Vaccination and Chronic Disease

Richard Moskowitz, M. D.

In my 53 years as a family doctor, I cared for a large number of children who were adversely affected by many different vaccinations, with diagnoses as varied as an average pediatric practice. Yet they all reacted in closely similar fashion, hinting at something important in the nature of chronic disease, the great riddle that has confounded physicians since the earliest times. My plan is to begin with a summary of my own clinical experience, together with pertinent findings in the scientific literature, and then explore the questions it raises about chronicity itself, a dysfunction that somehow manages to insinuate itself into our everyday physiology, achieves in effect a new "normal" of healthy and diseased modes co-existing side-by-side in place of the old, and resists cure by perpetuating itself over the lifetime. With all that in mind, I'll finish with the COVID to bring everything up date, followed by a brief epilogue on the special vantage point of clinical practice.

1.

Chronic disease is everywhere.

Always a troubling enigma to physicians, chronic diseases have become so prevalent in in recent decades that they now command a preponderance of the time, space, and energy of most practicing physicians in the United States and the developed world**.** As far back as 2008, the CDC surveyed the incidence of six prominent types in

the United States -- diabetes, cardiovascular disease, COPD, asthma, cancer, and arthritis -- and found that

> 60% of all adults had been diagnosed with 1 or more of them, as had
> 78% of those 55 and older, and
> 85.6% of those 65 and older,

and that

> 40% of all adults had been diagnosed with 2 or more, as had
> 47% of those 55 and older, and
> 56% of those 65 and older.[1]

Since then, the fractions of our population affected by the most common ones have been estimated as follows, taking them one by one:

asthma, COPD, and chronic lung disease	15% of all adults[2,3]
arthritis	23% of all adults[4]
hypertension	33% of all adults, 76% of ages 75-84[5]
obesity	42% of all adults[6]
diabetes	10% of all adults[7]
chronic kidney disease	15% of all adults[8]
dementia	14% by age 71[9]
some form of cancer	50% of males and 33% of females at some point in their lifetime[10]

Although these figures have been steadily increasing throughout the industrialized world, the United States leads all other countries by a considerable margin, with by far the lowest life expectancy, despite spending the most per capita on health care.[11]

Even more striking is the prevalence of chronic disease in children, presumably our healthiest demographic. In 2008, a study of 91,000 children found that 43% of them suffered from at least 1 of the 20 chronic diseases surveyed, and that adding

obesity and neuropsychiatric disturbances to the list raised the total to a shocking 54.1% of all children afflicted with some form of chronic disease.[12]

The most dramatic increases that I personally witnessed in my practice fall under the general heading of brain dysfunction, including ADHD, autism, dyslexia, and sensory, motor, learning, and developmental disabilities, all relatively uncommon when I began practicing in the late 1960's, and only slightly less so in the 1970's. Since the late '80's, all of them have been spreading rapidly, to the point that in 2017 the National Center for Learning Disabilities reported that approximately 20% or one-fifth of all children ages 3-17 were struggling with some form of learning disability,[13] and that those enrolled in Special Ed ranged from 9.2% in Texas to 19.2% in New York, or 13.7% overall.[14]

Our stingy Congress still chooses not to appropriate funds for programs to mitigate these conditions, and even the CDC seems uninterested in doing so, and to regard them as simply part of our way of life, as indeed they seem to have become. But, even though our government still prefers to ignore them, a mountain of information is available about many factors contributing to this genuine pandemic of modern life, like

1) pesticides, herbicides, petrochemicals, endocrine disruptors, and other toxins that pollute our air, water, soil, and food;

2) electromagnetic emissions and ionizing radiations from our machines and devices;

3) the pathophysiology of our fast-paced and stressful way of life; and

4) the morbidity and mortality of poverty, war, racism, oppression, incarceration, and homelessness,

all of which are likewise more prevalent in the United States than in any other wealthy, industrialized country.

Vaccines get off scot-free.

But vaccines are largely exempted from even a suspicion of being unsafe, and indeed have been mandated for the entire population, no longer just children, both because and in spite of an act of Congress protecting the industry from any liability for the deaths and serious injuries they cause.

In my practice, I regularly witnessed chronic diseases being both brought on and worsened by them; yet parents and doctors routinely missed the connection. The prevailing wisdom, espoused by the CDC, most scientists and physicians, and humane politicians, is that vaccines are almost ideally safe, and indeed among the greatest healing miracles of all time, such that it is entirely acceptable and even desirable to pile on as many as we wish, and to repeat them as often as we see fit.

2.

My own experience with vaccine-injured children.

I shall now describe my own experience with children who were adversely affected by vaccines,[15] including the circumstances that conspired to help their parents overlook any link to vaccines at first, and still deceive most pediatricians as well.[16] To

begin with, physicians are naturally trained to look for the *specific* effects of each particular drug they give; so the first cases I was sure of were relatively minor ailments that were traceable to a specific vaccine component because of signs and symptoms that were characteristic of the corresponding disease. But with more and more vaccines being introduced, often several being given at once, and the DTP and MMR sporting 3 components each to begin with, it became increasingly difficult to identify a specific vaccine or component as solely responsible for any specific complication.

By the late 1980's, I began to notice that children recently vaccinated were reacting *nonspecifically*, by becoming more prone to contracting whatever acute infections were going around their school or neighborhood, or developing a more intense or prolonged version of whatever chronic illnesses they were already bothered by, such as recurrent ear infections, which were practically ubiquitous at that time.

One 19-month-old girl didn't react overtly to her DPT or polio vaccines, and ran a fever with her first ear infection only after being weaned and entering day care around her first birthday. After that she seemed fine until her MMR at 15 months, when she came down with 5 ear infections in rapid succession, along with marked intensification of her nasal allergies and eczema, which she had had only mildly since birth. Her ear infections cleared up nicely with homeopathic treatment and putting off any further vaccinations, and she remained in good health; but her parents were dead set against resuming her shots.

Still wedded to the idea of specific reactions, I wondered if ear infections might be a specific effect of the MMR; but many other cases soon proved otherwise. One 6-year-old girl had had repeated episodes since early infancy, and remained generally "run down" in between, needing more sleep, and likely to catch whatever colds and such were going around, which her mother wearily summed up as "being sick all the time." She'd had all her shots, but her DPT booster before entering First Grade brought on an unusually severe episode, lasting 4 months despite antibiotics, and persuaded her mother to try a different approach. She too recovered nicely with homeopathic treatment, and remained in good health.

Acute and chronic.

Another "aha" moment arose from a different series of cases, like that of a 15-month-old girl, otherwise in good health, whose ears hadn't healed after 11 rounds of antibiotics. After a healthy pregnancy and easy labor, the mother chose to bottle-feed, and the first ear infection followed at 2 months, with a high fever and violent earache, soon after her first DPT, HiB, and polio combination. But her later episodes were all afebrile, with some fretting and pulling at the ear, and one was totally asymptomatic, with nothing but some fluid behind the eardrum at a routine checkup. Yet she too seemed vaguely unwell most of the time.

Advising her parents to put off any vaccinations for a while, I gave her a constitutional medicine to strengthen her immune system; and within a week she was

sick again, but this time with loud screaming and 103° fever, just like her first attack. She recovered from it in less than a day, and never had another episode. By her next visit, 3 months later, she was completely well, and remained so for the 3 years that we kept in touch, with no ear infections, no antibiotics, and, at her parents' insistence, no shots.

Her story reminded me that most acute illnesses of childhood with fever and strong, well-defined symptoms tend to indicate strong vitality and an immune system that is developing normally, while children who don't respond acutely and vigorously to infection are often chronically ill and warrant closer attention. But what impressed me most of all was that vaccines had evidently pushed her into chronic territory and kept her there for some time.

