broader medical community so that all sing from the same book of carefully curated hymns. This framework may sound unreal, but as you dig through the rest of this book, you may find the foregoing to be understated.

Given the lack of any real pushback over the last four decades, the public mythology surrounding the benefits and safety of these products is embellished just a bit more with each repeated iteration, and has become entirely detached from reality, yet is accepted as fact. When someone dares question these “facts,” that person is often met with an emotional reaction, reaffirming they are indeed beliefs. Not facts. We will go through the mythical claims about the purported benefits of vaccines in Part III, before we finally turn to vaccine safety in Part IV.

PART III

THE FAITH

Chapter 7

"Vaccines Save Millions of Lives!"

I hope that in thinking about the original sin of financial immunity, pharma's uncontested control of the narrative around vaccines for over 40 years, and the hopelessly conflicted health agencies, you realize there is no need to believe in any nefarious conspiracy. Just a broken economic and regulatory structure that all cuts in one direction with no pushback against pharma. A paradigm that does not exist for any product other than vaccines.

As pharma pushed its product with almost no pushback, a few tenets of faith have become part of the public's general consciousness. Mythical claims about the miracles these products have performed. The reasons vaccines should be revered. Worshipped. These articles of faith, however, are mostly that: myths divorced from reality.

We begin with the incantation about vaccines repeated more than any other and typically with reverence: the claim that "millions of Americans would die every year without vaccines." This claim, however, is just a belief. Not a fact. Disproving this belief requires simple statistics.

"The Measles Vaccine Saved Us!"

Let's start with measles, the disease discussed with histrionics and dread by the American media and public. Americans have been repeatedly led to believe that the reduction in measles deaths in the United States was due entirely to the measles vaccine and, had it not been introduced, Americans would have been dropping dead left and right from measles.

For example, *The Washington Post* reported in April 2025 that at "current state-level vaccination rates," which were 92.7% nationally by the CDC's last count, "measles could become entrenched, resulting in hundreds of thousands of cases, where deaths are commonplace."¹ Prestigious medical journals and publications also fearmonger. For example, in a publication about (ironically) vaccine misinformation, the

prestigious Royal Society and British Academy falsely wrote that "at the start of the 20th Century, measles resulted in around 530,217 deaths per year in the United States alone."²

These claims flow from beliefs that attribute mythical properties to the measles vaccine. The reality is quite different.

Decline in Measles Deaths Unrelated to Measles Vaccine

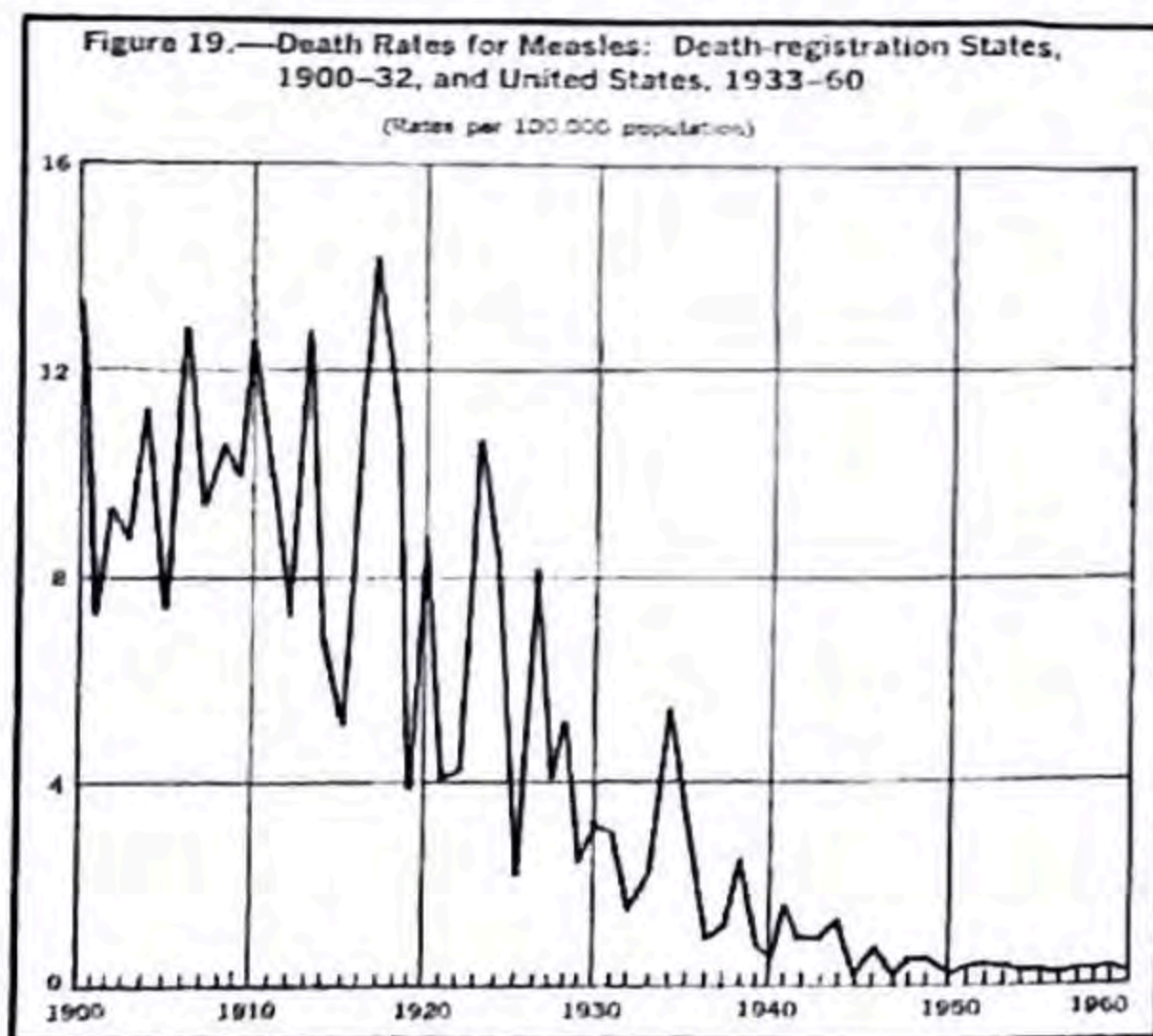
The core of measles vaccine worship is the belief that it reduced the death rate from measles in the United States; and that, until the vaccine was introduced, children in the United States were dying *en masse* from measles. The reality is quite different.

The following official United States government chart shows a decline in the measles death rate by over 98% from 1900 to 1960, three years *before* the first measles vaccine was introduced in the United States in 1963.³ Meaning, the measles vaccine had nothing to do with the over 98% reduction in the death rate from measles in the United States from 1900 to 1960.⁴

This chart comes directly from the official mortality report of the United States government.⁵ I did not create this chart. The United States government created it based on data collected when there was no measles vaccine that influenced the way in which health authorities reported these numbers.⁶

Taking a slightly closer look, what this chart and official United States government data show is that in 1900, the rate of mortality from measles was 13.3 deaths per 100,000 individuals.⁷ By 1960, it was 0.2 deaths per 100,000 individuals.⁸ The same was true for 1961 and 1962.⁹ Remember, the first measles vaccine came on the market in 1963.¹⁰

A similar decline of over 99% in measles deaths occurred between 1900 and 1967 in England and Wales, and it was only after that decline that the first measles vaccine was introduced there in 1968—five years after its introduction in the United States.¹¹



For those who find it difficult to accept that the rate of death from measles had already declined in the U.S. over 98% between 1900 and the introduction of the first measles vaccine in 1963, then Vaccines, Amen.

If you *can* accept that this is what the official federal government mortality data shows, then you have to acknowledge that something *other than* the measles vaccine caused this reduction in the measles death rate. Was it better health care? Cleaner water? Improved sanitation? Better nutrition? It is probably a combination of these and other factors.

What is certain, and I mean certain, is that the data show that the measles vaccine had nothing to do with the over 98% decline in measles mortality from 1900 to 1962.

Pre-Vaccine, 1 in 450,000 Americans Died of Measles

The Vaccines Amen crowd also finds it too difficult to accept that in the several years before the first measles vaccine was introduced in the United States in 1963, there was, according to the CDC, a total of around 400 deaths from measles each year.¹² Not millions. Not even thousands.

Putting 400 deaths per year into context: based on the U.S. population in the early 1960s, that amounted to one measles death for every 450,000 Americans at a time when *nearly every American got measles*.¹³

The Vaccines Amen crowd also cannot accept that the same factors that caused measles mortality to decline by over 98% from 1900 to 1962, no doubt continued to cause a further reduction in the measles mortality rate after 1962. Meaning, at least a portion of the decline in the 400 deaths per year *after* the vaccine was available is no doubt attributable to the same factors that caused a steady decline in the measles death rate for decades *prior* to the introduction of the measles vaccine. Therefore, even without the measles vaccine, the death rate would have, no doubt, continued to decline after 1963.

In pockets of the country with poor nutrition, sanitation, and water, deaths from any pathogen, including measles, can occur at a higher rate. Those conditions still existed in some pockets of the United States in the early 1960s. As living conditions in those pockets of America improved with the introduction of clean water, improved sanitation, and better living conditions, deaths from measles declined, which is what typically occurs when these conditions improve.

Let's also not ignore that health care, especially the management and treatment of acute infections, has vastly improved since the 1960s. Doctors readily concede this point, *unless* you are talking about vaccines. Vaccines, Amen?

That brings us to the next point about the measles vaccine. While it can prevent transmission of the measles virus, and therefore prevent

some deaths from measles, that is not the whole story. By preventing transmission, the measles vaccine broke the natural ecological relationship humans had developed with measles over millennia; and unlike other pathogens that have come and gone, humans developed this lasting relationship with measles because, as we will discuss, it appears those infected with this virus have a survival advantage over those who did not get infected.

Measles Vaccine Likely Caused More Deaths of Americans Than It Saved

This is where most Vaccines Amen believers absolutely lose their minds. And to be fair, most people will find what follows difficult to accept. It requires real intellectual rigor because its implications can cause serious cognitive dissonance.

With that, here it is: *Studies show that those who have had measles are less likely to die from heart attacks and cancer and are less likely to suffer from various chronic diseases.* That may seem incredible. But hold tight.

The studies supporting this claim were conducted and published *after* federal health authorities had already committed to the measles vaccine program. This may explain the reluctance to accept these findings and why this is likely the first time you will learn about these studies. But none of that can change the reality of their existence.

In one of these studies, and it was a massive study, the nation of Japan followed over 100,000 of its citizens for approximately 21 years. They found, among other things, that those who had been infected with measles and mumps had a statistically significant lower risk of death from cardiovascular disease, strokes, and heart attacks.¹⁴ For example, men who had measles and mumps (as compared to those who did not have measles and mumps), had a 17% reduction in strokes, 20% reduction in cardiovascular disease, and 29% reduction in heart attacks.¹⁵ Critically, after 21 years, approximately 7% of the men who had measles and mumps had died of cardiovascular disease while approximately 14% of the men who never had measles or mumps died of cardiovascular disease.¹⁶ Meaning, the men who never had measles and mumps were far more likely to die. The statistically significant findings in this study remained statistically significant even after adjusting for all kinds of variables (including age; body mass; family history of cardiovascular disease; alcohol intake; energy intake; smoking; walking; sports; mental stress; education; and history of hypertension, cardiovascular disease, or diabetes).¹⁷

Cardiovascular disease is the number one killer of Americans, taking the lives of over 900,000 Americans a year.¹⁸ In contrast, as discussed above, according to the CDC, around 400 Americans died of measles

annually in the several years before the first measles vaccine arrived in 1963 (and remember that number was declining without a vaccine), and around 40 Americans died annually of mumps in the several years before the first mumps vaccine was introduced in 1967.¹⁹

Putting this together, what this robust and extremely reliable prospective study spanning 21 years with over 100,000 individuals reflects is that the use of the MMR vaccine to prevent measles and mumps may have resulted in multiple times more annual deaths in the United States from cardiovascular disease than it could have possibly saved from measles and mumps.

That is an incredible reality. Even more incredible is that nobody has done any study showing otherwise. The evidence that "health" authorities have messed with nature to save a few but may have caused far more deaths from heart disease is not something they would likely ever acknowledge.

This Japanese study shows why measles, unlike most pathogens, may not have died out over time through natural selection. It is because having measles appears to confer a survival advantage. Meaning, people who had measles were more likely to survive and procreate and not vice versa.

Similar to the finding regarding heart disease, some studies, although not nearly as robust, have found that eliminating measles appears to have caused a measurable increase in certain cancer rates. For example, the International Agency for Research on Cancer found that those who never had measles had a 66% increased rate of non-Hodgkin lymphoma and a 233% increased rate of Hodgkin lymphoma.²⁰ These two cancers are expected to kill an estimated 20,540 Americans in 2025.²¹ There are even studies documenting children with Hodgkin's disease experiencing remission when having measles.²²

Likewise, researchers at the Department of Health Care and Epidemiology at the University of British Columbia and the Department of Biology at the University of Victoria found that those who never had measles had a 50% increased rate of ovarian cancer, which is expected to kill an estimated 12,730 Americans in 2025.²³

Other studies have reached similar conclusions that measles, as well as mumps, rubella, pertussis, and chickenpox, reduce the rate of various forms of cancers, including a study from researchers at the University of Berne, Switzerland that specifically reviewed these fever-inducing (*i.e.*, febrile) infections and found that the "study consistently revealed a lower cancer risk for patients with a history of FICD [febrile infectious childhood diseases]."²⁴ And as an article in *The Quarterly Review of Biology* explained,

[D]etailed retrospective and prospective clinical studies ... supported the conclusion that frequency of the infectious fever episodes and cancer diagnoses are inversely related (Abel et al. 1986; Mastrangelo et al. 1998; Kleef et al. 2001; Kleef and Hager 2006). For example, Grossarth-Maticek et al. (1987) performed a 10-year prospective cohort study of 1353 patients, concluding that episodes of high fever as a typical reaction to an acute illness during the entire life span are inversely related to later cancer incidence. Kölmel et al. (1992), based on 271 controls versus 139 melanoma patients, demonstrated an inverse relation between the number of febrile infections and the incidence of malignant melanoma. Similarly, Wrotek et al. (2009) have reported a lower frequency of fever in a population of 355 breast tumor patients, compared to 244 healthy women volunteers.²⁵

This article also explained how a survey of studies of spontaneous cancer remissions found that “approximately 70% of documented cases [of remission] were immediately preceded by an acute infection associated with high fever” and that this phenomenon has “been reported for centuries.”²⁶

If that were not enough, studies have found that children who have had measles have far fewer allergies and atopic diseases, such as asthma, and adults who have had measles have a reduced risk of Parkinson’s disease.²⁷

The bottom line is that, prior to the introduction of the vaccine, measles was considered a mild childhood infection, like chickenpox. The ecological relationship humans developed with measles through millennia did not eliminate measles; and having had measles confers survival benefits that appear to far exceed the infection’s negative effects.

I raised these studies at a court hearing in which I challenged violations issued by the New York City Department of Health to families that refused to give their child an MMR vaccine. The vaccine expert for the health department was a medical doctor and the Director of Epidemiology and Surveillance in its Bureau of Immunizations. When confronted with these studies, she had no retort.²⁸ When we reconvened for a second day of hearings in the case, 28 days later, she still had no response to these studies and not a shred of evidence to oppose their findings, nor did the health department offer a shred of evidence to the contrary on appeal despite the fact it offered an extensive affidavit of additional medical information.²⁹

Another Unintended Consequence

Continuing the heresy, another blasphemous, unintended consequence of the measles vaccine is that for anyone infected today in the United States, it has made measles more of a concern. This is because, before the use of the measles vaccine, mothers who were previously infected with the measles virus provided passive immunity to their babies, and that immunity protected them from measles in the first months of life.³⁰ Moreover, adults were protected because they almost always were infected with measles as children. This natural protection was critical, since measles poses the greatest risk to infants and adults.

The measles vaccine, however, does not afford the same protection as having had measles. A mother who has only had the measles vaccine, as opposed to the natural infection, will confer only limited protection to her baby.³¹ As for adults, 2% to 10% of them, depending on which study you look at, will not develop immunity even after two doses of measles vaccine.³² And for those who develop immunity from the vaccine, a joint CDC and FDA study found that the vaccine immunity wanes over time.³³

The measles vaccine thus reversed the declining virulence of measles, including by making vulnerable groups—infants and adults—who had generally been protected in the pre-vaccine era, now potentially vulnerable to measles. It also upended the natural decline in the virulence of this virus since 1900 and broke the natural ecological relationship humans had developed with measles which, as we reviewed, studies reflect conferred a survival advantage to those who had measles as children.

Belief in Measles Vaccine Runs Deep

The simple statistical reality laid out above causes incredible turmoil to the Vaccines Amen crowd. Some get angry, while others simply cannot accept reality. There is one such doctor, who had difficulty accepting the reality regarding vaccines, whom I would frequently see in social settings. He knew about my vaccine work but never broached the topic. I never did either.

That changed after the news reported a few cases of measles. With that, it was like a dam broke inside of him, and he could no longer stop himself from spewing vaccine mantras. After his short tirade about measles and death, I asked him what he thought caused the massive reduction in measles deaths in the United States since the early 1900s. He proudly and emphatically responded that it was the measles vaccine. I then advised him, as you now know, that according to the official, uncontested government data, the death rate from measles declined by

over 98% from 1900 to 1962, and the first measles vaccine did not arrive until 1963.

After sharing this information, I asked him a simple question: "Did the measles vaccine cause the dramatic decline in measles mortality from 1900 to 1962?" His initial reaction was, "Yes, of course it did!"

I again reminded him that the first measles vaccine was not in use until 1963. He repeated, clearly without thinking, in a higher pitch, "the vaccine!" The third time did the trick, and he finally got it: since there *was no* measles vaccine between 1900 and 1962, it could *not* have caused the over 98% reduction in the measles death rate during that period.

Now, as noted, I know this doctor. He is, based on our other conversations, an intelligent person. But when it came to the measles vaccine, he drew on his beliefs and emotion, not knowledge and logic. It caused him to suspend reason. Had that form of faith-driven understanding occurred in an exchange among like-minded doctors, there would have just been a reinforcement of beliefs rather than an evidence-based discussion.

Even some of the most prestigious publications in the world rely on religious beliefs, not evidence, when writing about this product. For example, *The BMJ*, a leading international medical journal, published an article by a distinguished Oxford professor who wrote "Vaccination is a miracle of medicine," described "vaccine disinformation" as "incorrect beliefs," and argued that anyone holding incorrect beliefs should be criminally prosecuted.³⁴ Ironically, under this Oxford professor's own standard, she would have to be criminally indicted. This is because in her article about vaccine misinformation, published by The Royal Society and The British Academy, she asserts on the very first page that "at the start of the 20th Century, measles resulted in around 530,217 deaths per year in the United States alone."³⁵ Looks like it is time for handcuffs because this statistic is categorically false.

According to CDC data, approximately 10,150 Americans died from measles in 1900.³⁶ That is obviously far fewer than the article's claimed 530,217 deaths. Compounding this falsehood, the article then attributes the annual decline in measles deaths since 1900 to the measles vaccine.³⁷ This is also categorically false for reasons you now know. The article also ignores the impact eliminating measles may have had on mortality from heart disease, cancer, and other health issues. Ironically, under the Oxford professor's own standard, she should be criminally prosecuted for this plainly false information about the measles vaccine.

Critically, overstating the benefits of the measles vaccine can be dangerous. It deprives medical professionals and individuals of their ability to weigh the benefits against the risks for each patient of a given medical

intervention. But overstating the benefits of the measles vaccine is the norm. Just as understating its risks is the norm.

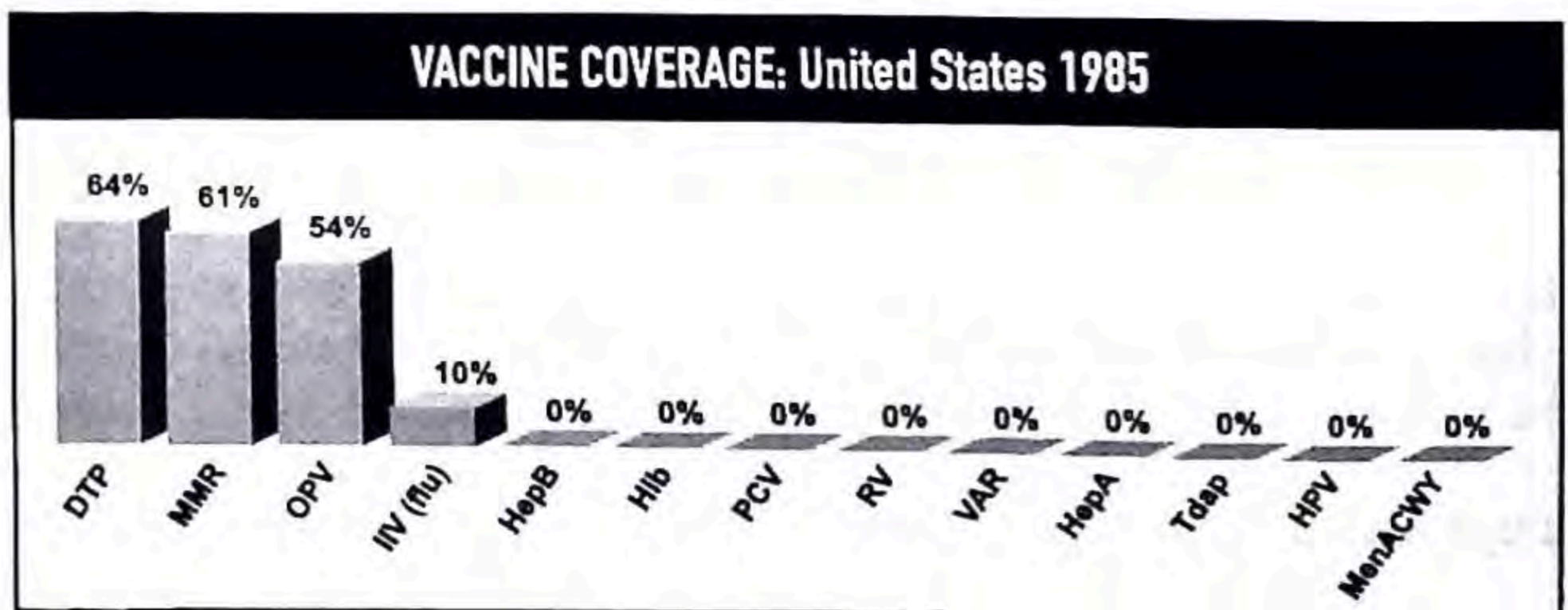
"Other Childhood Vaccines Saved Us!"

If the information about measles seems astounding given the narrative you typically hear, that is because it is. If you are at all skeptical about what you read thus far, I implore you to look up each of the cited primary sources and confirm each data point yourself. If you have gotten past skepticism about the foregoing, then maybe you have moved on to saying, "But what about all the other vaccines? Fine—maybe measles wasn't the great killer I was told, but surely the other childhood vaccines saved America from certain doom!"

Well, again, the facts just don't bear that out. Let's begin with a little perspective. As previously discussed, in the early 1980s there were only three routine childhood vaccines. After giving pharma immunity for injuries in 1986, the number of routine childhood vaccines climbed rapidly over the subsequent decades.³⁸

Meaning, the vaccination rate until the late 1980s was 0% for almost all the vaccines currently on the CDC childhood schedule. That is because the vaccines did not exist yet. As for the three routine vaccines used in 1985 that drove the passage of the 1986 Act, coverage was 63.6% for three doses of DTP, 53.6% for three doses of OPV, and 61.2% for one dose of MMR.³⁹

This chart reflects the reality that vaccine uptake in 1985 was 0% for most current routine childhood vaccines (and was also 0% for non-routine vaccines, including for MenB and Covid-19, which are not part of this chart).⁴⁰ Really let that sink in for a moment.



With that perspective in mind, the next chart reflects the total deaths in the year prior to licensure of the first vaccine for a given childhood disease. The only exceptions are Hib vaccine (for which 1990 is used

because, as explained below, it was the first year a Hib vaccine considered effective for infants was licensed) and DTP vaccine (for which 1949 is used because, as explained in the endnote, earlier vaccines for diphtheria, tetanus, and pertussis were rarely used and/or were ineffective).⁴¹ Putting aside whether vaccines can take credit for the decline in these deaths (we will discuss that in detail shortly), this chart, which we will call the **Pre-Vaccine Chart**, makes plain that these childhood diseases were not a significant contributor to the over 1.4 million people who died in the United States in 1949, or the over 3 million who died in 2023.⁴²

Disease	Year Vaccine Licensed	Number of Deaths in Year Prior to Licensure
Diphtheria	1949 (DTP)	634
Pertussis		1,146
Tetanus		506
Polio	1955	1,368
Measles	1963	408
Mumps	1967	43
Rubella	1969	24
Hepatitis B	1981	294
Hib	1990	34
Hepatitis A	1995	97
Varicella	1995	124
Pneumococcal	2000	200
Meningococcal	2005	8
Rotavirus	2006	20

It is clear from this chart alone that the claim “vaccines save millions of lives every year in the United States” is simply untrue. Let’s go through each disease listed to make this abundantly clear.

Diphtheria, Tetanus, & Pertussis

Scanning down from the top of the table, you’ll note that when a vaccine was introduced for each disease, U.S. deaths were already rare. You will also notice that most of the deaths are attributed to diseases for which vaccines were introduced before 1950 (diphtheria, pertussis, and

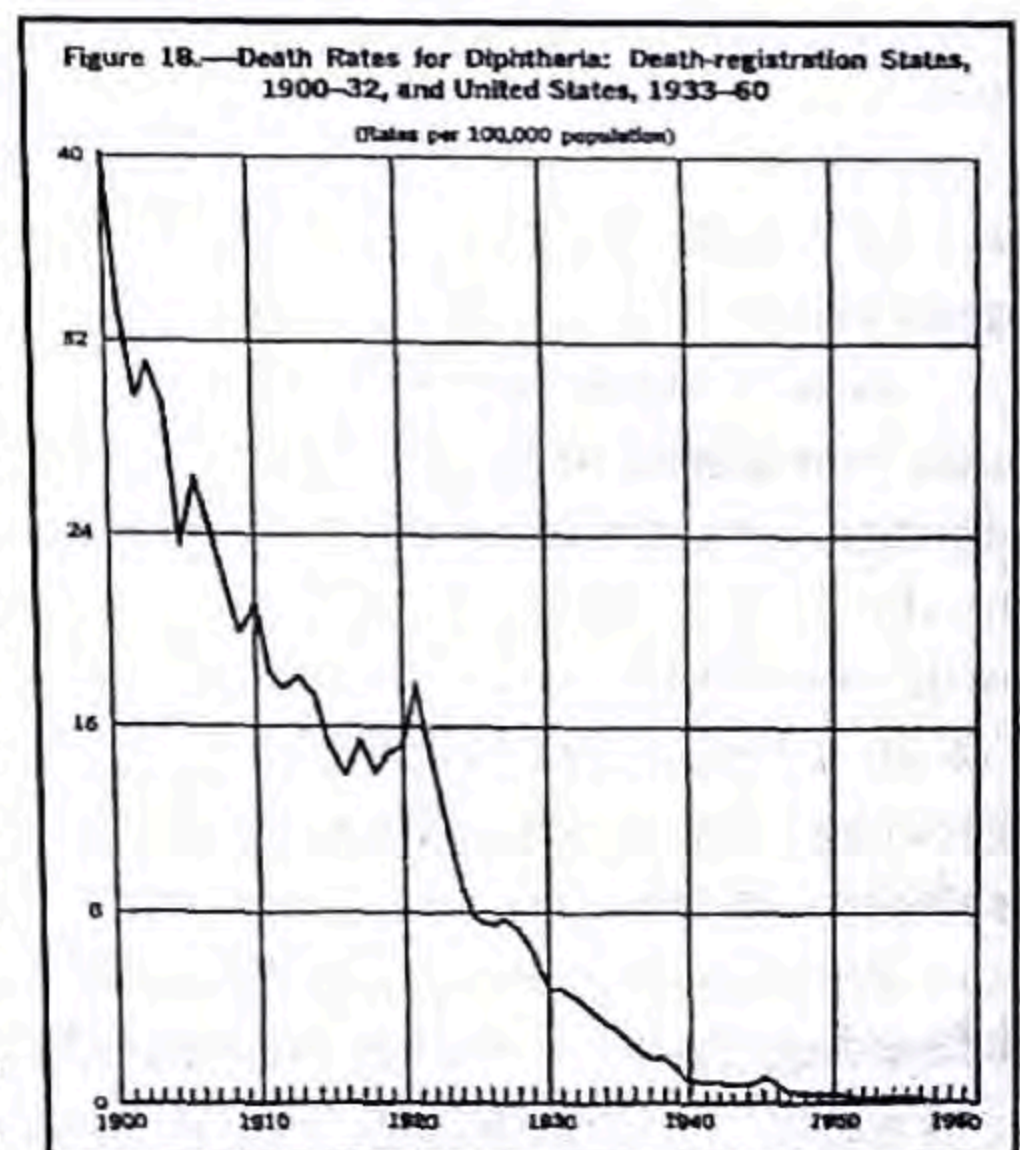
tetanus). What the Vaccines Amen crowd cannot accept, however, is that just like measles, the mortality rate for these three diseases had already precipitously declined before introduction or material use of a vaccine and would certainly have continued to decline without a vaccine. This chart, using CDC data, makes that plain as it shows the already precipitous decline in mortality between 1900 and 1949, the year DTP was licensed (as well as the decline between 1900 and 1940):⁴³

Disease	% Mortality Decline Between 1900 and 1940	% Mortality Decline Between 1900 and 1949
Diphtheria	97.3%	97.8%
Pertussis	83.3%	92.6%
Tetanus	82.0%	87.5%

Let's take a closer look at the first disease listed above, diphtheria. The first vaccine for diphtheria was introduced in 1926, but studies found it had no material impact on mortality. Between 1900 and 1926, when the first diphtheria vaccine was introduced, the death rate from this disease had already declined 81%, from 40.3 to 7.8 deaths per 100,000 individuals.⁴⁴ A vaccine had nothing to do with this sharp decline since no vaccine of any kind for diphtheria existed until 1926. The further decline from 1926 to the mid-1940s also had little or nothing to do with the vaccine. It was rarely, if ever, used outside of certain demographics in major cities, and diphtheria mortality declined at a similar rate in areas with or without its use.⁴⁵

What did cause the decline in mortality leading up to the late 1940s? No doubt the same factors that caused the decline in mortality from almost all other childhood diseases during that period—improvements in sanitation, water, acute care, living conditions, etc. This is an official United States government chart showing the decline in the diphtheria death rate starting in 1900, decades before the first vaccine.⁴⁶

In fact, the diphtheria vaccine, as we will discuss in Chapter 9,



does not prevent infection or transmission because it only produces antibodies to the toxin sometimes released by the diphtheria bacteria—not to the bacteria itself. Moreover, whatever efficacy the diphtheria vaccine provides wanes rapidly, even after six childhood doses.⁴⁷ This necessitates a booster dose every ten years in adulthood,⁴⁸ yet about 40% of adults skip these boosters.⁴⁹ Nonetheless, despite not preventing transmission—and despite a large portion of adults not receiving boosters—the last case of respiratory diphtheria in the United States was nearly three decades ago.⁵⁰ This almost certainly reflects the extensive literature which supports that any harmful effects by the diphtheria toxin are counteracted by iron, vitamin C, and vitamin B3, and deficiencies of these vitamins and minerals have mostly been eliminated in developed countries.⁵¹

As with diphtheria, mortality from tetanus and pertussis declined by more than 80-90% between 1900 and the 1940s—long before vaccination played a role.⁵² These vaccines were first introduced into routine use in the late 1940s with the licensure of DTP in 1949. As explained by the NIH: “The whole-cell pertussis vaccine became widely available in the United States in the 1940s, although it was first licensed in 1914. It was crudely made and had limited use until the 1940s, because of reports of serious side effects including death.”⁵³ Similarly, as the CDC explains regarding the tetanus vaccine: “In the late 1940s, tetanus toxoid was introduced into routine childhood immunization.”⁵⁴

What caused the decline in diphtheria, tetanus, pertussis, and other diseases before introduction of vaccination (and thereafter)? This decline is likely caused by many factors, including improvements in sanitation, clean water, nutrition, and medical care. Medical care acutely improved from the 1940s when, for example, the Nobel Prize was awarded for the development of the prefrontal lobotomy.⁵⁵ Even absent a vaccine, the death rate would have continued to decline as living conditions improved, including improvements in medical care, and particularly acute medical care (as well as the decline of certain barbarous medical practices).

Nonetheless, even assuming the number of deaths from a given disease remained stagnant since the year before the first vaccine for each disease was introduced, the total deaths per year, combined, would be in the low thousands. Every death is a tragedy, but this is far from the millions often claimed, and the death figures in the Pre-Vaccine Chart (from a few pages back) do not account for the fact that, even absent a vaccine, the deaths caused by these diseases were almost universally on a sharp decline.

This decline would have no doubt continued absent vaccination. Meaning, had the vaccines of the 1940s instead been introduced in the

1960s or 1970s, deaths would have already declined to a mere fraction of their 1940s levels.

Reflecting this reality, there are diseases that used to kill children in the United States that disappeared without a vaccine. For many of these diseases, researchers sought to develop a vaccine but failed. For example, scarlet fever was one of the deadliest infectious diseases for children in 1900, with a death rate of 9.6 deaths per 100,000 children, with even higher death rates in many years during the early 1900s. Researchers furiously sought to develop a vaccine but repeatedly failed. By the 1950s, deaths from scarlet fever had significantly declined and by the late 1900s, deaths from scarlet fever were essentially non-existent.⁵⁶

Had a vaccine for scarlet fever been developed in the 1920s, 40s, or 60s, that vaccine would almost certainly still be on the childhood schedule today, and its use would be considered essential for controlling scarlet fever. There would be public health campaigns spelling doom and the return of the killer scarlet fever if we were not to maintain a high vaccination rate for scarlet fever. Even if the vaccine did not arrive until the 1960s, when mortality had declined by over 98%, I have no doubt, as is done with other vaccines, that the medical community would attribute the decline in mortality to the vaccine even though that would require suspending reality.

In fact, scarlet fever and diphtheria are similar in that each is caused by a bacterium that releases a potentially harmful toxin when the bacterium has been "infected" by a certain virus. Both diseases cause sore throats, and many doctors, without a lab test, will confuse diphtheria with scarlet fever, and vice versa. These two diseases also have something else in common: both declined at nearly the same rate beginning in 1900. The primary reason why public health officials, pharma, and the medical community behave differently with regard to these two diseases is that a vaccine was developed for diphtheria, but not for scarlet fever.

If a vaccine for diphtheria had not emerged, this disease would have likely gone the way of scarlet fever and other childhood diseases that effectively disappeared without a vaccine. (And not because there was no attempt to develop a vaccine for these other diseases that disappeared on their own; there were, but the attempts did not result in a commercially viable product.)

Polio

Next on the Pre-Vaccine Chart is polio, the only disease for which a vaccine was introduced in the 1950s. In contrast to every other disease listed, where mortality was sharply declining in the decades before and after 1900, polio caused almost no deaths in 1900. Instead, it

paradoxically went from being nearly innocuous up until around 1890, to then having an increasing rate of mortality, to then having a sharply increasing reported rate of mortality in the few years leading up to 1952. From that peak, its mortality rate declined sharply before introduction of the first polio vaccine in 1955. What this and the greater history about polio reflect is that one or more factors made the polio virus more lethal in the first half of the 1900s. As these outside factors declined, so did the mortality of polio. But more on polio in the next chapter.

Measles, Mumps, & Rubella

Next on the Pre-Vaccine Chart is measles, which we already discussed in depth, so we won't review that information again except to repeat that the rate of mortality from measles declined by over 98% between 1900 and 1962, prior to the introduction of the first measles vaccine in 1963 and would have no doubt continued to decline without a measles vaccine.

Next on the list are mumps and rubella. The first vaccine for each was introduced in 1967 and 1969, respectively. By the time a vaccine was developed, both diseases caused few deaths annually in the several years before a vaccine was developed.⁵⁷ In addition, between 1960 and 1975, the rate of decline in mumps deaths continued at roughly the same pace before and after licensure of mumps vaccine in 1967, and the rubella deaths actually *increased* after licensure of the first rubella vaccine in 1969.⁵⁸ But either way the number of deaths was low.

Further evidencing that mumps would have disappeared without a mumps vaccine, at most 50% to 60% of children received this product in the 1970s, and they only received one dose (and we now know that even two doses of the same formulation, let alone one, often fails to confer protective immunity), but nonetheless, mortality from mumps reached essentially zero in the 1970s.⁵⁹

Hepatitis B

Next on the Pre-Vaccine Chart is Hep B, a primarily blood-borne infection that is typically spread through sexual contact and contaminated needles. The first Hep B vaccine was introduced in 1981 and made with human blood plasma from donors who were chronically infected with the Hep B virus. In 1986, a new Hep B vaccine using recombinant DNA technology without human blood was licensed. In any event, the mortality from Hep B climbed after introduction of the 1981 vaccine, continued to climb after the introduction of the 1986 vaccine, and has never returned to pre-vaccination levels. In 1980, there were 294 deaths

in the United States from Hep B.⁶⁰ Today, there are around 1,700 deaths per year.⁶¹

Hib

Next on the Pre-Vaccine Chart is Hib vaccine—often cited by vaccinologists as a modern vaccine success story. The problem is that the data does not match the belief. The first Hib vaccine was introduced in 1985 but was withdrawn three years later because it was entirely ineffective among children 18 months and younger and may have increased the incidence of disease in older children.⁶²

In 1991, after another Hib vaccine considered effective was introduced, the CDC for the first time recommended a three-dose series of Hib vaccine in the first year of life.⁶³ In 1992, only 28.2% of children were vaccinated for Hib, and there were a total of 17 deaths from Hib in the United States in 1991.⁶⁴ Yet, the steady decline in mortality from Hib in the prior decades, which had dropped rapidly without the existence of any Hib vaccine, is somehow magically attributed to the Hib vaccine.⁶⁵

Notably, mortality among infants under 1 year of age in the 1980s declined rapidly and sharply when there was no Hib vaccine for infants (not even an ineffective one like the one introduced in 1985 for children 18 months and older and then withdrawn a few years later for lack of efficacy).⁶⁶ Yet, unsurprisingly, vaccinologists still take credit for the rapid decline in mortality among infants from Hib in the 1980s despite no Hib vaccine existing for infants in the 1980s.

Hepatitis A

Next is Hep A vaccine. In the decade prior to introduction of this vaccine in 1995, there were *fewer than* 100 deaths every year in the United States from Hep A, with an average of 80 deaths per year.⁶⁷ Fast forward to the present, there have consistently been *more than* 100 deaths per year from Hep A, with an average of 166 deaths during the last five years for which death figures are available.⁶⁸

Varicella, Pneumococcal, Meningococcal, & Rotavirus

For the final four diseases on the Pre-Vaccine Chart, varicella, pneumococcal, meningococcal, and rotavirus, the annual deaths among children for each are so low that the CDC has to estimate them. You would think a child dying would be hard to miss, but, apparently, the CDC can't find actual dead children, so it estimates those numbers. This was not always the case. Long before vaccines were introduced, each of these diseases *did*

cause deaths each year that could be counted. But by the time a vaccine was introduced, the deaths had already become so exceedingly rare, if they occurred at all, that the best they could do for these four diseases was *estimate*. For example, the CDC begrudgingly admits regarding meningococcal: "Much of the decline occurred before the routine use of MenACWY vaccines. In addition, serogroup B meningococcal disease declined even though MenB vaccines were not available until the end of 2014."⁶⁹

Putting this into context, the CDC knows the precise number of people that die each year in the United States by lightning, averaging 30 deaths per year, and even has these deaths broken down by state and by month.⁷⁰ Yet, the CDC, the Centers for *Disease* Control, does not know how many children died of meningococcal disease? Rotavirus? It has to estimate these deaths? The fact that the CDC cannot identify actual deaths from these diseases to count, but it can identify with precision each death from lightning, casts serious doubt on the CDC's estimated disease death figures. Especially given that the CDC has a history of inflating the severity of diseases to promote vaccines.

But even assuming the *estimated* deaths are accurate, these estimates reflect that an American, prior to a vaccine even existing, had around the same odds of dying from each of these four diseases as being killed by lightning.

Wrap-Up

Let's accept as true for a moment the following Vaccines Amen assumptions:

- vaccines account for the entire decline in deaths listed on the Pre-Vaccine Chart (which they certainly do not, see discussion above);
- vaccines are perfectly safe (which they are not) and do not cause deaths (which they do); and
- the number of annual deaths would have remained the same (which requires suspending reality since annual deaths from each disease prior to introduction of a vaccine were steadily declining from 1900 onward—save polio—even as the total U.S. population rose sharply).

Even applying these reality-defying Vaccines Amen assumptions, the claim that routine childhood vaccines save millions of Americans every year is still off by at least 99.9%.⁷¹

Now, if you stop suspending reality and make fair assumptions, this tiny, ascribed benefit quickly upends. For example, since deaths were already declining for each disease (save polio) before a vaccine was introduced, we should *only* credit vaccines with any acceleration in the ongoing rate of decline. When doing so, the ascribed benefit that vaccines had in reducing deaths becomes even more insignificant. Any tiny remaining potential benefit quickly becomes negative if you then account for any deaths caused by these products, either directly (such as infants dying from vaccination) or indirectly (such as increased deaths from heart disease and cancer), as discussed above and in later chapters. This means that, when taking a full accounting, you can quickly end up with more harm than good from these products.