Any vaccine will do.

An even more striking finding was that *any* vaccine might suffice, as with a 10-month-old girl who reacted in exactly the same way to two different vaccinations. Again her chief complaint was recurrent otitis media, but her episodes always involved a high fever, intense earache, and loud screaming; she'd already undergone 5 of them since 2 months of age, each new one beginning soon after finishing the antibiotic from the one before.

Fussy and irritable as a newborn when her mother weaned her and went back to work, she developed a rash from her milk-based formula; and everything flared up

strongly after her first DPT, HiB, and polio combination, culminating in her first ear infection two weeks later. After that, she got only the DT, and didn't react to it overtly at all; but her ear infections continued unabated.

When her mother stopped vaccines and antibiotics and began homeopathic treatment, they quickly subsided, and she remained healthy and symptom-free. But 6 months later her parents separated, and her father took her for her MMR, which promptly brought on 3 typical episodes and 3 rounds of antibiotics. Once again, she recovered quickly at her mother's, and remained generally healthy through high school, despite a tendency to relapse when she visited her dad, who indulged her with dairy products and took her to the doctor for her full quota of vaccines and antibiotics. In short, she reacted more or less identically, in a pattern distinctively her own, to every vaccine she was given, a pattern which didn't implicate any particular vaccine, but rather some as yet unidentified feature of the vaccination process itself.

Making worse what's already there.

As the years went by, a lot more cases with a wide variety of complaints reacted to their vaccinations in much the same way, removing any suggestion that such nonspecific reactions to the vaccination process might simply be aberrations or idiosyncrasies of rare, hypersensitive individuals. Quite the contrary: it gradually became clear that children who got well for a period of time from asthma, eczema, ear

infections, allergies, ADHD, autism, or just about any other chronic complaint would consistently relapse within a few weeks of their next shots.

A few cases will suffice to establish the pattern, no matter which vaccines were involved, or what types of illness, or how grievously the children were afflicted with them. The clearest example and the easiest to understand was an 18-year-old girl who had been my patient since early childhood and was about to leave for college. Plagued with bedwetting and obsessive-compulsive behavior in elementary school, she had successfully overcome both complaints with homeopathic treatment and remained in excellent health, largely symptom-free, for more than 10 years.

But her top college required an MMR booster for admission, and within a week of receiving it her old pattern of bedwetting and OCD returned, true to form and in full force. Fortunately, she recovered quickly with the help of the same medicine as in the past, and stayed healthy thereafter.

The other adverse reactions that I witnessed ran the gamut of typical pediatric complaints, and were similarly characteristic of the patient rather than of any particular vaccine. One boy of 15 months was brought in for croup, recurrent colds, and developmental issues. Born to a diabetic mother, he weighed 8 pounds at birth, and spent weeks on a respirator in the Newborn ICU for "undeveloped lungs," with cyanosis and unstable blood sugars. At home, he was colicky and prone to severe diarrhea, but recovered when his mother eliminated wheat from her diet.

At 3 months, a week or so after his first DPT, HiB, and oral polio combination, he became restless, with swollen glands and a sickly pallor that lasted for months, and culminated in an attack of croup, with high fever and a swollen chest, that her pediatrician treated aggressively with hospitalization and IV corticosteroids. His mother cautiously postponed the next round of shots for as many months as she dared, but the same croupy illness reappeared within days after she finally agreed to it, with swollen glands and exactly the same symptoms as before.

When I first saw him, the boy appeared subnormal, drooling profusely, with his mouth hanging open, and hiding behind his mother. My first two medicines had no effect at all, but after a third one the whole illness cleared up in a few days, as if by magic; and it never came back. A month later, his mother was ecstatic, with no croup and no swollen glands in the dead of winter. I never saw him again, but the mother called years later to report that he was "thriving and developing normally, like other children his age!"

Asthmatic since 2 years of age and testing positive for a broad range of allergens, another boy of 4 was brought in because bronchodilators and inhaled corticosteroids hadn't prevented major flare-ups the previous fall and winter, some requiring oral prednisone and antibiotics as well. With homeopathic treatment, he cut his inhaled steroids in half, maintained higher peak flows of 150 or more, and recovered from a cold without asthma or drugs for the first time in his life.

The next spring and summer, at the height of his allergy season, he was still doing well on half-doses of inhaler, and remained healthy and energetic, with peak flows at record levels of 160-175. Before entering kindergarten in the fall, his DPT booster brought back his bronchitis almost immediately, and his allergies flared up worse than ever. Again he responded beautifully to the same medicine as before, stopping all drugs and vaccines, and did well without them for the years we stayed in contact.

Most adverse reactions are missed.

In the hundreds of similar cases that I cared for, the diversity of their complaints and the similarity of their reactions to vaccination taught me several overlapping reasons why their linkage is so readily overlooked:

1) some don't become diagnosable until more than two weeks after the shots, an interval beyond the official limit set for those accepted as vaccine-related;

2) they typically aggravate or reactivate chronic diseases that have already been diagnosed, and are characteristic of the child, rather than any particular vaccine;

3) they indicate a nonspecific reaction to the vaccination process itself, which few parents or doctors think of or know how to look for;

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4) they involve the same illnesses that their unvaccinated companions are also coming down with, encompassing the whole range of pediatric practice; and

5) drugs, herbicides, pesticides, industrial wastes, toxins, and pollutants may also be implicated, so that vaccines are not the only causal factor.

But the most important reason of all is that chronic diseases naturally tend to

drag on, waxing and waning idiosyncratically, without any preformed schedule. With so many different vaccines being given to infants and small children and so little time in between them, it is usually difficult for parents to make the connection unless the child recovers and remains essentially well for several months, only to relapse in identical fashion soon after the next shots are given.

Merely suppressing the symptoms with drugs and antibiotics rarely meets that standard. With chronic diseases, achieving a level of healing that surpasses their natural ups and downs generally requires withholding all vaccines and antibiotics, stopping or drastically curtailing suppressive drugs, and treating with natural methods like herbs or homeopathic medicines or acupuncture. Then the dramatic flare-up following the next vaccination leaves parents and doctors in no doubt of its causative rôle.

3.

Vaccines and chronic disease in the literature.

The cumulative weight of all these cases admitted of no other conclusion than that all vaccines, no matter what good they accomplish, also pose a major threat of chronic disease that is seldom acknowledged, and that giving them routinely and repeatedly to whole populations of healthy people has contributed substantially to the huge burden of chronic diseases that we collectively bear, not as rare aberrations or side effects, but quite the opposite, as something built into their design.

With that realization in mind, I began combing through the scientific literature, and was surprised to discover a substantial body of reputable, published research along much the same lines, but seldom read or taken seriously, and directly contradicting what most practicing physicians are authoritatively taught, fondly believe, and seldom think or dare to challenge.

In 2011, two investigators showed convincingly that the Infant Mortality Rates in 33 developed countries were directly proportional to their total vaccine load administered to infants in the first year of life, ranging from an average of 3.36 per 1000 live births in Japan and the Scandinavian countries, which gave 12-14 doses of individual vaccine components, to 5.19 per 1000, over 50% higher, in Canada, Australia, the Netherlands, and the US, which gave 24-26 doses.[17] The figures were most dramatic for the United States, with by far the highest IMR of 6.2, well over double that of Japan and Sweden with 2.8 at the low end,[18] amply confirming the general consensus of epidemiologists that the US is by far the unhealthiest of industrialized countries in that fundamental respect.