So, to recap, most of the deaths in the Pre-Vaccine Chart are from three diseases for which routine vaccination began in the late 1940s and would have continued to decline without a vaccine. Indeed, the rate of decline in mortality for most diseases was the same or slower after introduction of a vaccine. But let's assume that vaccines account for most of the decline in deaths after introducing each vaccine (even though that requires suspending reality); still, total deaths are nowhere near millions. Not even hundreds of thousands, such as deaths from heart disease or accidents. Not tens of thousands. Not even high thousands. And even accounting for population increase, claiming vaccines save thousands each year in the United States is, based on the data, an exaggeration because the death rate for these diseases was already declining before introduction of a vaccine, and the factors likely causing the decline (improved living conditions, nutrition, antibiotics, acute medical care, etc.) continued to improve for decades after the introduction of most vaccines. This also does not account for the fact that, for some diseases, deaths increased after a vaccine was introduced; for almost all others, the decline in mortality did not accelerate after a vaccine was introduced; and that deaths are just estimated for some of the diseases, making any claimed reduction for those entirely speculative.

Now, that is not to diminish any death. Every death is a tragedy. Including when it happens from a vaccine. The point is that the benefits of vaccination regarding mortality in the United States are vastly overstated. The claim that "millions of deaths" are averted each year in the United States is categorically false, off by well over 99.9%. Let that sink in for a minute. And after you do, maybe you will also be open to the idea that the claim that vaccines only rarely cause serious harm to children is similarly off by a large factor. We will go over the evidence for that later.

In the meantime, the point is that we need to assess the benefits of vaccination rationally and objectively—not listen to people who

hysterically and instinctively yell that millions of Americans would die without these products. That is simply false. It does a disservice to everyone to make this exaggerated claim, especially when it may, in fact, be that vaccines are causing far more deaths than they prevent.

“Vaccines Save Millions of Lives in Developing Countries Every Year”

I can already hear the retort. “Fine! Maybe vaccines do not save millions, or even thousands, of lives every year in the United States or other developed countries, but they do in developing countries!!”

Well, let’s look at the most widely used vaccine in developing countries, DTP (the diphtheria, tetanus, pertussis vaccine we discussed earlier). This is *the* most commonly used vaccine in the world, and the World Health Organization (WHO) uses its uptake as the benchmark to rank vaccination programs in developing countries.⁷²

You would therefore expect that the studies would clearly show that use of DTP *reduces* mortality. Meaning, using DTP results in reducing deaths among those receiving this vaccine. Incredibly, the opposite is true. I know, more sacrilege. But that’s what the data shows.

DTP was first developed in the late 1940s and, in many countries, began being widely used in the 1970s. Beginning in 1981, and continuing over the next two decades, every developed country in the world ceased using DTP and replaced it with DTaP (a vaccine containing acellular pertussis, as opposed to DTP, which contains whole cell pertussis).⁷³ But that is not true of the developing world where United Nations International Children’s Emergency Fund (UNICEF) has been, and continues to be, the largest purchaser, promoter, and distributor of DTP.⁷⁴

The crazy part is that nearly a dozen studies have found DTP *increases* mortality. Meaning *it increases infant deaths*. That may sound unbelievable—and it should—but it is sadly true.

A landmark study in 2017 by highly regarded mainstream vaccine experts found children vaccinated with DTP were 10 times more likely to die in the first six months of life compared to unvaccinated children (the **2017 Study**).⁷⁵ Let me repeat: 10 times more likely to die.

The 2017 Study was published in an *Elsevier* peer-reviewed journal which collaborates with *The Lancet* and was funded by the Ministry of Foreign Affairs of Denmark and the European Union.⁷⁶ The authors of this study include Peter Aaby, DMSc; Søren Wengel Mogensen, PhD; Andreas Andersen, PhD; Amabelia Rodrigues, PhD; and Christine S. Benn, MD, PhD, DMSc.

Its lead author, Dr. Aaby, is renowned for studying and promoting vaccines in Africa and has published over 400 studies.⁷⁷ Dr. Aaby, among other things, established the Bandim Health Project in 1978, a Health and Demographic Surveillance System site in Guinea-Bissau which he continues to direct.⁷⁸ Among his accolades, in 2000, Dr. Aaby was awarded the Novo Nordisk Prize, the most important Danish award within health research,⁷⁹ and in 2009, the Danish Ministry of Foreign Affairs selected Dr. Aaby as a leader in the fight against global poverty.⁸⁰

What exactly did the 2017 Study find? After comparing children who were vaccinated with DTP with children who had not received DTP (nor any other vaccines), it found that DTP-vaccinated children were 10 times more likely to die in the first 6 months of life. The study therefore concluded:

All currently available evidence suggests that DTP vaccine *may kill more children* from other causes than it saves from diphtheria, tetanus or pertussis.⁸¹

And this is the most used vaccine in the world. Even more concerning is that the 2017 Study found that children vaccinated with DTP were dying from causes never associated with this vaccine, such as respiratory infections, diarrhea, and malaria.⁸² This indicated that, while DTP may have reduced the incidence of diphtheria, tetanus, and pertussis, it increased susceptibility to other infections.⁸³ A startling finding.

When I first read the 2017 Study, I was shocked. And when I read the many studies that preceded it which also found DTP increases mortality, I was dumbfounded. So, we worked with ICAN to send a formal letter to UNICEF in December 2017 which attached a copy of the 2017 Study and asked that UNICEF provide evidence that DTP does in fact reduce, not increase, mortality.⁸⁴ UNICEF responded in February 2018.⁸⁵ Its response only confirmed the worst.

UNICEF's response did not even address the 2017 Study. It instead pointed to a 2014 review of DTP and mortality by an advisory group to the WHO, called the Strategic Advisory Group of Experts (**SAGE**), which found that "the available data neither exclude nor confirm the possibility of beneficial or deleterious non-specific effects of DTP vaccines on all-cause mortality" (the **2014 SAGE Review**).⁸⁶

Meaning, UNICEF responded to the 2017 Study by pointing to a review that occurred three years prior. Even more concerning is that the 2014 SAGE Review identified 16 studies that compared death rates between children receiving DTP and children not receiving DTP, and a majority of these 16 studies found that DTP increases mortality.⁸⁷ As

the SAGE Review explains, a “majority of studies indicated a negative effect of DTP.”⁸⁸

For example, one of these studies found that children who received DTP were between 54% and 1,119% more likely to die than those who did not receive DTP.⁸⁹ SAGE, however, chose to not give much weight to these studies. Why? The real reason is that they did not fit the dogma. SAGE’s stated reasons were: (i) these studies were not “randomized” (*i.e.*, children were not randomly assigned to either receive or not receive DTP, hence potentially introducing bias); (ii) “OPV [Oral Polio Vaccine] was administered concomitantly with DTP in most included studies” and hence it “was not possible to separate any possible effects of DTP from OPV in the available studies”; and (iii) these studies were often conducted in communities with existing so-called “herd immunity” that could have introduced further bias.⁹⁰

UNICEF’s reliance upon the 2014 SAGE Review is truly incredible because the 2017 Study was specifically designed to address the three concerns raised by the 2014 SAGE Review.

The 2017 Study addressed the “randomized” issue by comparing children vaccinated solely based on birthdates, thereby creating a random grouping.⁹¹ It addressed the “OPV with DTP” issue by comparing children receiving no vaccines with those receiving only DTP.⁹² It also addressed the “herd immunity” issue by looking at death rates at the time of the introduction of DTP in that region.⁹³

Meaning, the 2017 Study was expressly designed to address the thinly veiled pretextual excuses made in the earlier 2014 SAGE Report—a report which did not even find that DTP reduced mortality. Instead, remember, it found that most studies evidenced that this vaccine increased mortality, but SAGE wanted a “better” study to confirm this finding. ICAN had shared the “better” study, yet UNICEF, in its response, simply pretended the 2017 Study did not exist.

The 2017 Study is likely the best available evidence the world will ever have regarding whether DTP kills more children than it saves. Why? Because even though DTP has never been through a placebo-controlled trial, scientists will not now conduct a placebo-controlled trial because it is generally considered unethical to conduct a trial in which one group of children gets DTP and another group does not get this vaccine.⁹⁴ This is despite the fact that studies have found DTP kills more children than it saves. The 2017 Study is therefore the best study and the best evidence that modern science will likely ever have to determine whether DTP kills more children than it saves.

Given UNICEF’s inadequate response, ICAN sent a follow-up letter to UNICEF explaining the foregoing.⁹⁵ And what did UNICEF then have to say? Nothing. Literally, nothing. It had no response. Even after ICAN

sent a second follow-up letter and even after ICAN provided UNICEF with yet another study from 2018 that again confirmed that DTP was increasing deaths (the **2018 Study**), it still had no response and took no corrective action.⁹⁶

The 2017 Study looked at children in the first six months of life, while the 2018 Study looked at children between six and thirty-five months of age. The 2018 Study *compared* children who were healthier and had better nutritional status who then received DTP, *with* children who were less healthy and had worse nutritional status who did not receive DTP. Meaning, the children who did not receive DTP should have had worse health outcomes because they were already less healthy and had worse nutrition. The incredible result:

Although having better nutritional status and being protected against three infections, 6-35 months old DTP-vaccinated children tended to have higher mortality than DTP-unvaccinated children. All studies of the introduction of DTP have found increased overall mortality.⁹⁷

Everyone involved in pushing out DTP vaccine should have fallen out of their chair after reading this study. So, what did UNICEF have to say when it got this study? Again, nothing. It didn't respond because it had no data to rebut this finding. There are no studies to rebut these findings nor the numerous other studies with the same finding that DTP is killing more children than it saves.⁹⁸

UNICEF clearly understood the gravity of these findings as revealed by internal CDC emails obtained via FOIA. In these emails, UNICEF asked the CDC to help draft a response to ICAN's letters regarding DTP. After the CDC stretched the truth beyond reality in its proposed response, UNICEF wrote to the CDC that "we are feeling that the response may not be strong enough," imploring the CDC to explain "why we cannot prove or disprove this claim despite the fact that this issue[] has been followed since 2001."⁹⁹ The concern among UNICEF officials is palpable, as one of them writes: "We are all implicated in this and I want to ensure that you are all comfortable with the content."¹⁰⁰

What is most troubling about the emails between the CDC and UNICEF is that they show these organizations did not view the repeated finding of increased deaths among infants as a critical health issue or a humanitarian issue. Rather, they were concerned about personal exposure and otherwise viewed it as a public relations issue. This provides a good example of why government officials, national and international, should never promote these products because once they do, they need

to defend them to the end irrespective of how much harm or death the products cause, and regardless of what the data shows.

Since then, for over five years, ICAN has persisted in demanding studies and data that DTP does not increase mortality. Despite numerous demands, ICAN has not received any data from UNICEF that would justify administering DTP. ICAN, through my firm, even filed a formal petition with the International Criminal Court against UNICEF regarding this issue.¹⁰¹ Since UNICEF is an agency in the United Nations, we also wrote to four separate special rapporteurs at the United Nations, including those responsible for health, poverty, and indigenous peoples.¹⁰² We even provided video testimony from a couple in Kenya whose baby died after a DTP vaccine.¹⁰³

After over five years of searching for and repeatedly demanding studies and data to counter the weight of evidence supporting that DTP increases mortality, none has been provided. There are no better studies. And there is nobody relevant left to ask for better studies or data to show that DTP does not increase mortality.

I can already hear the Vaccines Amen crowd howling. "Okay, DTP may just be an exception! It may just be a fluke that repeated studies show that the most commonly used vaccine in the world increases mortality." Sure it is.

But even if DTP is an exception, which it is not, it should still be shocking. How could this happen? How can it be that when repeated studies show that DTP increases deaths, this product is still being used? In babies. The answer, of course, is not surprising when one applies a central tenet of vaccinology: if the data fits the dogma, the data supports causation. But if the data does not support the dogma, it is just correlation.

Applying this religious tenet to DTP vaccine means: despite the robust evidence that DTP increases mortality, all this evidence is considered correlation, because it does not fit the dogma. Vaccinologists simply refuse to consider it proof that DTP causes an increase in mortality. Just like they refuse to consider the studies that show other inactivated vaccines, such as IPV and Hep B vaccines, increase mortality.¹⁰⁴

The refusal to give weight to this data is made even more incredible given that mortality has otherwise decreased over time; hence, when DTP causes an increase in mortality, it is going against the overall trend. Yet, increased death from DTP is simply dismissed as correlation.

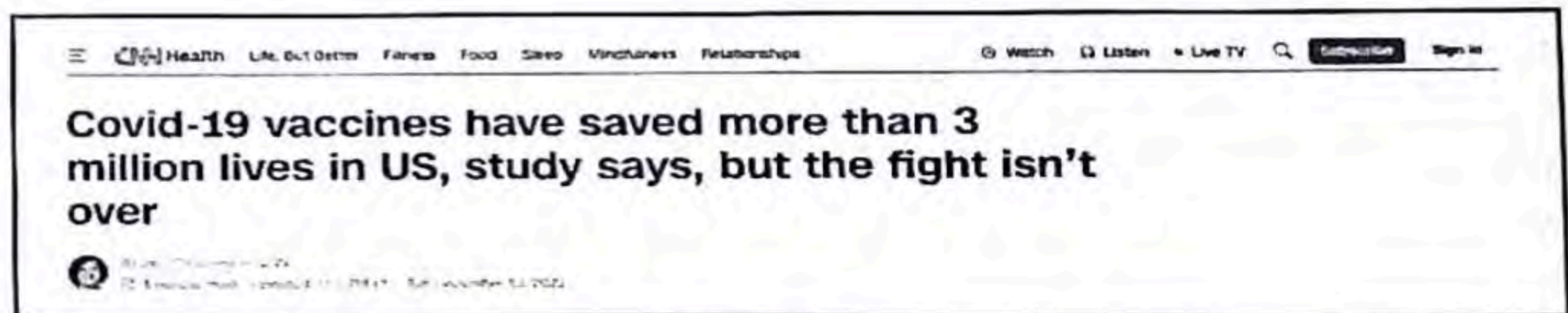
Let me put this into sharper focus. Despite mortality already declining over the last few decades in developing countries due to improved living conditions (including clean water, sanitation, nutrition, and medical care), when mortality declines after introduction of a vaccine, it is taken as proof the vaccine caused the decline. Any reduction in mortality

is used as proof the vaccine caused the reduction even if the rate of mortality was already declining at the same or even a faster rate prior to the vaccine's introduction.

But when mortality *increases* after introducing a vaccine, for example after introduction of DTP vaccine, Hep B vaccine, Covid-19 vaccine, etc., the increase in mortality for the target disease is never considered related to the vaccine, even if studies or data point to the vaccine as a cause. Meaning, heads, vaccines win; tails, vaccines win. And the children? The reality is that they are not part of the equation. The metric of success used by vaccinologists and "health" authorities is rarely childhood health. It is, instead, the rate of vaccine uptake. Such is the cult of vaccines.¹⁰⁵

"Covid-19 Vaccines Saved Us!"

Let's end this section with Covid-19 vaccines. After all, as a CNN headline declared to the world in 2022: "Covid-19 vaccines have saved more than 3 million lives in US, study says. ..." ¹⁰⁶



Nearly every major media outlet repeated this claim. This claim, based on a blog, not a peer-reviewed study, that relied on a mathematical model built on the author's assumptions rather than actual mortality data,¹⁰⁷ is demonstrably false.

The quick way to cut through the noise on this claim, again made in a blog using a computer model, is to look at actual mortality data. To that end, we will review the total number of deaths from all causes, known as *all-cause mortality* data, in the United States.

Why look at all-cause mortality data? Because the claim made about Covid-19 vaccines is that they would prevent deaths from Covid-19. This means the vaccines should cause the total deaths in the United States, all-cause mortality, to return to the levels seen before Covid-19. To be even more precise, we should see the total deaths in the United States begin to move toward the level seen in 2019 before Covid-19 spread through the country in early 2020.

In 2019, according to the CDC, the total number of deaths in the United States was 2,845,819.¹⁰⁸ That is similar to the total deaths in the United States in 2018 (2,831,835) and 2017 (2,804,358).¹⁰⁹ But, in

2020 the total deaths in the United States was 3,433,986.¹¹⁰ That means 588,167 more people died in 2020 than died in 2019. Health authorities attributed this increase in deaths to Covid-19. This means that if the Covid-19 vaccine reduced deaths from Covid-19, we should have seen the total deaths in the United States begin to revert closer to the 2019 total death figure as this vaccine was widely used, or at least drop below the total deaths seen in 2020 when there was a pandemic but no vaccine.

What actually occurred? The total deaths in the United States did not decline after introducing the Covid-19 vaccine. Indeed, in 2021, there were a total of 3,449,536 deaths which exceeded the total deaths from 2020 of 3,433,986.¹¹¹ And keep in mind that Covid-19 had presumably killed many of the most vulnerable in 2020 such that fewer people should have died in 2021 even without a vaccine. Moreover, an estimated 17.1 percent of the U.S. population was infected in 2020, with another 18.2 percent infected in 2021.¹¹² Meaning, because a similar number of people were infected in the United States in 2020 and 2021, the total deaths in 2021 should have declined as a large majority of the United States population was vaccinated, especially because many of the most vulnerable already died in 2020 (and, as a new variant arrived in the second quarter of 2021, according to the CDC, there was a high level of immunity: “an estimated 68.4% of persons aged ≥ 16 years had infection- or vaccination-induced SARS-CoV-2 antibodies.”)¹¹³ But instead of declining, overall mortality increased in 2021.

The fact that total deaths increased in 2021, as compared to 2020, is the best available data point on whether Covid-19 vaccines reduced deaths. This is because it avoids the controversy regarding whether someone died with or from Covid-19. It also avoids the controversy of whether someone died after or because of a Covid-19 vaccine. Simply put: if Covid-19 vaccines reduced mortality, all-cause deaths should have declined toward 2019 levels. They didn't.

This increase in mortality, however, does match what occurred in the clinical trial for Pfizer's Covid-19 vaccine. In that trial, the placebo group and vaccinated group had approximately the same number of participants (with the placebo group actually having slightly more participants). So, if the vaccine prevented deaths, there should have been more deaths in the placebo group. If the vaccine had no impact on mortality, the number of deaths in both groups should have been roughly the same. And if the vaccine caused deaths, there should have been more deaths in the vaccinated group.

So, what happened in the trial? The official FDA documentation of this trial states that there were 21 deaths in the vaccinated group and 17 deaths in the placebo group.¹¹⁴ Meaning there were more deaths in the vaccinated group than the placebo group. One would expect this finding

to have been the end of the road for this product, but instead, the FDA allowed Pfizer to explain why every death was unrelated to the vaccine. But when it came to finding a 95% efficacy at reducing some symptoms, the FDA permitted Pfizer to do a simple statistical comparison: 162 positive cases in the placebo group versus 8 in the vaccinated group (putting aside the 3,410 "suspected" but unconfirmed cases).¹¹⁵ A statistical comparison should have also occurred when evaluating whether this product increased or reduced deaths. But that is not the way the cult of vaccinology works. When the data fits the dogma, accept a statistical comparison (as in reduction of some symptoms); but when it does not, insert bias to explain away the troubling finding (as in the increase in deaths). But more on that in chapter 10.

What is also very revealing is that when Covid-19 deaths were decreasing during the first half of 2021, legacy media outlets credited Covid-19 vaccines with this decline, publishing headlines such as: "Vaccines may have prevented a quarter-million Covid-19 cases and 39,000 deaths among seniors."¹¹⁶ But then, when deaths began rising again in the latter half of 2021 and early 2022, did the headlines report the opposite? Did they report that Covid-19 vaccines cause an increase in deaths? Of course not. Vaccinologists and public "health" officials have been well-trained—consciously or unconsciously—that if the data fits the dogma, the data supports causation. But when the data does not fit the dogma, it is merely correlation. So, headlines became, "Covid vaccines not linked to deaths, major US study finds."¹¹⁷

Similarly, health agencies around the world—having once, with great fanfare, published data showing the unvaccinated were dying at higher rates than the vaccinated—quickly removed these dashboards and ceased public data sharing once the data began to show the opposite. And to be clear, this data was standardized as a rate, not an absolute number. Therefore, if Covid-19 vaccines truly reduced mortality, the death rate among the vaccinated should have remained lower—regardless of how many people were vaccinated.