The same authors demonstrated a similar effect on mortality and the rate of hospitalization from giving multiple vaccines and vaccine components simultaneously at the same visit, by analyzing the raw data of nearly 39,000 adverse reactions reported to the VAERS system between 1990 and 2010, and counting the individual components of the MMR and DTaP as 3 separate doses each. They found that infants receiving 6, 7, or 8 doses simultaneously were much more likely to be hospitalized afterwards than

those receiving 2, 3, or 4, and that those receiving 5-8 doses were also more likely to die afterwards than those receiving 1-4.[19]

In 2013, another team analyzed nearly 325,000 American children under 2 years of age who were enrolled in 8 managed-care organizations, comparing those receiving all vaccines recommended on the official CDC schedule with those who received a smaller number, and likewise found that the "under-vaccinated" kids were significantly less likely to require outpatient visits, ER visits, and hospitalizations than those who were up-to-date.[20]

To be sure, epidemiological studies seldom provide conclusive proof; but the three just cited do present mutually-reinforcing evidence of a linear or proportional relationship between infant morbidity and mortality and *the total number* of vaccines given, both when given together at the same visit and when tallied up cumulatively throughout infancy and early childhood. Just as with my clinical cases, these findings clearly and unmistakably implicated the vaccination process *per se* more than any particular vaccine, and incidentally corroborated the instinctive fear of many parents that the total number of vaccines given does matter, and that far too many are being given.

Where are the unvaccinated?

On the other hand, even the Japanese and Swedish infants and the "under-vaccinated" group still receive a sizable number of vaccines. It is glaringly obvious that

the best way to evaluate the broad effect of vaccination on large populations would be to compare two demographically-matched groups of children, one fully vaccinated according to the CDC schedule and the other not vaccinated at all. It truly boggles the mind that our country, which yields to none in its professed commitment to science, has never undertaken such a simple and practical survey, or even proposed it as a good idea. The predictable if not intended result has been to stigmatize the large numbers of unvaccinated children who could provide the ideal control group for it, and therefore deserve our gratitude and admiration, rather than the bullying and opprobrium that they typically receive.

Vaccines promote chronic disease.

A number of other researchers provided equally suggestive findings regarding specific chronic diseases that have become increasingly prevalent. One 2005 study of over a thousand children in New Zealand showed that 23% of those vaccinated with DTP and polio developed asthma before the age of 10, and 30% saw specialists for various types of allergies, while none of the unvaccinated did so, with similar discrepancies noted in 5- and 16-year-olds as well.[21]

Other comparisons between vaccinated and unvaccinated individuals revealed significantly higher risks of developing epilepsy,[22] type 1 diabetes,[23] and the hemorrhagic disease ITP[24] in those vaccinated, while three studies of premature newborns in the NICU showed alarmingly higher levels of C-reactive protein, a warning sign of

autoimmune phenomena, in those receiving several vaccines simultaneously than in those receiving only one, and a much higher incidence of cyanosis and other life-threatening complications as well.[25,26,27]

The link between vaccines and chronic disease is similarly highlighted by numerous studies of the converse phenomenon, showing that children who come down with and recover from the typical acute, febrile infections of childhood, like measles, mumps, chickenpox, and influenza, are much less likely to develop chronic autoimmune diseases and cancer later in life than those merely vaccinated against them.

One study comparing 379 patients with many different types of cancer to the same number of matched controls found that adults with a history of having acquired measles, mumps, rubella, chicken pox, pertussis, or scarlet fever were 20% less likely to develop genital, prostate, GI, skin, or ENT cancer if they had experienced any one of these infections, 60% less likely if 3 or 4 of them, and 76% less likely if more than 4.[28]

The More, the Merrier.

As we've seen, the clinical and experimental evidence cited above explains why the links between vaccines and chronic disease are so easily and indeed routinely missed by doctors and parents alike, an omission that gives credence to the CDC's repeated insistence that vaccines are safe and effective across the board, so that it's entirely OK and even desirable to pile on as many as we like, and to repeat them as often as we think fit. But it also proves that vaccines regularly promote chronic diseases as a built-in

feature of their design, a risk directly proportional to the *number* of vaccines given, both simultaneously at the same visit, and cumulatively over the patient's lifetime.

For children and adolescents, the ACIP's recommended vaccine schedule for 2016 stipulates a total load of 70 separate doses of individual vaccine components by the time they enter college,[29] while for adults from 19 to 65, the comparable figure is 79 more,[30] for a grand total of 149 doses, which doesn't even include the extra doses for seniors over 65, pregnant women, their fetuses yet unborn, and other special indications.

In short, it is difficult to escape the conclusion that all those adhering faithfully to the CDC schedule, or even some watered-down version of it, are practically guaranteed to develop at least one and quite possibly more major chronic diseases to endure and suffer with throughout life, if not eventually die from.

The Bottom Line.

The same reasoning also gives the lie to the CDC's standard argument that vaccines are wonderfully cost-effective when compared to the medical and social costs of treating the corresponding diseases.[31] This claim dates from the advent of cost-benefit analysis in the Clinton years, when the chickenpox and rotavirus vaccines were introduced for illnesses that are rarely serious in the developed world and are advocated primarily to save the social costs of parents missing work and having to stay home and care for their sick children.[32]

As applied to all vaccines and their corresponding infections, these analyses completely ignore the monumental expense of caring for

1) the large number of patients killed or disabled by brain damage, including autism, ADHD, GBS, MS, seizures, learning disabilities, etc., and by other serious autoimmune diseases that have been shown to be vaccine-related but not yet acknowledged as such;

2) the even larger volume of patients with common diseases that are similarly activated or made worse by vaccines, like all the cases of asthma, allergies, ear infections, eczema, etc., that are likewise overlooked, yet common enough to be the rule, not the exception; and

3) the cumulative effect of the total vaccine load, the piling on of more and more vaccines without regulation or restraint, with every child being required to receive them, and the entire adult population now next in line.

Although the extent of this burden has never been seriously investigated or even acknowledged, it's already clear that these tidy official estimates of the social and medical costs of vaccinating represent just a tiny fraction of the true figures. Far from being economical, our ever more ambitious goal of vaccinating everybody against every disease we can think of has become one of the most reckless and wildly expensive medical experiments ever undertaken, and goes a long way toward explaining why our badly misnamed "health-care" system devours such an inordinate share of our GDP, and why we who live here are nevertheless so riddled with chronic disease and score so poorly on infant mortality and other standard measures of general health.

4.

Some thoughts on the chronic state.

On the other hand, vaccines do provide one important and unique benefit, one far more valuable than the partial, temporary, and counterfeit immunity that they provide. To begin with, the industry knows precisely how to make them, and how they succeed in eliciting an antibody response. If achieving that result does in fact proceed by way of or at least consistently results in the development of chronic diseases, as appears to be the case, it follows that vaccines offer a promising vantage point for exploring and hopefully solving the riddle we began with, the nature and origin of the chronic state, of how our illnesses become chronic and thus so much more difficult to heal.

If that much is true, then chronicity needs to be reframed as a disturbance of the immune mechanism that we've already alluded to, the formative experience of coming down with and recovering from the acute infectious diseases that we vaccinate against, because that process requires an impressive army of immune functions working in concert that vaccination is meant to replace, and are thus much too easily lost sight of.

The illness we know as the measles, for example, is precisely the collaborative effort of the immune system to expel the virus from the blood, an all-important task requiring a formidable array of mechanisms acting in unison, and unattainable by any one or part of them acting apart from the others.

It begins with inflammatory sensitization of the mucous membranes of the nasopharynx, the first tissues to receive the virus, and hence those best-equipped to get rid of it, by sneezing and coughing.[33] Next comes the activation and signaling of

monocytes and macrophages, wandering phagocytic cells that police the blood and connective tissues in order to detect, engulf, and digest invading viruses.[34] That process is further assisted by serum complement, proteins that attach to and fragment them,[35] and by cytokines, peptides and smaller proteins like interferons and interleukins, which help the phagocytes signal, communicate with, and direct one another to where they are needed.[36] Collectively, these mechanisms comprise the most basic or "cellular" level of immunity, our first line of defense against foreign invaders, which initiates, co-ordinates, and regulates the process as a whole.