For example, data published by Scotland at the end of 2021 began to show higher rates of hospitalizations and deaths among the vaccinated. The response by Scotland's health authorities was to pull the data from public view.¹¹⁸

Table 15 – Hospitalizations

Unvaccinated				Vaccinated			
Week	No. hospitalized	Population	Age-standardised hospitalisation rate per 100,000 (95% confidence intervals)	Week	No. hospitalized	Population	Age-standardised hospitalisation rate per 100,000 (95% confidence intervals)
18 December - 24 December 2021	133	1,111,023	34.38 (24.60 - 44.09)	18 December - 24 December 2021	170	1,864,017	25.88 (20.42 - 31.36)
25 December - 31 December 2021	164	1,105,001	54.08 (40.55 - 67.55)	25 December - 31 December 2021	226	1,518,096	41.81 (33.36 - 48.86)
01 January - 07 January 2022	174	1,009,417	43.76 (33.00 - 54.51)	01 January - 07 January 2022	247	1,116,431	61.14 (50.62 - 71.78)
08 January - 14 January 2022	130	1,003,830	32.48 (23.48 - 41.44)	08 January - 14 January 2022	191	980,348	48.18 (36.00 - 64.35)

Table 16 - Deaths

Unvaccinated				2 Doses			
Week	No. of deaths	Population	Age Standardised Mortality Rate per 100,000 with 95% confidence intervals	Week	No. of deaths	Population	Age Standardised Mortality Rate per 100,000 with 95% confidence intervals
11 December - 17 December 2021	18	1,567,729	7.21 (2.67 - 11.74)	11 December - 17 December 2021	35	1,868,427	7.68 (5.04 - 10.31)
18 December - 24 December 2021	8	1,559,729	1.79 (0.23 - 3.15)	18 December - 24 December 2021	24	1,522,561	6.54 (3.79 - 9.28)
25 December - 31 December 2021	8	1,549,716	4.93 (0.53 - 9.30)	25 December - 31 December 2021	21	1,121,214	7.11 (3.85 - 10.38)
01 January - 07 January 2022	12	1,541,298	7.82 (2.38 - 12.85)	01 January - 07 January 2022	26	985,655	11.89 (7.14 - 16.64)

Some studies, as the data from Scotland began to show, found that Covid-19 vaccines increased deaths; on the other hand, other studies found they reduced deaths. A serious issue with all these studies is that vaccinated individuals are less likely to be tested for Covid-19 or be coded as dying from Covid-19, both of which improperly result in fewer deaths being ascribed to Covid-19 in the vaccinated groups. These studies also do not account for any deaths from the Covid-19 vaccine. The good news is that the all-cause mortality figures cut through these flaws, also known as confounders.

All-cause mortality data avoids these confounders by taking human judgment and bias out of the equation. It provides a natural experiment. In 2018 and 2019, there was no Covid-19 and no vaccine. In 2020, there was Covid-19 but no vaccine. And in 2021 and 2022, there were both. Given the claims by "health" authorities, we should see a rise in all-cause mortality in 2020 and then a decline in 2021 as a large majority of Americans received the Covid-19 vaccine. That is, unless the vaccine does not actually reduce mortality.

It is also worth noting that the number of deaths claimed to be caused by Covid-19 is truly unprecedented as compared to all other diseases for which Americans vaccinate. As we reviewed above, CDC data plainly reflects that there were a few dozen to a few hundred deaths per year from most diseases prior to introduction of vaccination for any given disease. And these deaths typically occurred before significant advances in general and acute medical care, abundant clean water, universal sanitation, and improved living standards in this country. In contrast, the CDC claims Covid-19 killed hundreds of thousands of people annually. Putting aside that this reflects that the virus that causes Covid-19 is likely not of natural origin, it puts into focus how vaccinology works.

Meaning, even for a disease that they claim killed over one million Americans (not dozens or hundreds),¹¹⁹ with presumably far more advanced technology to create effective vaccines, billions of taxpayer dollars spent to design and develop the most effective vaccines, and after over 80% of Americans were vaccinated in 2021, they cannot even show the vaccines reduced overall mortality. Yet, instead of acknowledging this reality, they offer faith-based assertions—such as relying on a blog

post to claim that Covid-19 vaccines saved over 3 million people in the United States.

This exact claim was raised by a U.S. Senator while I was testifying in May 2025 before the U.S. Senate Permanent Subcommittee on Investigations.¹²⁰ This U.S. Senator was the ranking member of that committee. At the start of his opening statement, he put up a large poster board behind him which stated, in all caps: "COVID-19 VACCINES HAVE SAVED MORE THAN 3 MILLION AMERICAN LIVES." The Senator then proceeded to emphatically explain that:

We need to be clear about the most important fact for all Americans. COVID-19 vaccines have saved millions and millions of lives. There is no scientific question about that fact. Let's be very clear that fear mongering and rushing to conclusions without examining the evidence can lead to tremendous harm.

When it was my turn to give my opening remarks, I addressed the Senator's claim as follows:

Our vaccine practice ... has over 40 professionals [and] doesn't represent pharmaceutical companies. I believe it is the largest vaccine practice in the world. When we litigate vaccine cases, we cannot rely on credentials or fancy titles. We have to prove our claims with high impact data and sources.

For example, I saw a slide put up that showed 3,000,000 lives were saved from COVID-19 vaccines. The citation to it was to the Commonwealth Fund. If you follow that, that's not a peer reviewed study, that's a blog. It's a blog that used a mathematical model to calculate that 3,000,000 lives were saved.

So, I agree with the Senator Blumenthal ..., who said,... quote, ... "we need to examine the evidence," and that's an example of that. We need to look carefully at the evidence we are relying upon when we are making claims about vaccines. ...

If I went into court and I was relying on a blog that used a mathematical model, I would be laughed out of court if I was making those claims about vaccines.

But unfortunately, when it comes to promoting vaccines, that's what we often see. The underlying data is not typically really carefully evaluated. Claims about what vaccines do when they're positive, because our health agencies are responsible for promoting them, easily made. Claims that vaccines cause any harms or injuries often get ignored no matter how good the underlying data.

That exchange happened at the very start of an over three-hour long hearing. The Senator, despite addressing many points raised during that hearing, never contested my response. Of course, you can't point to data that does not exist.

Yet, the claim that Covid-19 vaccines "saved three million lives"—a number derived from a blog post built on unrealistic and unsubstantiated modeling assumptions—persists even though believing this claim requires suspending reason and logic and ignoring statistics. Similarly, believing that millions, or even one tenth of one percent of millions, would die annually in the United States absent routine childhood vaccination requires suspending reason and logic and ignoring statistics.

But such is the religion of vaccines.

Chapter 8

"Vaccines Save Millions From Harm!"

After the article of faith that millions of Americans would die each year without vaccines, comes the belief that millions more would be paralyzed by polio or harmed by other diseases for which we vaccinate. That is the faith. The reality is far different.

The reality is that childhood diseases for which we vaccinate cause relatively few harms. Even paralytic polio was considered a relatively rare condition, so much so that studying the efficacy of the first polio vaccine in 1954 required a trial of over a million children to be able to detect whether it had any efficacy. Medical researchers of the time even complained about the attention given to polio since many of them were working on solutions for other diseases that, while also rare, were far more prevalent than polio.

Given page constraints, a full treatment of this reality, however, will require its own volume. But no book about vaccines would be complete without at least some discussion regarding polio and paralysis.

The Word "Polio" Can Elicit Strong Emotions

In my experience, there is no vaccine that elicits a more emotional response than that for polio. For many, the idea of polio conjures images of iron lungs, paralyzed children, and the "Salk vaccine" that is claimed to have saved millions. This emotional reaction makes it difficult for many to discuss this product objectively. So much so that *The New York Times* purposely tapped into that emotion to create national outrage with this headline: "Kennedy's Lawyer Has Asked the F.D.A. to Revoke Approval of the Polio Vaccine."¹

The New York Times intended everyone in the country to believe that a lawyer, meaning me, had, on behalf of Mr. Kennedy, asked the

FDA to revoke "the" polio vaccine to deprive Americans of the ability to get vaccinated for polio. Its false headline worked. It caused a massive news cycle of outrage.

The reality was that the petition, filed on behalf of ICAN, had nothing to do with Mr. Kennedy and, if granted, would not have left a single person in America unable to obtain a polio vaccine. Not one person.

The petition concerned only one of six polio vaccines currently licensed for children. Meaning, even if the petition was granted, the one vaccine that was at issue would have remained licensed for adults (and hence remained available for off-label use for children) and there still would have been five other licensed polio vaccines available for children. But *The New York Times* didn't care about the truth. It wanted to create outrage in the hope of derailing Mr. Kennedy's confirmation for Secretary of HHS, and it was willing to mislead the public to achieve that end.²

ICAN's polio petition should have sparked outrage, but not for the false reason concocted by *The New York Times*. It should have caused outrage because of the facts contained in the petition. The one vaccine at issue in the petition was not the Salk polio vaccine (licensed in 1955) nor the Sabin polio vaccine (licensed in 1961) but rather a different polio vaccine licensed in 1990 based on a novel technology: monkey kidney cells that had their chromosomes modified to render them immortal, like cancer, and that end up as an ingredient in each vial. This novel polio vaccine was licensed based on a clinical trial that reviewed safety for only three days after injection, with no control group. That is patently insufficient to confirm safety. ICAN's petition to the FDA therefore made the reasonable request that its licensure for children be based on a proper trial.³ *The New York Times*, instead of informing the public about the true nature of the petition, understood that many would not be able to get past their emotions surrounding polio vaccines, and so it played on those emotions.

That is all to say that any discussion of polio and polio vaccines requires an extremely heavy, evidence-based, thorough review, as well as a healthy dose of objectivity. That level of detail requires an entire book of its own; one that gives it full, proper treatment. But, as noted, I will give a short overview here.

The Emergence of Polio

Here are some facts about polio that are typically ignored by the Vaccines Amen crowd. The evidence reflects that the polio virus had been endemic and benign for millennia, infecting generation after generation of humans, causing almost no harm with only rare and sporadic

reports of individual cases.⁴ As Albert Sabin, the inventor of the oral polio vaccine, writing in the summer of 1947, explained: "paralytic poliomyelitis became an epidemic disease only a little more than fifty years ago" and that "the epidemic outbursts ... in the past thirty to forty years, are events that could not readily have been missed in the past."⁵ Meaning, like many other viruses that silently circulate, polio was for millennia just another silently circulating virus, causing only potentially a few individual isolated cases of harm.

That is, until around 1890 when, for the first time, there were reports of clusters of cases of paralysis and deaths in developed countries.⁶ Reported cases increased in the United States over the next few decades and then accelerated in the 1940s, peaking in 1952 at around 3,000 deaths attributed to polio and an estimated multiple of that number in paralysis cases attributed to polio.⁷ Meaning, while virtually every other virus was rapidly becoming less harmful during the decades after 1900, the polio virus was reported to be moving in the opposite direction.⁸

Researchers could not explain what made the previously innocuous polio virus increasingly pathogenic in the first half of the 1900s. And whatever that factor, it was plainly unique to industrialized nations, since outbreaks were not recorded in developing countries. As explained by Sabin:

One of the most important problems in the epidemiology of poliomyelitis is the determination of the factors relative to the virus, host and environment, which are different in cities like New York, Chicago, Minneapolis, Los Angeles and Denver, among many others in the United States with histories of large outbreaks of the disease, and cities like Peiping, Tientsin and Shanghai, occupying approximately the same latitude in China, in which only rare sporadic cases have been recorded thus far, despite the presence in these cities for many years now of excellent western trained physicians who could not have missed such outbreaks in the native population if they had occurred.

Reflecting this reality, there were many instances of polio outbreaks among U.S. military service members based overseas where, at the same time, there were no cases in the surrounding local populations. As Sabin explained in 1947:

Poliomyelitis has occurred among American troops in certain foreign countries, especially the Middle East, the

Philippine Islands and during the past summer Japan and North China, in numbers and under circumstances that raise puzzling questions. If the disease were occurring among American soldiers (and this holds true also for the British and Australians) at a time when the more numerous native children all around them were also having paralytic poliomyelitis, the situation would not be so puzzling—but that was not the case. ...

A report on poliomyelitis in the Philippine Islands published ten years ago stated that 16 of 17 patients with the disease at the Sternberg General Hospital in Manila were Americans. In 1945 there were 246 cases of poliomyelitis with 52 deaths among American troops in the Philippines according to the official reports received by the Office of the Surgeon General. Since the end of combat in the Philippines, poliomyelitis has been among the leading causes of death in American troops [and] ... the incidence of poliomyelitis in American troops in the Philippines has been at least ten times as high as in the Army within the continental limits of the United States during the past two years. ... And yet, checks of the surrounding native population revealed no outbreaks of poliomyelitis. ... Epidemics of poliomyelitis were never observed in the Philippines [despite] ... the presence of neutralizing antibodies for poliomyelitis virus in the serum of 9 of 10 Filipinos from Cebu, ... [yet] the disease was unknown there and that no evidence of sequelae were discovered.

This past summer I had occasion to observe an outbreak of poliomyelitis among American marines stationed in the Tientsin area of North China. Four men died, 1 was severely paralyzed and at least 25 others had nonparalytic attacks. There was no evidence of an outbreak of poliomyelitis in the native population at the time, and Dr. Grice, a British physician in practice in Tientsin for twenty-five years, informed me that while he not infrequently saw paralytic poliomyelitis in children in the foreign colony he rarely saw the disease among the Chinese.⁹

What were the troops and citizens from developed countries exposed to that made the polio virus reportedly virulent for them but remained innocuous for the surrounding population?

Another important question that Sabin struggled with—and continues to puzzle mainstream scientists—is why polio cases clustered around the summer months. As Sabin explained:

Next in importance among the questions that may be asked with regard to the epidemiology of poliomyelitis [after the question of why polio did not occur in developing countries despite the fact the virus circulated in those countries] is why paralytic poliomyelitis, with only rare exceptions, remains practically dormant during more than two thirds of each year, appearing in only an occasional person, and then seems to explode during the late summer and early autumn?¹⁰

Sabin then followed up with yet another important question: “do more people acquire poliomyelitis virus during the summer and early autumn months, or is there only a difference in the ratio between the number exhibiting the paralytic and inapparent [asymptomatic], non-paralytic forms of the disease during the different times of the year?”¹¹

In raising these questions, Sabin was effectively asking what exposure or differential was causing the otherwise innocuous polio virus to cause harm only among individuals in and from the developed world and only during summer and early autumn months.

Another oddity raised further questions. The only natural hosts for the polio virus are humans. Not animals. Yet, domestic animals also often suffered paralysis alongside humans when there were outbreaks among humans. As *The Medical Times*, in “The Correlation Of Epidemic Paralysis in Animal and Man,” reported in 1912, “A close relationship between paralytic cases in man and animal during epidemics of poliomyelitis has been observed in nine States of the United States, and in Sweden, Westphalia, and England,”¹² or as the Vermont State Department of Public Health published in 1924, “Instances of paralysis among domestic animals have always been noted as accompanying our outbreaks of human infantile paralysis.”¹³ This begs the question: why would animals that cannot be infected with the polio virus become paralyzed? Was there some common exposure that made humans susceptible to harm from the polio virus that also made these animals more susceptible to harm?

So, please pause and think about these facts regarding polio for a moment. What was previously a relatively harmless virus suddenly

started causing clusters of paralysis and death around the 1890s and these clusters increased in frequency and intensity, accelerating in the 1940s, and reportedly peaking in 1952 in the United States. During this entire period, polio epidemics of paralysis and deaths only occurred in developed countries, starting almost simultaneously in North America, Europe, and Oceania, but did not occur in developing countries where the virus was infecting most people without causing paralysis or death. In fact, polio is reported to have caused paralysis and death among U.S., British, and Australian military members stationed in developing countries but not among the highly infected surrounding populations. Also, it mysteriously caused increasing mortality through the first half of the 1900s when mortality from all other diseases was rapidly declining, it only caused paralysis and death (for the most part) in summer months (and originally mostly in rural areas), and paralysis occurred in domestic animals alongside humans even though the polio virus does not spread through animal populations.

These facts all point to a potential unknown factor or factors that may have caused the polio virus to become more harmful or, as some have argued, even potentially caused the harms that were instead attributed to polio. Something was making this virus harmful or lethal at times, or at least making it appear more lethal, but only when this unknown additional factor or factors were present. The scientists of that period, however, were at a loss to explain what was causing this increase in the virulence attributed to the previously innocuous polio virus. Sabin ended his 1947 article stating:

In conclusion I wish to reiterate what I regard as perhaps the most important question: Why did paralytic poliomyelitis become an epidemic disease only a little more than fifty years ago, and as such why does it seem to be affecting more and more the countries in which sanitation and hygiene, along with the general standard of living, are presumably making the greatest advances, while other large parts of the world, regardless of latitude, are still relatively unaffected? If I have left the reader somewhat bewildered and with the impression that physicians do not know the answers to these and other basic questions regarding the origin and evolution of epidemics of poliomyelitis, I apologize, but I must confess that it was precisely what I intended to do.¹⁴

Improved Hygiene Theory

Needing some explanation, a theory was eventually proposed to explain why the polio virus became more virulent: the "improved hygiene" theory. This theory speculated that the polio virus was historically harmless because most infants contracted the virus in the first year of life and were protected by maternal antibodies. As hygiene improved, babies contracted the polio virus later in childhood, after maternal antibodies had waned, leaving them unprotected.

This theory was easily shown to be wrong for two reasons. First, the populations in developing countries were often not infected with the polio virus until long after their maternal antibodies had waned. As explained by Sabin after he studied the improved hygiene theory:

The low incidence of paralytic poliomyelitis, even among the children of the Far East, Africa, and certain other primitive population groups, at a time when virulent virus is known to be in their midst, as indicated by the high attack rates among adult foreigners in their midst, cannot be attributed to subclinical immunization of infants under the influence of either placentally or milk-transmitted antibody, because serological surveys have revealed that 80 to 90 percent are still without antibody at the end of the first or second year of life.

Sabin therefore called the improved hygiene theory "untenable."¹⁵ This theory is also untenable because when polio virus started causing harm in the developing world in the 1970s, including in India, Afghanistan, and Somalia, it was blamed on *lack* of sanitation. As the WHO now explains: "The [polio] virus is shed by infected people (usually children) through faeces, where it can spread quickly, especially in areas with poor hygiene and sanitation systems."¹⁶ The reason the polio virus became virulent obviously can't be both improved hygiene *and* poor hygiene. It can't be that these conflicting reasons are both true.

So, what was the outside factor that appears to have made the polio virus more pathogenic in developed countries in the first half of the 1900s? What made it more pathogenic in developing countries starting in the 1970s? What outside exposure could cause the body to be susceptible to permitting the polio virus, otherwise harmless, to make its way to the spinal column and, in a tiny minority of cases, cause paralysis and maybe even death? A closer look at the introduction of the first polio vaccine in 1955 sheds further light on these questions.

Polio Vaccine

The following is an excerpt from a 1960 report following a meeting of leading national polio experts from government, industry, and academia, including the Director of Viral Research at Lederle (a major manufacturer of the Salk vaccine in the late 1950s), President-Elect of the Society of American Bacteriologists, and a delegate for the United States Public Health Service.¹⁷ The report begins by laying out basic facts about polio and the Salk polio vaccine after its introduction in 1955:

In preparation for the discussion, it was thought best to review some basic facts of polio: incidence, natural history, the disease, and immunity, all important to the understanding of the vaccine problem. ...

Figure 1 presents the natural variations in incidence of polio and infectious hepatitis. Both diseases were in a natural decline when the Salk vaccine was introduced in 1955. Since the wide acceptance of the Salk vaccine was based primarily on sharp decline in polio incidence, it is important to keep in mind that infectious hepatitis equally declined following the Salk vaccine.