Then, more or less concurrently, cloned subsets of lymphocytes and plasma cells from the thymus and bone marrow synthesize several types of specific antibodies directed against the virus, which promote clumping, render it insoluble, and assist the phagocytes in ingesting it.[37] These constitute the "humoral" aspect of immunity, which leaves a permanent memory of the virus encrypted within the genetic material of these immunocompetent cells, to help them respond to it even more promptly and efficiently should they encounter it again in the future.[38]

For most healthy people, the long-lasting immunity conferred by expelling the virus is profoundly health-giving in two fundamental ways. First, it is *specific*, in the obvious sense that virtually everyone who recovers from the measles will never again be susceptible to it, no matter how many times they are re-exposed to the virus, or how virulent the particular epidemic may be.[39]

Less often appreciated or talked about but at least as important is the *nonspecific*

immunity that results from having activated and co-ordinated this whole parade of mechanisms, which then primes the system to respond, acutely, vigorously, and in concert to whatever other infections it may encounter in the future. As we saw, hidden somewhere within that generic memory lies the so far unexplained miracle of protecting us against developing chronic, autoimmune diseases and cancer later in life.[40]

When discussing vaccines, it is important to remember that whatever good they accomplish doesn't provide anything even remotely like these precious gifts. When a vaccine is injected or ingested, there may be a brief inflammatory reaction at the site, but no local sensitization, no activation of macrophages and lymphocytes, no acute illness, and thus, above all, no clear mechanism or pathway for getting rid of it.

After a few weeks, yes, there will be measurable titers of specific antibodies; and yes, the recipients will probably be somewhat less likely to come down with the corresponding acute disease in the near future than they were before. But without the acute illness, there is no priming of their immune mechanism as a whole, no significant improvement in the general health, no way to expel the virus, and thus no encrypted memory of the infection. The purpose of vaccination is rather to prevent an infection that hasn't yet manifested from doing so in the future; so, without the memory, it would seem that the vaccine, or at least the instructions that it contains, must instead remain as a physical presence inside the body, to continue stimulating antibody production for long periods of time.

Either way, the bottom line is that vaccination is by definition a *chronic* phenomenon. It is dangerously misleading if not the exact opposite of the truth to claim that a vaccine renders us immune to or protects us against an infection if in fact it only drives the infectious agent deeper into the body, causing our vital organs to harbor it chronically, and thus presumably reprograms our immunocompetent cells to be less capable of responding to it acutely, and perhaps to other foreign antigens as well, such that our cellular immune responses are generally weaker, more chronic, and less capable of carrying out their healing work.

Vaccines and autoimmunity.

In either case, the industry's scientists surely know the answer; but they're not telling, and the CDC and FDA seem quite content to keep it a secret, even though it could help solve the enduring riddle of chronic disease, and in any case is far too important to be allowed to remain anyone's private property.

I'm a clinician, not a research scientist; but here are some general reflections on the subject that have occurred to me based of my own limited knowledge. First, I would divide vaccines into three broad groups:

1) live viruses, such as MMR, chickenpox, Sabin's oral polio (OPV), rotavirus, and some flu vaccines, which are attenuated versions of the corresponding pathogens;

2) killed or denatured viruses, bacteria, and antigenic fragments derived from them, like tetanus toxoid, diphtheria toxoid, cellular and acellular pertussis, HiB, pneumococcus, and most flu vaccines; and

3) bioengineered or genetically-modified viruses and antigenic fragments derived from them, like hepatitis B, HPV, and the various SARS-CoV-2 vaccines.

We already know that chickenpox, herpes simplex, and other herpesviruses are capable of introducing their genetic material into the DNA of their host cells and reproducing along with them, yet remaining latent as "episomes,"[41] and precipitating overt disease only years or decades later, if at all. If the live-virus vaccines have a similar capability, the host cells harboring them would similarly undergo some genetic modification, perhaps mild enough to remain subclinical at first, with few or no symptoms for a long time, but eventually perhaps to the degree of becoming recognizable as "foreign" and thus subject to autoimmune attack by their uninfected neighbors. Such carrier states would seem to provide a perfect recipe for chronic, autoimmune phenomena of every degree, from subclinical to life-threatening.

The toxoids and other "non-living" vaccines are more complicated, being only weak antigens on their own, and requiring the addition of chemical "adjuvants" to generate a robust antibody response. The commonest and most important adjuvants are the hydroxide and other water-soluble salts of aluminum, which have already been found to be powerfully neurotoxic all by themselves,[42] and to form antigen-antibody complexes of a molecular weight too high for the kidneys to be capable of excreting them;[43] so these too would appear to have achieved some sort of permanent residency.

The bioengineered vaccines also make use of adjuvants, and are said to be non-living and thus incapable of initiating an infectious illness; but I've classified them

separately, because "viruses" are simply strands of DNA or RNA embedded in a protein coat, and these vaccines, although modified from their live originals, still have both. So declaring them to be non-living sounds a lot like a policy statement based on wishful thinking, in lieu of knowing or maybe even wanting to know whether or not they're "alive," or not, or, in other words, what illnesses they might or might not be capable of.

A few other vaccine ingredients are known to be unhealthy, or look as if they might be, and have been added without providing any compelling reasons for doing so, and therefore warrant more thorough investigation for possible chronic toxicity of their own:

1) known toxins, like thimerosal, an organomercury germicide that is associated with neuropathology like that of the aluminum salts,[43] and formaldehyde, a known carcinogen;[44]

2) polysorbate 80, an emulsifying agent, used in the treatment of brain tumors, to help various chemotherapeutic drugs cross the blood-brain barrier,[45] a property which naturally raises the fear that it could be helping vaccines do the same, if not intentionally used for that purpose; and

3) foreign human and animal cells, genetic material, and proteins, all of which seem quite capable of instigating antibody responses all by themselves.[46]

Over and above the likelihood that all vaccines are capable of initiating and exacerbating chronic diseases, there is ample, clear scientific evidence that they also regularly initiate a variety of autoimmune responses, whether subclinical or overt, according to the makeup of each recipient, and that these capabilities are likewise built into their design, so that every dose may well have some such effect on every recipient.

Prof. Yehuda Shoenfeld, a leading authority on autoimmune phenomena, asserts that subclinical responses are the usual or baseline effect of vaccines, and are therefore typically overlooked, in which case the overt disease sometimes may require a further such stimulus to precipitate it:

> In 1982, epidemiological, clinical, and animal research showed that demyelinating autoimmune neuropathies such as Guillain-Barré syndrome and MS could occur up to 18 month following vaccination. The disease would first manifest with vague symptoms like myalgias, paresthesias, and weakness, which were deemed insignificant and ignored by the treating physicians. These would progress slowly and insidiously until the patient was exposed to a secondary immune stimulus, an infection or vaccination, which would then trigger the acute disease. It was the secondary response that would bring about the overt manifestation of an already present but subclinical, long-term, persistent disease.
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> The typical vaccine contains all the necessary biochemical components to induce autoimmune manifestations [that are] serious, disabling, and even fatal in certain individuals. [Since] they are administered to previously healthy people, efforts should be made to identify those more at risk. The necessity of multiple doses should also be considered, as [it] heightens the risk.[47]

An analogous line of reasoning has led to the discovery of autoimmunity as a probable causative mechanism for more and more chronic diseases, both old and new, with autoimmune phenomena turning up just about whenever and wherever anyone takes the trouble to look for them, as if they were coextensive if not synonymous with chronicity itself.