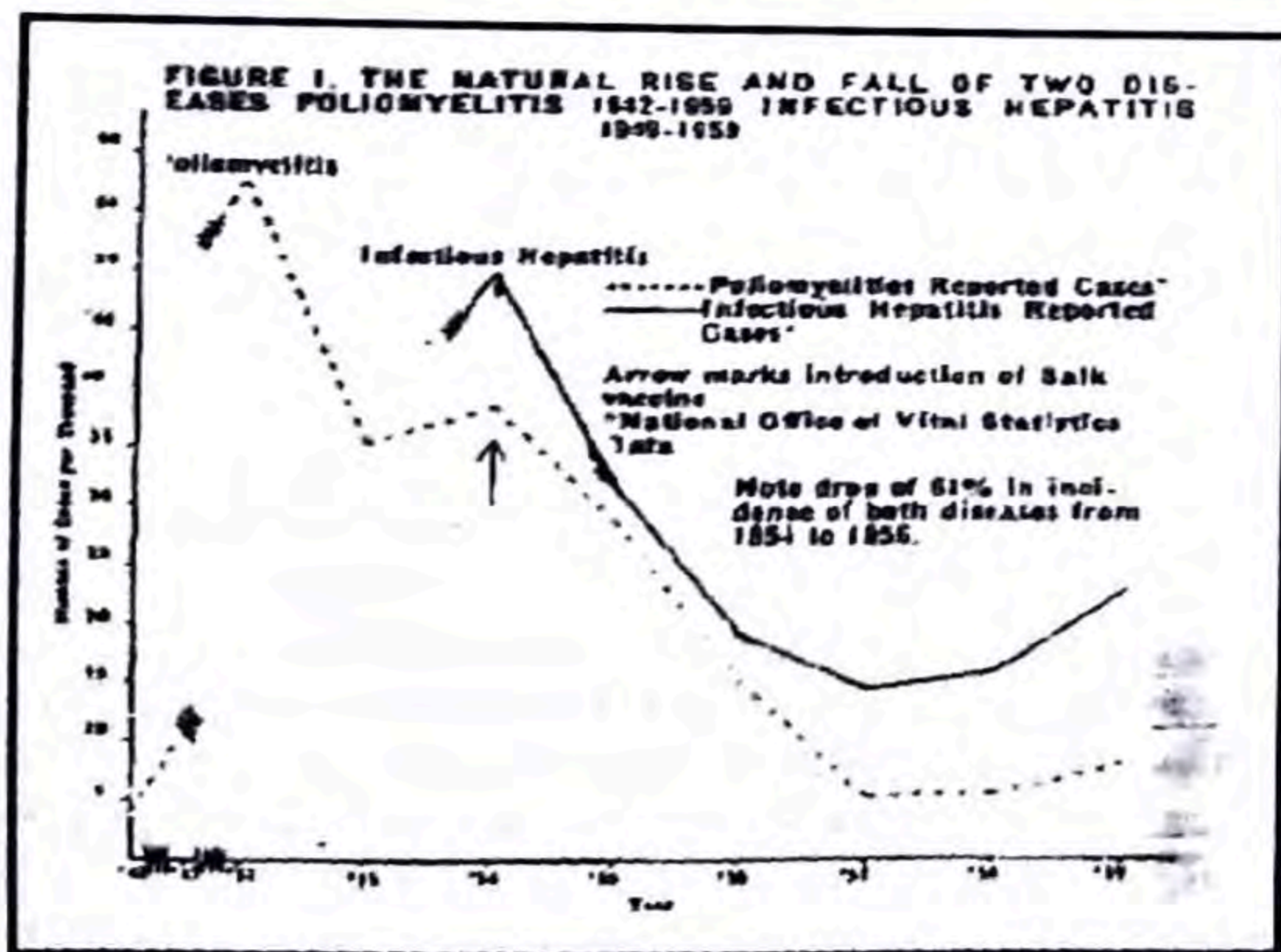
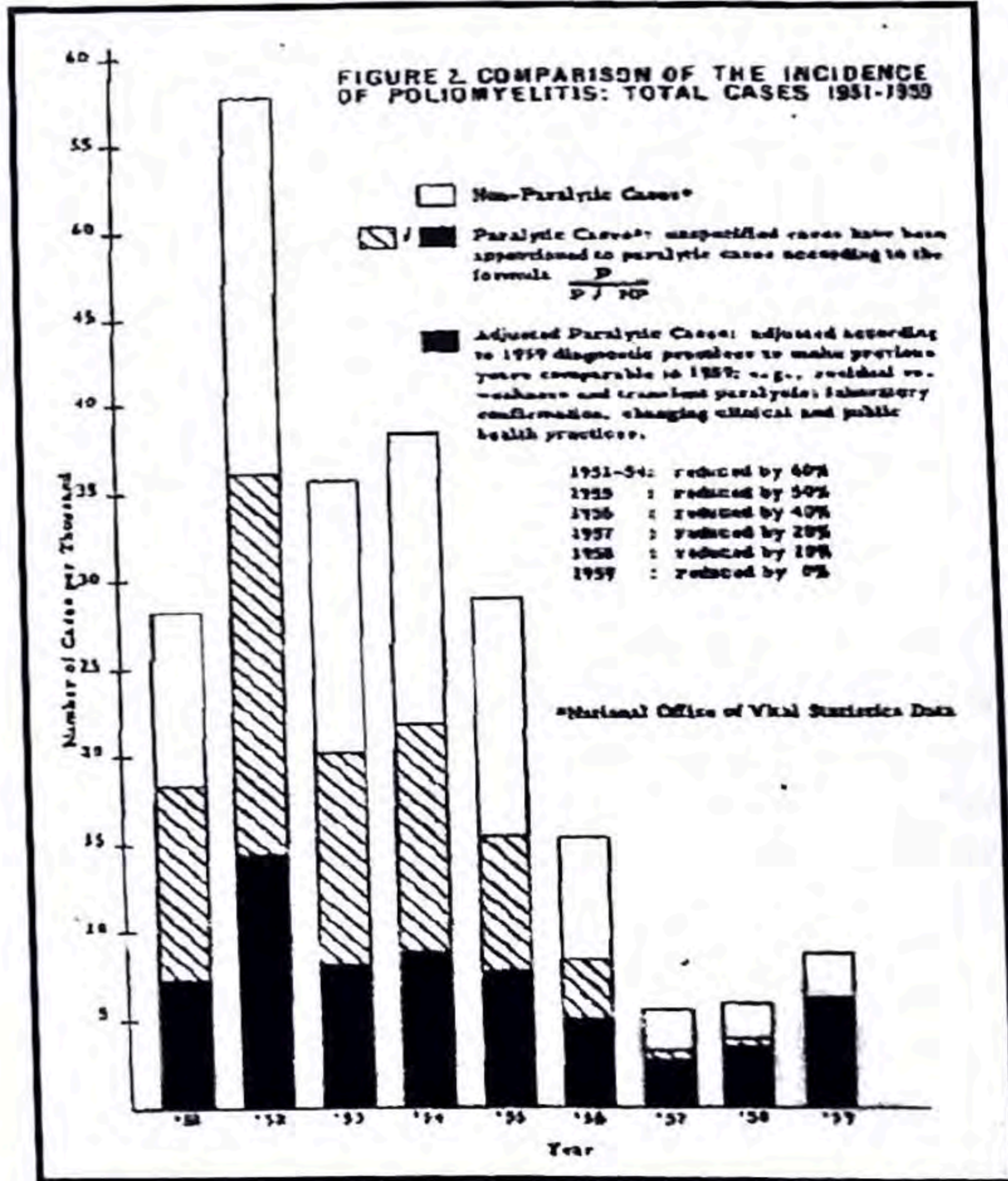


Figure 2 shows what the incidence of paralytic polio would have been from 1951 through 1959 if the figures were corrected for the radical changes in diagnostic

criteria since the introduction of the Salk vaccine. ... The solid column in figure 2 represent a conservative estimate of what the incidence of paralytic polio would have been in former years if the diagnostic criteria of 1959 had been used. This permits a more accurate comparison.



This chart shows that the decrease in paralytic polio, represented by the striped portion of the bars, was not real. It was merely the result of changing the definition of what constituted a case of "paralytic polio" to more strict criteria after introduction of the Salk vaccine, as we will discuss in more detail below. Specifically, the rate of paralytic polio in 1953 and 1954 (before a polio vaccine was introduced) was similar to the rate in 1955 and 1959 (after the polio vaccine was introduced), when applying the same diagnostic criteria used in 1959. Meaning, the leading polio scientists of the day, looking at the polio data without the modern-day worship of the Salk vaccine, and applying the post-1955

criteria for what constitutes a case of paralytic polio to the pre-1955 period, found that this data reflects the Salk vaccine had, at best, a negligible impact in reducing cases of paralytic polio between 1955 and 1959. More on this below.

In the meantime, the article continues with what would be considered blasphemy today, but were considered the basic uncontested facts about this product in 1960:

The low incidence of the disease also complicates evaluation of a vaccine. ... Because of the low incidence of polio, neither the private nor the local public health physician is in a position to judge the value of polio vaccine from personal experience alone. One central source must collect and evaluate the data. The result will be only as good as the thoroughness, objectivity, and statistical skills of the central source. Part of the difficulty in the evaluation of the Salk vaccine has been that the responsible authorities have not refined the techniques for evaluating high incidence diseases so that they can be applied to low incidence diseases.

We must also distinguish between polio infection and the clinical disease. ... For every one case of known paralytic polio we have about a thousand cases of subclinical polio infections. ... Crucial to the understanding of the contemporary vaccine problem is that you can get infection of the gut with or without disease. ...¹⁸

With that introduction, which consisted of what the leading polio scientists of the day considered uncontested facts, Professor Greenberg (head of biostatistics at the University of North Carolina, School of Public Health and former chairman of the Committee on Evaluation and Standards of the American Public Health Association) explained as follows:

One of the most obvious pieces of misinformation being delivered to the American public is that the 50 percent rise in paralytic poliomyelitis in 1958 and the real accelerated increase in 1959 have been caused by persons failing to be vaccinated. This represents ... an unwillingness to face facts and to evaluate the true effectiveness of the Salk vaccine. It is [also] double talk from the standpoint of logical reasoning: If the Salk vaccine

is to take credit for the decline from 1955-1957, how can those individuals who were vaccinated several years ago contribute to the increase in 1958 and 1959? Are not these persons still vaccinated?

The number of persons over two years of age in 1960 *who have not been vaccinated* cannot be more, and must be considerably less, than the number who had no vaccination in 1957. Yet, a recent Associated Press release to warn about the impending threat referred to the idea that the "main reason is that millions of children and adults have never been vaccinated." If they were never vaccinated, undoubtedly many more than were reported were unvaccinated during 1955, 1956, and 1957 when the same officials were claiming that reduction in rates was due to the vaccine.

... [O]fficials urging vaccination have taken the stand that the rate increased because large segments of the American population, about 49 percent, have had no vaccine at all!¹⁹

Professor Greenberg's point, true in 1950 and even more so today, is that vaccine believers will credit the vaccine when cases decline; but when cases increase, they will blame those who did not get vaccinated even when the overall vaccination rate has increased. Specifically, he points out the absurdity of crediting the Salk vaccine for a reported decline in cases between 1955 and 1957 while blaming those who had not received the Salk vaccine for the increase in cases in 1958 and 1959, despite the overall vaccination rate being higher in 1958-1959 than it was in 1955-1957. This illogical belief has long been part of the lore of vaccine mythology, but at least in the 1950s, respected academics were able and willing to chastise such beliefs.

Next, Professor Greenberg took apart the argument that the Salk vaccine was responsible for a massive decline in polio cases between 1955 and 1957:

If the vaccine was not as effective, one might wonder why the tremendous reduction occurred in the 1955, 1956, and 1957 reported rates. Here, again, much of this reduction was a statistical artifact.

Prior to 1954 any physician who reported paralytic poliomyelitis was doing his patient a service by way of subsidizing the cost of hospitalization and was being community-minded in reporting a communicable disease. The criterion of diagnosis at that time in most health departments followed the World Health Organization definition: "Spinal paralytic poliomyelitis: signs and symptoms of nonparalytic poliomyelitis with the addition of partial or complete paralysis of one or more muscle groups, detected on two examinations at least 24 hours apart."

Note that "two examinations at least 24 hours apart" was all that was required. Laboratory confirmation and presence of residual paralysis was *not* required. In 1955 the criteria were changed to conform more closely to the definition used in the 1954 [Salk vaccine] field trials: residual paralysis was determined 10 to 20 days after onset of illness and again 50 to 70 days after onset. The influence of the field trials is still evident in most health departments; unless there is residual involvement at least 60 days after onset, a case of poliomyelitis is not considered paralytic.

This change in definition meant that in 1955 we started reporting a new disease, namely, paralytic poliomyelitis with a longer lasting paralysis. Furthermore, diagnostic procedures have continued to be refined. Coxsackie virus infections and aseptic meningitis have been distinguished from paralytic poliomyelitis. Prior to 1954 large numbers of these cases undoubtedly were mislabeled as paralytic poliomyelitis. Thus, simply by changes in diagnostic criteria, the number of paralytic cases was predetermined to decrease in 1955-1957, whether or not any vaccine was used. At the same time, the number of nonparalytic cases was bound to increase because any case with poliomyelitis-like disease which could not be classified as paralytic poliomyelitis according to the new criteria was classified as nonparalytic poliomyelitis. Many of these cases, although reported as such, were not nonparalytic poliomyelitis. If this inaccurate number of cases of nonparalytic poliomyelitis reported in 1957 is accepted as accurate and considered as a base

for subsequent comparisons, it is no wonder that we now say nonparalytic cases went down in 1958.

There is still another reason for the decrease in the reported paralytic poliomyelitis cases in 1955-1957. As a result of the publicity given the Salk vaccine, the public questioned the possibility of a vaccinated child developing paralytic poliomyelitis. Whenever such an event occurred, every effort was made to ascertain whether or not the disease was truly paralytic poliomyelitis. In fact, I am certain that many health officers and physicians here will ask routinely if a child has been vaccinated when signs of poliomyelitis are present during the summer months. We have been conditioned today to screen out false positive cases in a way that was not even imagined prior to 1954.

As a result of these changes in both diagnosis and diagnostic methods, the rates of paralytic poliomyelitis plummeted from the early 1950's to a low in 1957.²⁰

Professor Greenberg thus made plain, as many publications of that day did, that the reduction in polio cases was, to summarize what he said, mostly an artifact of:

- (i) changing the definition of what constituted a case of paralytic polio from two examinations at least 24 hours apart (easier criteria resulting in higher reported cases pre-1955) to requiring paralysis symptoms at least 60 days apart and laboratory confirmation (far more difficult criteria resulting in fewer reported cases post-1955);
- (ii) the post-1955 requirement of laboratory confirmation to confirm a case of polio resulted in identification of numerous other conditions that cause paralysis (including Coxsackie, ECHO viruses, aseptic meningitis, etc.) that pre-1955 would have been diagnosed as polio (resulting in even fewer reported cases post-1955); and
- (iii) the incentive to the patient pre-1955 to be diagnosed with polio (resulting in higher reported) and the lack of such incentive thereafter, and instead a

strong bias to not find polio among the vaccinated (resulting in even fewer reported cases post-1955).

Thus, the reality is that the significant decline in paralytic polio after introduction of the Salk vaccine was, according to the respected researchers of the day, an artifact of these factors and not a result of an effective vaccine.

Before moving on, let's take a moment to focus on the change in the diagnostic criteria. Before Salk's vaccine, a person would be diagnosed with paralytic polio if presenting with symptoms at least 24 hours apart (without any laboratory confirmation required); but after Salk's vaccine was introduced, a person would be diagnosed with paralytic polio *only* if they presented with paralysis at least 60 days apart *and* if they had laboratory confirmation it was the polio virus. There is nothing subtle about the drastic change in the criteria for what qualified as a case of paralytic polio.

This change in what qualified as a case of paralytic polio alone caused the number of reported cases to plummet, thereby making the Salk vaccine appear effective. And, as explained above, if one were to use the same criteria to diagnose a case of paralytic polio pre- and post-introduction of Salk's vaccine, there would be *no* statistical difference in cases of paralytic polio in various years directly before and after use of Salk's vaccine. That is not *my* claim, but rather the claim of the leading polio scientists of the day.

It requires suspending reality to ignore this major change in diagnostic criteria, let alone to ignore the other factors listed above. These include: before 1955, many cases of paralysis attributed to polio were in fact caused by a long list of other pathogens or conditions; after 1955, these pathogens and conditions were no longer counted as polio; before 1955, diagnosing a case of paralysis as polio meant financial support for the family; and after 1955, there was an incredible bias against finding paralysis in a vaccinated child.

But suspending reality is something the vaccinologists have no problem doing. They will tell you with a straight face that the polio vaccine was the only reason cases went down after 1955. End of story. And the reason they get so mad when you point out the above facts is that it causes cognitive dissonance.

Returning to the meeting, Dr. Cox, then director of virus research at Lederle (a major manufacturer of the Salk vaccine), President-elect of the Society of American Bacteriologists, and considered one of the world's leading authorities on killed vaccines, explained as follows:

The only way you really can determine vaccine effectiveness is by direct challenge. Obviously, in polio you cannot make a direct challenge on man. We know, however, from experience with other vaccines that the most accurate indirect method we have is measuring the levels of neutralizing antibodies in the blood...²¹

Building on that, Dr. Kleinman, an epidemiologist from the Minnesota Department of Health and delegate for the United States Public Health Service regarding polio, explained:

If polio antibodies mean anything in respect to protection, then I am forced to conclude that much of the Salk vaccine we have been using is useless. For two years now we have done antibody titrations on children who have received three or more doses of Salk vaccine. These titrations show that over 50 percent do not have antibodies to Types I and III and 20 percent lack antibodies to Type II poliovirus. This is a very disturbing fact.²²

Dr. Cox explained why this is a particularly disturbing fact:

...Type II [poliovirus] represents only about 3 percent of paralytic cases throughout the world. The killed vaccine [Salk's vaccine] does a poor job against Type I, however, which causes 85 percent of paralytic cases, and against Type III, which causes about 12 percent. In other words, the killed vaccine is doing its best job against the least important type [of poliovirus].²³

Professor Meier, a biostatistician from the University of Chicago, then provided an insightful observation. Reading his words today, you would think he was critiquing the modern mainstream media coverage of the Covid-19 vaccine:

The thing that impresses me most about this question of polio vaccine is a problem that has been discussed only by indirection. How is it that today you hear from the members of this panel that the Salk vaccine situation is confused; yet what everybody knows from reading the newspapers, and has known since the vaccine was introduced, is that the situation as far as the Salk vaccine is concerned was and is marvelous? The reason for

this discrepancy lies, I think, in a new attitude of many public health and publicity men. It is hard to convince the public that something is good. Consequently, the best way to push forward a new program is to decide on what you think the best decision is and not question it thereafter, and further, not to raise questions before the public or expose the public to open discussion of the issues. ...

The reason for this unhappy situation lies first in the attitude I referred to earlier: that dissent and discussion in public are unwelcome. ...²⁴

Just as startling, Dr. Ratner, Director of Public Health and Professor of Preventive Medicine and Public Health at the Stritch School of Medicine in Chicago, then addressed the question of whether a state health department would recommend against children being injected with the Salk vaccine: "This is a question of whether a state health department is in a position to oppose mass propaganda and the public opinion that has been formed by it." Dr. Meier agreed, adding:

.... The great pressure of publicity has been exerted. It would be a health officer with great self-confidence who would say that on the basis of the little he knows is prepared to make a judgment different from that of the USPHS [United States Public Health Service] and to decide not to give it. On the other hand, I don't consider it convincing evidence of the efficacy of Salk vaccine that all, or almost all, health officers have gone along with it.²⁵

Dr. Ratner also added: "It should also be stressed that safety testing was inadequate when Dr. Salk developed his vaccine and when the vaccine was commercially prepared for the field trials of 1954 and for licensing and use in 1955." Dr. Greenberg then stated that, "like Dr. Kleinman, I am sorry that I do not know what the effectiveness of the Salk vaccine is" but "since nothing else is available there seems to be no alternative but to push the use of it."

Even with all these criticisms, the vaccinology creed, even back in the 1950s, was "when in doubt, vaccinate"—even when Dr. Cox made clear that, "with low concentrates of antigen [as in the Salk vaccine] you may do more harm than good."

The statistical reality is that the use of Salk's vaccine starting in 1955 cannot account for the drop in the number of polio cases in the United States in the few years thereafter. Something else must have contributed, including the changes in the diagnostic criteria of what constitutes a case of "polio" as well as a change in the environmental factors that made the previously innocuous polio virus pathogenic. This comes into sharp focus when looking at countries (including Sweden, Iceland, and the Netherlands) that only used Salk's or another inactivated polio vaccine, products which did not and could not stop transmission (as explained in the next chapter), and the fact that polio in those countries disappeared nonetheless, including for the unvaccinated.

What these facts make clear is that the most parsimonious explanation regarding polio is that something rendered this virus more virulent; similarly, as that exposure subsided, the harm caused by this virus would have presumably also subsided. This would certainly help explain why countries that have only used a version of the polio vaccine that does not prevent transmission (as explained in the next chapter) nonetheless ceased having any polio cases or epidemics.

As for what made the polio virus more virulent starting in the 1890s in developed countries, an evaluation of prevailing theories would require an entire volume of evidence-heavy and careful review. While it may be unsatisfying to not have a deeper dive into this topic, beyond the improved hygiene theory briefly covered earlier, the good news is that there are numerous books and articles spanning decades which propose various explanations.

Wrap-Up

The first time I read the reports discussed earlier from the 1940s to 1960, especially those from leading polio scientists of the day, I found them breathtaking. It is hard to imagine that this was the reality, given the current-day lore around polio and the Salk vaccine. But the objective facts are: something apparently made the previously innocuous polio virus pathogenic starting in the 1890s, paralysis was relatively rare even at polio's peak in the United States, the number of cases of polio dropped precipitously after 1955 in the United States after changes in diagnostic criteria and the identification of other causes of paralysis, physicians were reluctant to diagnose paralytic polio in a vaccinated child, misinformation drove a fearful public to rally around the Salk vaccine, and individuals were "clinging" to the vaccine "for sentimental or personal reasons."²⁶

Sound familiar? To anyone who paid attention and examined the primary sources during the recent Covid-19 pandemic, it should. But no doubt as memories fade regarding what really occurred, "health"

authorities will write into history that the only things that saved us from Covid-19 were the Covid-19 vaccines. And the medical community will dutifully proclaim that anybody who contests this dogma is anti-science or worse.