The following is a composite list of chronic autoimmune diseases that I put together from those cited in the PDR and the literature as adverse reactions to just the MMR,[48] Hep B,[49] HPV,[50] influenza,[51] and pneumococcal vaccines.[52] It covers a large proportion of the various chronic diseases diagnosed in clinical practice, but not those

linked to other vaccines, and those for which no autoantibodies have as yet been found or looked for:

Guillain-Barré syndrome
autism
angioedema
urticaria
Henoch-Schönlein purpura
rheumatoid arthritis
thrombocytopenic purpura
erythema nodosum
multiple sclerosis
polyarteritis nodosa
systemic lupus (SLE)
myasthenia gravis
vasculitis
antiphospholipid syndrome
temporal arteritis
uveitis
bullous pemphigoid
alopecia areata
dermatomyositis
lichen planus
erythema multiforme
thyroiditis
hemolytic anemia
pericarditis
hemolytic-uremic syndrome
Graves' disease
prostate cancer
temporal arteritis
encephalitis and encephalopathy
inflammatory bowel disease
Kawasaki syndrome
type 1 diabetes (IDDM)
lymphadenopathy
transverse myelitis
retinal vein thrombosis
chronic fatigue syndrome
optic neuritis
hemolytic anemia
aplastic anemia
glomerulonephritis
nephrotic syndrome
cerebellar ataxia
bronchiectasis and COPD
pericarditis pancreatitis,
Reiter's syndrome
demyelinating polyneuropathy
demyelinating CNS diseases
aseptic meningitis
toxic granuloma
cryglobulinemia
pancreatitis
demyelinating polyneuropathy
myasthenia gravis
demyelinating CNS diseases
narcolepsy
scleroderma

It remains to be determined if autoimmunity is the fundamental mechanism behind *all* cases of chronic disease initiated or exacerbated by vaccines, or only some of them, and if there are cases and varieties of chronic disease that are neither autoimmune nor adversely affected by vaccines at all. But as the list keeps growing, it is already clear

that vaccines are indeed a major factor in producing and aggravating them, and that these remaining questions could all be answered without serious difficulty if we simply bothered to look.

Along these same lines, it would be extremely interesting, highly worthwhile, and logistically simple to test everyone, both vaccinated and not, for the presence of autoimmune markers in the blood. As soon as this idea first came to me some years ago, I learned that just such a study had already been conducted by a group of veterinarians at Purdue University, with remarkable results, albeit on a very small scale.

The authors divided 10 purebred beagle puppies into two groups of 5, one vaccinated on the usual schedule, and the other not vaccinated at all, and followed them closely for 3 years with blood tests and immunoassays. They found that all of the vaccinated puppies tested positive, showing significant titers of autoantibodies directed against important tissue proteins, chiefly

1) fibronectin, antibodies against which are implicated in the pathogenesis of scleroderma, rheumatoid arthritis, and systemic lupus in dogs, humans, and other species;

2) laminin, antibodies against which are found in rheumatoid arthritis, systemic lupus, glomerulonephritis, and vasculitis;

3) cardiolipin, antibodies against which have similarly been implicated in cardio-myopathy; and

4) cytochrome C, collagen, transferrin, serum albumin, and DNA,

while none in the unvaccinated group did so,[53] a discrepancy which led them to comment as follows:

> These proteins are typically of bovine origin, since fetal calf serum is used to grow the viruses for vaccine production. Their close similarity to dog proteins results in a situation where antibodies produced by [the] vaccinated dogs may cross-react with dog proteins in a process similar to autoimmunity.[54]

Interestingly, none of the vaccinated dogs developed any overt chronic disease throughout the observation period;[55] but unfortunately the authors' request to extend the study for a longer period was denied, and their funding was abruptly terminated.

Redesigning clinical trials.

For all of the reasons discussed above, the relative invisibility of vaccinations as a cause of chronic disease means that we've been measuring the wrong thing. At present, the CDC simply accepts the data from vaccine safety trials that are financed, conducted, and micromanaged by the manufacturers themselves, as outlined by Marcia Angell, M. D., a Professor of Social Medicine at Harvard Medical School, who was fired as Editor-in-Chief of the *New England Journal of Medicine* for her many writings that were highly critical of the drug industry:

> It is no longer possible to believe much of the clinical research that is published. The boundaries between academic medicine and the pharmaceutical industry have been dissolving since the 1980's, and the major differences between their missions are becoming blurred.
>
> Most clinical trials are conducted by the industry. They contract with academic

> medical centers, [but] the researchers are little more than hired hands who supply human subjects and collect data according to instructions from their corporate paymasters. Their sponsors keep the data, analyze it, write the papers, and decide whether, when, or where to submit them for publication. In multi-center trials [the researchers] may not even be allowed to see the data.
>
> [They] also have other financial ties to the companies that sponsor their work. They serve as consultants to the companies whose products they evaluate, join corporate advisory boards and speaker bureaus, enter into royalty arrangements, agree to be listed authors of ghost-written articles, promote drugs and devices at company symposia, and allow themselves to be plied with expensive gifts and luxurious trips.[56]

A pithier, more succinct version was provided by Dr. Peter Rost, a former VP of Pfizer, in an exposé about the HPV vaccine, which featured him practically boasting of his aggressive marketing tactics for promoting the company's products, in flagrant violation of the ethical guidelines that Pfizer still subscribes to, which were nevertheless standard practice throughout the industry, as indeed they still remain:

> Universities and health organizations [are] out there begging for money. Nobody has any money. The only ones who do are the big international corporations, and they have lots of money. They give grants for research, pay doctors and researchers thousands of dollars to travel around, speak at conferences, and establish educational programs, all to make profits for their products. [The safety trials] are supposedly third-party and independent, but the money won't keep coming unless they support your drug, unless they say what you want them to say. Everybody know this is how things work. The drug companies know it, and you know it. Only the public doesn't know it.[57]

A closer look at these safety trials reveals four areas of glaring scientific misconduct by the industry:

1) As a matter of policy, they prefer not to use unvaccinated control groups for comparison,[58] so that it becomes impossible to establish a strict causal

> relationship between the vaccine and [any] adverse reactions observed after giving it. Their so-called "control" groups receive either the chemical adjuvant alone, with its own documented toxicity, or another vaccine entirely, typically one produced by a competitor, or discontinued because of its known adverse effects.[59]

2) To be considered vaccine-related, most adverse reactions must happen within 14 days of the shot, thus ruling out the entire chronic dimension where most of them occur.[60]

3) Many trials involve several doses administered months apart, with the period of active supervision limited to 14 days or less, and a vanishingly small list of adverse reactions already agreed upon and specifically asked about, with other unsolicited complaints volunteered by the subject apt to be disqualified.[61]

4) The lead investigator is given absolute authority to decide whether any adverse reaction is or is not vaccine-related, based on criteria that are never specified.[62]

Obviously, to provide a truer picture of how vaccines initiate chronic diseases or make them worse, safety trials will need to be redesigned, conducted, and supervised by an agency that is truly independent of the industry. They could be retrospective at first, with a control group of those much-maligned children and adults who have already refused their shots. With so many different vaccines to consider, and several containing multiple components, they should include those fully vaccinated according to current guidelines, those partially vaccinated according to their choice, and those who are not vaccinated at all. But even for prospective trials, blinding is both unnecessary and undesirable; everyone should receive precisely the level of vaccination and non-vaccination that they choose.

Secondly, the definition of adverse reactions, injuries, and illnesses from vaccines need to be broadened, to include subclinical autoimmune phenomena as well as the

initiation, re-activation, and intensification of pre-existing complaints. The trial period should be lengthened to several years at least, with active supervision throughout, and subjects should be encouraged to report every adverse reaction, not merely the few already acknowledged.

Investigators should be given clear guidelines about subjects' reports, not blanket authority to dismiss them as unrelated; and their supervision should include social psychological, and emotional variables, like absenteeism, school and job performance, relationships, temperament, subjective feelings of contentment, well-being, anxiety, and the like, supplemented when appropriate by reports of relatives, friends, and colleagues, to give a more well-rounded sense of the health and well-being of each subject, and to what extent they were affected by vaccination.

Investigators should also be trained clinicians, attentive to each patient and their particular circumstances, and capable of judging whether or not reported complaints are vaccine-related, rather than simply checking off the presence or absence of a few specific diagnoses already agreed upon in advance.

Above all, because the chronic diseases linked to vaccination encompass the entire spectrum of clinical medicine, the metric providing the simplest and clearest overview of the whole subject will necessarily be the All-Cause Morbidity and Mortality, i.e., the total number of deaths, severe diseases, and disabilities from all non-traumatic causes, combined into one over-arching statistic, comparing those receiving varying

levels of vaccination, according to their own choice, with those refusing to be vaccinated at all.

Regardless of outcome, the result of this survey would provide important information to all. If the all-cause morbidity and mortality proves to be lower for the vaccinated than the unvaccinated, or even the same, then people like me will need to stop blaming the vaccines for everything I've been accusing them of, while if the unvaccinated turn out to be healthier, these agents will end up being reconsidered in a completely different light. Either way, we will all have learned something important and valuable about vaccines and the nature of chronic diseases that we are all at risk for.

5.

The COVID-19 illness behaves very much like a chronic disease.

Right from the beginning, the pandemic virus displayed the very same chronic features of vaccine-related illness that I've just been describing. First of all, around 40% of those testing positive remained completely asymptomatic,[63] while the true figures, including those who were not tested, were of course far higher; and of those who actually became ill, 80% were only mildly so,[64] just as most people vaccinated for any reason experience very few and usually mild symptoms immediately afterward.

Secondly, the deaths and worst cases were clustered predominantly among the elderly and chronically ill, especially in nursing homes or extended-care facilities, where the victims had already been suffering with one or more chronic diseases, such that it was often difficult to say whether the actual cause of death was the COVID or the

comorbidity,[65,66,67] an ambiguity that closely resembled my clinical experience with vaccines, which most commonly was that they simply made worse what was already there.

Third, even though most acute cases began as a flu-like syndrome, with cough, chest congestion, and weakness, and the worst of them progressed to deoxygenation of the blood and microcoagulation in the pulmonary alveoli, known as Acute Respiratory Distress Syndrome, or ARDS, this complication also tended to develop slowly and insidiously over many days or weeks, during which the patients appeared to be doing well and breathing normally, with no idea of the danger until shortly before they died.[68,69]

Fourth, many of the most serious cases spared the lungs entirely, or produced microscopic lesions indicating a disturbance of the clotting mechanism in other organs and tissues as well as the lungs;[70] and, no matter which organs were involved, autopsies consistently revealed signs of immunological dysregulation known as "cytokine storm," which involved excessively high levels of interleukins in the damaged cells and tissues.[71]

Finally, in a very substantial number of patients, as many as 20-30% in some series, chronic symptoms appeared and persisted chronically, for weeks or months afterward, as well as proving refractory to treatment in many cases. Known as the "long COVID," these cases at first seemed like residues of the acute phase, but have since behaved more like chronic diseases in their own right, with lesser degrees of the same

hyperimmune dysregulation, and even developed in quite a few patients who had seemingly recovered, or been only mildly ill until then.[72]

In all of these respects, the COVID-19 illness has behaved much like other chronic diseases, with a slow course, acute phases and even flare-ups, and characterized by varying degrees of immune dysregulation in both the fatal cases and those with the "long-COVID" version. Like any chronic disease, it can progress to an acute, fatal termination, or linger indefinitely, and perhaps flare up intermittently in the future, a capability that might cast new light on those cases of presumed reinfection as simply exacerbations of the original in its ongoing, chronic state.

Further confirmation of chronicity lies in its other major clustering of severe and fatal cases in our society's least fortunate, those handicapped by poverty, discrimination, malnutrition, homelessness, and overcrowding, just like the other chronic diseases that plague us all.[73] In these respects, too, the fact that the U. S. already carries the heaviest burden of chronic disease in the developed world, and that the COVID saves most of its fire for those who are already ill, helps to explain why our deaths from it also outnumber everybody else's, and why the pandemic will undoubtedly potentiate both trends still further in the future.

The SARS-CoV-2 virus is unique.

Right from the beginning, important features of the COVID-19 illness set it apart from almost all other viral infections that we know about and vaccinate against. First,

as we saw, the strikingly large percentage of known cases of infection who were asymptomatic, combined with the undoubtedly far greater percentage who were never even tested, seem unequalled, as do the vast majority of its most severe and fatal cases who were elderly and chronically ill, especially in nursing homes and rehab facilities. Naturally, these folks tend to fare worse with the flu and other seasonal infections as well; but with COVID the statistics were so lopsided that it almost seemed as if the illness were actively seeking them out, which seemed quite new.

Secondly, there were the hyperimmune phenomena of cytokine storm, which had previously been described in fatal cases of SARS and MERS, the first major coronavirus outbreaks we're aware of, as well as influenza;[74] but with the COVID they were present in not only the most serious ARDS cases,[75] but also to a lesser degree in the chronic "long COVID,"[76] which pointed to immune dysregulation as the unique, signature pathology of the illness in all of its forms, just like other chronic diseases.

And finally, there is simply its chronic, persistent nature, which it shares with many types of herpesvirus, notably Epstein-Barr, Cytomegalovirus, Herpes Simplex, and Varicella-Shingles, as well as Hepatitis C. But it is the only known coronavirus with that capability.

The official claim that the SARS-CoV-2 virus originated in the Wuhan live-animal market,[77] in the same city as the Chinese government's virus research laboratory, has fueled much speculation that it was actually bioengineered and subsequently escaped from there, a theory given further credence by much circumstantial evidence,

including the NIH's gift of $3.7 million to that lab for "gain-of-function" research on coronaviruses specifically, soon after Trump took office in 2017,[78] which also roughly coincided with none other than Dr. Fauci brokering the deal, not to mention his predicting the massive outbreak of a new disease 3 years before it actually happened.[79]

But to my mind the most compelling reason for favoring a lab origin is this combination of strikingly improbable if not unprecedented features in the illness that it caused, and is still causing, all of which could conjure up the fiendish possibility of its having been designed as a stealth bioweapon for purposes of global depopulation:

1) that it outstrips all other viruses we know of in its contagiousnesss, on the one hand, and the percentage of infected people who are asymptomatic or only mildly ill, on the other;

2) that it selectively targets and kills those who are already chronically ill;

3) that it appears to be even more mutable than the influenza viruses, and thus has the power to continually reinvent itself;

4) that it is essentially a chronic disease, capable of bringing about a rapid and fatal termination in many patients, a lingering chronic version in others, and even apparent reinfections months or years later that may prove to be recurrences of the original; and

5) that the micropathology of both acute and chronic forms involves varying degrees of immune dysregulation, up to and inclusing cytokine storm,

all of which make it appear highly probable

6) that it was bioengineered in the Wuhan lab, to a great extent with our help, if not at our behest;

6) that it escaped, either intentionally or by just the sort of accident that our

scientists have long been worried about; and

7) that the program seems to have succeeded brilliantly in achieving precisely what its paymasters had in mind, whatever that may have been.