The above quotes are meant to provide just a small sample of the facts from the 1890s until the 1960s regarding the reality of polio and the Salk vaccine. I purposely used block quotes to avoid any question about what was written at that time.

Stepping back more broadly to all the diseases on the CDC's childhood vaccine schedule, the reality is that serious permanent harm from any of these diseases is exceedingly rare. This makes ensuring vaccine safety all the more critical. If a disease causes serious permanent harm in one in thirty thousand children, we must be certain the vaccine does not cause similar harm (*e.g.*, a serious chronic disease) at the same or a greater rate, and we must also consider the benefits of natural infection, such as the potential reduction in cardiovascular disease, cancer, etc.

A careful, in-depth analysis of the harm claimed to be averted by each vaccine would also require another volume, partly because it is rare for serious permanent harm to be caused by these infections. Claims to the contrary are simply not supported by the hard contemporaneous data. It just takes a bit of work to properly cut through the post-vaccine estimates and propaganda intended to fearmonger and sell products. It's a lot of detail and review of evidence so you may be thankful this chapter ends here.

Chapter 9

"Vaccines Prevent Transmission!"

After the "we would all be dead without them" mantra, the next most common mantra is "everyone must be injected to achieve herd immunity!"

"Herd immunity," also known as "community immunity," is the idea that if enough individuals in a community are infected with a pathogen, the natural immunity they develop will prevent further transmission of the pathogen in that community. Many believe that all vaccines can create herd immunity.

The main problem with this belief is that "herd immunity" requires the prevention of transmission and many vaccines do *not* prevent transmission of the pathogen they are targeting. Let me write that again: many vaccines do *not* prevent transmission. The measles vaccine can prevent transmission of measles in most people receiving this product for a certain duration of time. But that is *not* the case for many vaccines. I know, heresy.

Let's take a look at the vaccines commonly mandated for school attendance: IPV, DTaP/Tdap, MenACWY, HepB, MMR, and Varicella. After all, if any vaccine should prevent transmission, it should be those mandated to children under the illiberal, informed consent-crushing, draconian threat of expulsion from school.

Polio Vaccine

Let's start with polio. The polio vaccine used exclusively in the United States for over two decades, inactivated polio vaccine (IPV), does not prevent transmission of the polio virus. In the 1990s, IPV was phased in and oral polio vaccine (OPV), which had been used starting in the 1960s, was phased out due to safety issues.

Polio is transmitted from fecal to oral contamination. Meaning, to become infected with the polio virus, the virus must come out of someone's bottom and end up in another person's mouth. That lovely image

aside, OPV (the one long ago phased out in the U.S.) is a liquid that is administered by placing a few drops of live but weakened (Frankenstein version of the) polio virus in one's mouth. By placing it in the mouth, it introduces live polio virus (plus a bunch of other ingredients) into the intestinal tract, which is how one would normally be infected with polio.

The vaccine virus of polio then proliferates in the intestinal lining, intending to mimic what the real virus would do, and generates a form of immunity, including IgA antibodies, in the intestinal lining. Because of this, studies reflect that if one encounters polio again in the wild after getting OPV, the polio virus is less likely to multiply in the intestines and hence is less likely to be pooped out (lessening the chances of further transmission).

However, OPV, while having a certain degree of efficacy, has serious safety issues. One issue is that OPV can cause paralysis in some children, which is one reason why it was phased out in the United States starting in the 1990s and replaced with IPV.

IPV, as noted, does *not* prevent transmission of polio. This is because it is injected into the arm and primarily creates antibodies to polio virus in the blood (IgG antibodies) but not in the intestinal tract (IgA antibodies) where the polio virus proliferates. The result is that not a single child in the United States vaccinated for polio since 2000 has immunity that prevents them from becoming infected with or transmitting the polio virus. If they encounter the polio virus, it can still multiply in their intestinal tract, and they will still poop out the virus. The only difference is that children getting IPV are theoretically more protected from having the polio virus travel from their intestinal tract into their bloodstream and then to their spinal column.

Sound untrue? Well feel free to argue with the CDC, which explains on its website that IPV "does not stop transmission of the virus" and that "IPV does not prevent intestinal infection and therefore does not prevent poliovirus transmission."¹ So, there you have it from the horse's mouth.

So, think about it. Children not vaccinated for polio and children vaccinated with IPV can both become infected with and transmit polio. The only difference is that the IPV-vaccinated children are supposed to have fewer symptoms if they become infected. So, if an IPV-vaccinated and an unvaccinated child both become infected with polio, the IPV-vaccinated child is supposed to have fewer symptoms and hence will be more likely to continue to socialize; whereas the unvaccinated child is supposed to be more likely to have symptoms and hence would be more likely to remain home in bed. Meaning, as compared to the unvaccinated child, the IPV-vaccinated child is more likely to come into contact

with others and—hold your breath—therefore, more likely to spread the polio virus. I know, sacrilege. But those are the facts.

I can already hear the hysterical reactions. "But polio vaccine saved everyone!" Putting aside the fact that this claim lacks footing as briefly discussed in Chapter 7, it doesn't change the reality that IPV does not prevent transmission—a fact begrudgingly accepted even by "health" authorities—which means IPV cannot have any impact on so-called herd immunity.

Pertussis Vaccine

Let's move on to pertussis vaccine. After polio and measles vaccine, this is probably the most celebrated and venerated of all the vaccine gods. The issue is that, like IPV, the pertussis vaccine potentially reduces symptoms but does not prevent transmission of pertussis, so those who receive this vaccine are *more* likely to spread pertussis. Sound familiar?

Before someone blows a gasket, here are the facts. Until the 1990s, the pertussis vaccine used in the United States was known as "whole cell pertussis vaccine." It is the "P" in DTP—the vaccine discussed in Chapter 7 that is increasing deaths among babies. The United States replaced this vaccine with "acellular pertussis vaccine" in the late 1990s.² This newer version is typically denoted as "aP" which is the "aP" in DTaP.

After introducing aP in the United States in the 1990s, and as time marched on, outbreaks of pertussis continued to occur despite increasing coverage of this vaccine. As with all problems, the vaccinologists' go-to solution was ... yep, increase coverage and add more doses. They expanded efforts to vaccinate the entire globe with pertussis vaccines, and, in the United States, the number of recommended doses rose to six by age 12 with a recommendation to receive another dose every ten years thereafter through adulthood.³

Along the way, another curious phenomenon became apparent and, try as they may, they could not ignore nor explain it away. This phenomenon was that, even with increasing numbers of doses being administered, the time period between outbreaks of pertussis *remained the same or got shorter*.⁴ This phenomenon meant that the amount of pertussis bacteria in circulation was the same or was increasing.

Had there been a reduction in pertussis bacteria in circulation because of increased vaccination, then the time period between epidemics should have gotten longer. But that did not happen. The only logical conclusion was that there was at least the same amount or more pertussis bacteria circulating than there was before the use of acellular pertussis vaccine. That thought drove vaccinologists wild—how could that be?!

After decades of pretending this problem did not exist, the FDA did something it rarely does. Or at least three brave scientists in the FDA did something almost no scientists at the FDA or CDC would typically dare to do. They conducted an actual experiment to determine whether pertussis vaccines prevent infection and transmission. And here is the really amazing part: when the findings showed the vaccine does not prevent infection or transmission, they published the findings.

Those findings came from a baboon study published in 2013.⁵ To geek out just a bit on this study, let's quickly walk through how it was conducted and what its findings were. This study could not be conducted with humans since it would require purposefully exposing people to the pertussis bacteria which is considered unethical. So, the FDA scientists used baboons instead. The reason they chose baboons was that baboons have similar biological systems to humans relevant for conducting this experiment.

The FDA scientists split the baboons into separate groups. One group of baboons was exposed to pertussis bacteria so that they developed natural immunity. A second group of baboons received acellular pertussis vaccine. And a third group of baboons were left alone—meaning, no exposure to pertussis bacteria or to the pertussis vaccine.

The FDA scientists then exposed all three groups of baboons to pertussis bacteria. (This means the group previously exposed to pertussis was exposed a second time, the group vaccinated for pertussis was exposed, and the group that was neither exposed nor vaccinated originally was now exposed). After exposing these three groups to the bacteria, they then stuck a swab up the nose of all baboons every day and sought to culture (*i.e.*, grow in a petri dish) pertussis bacteria. The findings were striking.

The group of baboons with natural immunity (previously exposed) never shed any pertussis bacteria. None. But the group that had no prior immunity to pertussis (had not been exposed to vaccine or bacteria) *and the group that had been vaccinated* were both equally shedding pertussis bacteria. In fact, the baboons with no prior immunity shed pertussis bacteria for an average of 38 days while the vaccinated baboons shed the pertussis bacteria longer—for an average of 42 days. This finding was, no doubt, jaw dropping. The moral fortitude of those FDA scientists to conduct the study was incredible, but what it took to actually publish the study is hard to imagine.

This study brought into sharp focus the reality that vaccinologists had been trying desperately to ignore by covering their ears, keeping their eyes shut tight, and yelling loudly “more coverage!” and “more doses!” for decades. It forced a reckoning. It took years, but eventually, on June 22, 2018, there was a “Consensus Conference” held regarding

pertussis vaccine organized by the World Association for Infectious Disease and Immunological Disorders. In attendance were those considered the "world-leading" experts on pertussis and pertussis vaccines from numerous countries—each one of these mainstream experts more beholden to the mythology of vaccines than the next. From the United States, in attendance was Dr. Kathryn Edwards, the godmother of vaccinology, and Dr. Tina Tan, an author of *The Vaccine Handbook* for practitioners.

These Plotkin disciples were not only fervent vaccine zealots, they were also paid spokespersons for the pharmaceutical companies—Sanofi and GSK—that produce and sell pertussis vaccines. For example, Dr. Edwards has been paid by Sanofi and by GSK to give lectures, has consulted for these companies, has taken trips paid for by Sanofi to cities around the world, and has been on the advisory board within GSK.⁶ Dr. Tan has similar conflicts and has also been a member of the speakers' bureau for both of these companies.⁷

Despite the powerful dogma and the pharma conflicts, after the FDA study, its fallout, and most critically, the anticipated licensure of a new pertussis vaccine that could prevent transmission, *they were allowed to tell the truth*. In a consensus paper published after that conference authored by sixteen pertussis "experts," together with the World Association for Infectious Diseases, they said in no uncertain terms:

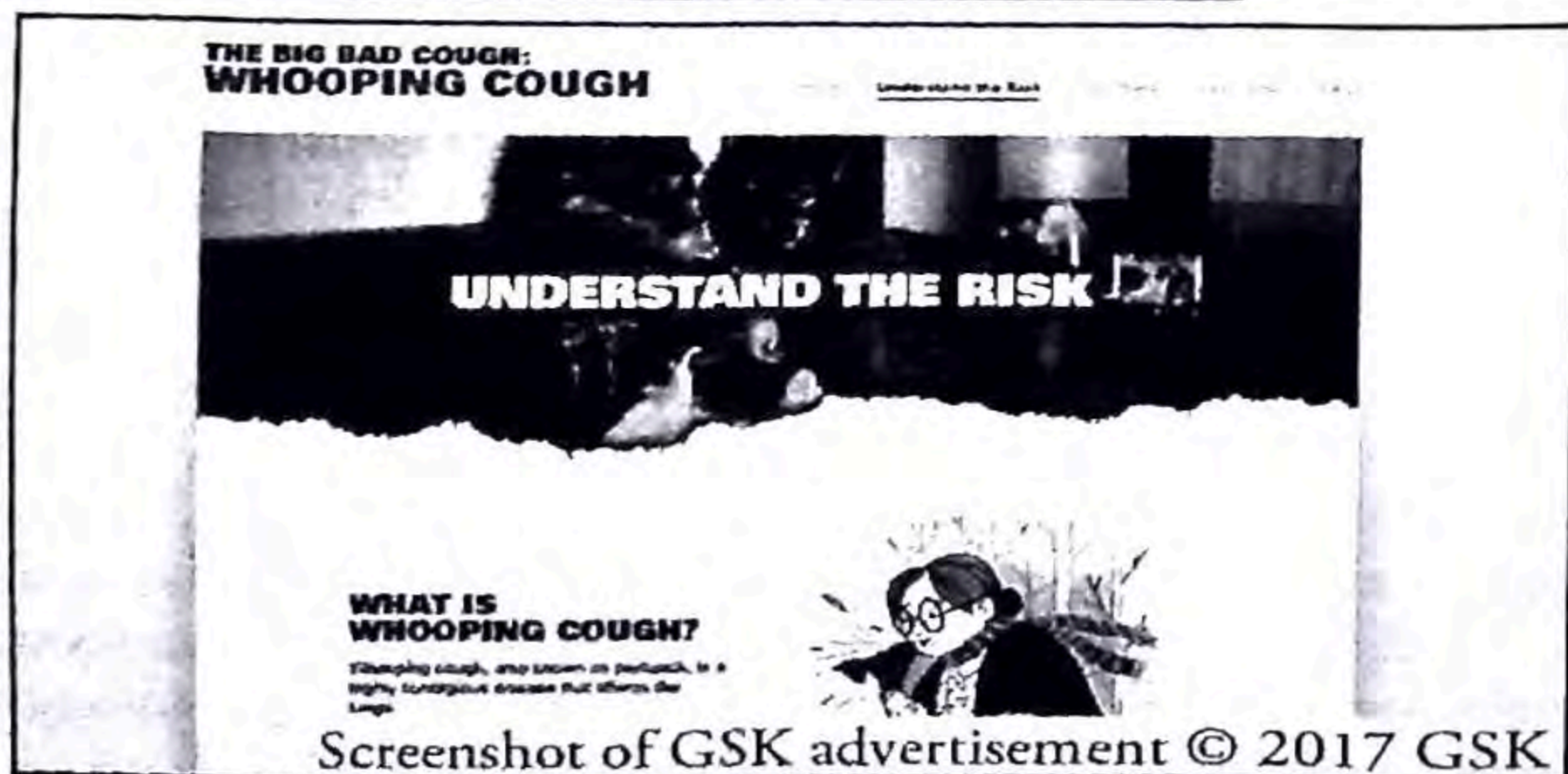
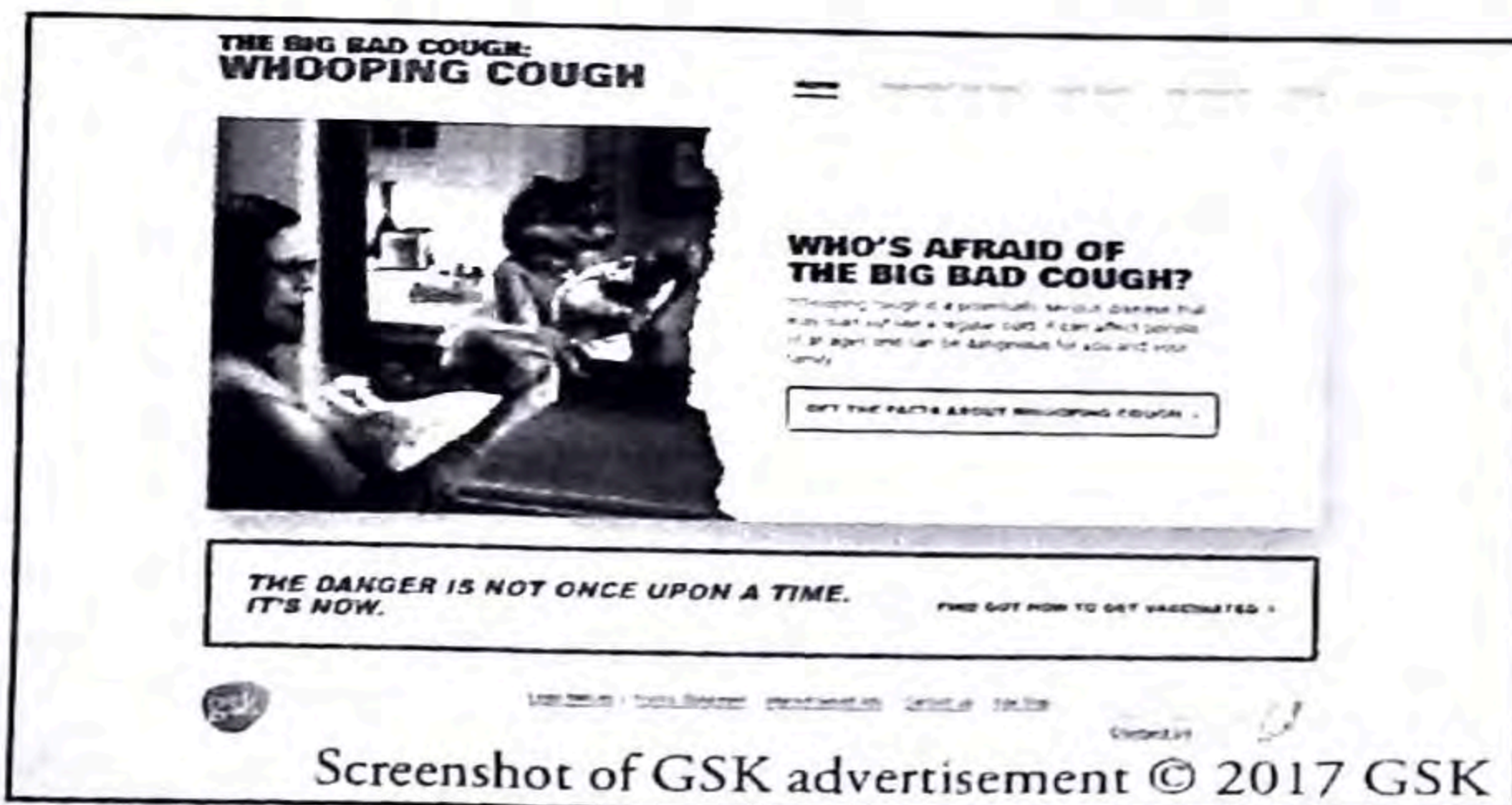
Natural infection evokes both mucosal and systemic immune responses, while aPVs [acellular pertussis vaccines] induce only a systemic immune response. ... Mucosal immunity is essential to prevent colonization and transmission of *B. pertussis* organisms. Consequently, preventive measures such as aPVs that do not induce a valid mucosal response can prevent disease **but cannot avoid infection and transmission.** ...

aPV pertussis vaccines do not prevent colonization. Consequently, they do not reduce the circulation of *B. pertussis* and do not exert any herd immunity effect.⁸

If the above is at all unclear, just read the bold portions again. Let me quote just one more time: "aPV pertussis vaccines do not prevent colonization" and "do not exert any herd immunity effect."⁹ The authors even admit that the lack "of mucosal immune responses after aPV administration favor infection, persistent colonization, and transmission of the pathogen."¹⁰ It took a few decades of the obvious staring them in the face but there it finally was: the truth.

I would like to think that it was the truth that drove them to make these admissions, but that was no doubt not the reason. Nor public health, nor morals, nor conscience. They apparently were finally ready to admit this truth (regarding the only pertussis vaccine used in the United States and almost all other developed countries) because there was a lot of excitement around 2018 regarding a potential new pertussis vaccine, inhaled through the nose, which was expected to prevent transmission. The clinical trial for this vaccine was ongoing at Dr. Edwards' university, Vanderbilt, at the time, but when this experimental vaccine later petered out, I am sure these scientists regretted their admission above.¹¹

In any event, here is a final story that should really drive home the reality of pertussis vaccine. GSK sells a pertussis vaccine administered to adults. To increase sales of its pertussis vaccine, GSK created and launched an advertising campaign in which grandmothers who don't take this vaccine are depicted as wolves that will kill their own grandchildren. A truly heartwarming way to sell a product. Here are images from this campaign:



And here are images from the television commercial for this campaign:



A voice-over during this GSK commercial ominously warns: "There's something out there. It's a highly contagious disease. It can be especially serious, even fatal to infants. Unfortunately, many people

who spread it may not know they have it. It's called whooping cough." The voice-over then urges grandparents to: "Understand the danger your new grandchild faces. Talk to your doctor or pharmacist about you and your family getting a whooping cough vaccination today."¹²

But, given the reality that this product does not prevent infection and transmission, but does appear to reduce symptoms, being vaccinated makes you more likely to spread pertussis. Why? Because if you can still get infected and transmit pertussis when vaccinated, but you have fewer symptoms, you are more likely to spread pertussis to your grandchild unknowingly. If you had symptoms, you would know to stay away. It's common sense.