The lab-origin theory has also received important scientific backing from the Nobelist Luc Montagnier, the discoverer of HIV, the virus linked to AIDS, when he detected significant nucleic acid sequences of that virus in the SARS-CoV-2 genome.[80] I leave it to the proper authorities to determine whether its release from the lab was accidental or deliberate, and whether, as American intelligence has since maintained, the outbreak actually began in the summer or fall of 2019,[81] such that the CDC and NIH already knew about it months before making it public.

In any case, whether or not the SARS-CoV-2 was man-made, whatever we were up to with the Chinese in Wuhan was a disaster waiting to happen, now or in the future, such that President Obama was entirely right to have banned all such "gain-of-function" research in 2014,[82] just as even Trump, for all of his dismissals, had little choice but to belatedly cancel the NIH's Wuhan project in the midst of the pandemic.[83]

COVID vaccines.

Like all vaccines, those directed against the COVID will undoubtedly initiate and worsen whatever chronic diseases are already there, including, and by no means least, the COVID itself. Several of them also utilize a new mRNA technology that promises cutting-edge benefits and threatens brand-new complications as well.

Showcasing the gene-splicing technique that won a Nobel Prize for its inventors, these bioengineered mRNA vaccines are supposed to have eliminated the need for them to remain physically present as antigen-antibody complexes inside the body for long periods of time. In lieu of the antigen itself, in this case the SARS-CoV-2 virus or its "spike" protein, these vaccines deliver a bioengineered strand of genetic instructions to the recipient's messenger RNA to synthesize the similarly bio-engineered protein. Then, after serving that purpose, we're assured that the resulting mRNA is promptly degraded, leaving nothing behind.[84]

But if the protection these vaccines provide is meant to be long-term, as was true for all previous vaccines, then even if the messenger RNA is destroyed, the genetic information it contained will still need to be retained and used in the future, presumably by encryption within the DNA of the cells receiving it, which would then become a permanent part of the genome, despite the manufacturers' and the CDC's reassurance that that doesn't and indeed can't possibly happen.[85]

On the other hand, if the mRNA is indeed destroyed, then its action will likewise be transitory, as will any protection that it confers, in which case its power to prevent the infection, which has always been the main reason for vaccinating, will be forfeit. That does indeed appear to be what has happened, with the CDC reluctantly admitting that they don't prevent infection, and with new boosters being promoted every few months, it seems, as new variants continue to emerge.[86,87] Even if this new technology lives up to its billing of custom-designing a new booster for each new variant as it

appears,[88] it might not be developed and deployed fast enough to stop it before it recedes on its own; and even if it could, giving so many vaccines so often would only emphasize the impermanence of their effect, not to mention their long-term effect in prolonging the outbreak, and weakening our immune status in the process.

In any case, a number of researchers have found that the mRNA synthesized in response to these new vaccines is not entirely destroyed, and can indeed be incorporated into cells of the recipient, by means of the process known as "reverse transcription" of the RNA information into the DNA of the host's genome.[89,90] Even before that, scientists from Johns Hopkins and elsewhere showed that the mRNA vaccines don't prevent transmission of the virus, and are thus not really vaccines at all in that bottom-line sense, as the CDC was finally forced to admit:

> New data was released by the CDC last week showing that vaccinated people infected with the delta variant carry viral loads similar to those of people who are unvaccinated.[91]

In short, it is now clear that the new mRNA COVID-19 vaccines are being given mainly *as a treatment*, to prevent serious illness and death in those already infected, which the official statistics would appear to confirm that they are doing, at least in the short run.[92]

A partial explanation of these paradoxes may lie buried somewhere within the novel circumstance that these agents are not being used to prevent an infection from happening in the future, like all other vaccines in the past, but rather on an emergency basis to deal with an actual epidemic, for the very first time in history.

Precisely how this will affect the future of the pandemic, not to mention the long-term health of our country and planet, are still unclear. Almost certainly, like all previous vaccines, they'll make worse what's already there, and will do so by means of autoimmune phenomena of every description, encompassing both subclinical and overt chronic diseases, as well as worsening slowly and insidiously over time. In particular, since what's already there includes the COVID, a chronic disease in its own right, these effects will almost certainly involve immune dysregulation, and sometimes terminate in ARDS, cytokine storm, multi-organ failure, and death in the future, or linger on as "long COVID," or flare up again perhaps, simulating a reinfection in the more distant future.

In addition, vaccinating in the midst of the outbreak, even with more traditional vaccines not using the mRNA technology, will almost certainly potentiate the virus' well-known mutability, and indeed has already accelerated the development of mutant strains and the emergence of clinically significant variants, as Dr. Montagnier has repeatedly and insistently warned.[93]

But perhaps the greatest threat of all is its subtle conditioning of the general population, building on the inevitable fear and uncertainty, to justify mandating and enforcing more and more vaccinations on top of the COVID, including adults as well as children, and thus weakening even further our ability to respond acutely and vigorously to future infections by promoting chronic responses in general, as we saw.

Another important reason to avoid the COVID vaccines may be the SARS-CoV-2 spike protein itself, the decisive element in the pathogenesis of the COVID illness,

which the more traditional vaccines provide a bioengineered fragment of, and the mRNA types instruct their recipients how to synthesize. Professor Byram Bridle and his team of Canadian virologists have shown that the spike protein is significantly toxic all by itself, circulates widely through the blood after vaccination, and poses a significant threat of damage to major organs, including the heart, lungs, liver, spleen, bone marrow, adrenals, and ovaries,[94] even if it doesn't manifest clinically until much later.

Finally, in addition to weakening our natural immunity, our addiction to vaccines is built upon a basic misunderstanding that is fraught with perils of its own. As we wait for them to ward off diseases we might not get, most of which probably wouldn't hurt us if we did, we measure their effectiveness by the high titers of specific antibodies they provide, and infer from it our level of immunity as well.

The antibody level thus becomes a substitute for our natural response to infection, but the latter, as we saw, is a massive, co-ordinated, *acute* process, of which antibodies are merely the finishing touch.[95] Once we recover from the illness, they're no longer needed, because the memory of the infection is encrypted within the B and T cells.[96] In other words, once again, we're measuring the wrong thing: the immune process is directed by these cells, which then preserve the immunity we've earned in ways that we don't yet know or even seem to care how to measure.

As far back as 1980, Dr. James Cherry, a leading vaccine advocate, showed conclusively that children previously vaccinated against the measles whose antibody levels had fallen below supposedly immune levels responded only minimally and for an

unacceptably short time to a booster shot.[97]

Taking this discovery a step further was a memorable case from my own practice, a healthy 31-yer-old lab tech who reacted badly to her first round of 3 Hep B shots as required for her training, but eventually recovered. 4 years later, her new employer retested her and found zero antibodies, which led him to infer that she was still susceptible and insisted that she receive a second set, which initiated a series of chronic complaints, chiefly autoimmune thyroiditis, for which she sought compensation under the Federal VICP program, and hired me to write a report in support of it.[98] Her claim was dismissed without even a hearing, since thyroiditis was and still is not listed as an official complication of the Hep B vaccine.

I cite her case and Dr. Cherry's finding to take issue with the largely unchallenged assumption that immunity is a purely quantitative variable, that the specific antibody titer accurately measures it, and that repeated boosters applying sufficient chemical force can ratchet it up to the desired level more or less at will.