So, my firm brought a class action lawsuit against GSK alleging, among other things, claims for consumer fraud and false advertising. We served the lawsuit on GSK on July 14, 2020. By mid-September, these ads and the entire campaign were taken down.¹³ Wiped, except, from what we could find, copies saved by others and reposted to criticize the campaign.

As an example, the GSK website for its Big Bad Cough campaign used to say, "you should receive a booster at least 2 weeks before having close contact with an infant."¹⁴ After filing the lawsuit, this statement was scrubbed.

It is amazing what happens when faced with potential financial liability, a rare occurrence for a pharmaceutical company with regards to a vaccine. It's too bad this type of lawsuit cannot be brought for serious injuries and deaths caused by vaccines.

But for the Vaccines Amen crowd, I am sure even all the foregoing is not enough. They still hold onto the belief that somehow, the pertussis vaccine must do what they believe it does. That it still somehow prevents the spread of pertussis. How could it not? It is a vaccine, dang it! But, alas, the truth is that the vaccinated are more likely to spread the pertussis bacterium.

Yet the religion of vaccinology expels children from school who do not have this vaccine to prevent transmission of pertussis. There is something evil about kicking children out of school altogether, but especially when it is done in the name of a cult belief that has nothing to do with reality.

Tetanus Vaccine

Moving onto the tetanus vaccine. As explained by the CDC: "Tetanus is not contagious from person-to-person."¹⁵ This means someone infected with tetanus cannot transmit it to another person. The vaccine therefore

cannot prevent transmission of tetanus because this bacterium does not spread from person to person.

It is also noteworthy that the tetanus vaccine is a toxoid vaccine—meaning it contains only antigens to a toxin sometimes released by the tetanus bacterium. It does not have any antigens in the vial for the tetanus bacterium itself. The tetanus vaccine therefore does not, after injection, result in any antibodies being created to the tetanus bacterium.

Hence, even if the tetanus bacterium could be transmitted from person-to-person, which it cannot, the tetanus vaccine does not, in any event, create any immunity to the tetanus bacterium that would prevent it from colonizing and multiplying. It only, potentially, generates immunity to a toxin sometimes released by this bacterium. Similarly, the diphtheria vaccine, like the tetanus vaccine, is also a toxoid vaccine and hence does not create any immunity to the diphtheria bacterium, just potentially a toxin it sometimes releases.¹⁶

Meningococcal Vaccine

Next is the meningococcal conjugate vaccine, (**MenACWY**), often required for school attendance. According to the CDC: "Rates of meningococcal disease have declined in the United States since the 1990s and remain low today. Much of the decline occurred before the routine use of MenACWY vaccines. ... [D]ata suggest MenACWY vaccines have provided protection to those vaccinated, *but probably not to the larger, unvaccinated community (population or herd immunity)*."¹⁷

Also consider that, according to the CDC: "Protection from MenACWY vaccination wanes in most adolescents *within 5 years*," and the CDC does not recommend routine administration of this vaccine for adults.¹⁸

The Rest of the Vaccines Mandated for School

Aside from the vaccines covered above, the only remaining vaccines typically required for school are Hep B, MMR, and Varicella. Let's go through each.

Regarding the Hep B vaccine, mandating this vaccine for school (and hence expelling children from school for not having this vaccine) is not rational since Hep B is mainly passed through sexual intercourse or sharing needles, neither of which are school related activities.

To confirm and drive home this point, my firm, on behalf of ICAN, sent a FOIA request to CDC for "documentation sufficient to reflect any case(s) of transmission of Hepatitis B in an elementary, middle, or high school setting."¹⁹ CDC's response? It could not identify any such case.

Not one. As CDC conceded: "A search of our records failed to reveal any documents pertaining to your request."²⁰ Meaning, CDC could not find documentation of a single case of Hep B being transmitted in a school setting.

That brings us to the final two vaccines typically required for school—MMR and Varicella. And for those in the Vaccines Amen crowd pulling their hair out from the above, we have finally arrived at vaccines that can prevent transmission (well, at least in some people for some period). But as addressed in Chapter 7, eliminating these infections, based on the best available science, has likely caused more deaths than it has prevented. As discussed therein, over millennia, humans developed an ecological relationship with measles, mumps, rubella, and chickenpox, and eliminating these typically benign infections appears to have been a disastrous idea. And in Chapters 10 and 11, we will go through the concerning safety issues with these products.

The Fanatics? Those Wanting Informed Consent or Those Seeking to Mandate

I know that those in the Vaccines Amen crowd reading the foregoing are yelling to themselves that it is crazy to claim that most vaccines do not prevent transmission! But, alas, it is simply a fact that even most vaccines mandated for school do not prevent transmission. And they don't just fail to prevent it sometimes or in some scenarios—they fail every time.

Here is the critical point: the claim that everyone must get fully vaccinated to prevent transmission is simply a belief, even for most school-mandated vaccines. Again, belief, not "science." In fact, for many of these products, the opposite is true: it is the vaccinated who are more likely to spread the pathogen in school. This flips the script that the unvaccinated are more likely to transmit and are relying on others for protection. Using Vaccines Amen logic, the exact opposite is true for many vaccines.

Given this reality, and applying the logic of the vaccine fanatics, it is those vaccinated for pertussis, for example, who should be excluded from school, employment, etc., to reduce the spread of pertussis. Should we do this? Of course not. Individual and civil rights, including the rights to informed consent and to refuse an injection into one's body, are far too important.

This also brings into sharp relief another misconception: that it is those who are not vaccinated who want to force their medical decisions on others. The precise opposite is true. It is the vaccine promoters who want to force their medical decisions on others through mandates and

coercion, while those who are not vaccinated typically just want to be left alone.

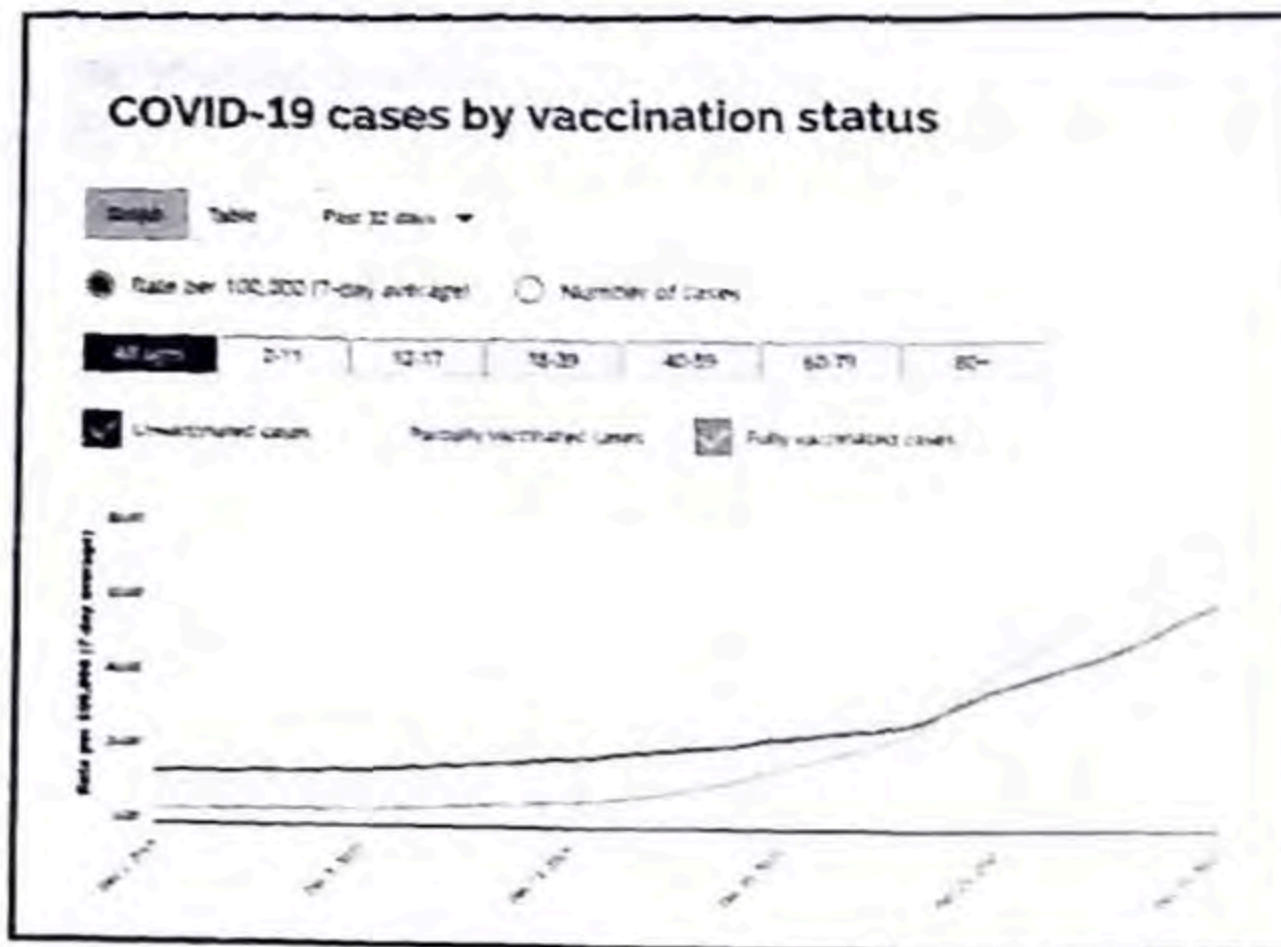
It is also cruel and illogical to expel a child from school for not getting a medical product—any medical product—but especially for not receiving a product that only provides personal protection. Even worse is expelling a child for not getting an injection that makes the child *more* likely to spread the pathogen at issue. What is the point of depriving a child of an in-school education for not getting a pertussis vaccine or tetanus vaccine? Not health. Rather, they are excluded for their refusal, or that of their parents, to slavishly believe a religious tenet of vaccinology. Punishing children for this refusal is the worst form of tyranny.

Covid-19 Vaccines

The belief that vaccines must prevent transmission is so strong it even causes otherwise intelligent individuals to suspend logic and reason and even hide the data and evidence that contradict their belief. Covid-19 vaccines provide a good final example of this phenomenon. The data reflects that these vaccines make the vaccinated more likely to become infected with, and hence spread the virus that causes Covid-19 than the unvaccinated. When this became apparent, let's see what the "health" officials in the countries that actually reported infection rate data did with that data.

In Ontario, Canada, the health department reported infection rate data to the public, at least for a while. The data clearly showed that the vaccinated were far more likely to become infected than the unvaccinated. That was not always true, but starting in December 2021, the number of cases per 100,000 residents among the "fully vaccinated" surpassed the number of cases per 100,000 residents among the "unvaccinated." This can clearly be seen in a chart published by the province of Ontario, Canada on its website. The gap between the number of cases among the vaccinated versus the unvaccinated kept getting wider and wider, until it was unmistakable: the vaccinated were far more likely to become infected.

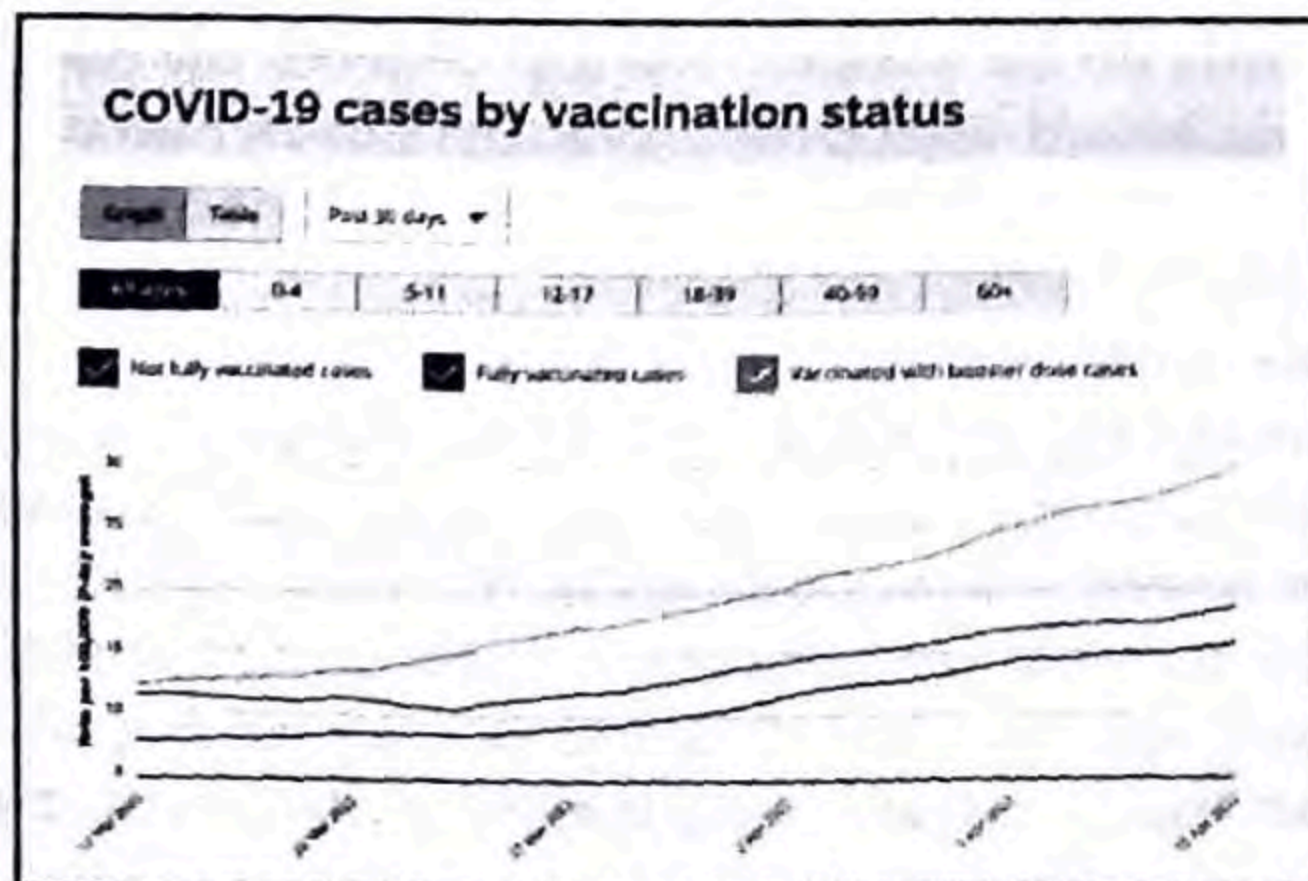
In fact, we used the following chart from the Ontario, Canada health department in our brief to the United States Supreme Court challenging the federal government's mandate that certain companies require their employees to receive a Covid-19 vaccine:²¹



As the line reflecting the rate of cases among the vaccinated kept climbing up and away from the line reflecting the rate of cases among the unvaccinated, it no doubt created unease among the believers. So, what was their solution? Admit the problem? Seek to correct the problem? Of course not. It was to change the chart.

Yep, they eliminated the “unvaccinated” category and replaced it with a “Not fully vaccinated” category, which included the unvaccinated *as well as* the partially vaccinated (including those who received a second dose of a 2-dose series and then developed symptoms within 14 days after that second dose). The only issue is that over time that also did not fix the problem. In fact, it made it crystal clear the vaccinated were the ones becoming infected with the virus.

Just look at the following chart from April 13, 2022, and you will see that the fully vaccinated plus booster had by far the highest rate of infections, the fully vaccinated had the second highest rate of infection, and the group with the *lowest* rate of infection were the “Not fully vaccinated”²²:



So maybe Ontario, Canada was a fluke? Let's jump across the Atlantic and look at Scotland. The following is from a report from Scotland's health authorities from January 2022 which clearly shows that those fully vaccinated had more than twice the case rate as the unvaccinated²³:

Table 14 – Cases

Unvaccinated			
Week	No. tested positive by PCR	Population	Age-standardised case rate per 100,000 with 95% confidence intervals
18 December - 24 December 2021	5,594	1,006,025	540.82 (518.55 - 563.08)
25 December - 31 December 2021	9,496	998,045	958.52 (926.37 - 990.68)
01 January - 07 January 2022	9,105	988,033	923.27 (893.85 - 952.70)
08 January - 14 January 2022	3,601	979,617	412.77 (390.36 - 435.18)
2 Doses			
Week	No. tested positive by PCR	Population	Age-standardised case rate per 100,000 with 95% confidence intervals
18 December - 24 December 2021	32,628	1,866,426	1,328.29 (1,310.47 - 1,346.10)
25 December - 31 December 2021	50,622	1,522,561	2,551.97 (2,522.57 - 2,581.37)
01 January - 07 January 2022	34,327	1,121,214	2,418.35 (2,383.69 - 2,453.01)
08 January - 14 January 2022	9,363	995,855	865.79 (839.92 - 891.67)

What did Scotland's health authorities do with this damning data? Address the underlying failing of the vaccine? Of course not. They simply stopped issuing these reports. Yep, they were apparently very happy to publish the data showing that the rate of infection in the unvaccinated was higher. But when it started to show the opposite, that the vaccinated were far more likely to be infected—meaning, the data dared to not fit the dogma—it had to go. And so, it did. They stopped publishing this data.

It is also worth noting that Ontario and Scotland have centralized government-run health care systems, unlike in the United States. This allowed them to capture more accurate health care information. And their data sure was startling.

The point is: when the data doesn't fit the dogma, the vaccinologists and public "health" agencies will stop collecting and/or reporting the data. They just pretend that the data does not exist. This is why what the three FDA scientists did in publishing the baboon data regarding the pertussis vaccine was a rare, almost incredible occurrence.

Transmission Wrap-Up

If one still cannot accept that many of the childhood vaccines do not prevent transmission, then Vaccines, Amen. If one still argues that measles vaccine prevents transmission to support mandating vaccines that do not prevent transmission, then Vaccines, Amen. If one still thinks every child who has an increased risk of transmitting an infection should be excluded from school, yet does not support excluding children vaccinated for pertussis, then Vaccines, Amen. If one still cannot accept that these products often do not possess what many of their worshippers say is their essential quality—preventing transmission (and for some products, increase transmission)—then Vaccines, Amen.

When those pushing a position cannot persuade on the merits, often the next step is force. And that is precisely what the Vaccines Amen crowd has resorted to—the use of force, by expelling children from school, removing them from the homes of parents who refuse to abide by their orthodoxy, and worse. Let's put it this way: if one thinks that a vaccine, like pertussis vaccine, which at best provides personal protection, should be mandated, then that person is supporting a belief through force. Depriving a child of an in-school education to force them to make a personal medical decision against their or their parents' will—maybe a pertussis vaccine, maybe an asthma inhaler—is simply cruel.

If the government can mandate a product that only provides personal protection, then it can mandate any medical procedure. Heart disease, for example, is the number one killer of Americans, so why can't the government mandate eating well, exercise, and heart medicine? The only reason some people think differently about vaccines, as opposed to heart medicine, is that they hold no religious beliefs about heart medicine—but they do about vaccines.

PART IV

THE GOLDEN

CALF

Chapter 10

"Vaccines Are Thoroughly Studied Pre-Licensure!"

Some may say, "*Fine, so the benefits are vastly exaggerated, and pharma companies and regulators are not minding vaccine safety, but the safety profile of each vaccine is proven in a clinical trial before licensure. Right? Otherwise, each would not have been licensed.*" Get ready for more heresy—but first, a very quick primer on clinical trials.

Clinical Trial Basics

The data relied upon to license a vaccine is collected in a clinical trial. The pharma company seeking licensure conducts the trial—not the FDA. The company then submits the trial data to the FDA, which is then supposed to review the data and decide whether to license the vaccine.

Clinical trials begin with signing up participants. The participants are supposed to be randomly assigned into two groups. One group gets the vaccine. One group does not get the vaccine (this group is known as the **control group**). The researchers conducting the trial should be blinded, meaning they do not know which group each participant is in. Participants are then supposed to be tracked for adverse health effects. Eventually, the researchers are unblinded, learn which group each participant was in, and compare health outcomes between the groups.

Assuming proper randomization and blinding, to evaluate whether the trial is well-designed to assess safety, you would ask yourself at least these three questions:

What did the control group receive? The control group should receive a placebo or another vaccine for the same disease that was previously licensed based on a properly designed placebo-controlled trial. Absent this,

the control's safety baseline will not have been properly established, leading to spurious safety conclusions.

How long was safety reviewed after injection? If the review period is too short, the trial will miss safety issues that arise later.

How many individuals were in the trial? If too few participants are enrolled—for example, just a few thousand children—it will not be able to detect statistically significant safety differences between the vaccinated group and the control group.

With that primer, here comes the sacrilege.

Setting the Table with an Initial Example: A Newborn Vaccine

In my experience, most people assume that clinical trials for childhood vaccines review safety for years, involve hundreds of thousands of children, and include a placebo control group so that outcomes in the group receiving the vaccine can be compared against the control group. If you thought this, you are not alone. Sadly, this belief is just that – a belief.

To set a foundation for a broader discussion about this topic, let's start with the vaccine given on the first day of life – the hepatitis B vaccine. A baby is just taking his first breaths and bam, he is jabbed in his tiny muscle tissue with a pharma product intended to prevent infection by a pathogen typically transmitted by sex or drug users sharing needles.

At a minimum, a clinical trial lasting a few years would be needed to know this product's actual safety profile and health effects. No science degree needed to figure out this obvious fact. This is because, as discussed, there are numerous developmental, neurological, and immune disorders that are not apparent or diagnosed until a baby is at least a few years of age. Meaning, it would take years after an infant who received a vaccine on his first day of life to know whether and how that vaccine impacted his health.

Yet, as you may recall from Chapter 1, the clinical trial relied upon to license this vaccine monitored safety for *no more than five days after injection*. Five days. This still sounds unbelievable to me, even though I have known about it for a decade. But belief simply cannot change this unbelievable reality.

There are two hepatitis B vaccines that can be given to a one-day-old baby in the United States: Recombivax HB, licensed in 1986 and sold by Merck, and Engerix-B licensed in 1989 and sold by GSK. The first

time that I learned about the safety monitoring period in their clinical trials was from reading these products' package inserts.

A package insert is a piece of paper found in the box/package in which each drug or vaccine is sold. Section 6.1 of the package insert, as required by federal law, summarizes the clinical trial relied upon to license that product as safe. As you may recall from Chapter 1, here is what Section 6.1 of the package insert for Recombivax HB states about the clinical trials relied upon to license this vaccine for children, with the relevant portion highlighted¹:

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a vaccine cannot be directly compared to rates in the clinical trials of another vaccine and may not reflect the rates observed in practice.

In three clinical studies, 434 doses of RECOMBIVAX HB, 5 mcg, were administered to 147 healthy infants and children (up to 10 years of age) who were monitored for 5 days after each dose. Injection site reactions and systemic adverse reactions were reported following 0.2% and 10.4% of the injections, respectively. The most frequently reported systemic adverse reactions (>1% injections), in decreasing order of frequency, were irritability, fever ($\geq 101^\circ\text{F}$ oral equivalent), diarrhea, fatigue/weakness, diminished appetite, and rhinitis.

After reading this in Chapter 1, your jaw should have hit the floor. If it didn't, let me repeat that the FDA licensed this product for infants and children based on a clinical trial with "147 healthy infants and children (up to 10 years of age) who were monitored for 5 days after each dose."² If you don't believe this is really what is in the package insert prepared by Merck and approved by the FDA, you can read it yourself as it is linked in the endnote to this sentence.³

Let's count the ways the clinical trial relied upon to license this vaccine for babies is utterly useless for assessing safety. First, it only monitored safety for 5 days after each dose. Second, it only included 147 children. Third, no control group; but even if it had a proper control group, it wouldn't have mattered anyway since the trial included only 147 children and only monitored safety for 5 days after injection.

The first time I read this I was *certain* there must be more. I simply couldn't believe *this* was the clinical trial relied upon to license a medical product for anyone, let alone for babies. But as we discussed, the clinical trial reports for this product we obtained via FOIA from the FDA confirmed it was less than a week of safety monitoring after each injection into infants and children.⁴ This was also confirmed in a Merck study published in 1986, titled *Overview of clinical studies with hepatitis B vaccine made by recombinant DNA*: "Participants in the clinical trials recorded their temperature and any complaints they had for 5 days following each injection of vaccine."⁵

What makes this even more incredible is that this was the *first* vaccine ever licensed using a new recombinant DNA technology. As explained in the journal *Nature*, Recombivax HB "was the first vaccine

to be produced using recombinant DNA technology and although it was only the third recombinant product to be approved for clinical use, it was also the most complex in forming nanoparticles that resemble patient-derived virus particles in both structure and immunogenicity.”⁶

If you are not deeply troubled by the fact that a completely novel vaccine given to babies was approved by the FDA based on a clinical trial that monitored safety for only 5 days after injection in only 147 children without a control group, then Vaccines, Amen. For those already jumping up and down claiming, “Well, after licensure there have been safety studies!” hold tight, we get to that in the next chapter. You will be crestfallen.

Okay, so maybe this hepatitis B vaccine was an outlier. Sadly, no. The only other hepatitis B vaccine licensed for newborns monitored safety for only 4 days after injection. Again, this is clear in its package insert.⁷

The rest of this chapter will go through childhood vaccine trials in a methodical but succinct manner. First, I will address the control used in each trial, second, their safety review durations, and third, their size. If you haven’t already guessed, the bottom line is that none of the trials relied upon to license routine childhood vaccines determined their safety profile prior to licensure. Not conjecture – just the hard, cold facts as you will see for yourself.

Placebo Controls: Definition, Importance, and Failure to Use

Let’s start with the control used in clinical trials of childhood vaccines. The control should be a placebo or, at the very least, another vaccine for the same disease licensed based on a properly designed trial that included a placebo control group.

The importance of a placebo control group in a clinical trial cannot be overstated. The entire point of a trial is to evaluate the efficacy and safety of something new. A new drug. A new vaccine. And with something new, you don’t know whether it will work or what harms it may cause. What effect will it have on the heart? Cardiovascular system? Nervous system? Immune system?

If all you have is a group that gets the experimental drug or vaccine, and some of them develop cancer or have some other health issue, how do you know if it is caused by the experimental drug or vaccine? It is extremely difficult to judge. You can try to use the “background rate” for a health issue for a similar group in society (meaning, similar age, gender, socioeconomic status, health status, etc.) to see if there is an elevated rate of harm in the trial, but that poses a lot of issues because this “background rate” is often unknown or difficult to determine. It also introduces serious bias into the trial.

You could try to assess whether the drug or vaccine would cause the issue, but that is fraught with uncertainty and again introduces bias. Remember, it is a new product. How it works and what effects it has on the human body are unknown. So, how do you determine its safety profile?

You need a trial in which the group receiving the experimental product is compared to a "control group" that does not receive this experimental product. The control group in the clinical trials for a new *drug* will typically receive a placebo.

Now this is critical: a placebo is something inert.⁸ As explained by the CDC in its vaccine glossary, a "placebo" is: "A substance or treatment that has no effect on living beings, usually used as a comparison to vaccine or medicine in clinical trials."⁹ Or as explained by the FDA in its guidance regarding conducting a placebo-controlled trial: "Placebos, defined as inert substances with no pharmacologic activity, are commonly used in double-blind, randomized controlled clinical trials."¹⁰

The critical importance of a placebo control group is explained by the NIH as follows¹¹:

In undertaking a clinical trial, researchers don't want to leave anything to chance. They want to be as certain as possible that the results of the testing show whether or not a treatment is safe and effective. The "gold standard" for testing interventions in people is the "randomized, placebo-controlled" clinical trial. ... A placebo is an inactive substance that looks like the drug or treatment being tested.

Okay, so a placebo is important—and when it comes to children, especially infants, the importance is far greater. So, you would expect clinical trials for childhood vaccines to include a placebo control group, right? Sadly, that virtually never occurs.

The painful reality the Vaccines Amen crowd cannot come to terms with is that the clinical trial relied upon to license each routine childhood injected vaccine on the CDC schedule did not include a placebo control group. Instead, there was either no control group, the control group received an injection of a non-inert substance, or the control group received another vaccine that was either unlicensed or was never licensed based on a placebo-controlled clinical trial.

How can I be certain? It's all in black and white on the FDA website and pharma documentation for each trial. To see that every single routine childhood injected vaccine on the CDC schedule was not licensed based on a placebo control trial, you need to look no further than this

source material. We will walk through this material for each routine childhood vaccine in a moment, but first, the following tables also summarize this reality with citation to the source material.¹²

This first table lists the vaccines injected three times each in the first six months of life. None were licensed based on a placebo-controlled trial.¹³

Vaccine	Brand	Control	Placebo?
HepB	Engerix-B (GSK)	No control	NO
	Recombivax HB (Merck)	No control	NO
DTaP	Infanrix (GSK)	DTP	NO
	Daptacel (Sanofi)	DT or DTP	NO
Hib	ActHIB (Sanofi)	Hep B Vaccine	NO
	Hiberix (GSK)	ActHIB	NO
	PedvaxHIB (Merck)	Lyophilized PedvaxHIB	NO
PCV	Prenar 13 (Pfizer)	Prenar 7	NO
	Vaxneuvance (Merck)	Prenar 13	NO
	Prenar 20 (Pfizer)	Prenar 13	NO
IPV	Ipol (Sanofi)	No control	NO
Combo Vaccines	Pediarix (GSK)	ActHIB, Engerix-B, Infanrix, IPV, and OPV	NO
	Pentacel (Sanofi)	HCPDT, PolioVAX, ActHIB, Daptacel, and IPOL	NO
	Vaxelis (MSP)	Pentacel, Recombivax HB, Daptacel, and ActHIB	NO

The same is true for the routine vaccines licensed for injection starting at 6 months through 18 months of age: no placebo control, and each is injected more than once. Children in this age range also get more injections of vaccines from the above table.¹⁴

Vaccine	Brand	Control	Placebo?
MMR	M-M-R II (Merck)	No control	NO
	Priorix (GSK)	M-M-R II	NO
Chicken Pox	Varivax (Merck)	Stabilizer and 45mg of Neomycin per ml	NO
Hepatitis A	Havrix (GSK)	Engerix-B	NO
	Vaqta (Merck)	AAHS and Thimerosal	NO
Flu	Fluarix (IIV4) (GSK)	PCV13, Havrix, Varivax, or unlicensed vaccine	NO
	Fluzone (IIV4) (Sanofi)	Fluzone (IIV3) or unlicensed vaccines	NO
	FluLaval (IIV4) (GSK)	Fluzone (IIV4), Fluarix (IIV3) or Havrix	NO
	Afluria (IIV4) (Seqirus)	Fluarix (IIV4) or Fluzone (IIV4)	NO
	Flucelvax (IIV4) (Seqirus)	Afluria (IIV4), Menveo, or Menveo+Saline	NO
Combo Vaccine	ProQuad (Merck)	M-M-R II and Varivax	NO

The same holds true for the routine vaccines licensed for use in children between 18 months and 18 years of age: no placebo.¹⁵

Vaccine	Brand	Control	Placebo?
Tdap	Boostrix (GSK)	Decavac	NO
	Adacel (Sanofi)	Decavac	NO
HPV	Gardasil (Merck)	AAHS or Gardasil carrier solution (L-histidine, Polysorbate 80, and Yeast Protein) (594 subjects)	NO
	Gardasil-9 (Merck)	Gardasil or Placebo+Gardasil (3 doses)	NO
MenACWY	Menactra (Sanofi)	Menomune	NO
	Menveo (GSK)	Menomune or Menactra	NO
	MenQuadfi (Sanofi)	Menveo or Menactra	NO
	Penbraya (Pfizer)	Trumenba+Menveo	NO
Combo Vaccines	Kinrix (GSK)	Infanrix and Ipol	NO
	Quadracel (Sanofi)	Deptacel and Ipol	NO

These tables, reflecting FDA data, make plain that none of the routine childhood injected vaccines were licensed for children based on a placebo-controlled trial.¹⁶ This chapter could end right here but that wouldn't be fun.

I can already hear the Vaccines Amen crowd reading this book shrieking: "But the vaccines used as controls were licensed based on a placebo-controlled trial! Or down the chain, the first vaccine in the licensure chain was licensed based on a placebo-controlled trial!!" Sadly, this is simply untrue.

We are going to work our way down the CDC childhood vaccine schedule, reviewing each injected vaccine.¹⁷ This is where this chapter gets more interesting. Promise.

Injections Given in First Six Months of Life

Let's start with the vaccines injected in the first six months of life. Given that these pharmaceutical products are going to be injected into healthy babies, you would expect their trials to be incredibly rigorous. Which, at the least, would mean the trial included a placebo control group *or* another vaccine as the control that had been licensed based on a placebo-controlled trial. You already know that did not happen but when we go through each vaccine in a bit more detail, you will understand the potentially devastating results of not having a proper control group.

Hep B Vaccine

As discussed, the two licensed hepatitis B vaccines injected into newborns (and at 2 months and 6 months) were licensed with no placebo control and no more than five days of safety monitoring after injection. So, bottom line, they had no clue if these two products were safe for

babies when licensed. But that is not where the story ends, because these products were then used as controls for later hepatitis B vaccines. From those later trials, we can get a glimpse into their safety, and it is disturbing.

For example, Heplisav-B, a Hep B vaccine, was approved by the FDA in 2017 for adults.¹⁸ The trial for this new hepatitis B vaccine, which contains a novel adjuvant, did not use a placebo control.¹⁹ Instead, the control was Engerix-B.²⁰ The serious adverse event rate in the primary clinical trial for Heplisav-B was 6.2%, which the researchers deemed similar to the serious adverse event rate of 5.3% for Engerix-B.²¹

A “serious adverse event,” as defined by the FDA, means:

- Death
- Life-Threatening
- Hospitalization
- Disability or Permanent Damage
- Congenital Anomaly/Birth Defect
- Required Intervention to Prevent Permanent Impairment or Damage
- Other Serious (Important Medical Events) (...the event may jeopardize the patient and may require medical or surgical intervention ... to prevent one of the other outcomes)²²

Despite the 6.2% rate of serious adverse events, Heplisav-B was deemed safe only because it was as safe as Engerix-B. But Engerix-B was licensed without a control group and with only 4 days of safety monitoring after injection.²³ The serious adverse reaction rate for Engerix-B and Heplisav-B in the latter’s clinical trial should have caused massive concern regarding the safety of *both* vaccines, not confidence that the *new* Heplisav-B is safe.

DTaP Vaccine

Next up is DTaP vaccine, injected at 2, 4, and 6 months. There are two licensed DTaP vaccines, Infanrix (GSK) and Daptacel (Sanofi).

Infanrix was licensed for babies based on trials with no placebo control. Instead, the DTP vaccine was used as a control and safety was reviewed up to only 30 days after injection.²⁴ DTP vaccine, however, was not licensed based on a placebo-controlled trial and, as discussed in Chapter 7, studies have repeatedly found that DPT increases mortality in infants, meaning DTP-vaccinated infants die at far higher rates than their equally situated unvaccinated peers.²⁵

Had DTP been properly trialed prior to licensure against a placebo control group, the fact that it causes more children to die could have been identified. Instead, it was licensed without properly assessing its safety. Then, once licensed, it was assumed to be safe. Based on this assumption, it was then used as the control in the trial for Infanrix.

Think about that: a product repeatedly shown to increase deaths among babies was used as the baseline of safety to license Infanrix. That is beyond disturbing. It should hopefully bring into sharp focus the incredible danger of licensing any vaccine without a proper clinical trial. For childhood vaccines, doing so has resulted in a pyramid scheme of safety. DTaP was licensed because it was deemed to be "as safe as" DTP; but no trial validated DTP was safe in the first place and numerous post-licensure studies show that DTP is literally increasing infant mortality.

The only other DTaP vaccine, Daptacel, was also licensed without a placebo-controlled trial. Instead, DT or DTP vaccine was again used as a control and, in that trial, "[w]ithin 30 days following any dose of DAPTACEL, 3.9% subjects reported at least one serious adverse event."²⁶

Recall the definition of "serious adverse event" means death or another very serious harm. But, since there was no proper control group to compare against, the fact that 3.9% of previously healthy infants had a serious adverse event within thirty days of Daptacel in its clinical trial could be brushed under the rug. Let me put it this way: as long as Daptacel did not increase deaths among infants more than DTP increased deaths, it was considered safe. Meaning, "safe" by the FDA's standards—not by the standards of any thinking, reasonable, or moral person.

PCV Vaccine

Next up is the Pneumococcal (PCV) vaccine, injected at 2, 4, 6, and 12 months of age.²⁷ This vaccine provides another good illustration of the safety pyramid scheme in vaccine clinical trials.

The first PCV ever licensed for children in the United States was Prevnar 7 in 2000. Despite the fact it was the very first one ever licensed, the clinical trial to license this vaccine did not use a placebo. It could have used a placebo, but it didn't. Instead, and this is going to sound unbelievable, the control was another unlicensed experimental vaccine. Literally, it was "an investigational meningococcal group C conjugate vaccine [MnCC]," meaning an unlicensed experimental vaccine.²⁸ Let me repeat that: Prevnar 7 was licensed based on a clinical trial which compared safety to *another experimental vaccine*. Seriously, I couldn't have even dreamed of making this up.

Even a group of FDA and CDC scientists conceded that comparing Prevnar 7 to an experimental vaccine means it was not possible to determine whether it was safe:

Prior to licensure, ... the control group in [Prevnar 7's] main study received another experimental vaccine, rather than a placebo. If both vaccines provoked similar adverse effects, little or no difference between the 2 groups might have been evident.²⁹

Meaning, by FDA standards, Prevnar 7 just needed to be as safe as another experimental vaccine—which could have been a very dangerous product. That is obviously a ridiculous trial to use to determine whether Prevnar 7 was safe. And it would be funny if we were not talking about the health and safety of newborn babies.

It gets worse. In 2010, Prevnar 13 was then licensed based on a clinical trial in which Prevnar 7 was used as the control.³⁰ Of course, all that means is that Prevnar 13 was as safe as Prevnar 7 which itself was licensed only because it was as safe as another experimental vaccine. While that alone is concerning, here is where it gets really concerning. In Prevnar 13's clinical trial, the results showed: "Serious adverse events reported following vaccination in infants and toddlers occurred in 8.2% among Prevnar 13 recipients and 7.2% among Prevnar [7] recipients."³¹

That should have been a stunning finding. It should have been deeply concerning that, among previously healthy infants, 8.2% of Prevnar 13 recipients and 7.2% of Prevnar 7 recipients suffered a serious adverse event. As we have seen above, a "serious adverse event" means a grave harm. Instead of raising alarm bells, which this should have, Prevnar 13 was deemed "safe" by the FDA and licensed for use in babies because it had a similar serious adverse reaction rate as the control group receiving Prevnar 7.³² Again, safe by the FDA's approach, not safe by any thoughtful, moral, or ethical standard.

Seriously, when 7% to 8% of previously healthy infants had a serious adverse event rate from Prevnar 7 or Prevnar 13, that finding should have caused heads to explode. No PhD is required for that to cause concern. Just common sense and a smattering of empathy. It should have made them, at the least, question the safety of both products, given that Prevnar 7 was licensed only because it was as safe as another experimental vaccine.

Amazingly, in explaining this incredibly concerning rate of serious adverse events, Pfizer (which profits from these products) stated that because the trial for Prevnar 13 reviewed safety for six months, rather than 30 days (and 60 days for hospitalization) as occurred in the trial

for Prevnar 7, the high rate of serious adverse events may have been due to the longer observation period. But that is not an excuse. It is an indictment. Yet the FDA accepted this excuse.

As Pfizer's FDA-approved package states: "This reporting period [of 6 months] is longer than the 30-day post-vaccination period used in some vaccine trials. The longer reporting period may have resulted in serious adverse events being reported in a higher percentage of subjects than for other vaccines."³³ Again, how in the world is this an excuse? This should be cause for real alarm and highlights the issue with short safety reviews.

Yet, instead of pausing to ensure the safety of these products after this shoddy trial showed troubling results, the pyramid scheme continued. Prevnar 13 was then used as the control to license Vaxneuvance, PCV-15, for children in 2022.³⁴ In that trial, "serious adverse events... were reported by 9.6% of VAXNEUVANCE recipients and by 8.9% of Prevnar 13 recipients" but the new vaccine was nonetheless deemed "safe" because there were "no notable patterns or numerical imbalances between vaccination groups."³⁵ In other words, the vaccine was deemed safe by the FDA's standard but not by any rational, thinking, or ethical standard.

In 2023, Prevnar 13 was again used as the control to license Prevnar 20, (PCV-20), for children, and this trial again showed high rates of serious events in both vaccine groups. This time, to obfuscate the concerning results, the findings were split into two categories: "serious adverse events" and "newly diagnosed chronic medical conditions." Despite the high rate of serious harm in both vaccine groups, the FDA deemed the product "safe" because there were "no notable patterns or imbalances between vaccine groups."³⁶

In short, PCV-20 and PCV-15 were licensed using PCV-13 as the control. PCV-13 was licensed using PCV-7 as the control, and PCV-7 was licensed using another unlicensed experimental vaccine as the control. In each of these trials, the serious adverse events rate was high in both vaccine groups; but because the rate was similar in both groups, each met the FDA's artificial standard for what it deems as "safe."

I have been in the room with parents whose children have been seriously injured by a PCV vaccine when they learn what was relied upon to license these products. The range of emotions is heartbreaking: some break down from guilt for not having more carefully reviewed these products, while others express anger—even rage. In my experience, however, these parents remain largely unemotional toward the products themselves—unlike the Vaccines Amen crowd. Their focus and pain relate to their injured child, whose safety was plainly not of real concern in these PCV vaccine trials.