The COVID illness demonstrates the same unwisdom even more dramatically, since the cytokine storm of the worst cases are characterized by excessively and indeed dangerously high levels of antibody. Similar reactions were observed in animal trials of vaccines against the SARS and other early coronaviruses,[99] and more recently during a vaccination campaign against dengue fever in the Philippines.[100]

In both these earlier cases, the subjects developed what were welcomed as splendidly high levels of antibody soon after the vaccines were given, only to suffer and

not seldom die from cytokine storm, also known as antibody-dependent enhancement, or ADE, when they contacted the virus some time later. These dramatic overreactions not only led to the discontinuation of these vaccines, but alarmed even notorious pro-vaccine advocates like Paul Offit to plead for caution when the first COVID vaccines were fast-tracked using the same technology.[101]

Indeed, the immune dysregulation involved in ADE and cytokine storm may be an extreme form of the immune dysregulation produced routinely by the vaccination process itself, in all of its guises, which substitutes hyperactivity of the humoral system for the concerted action of the immune mechanism as a whole, as mobilized by an actual infection, regulated by the cellular system, and preserved as an enduring memory for the future. The warning of Lucija Tomljenovic and Richard Shaw, two Professors at the University of British Columbia, might well stand for the concerns of a growing number of scientists who question the unlimited vaccination agenda that now prevails:

> Persistence of helper T-cells that stimulate antibody production, due to repeated administration of aluminum-adjuvanted vaccines, may have profound, long-term, adverse effects on the developing immune system in children.
>
> A newborn infant has an undeveloped immune system which is limited in function and requires a series of challenges to bring it to full capacity. Prior to vaccines, these were relatively minor childhood diseases, such as mumps and measles.
>
> Vaccines stimulating antibody production by the humoral immune system, located in the bone marrow, bypass the cellular immune system on mucosal surfaces of the respiratory and digestive tracts, leaving the latter unchallenged during their critical period of development. The end result of [this] prolonged

shift may be permanently stunted cellular immunity, which is far more efficient than the humoral system in clearing viral pathogens.[102]

6.

The clinical perspective.

For the clinician, "following the science" proves its value in and through our special vantage point of private encounters with individual patients and the collaborative, personal relationships that develop from them, which can unlock secrets that prove impenetrable otherwise. But although their purview includes the scientific realm of causes, mechanisms, diseases, and abnormalities, the clinical perspective ultimately succeeds or fails in the concrete realm of the here-and-now, the unique, lived experience of individual human beings.

When parents told me that their kids were injured or made sick by vaccines, it was obviously an important part of my job to determine as best I could whether and to what extent those judgments were accurate; and certainly there were times when I had good reason to suspect that they weren't. But the kind of relationship that makes practices work involves trusting what our patients tell us to be the truth of their experience *as they live it*, whether rightly or wrongly, until something happens to convince us otherwise, which happened very rarely in my experience.

The manufacturers, the CDC, and the medical profession have convinced most of us that vaccines are uniformly safe and miraculously effective, so that it is entirely acceptable and even desirable to pile on as many as we like and to repeat them as often

as we see fit.[103] But my long experience of caring for vaccine-injured children leads to a very different conclusion; and the best way I know how to summarize it is by appealing to my readers to hear the voices of those thousands upon thousands of parents who have personally witnessed the deaths and crippling illnesses of their children as the result of them, and must live every day amid the wreckage of their shattered lives, sufficient to break any heart, that cries out at the very least for caution, restraint, and simple compassion for the viewpoint of those whose lived experience, whatever may have caused it, is so tragically different from that of everyone else privileged enough to be ignorant of or somehow unmoved by their loss.

I'll put it another way: if vaccines were truly as safe and effective as the CDC and the drug industry are telling us, then the vast majority of these parents would have to be either lying, ignorant, deluded, or stupid, just like those "anti-vaxxers" demonized in the media, clinging to a wildly-flawed, anti-scientific ideology. Having cared for many, many such children, I can say with complete assurance that their parents are none of these, but simply eyewitnesses to their own tragedies, who must now bear the burden of that grief and the expense of caring for their loved ones for the rest of their lives.

"Ex-vaxxers" would be a more accurate term, since their only mistake was to have done exactly what they were told; they are asking for nothing more than a public acknowledgment of their plight, although they surely deserve a great deal more than that. Requiring no advanced degree, simple common sense is ideally equipped to understand that caring parents are better judges of what happened to their own kids

than those who make, sell, and profit obscenely from these products, yet can't be sued for the deaths and crippling injuries they cause.

Consider this tale of a 12-year-old boy who lived over a thousand miles away, never became my patient, and came to my attention solely through his mother's letter; but her words were so heartfelt and so congruent with the rest of my experience that I can't imagine them to be anything but the honest truth of what she witnessed first-hand, as well as the perfect encapsulation of the cognitive dissonance that I've just described and am still caught up in:

> My son Adam was healthy until his first MMR at 15 months. Within 2 weeks he had flu and cold symptoms, which persisted for 6 weeks, at which point his eyes became puffy, he was hospitalized with nephrotic syndrome, and a renal biopsy showed "focal sclerosing glomerulonephritis." When it didn't respond to steroids, I asked if it could be related to the vaccine, but they told me it couldn't, and we accepted that. Over the next 4 years he was hospitalized repeatedly, and missed many months of school, but finally went into total remission, seeming normal and healthy and staying off all medications for about 5 years.
>
> When he turned 10, his pediatrician recommended a booster, saying that a rise in measles cases made it dangerous for him not to be protected. Checking the PDR and other sources, I found no contraindication for kidney disease and no listing of it as a possible adverse reaction, so I agreed to the shot. In less than 2 weeks he relapsed, with 4+ protein in his urine, swelling, and weight gain, signs that we recognized immediately. He got worse even on Prednisone, and was admitted in hypertensive crisis, with blood in his urine, fluid in his lungs, and massive edema. On Cytoxan, high doses of Prednisone, and three other drugs, he slowly improved, but missed another 7 months of school.
>
> It's been 2 years since that horrible episode, and he still needs Captopril daily for high blood pressure and spills 4+ protein every day. The doctor says that he sustained major kidney damage, will always need medication to control his blood pressure, and will worsen as he grows older, necessitating a transplant eventually.

> This time I was sure that his condition was related to the vaccine, but still the doctors didn't take me seriously, and told me it was a coincidence.
>
> I began searching for information, and even contacted the manufacturer of the vaccine. Finally they sent me two almost identical case reports of nephrotic syndrome following the MMR vaccine. It's difficult for laypeople to get information or even ask questions, since we don't use correct medical terms and are made to feel stupid. Please tell me if my ideas are reasonable.
>
> I don't think my son could tolerate another episode, and I think he'd have normal blood pressure and kidney function today if not for that second vaccination. I also have a great concern for other children who develop nephrotic syndrome some weeks after receiving the MMR and whose doctors never make the connection. They could all be at great risk if revaccinated. I realize that this letter has taken up a great deal of your time, and I'd appreciate any help you can give me. If we were closer, I'd make an appointment to see you in person, so please feel free to charge me. Thank you.[104]

This woman honestly believed that the MMR vaccine had crippled her son for life, yet had no intention of suing the drug company that made it, the doctor who prescribed it, or the Federal Vaccine Injury Compensation Program, as she was certainly entitled to do, a lack of ulterior motive that only lends further credence to her story. She wrote to me simply to find a physician to hear and validate the truth of her experience, which neither the pediatrician who gave the shots, the specialists who treated Adam in the hospital, nor the other doctors she consulted were willing to do.

The events she had witnessed first-hand on two separate occasions and had been forced to endure the consequences of ever since indicated a causal link that would be sufficiently obvious to be grasped at once by any reasonably attentive eighth-grader of

average intelligence. Yet every one of the boy's physicians dismissed his misfortune as a coincidence.

Even today, thirty years later, renal failure has still not been recognized as an adverse effect of the MMR vaccine, an omission that would have assured his mother's defeat in court had she chosen that route. This glaring discrepancy between the boy's catastrophic illness and the ease with which his doctors and the vaccine manufacturers all escaped having to take any responsibility for it will serve to introduce the profound mystery that led her to write to me and has never ceased to trouble and indeed infuriate me, both before and since.

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