ALASKA LEGISLATURE COMMITTEE FILES 1991-1992 8672
7422 SENATE HEALTH EDUCATION & SOCIAL SERVICES

THE NEW YORK TIMES **HEALTH** THURSDAY, DECEMBER 1, 1988

Baffling Rise of Intestinal Disorder in the Young

By HAROLD M. SCHMECK Jr.

Crohn's disease, a serious disorder of the intestines, appears to be increasing sharply among children, a trend that may reflect some unknown influence of Western industrial civilization, a British scientist said yesterday at a scientific symposium in Houston.

"It's almost as if the infection-free environment of modern Western society could be a factor," said Dr. John Walker-Smith of St. Bartholomew's Hospital in London, an expert on intestinal diseases of children.

The cause of Crohn's disease is unknown, although there appears to be some hereditary influence involved. The painful disorder, which flares up in episodes and is often debilitating, involves inflammation of segments of the intestinal tract.

In children, the disorder also hampers normal growth and development. Children in whom the inflammation and obstruction of the intestine has been corrected by surgery sometimes experience growth spurts shortly afterward, said Dr. Walker-Smith and Dr. Anne Ferguson of Western General Hospital in Edinburgh.

Charting Dramatic Rise

In a telephone interview, Dr. Ferguson said that the excellent health records compiled through the National Health Service in Britain had allowed her to chart a dramatic and unexplained increase in Crohn's disease among children in Scotland over 15 years. Dr. Ferguson is an expert on the immunology of the digestive tract.

She said initial hospital admissions for treatment of the disease more than doubled from 1968 to 1983, suggesting an increase in incidence of the disease among 8- to 16-year-olds. In that period, the rate rose to 23 admissions per million population, from 6 per million.

Dr. James E. Everhart, an epidemiologist of the National Institute of Diabetes and Digestive and Kidney Diseases in Bethesda, Md., said that there were no good national figures on Crohn's disease in the United States, but that it was widely believed that the disease is increasing.

A study in Maryland estimated the number of new cases each year among 10- to 20-year-olds as 4.5 per 100,000 people. Another study, in Minnesota, estimated the overall incidence as 4.3 per 100,000 a year.

> Doctors don't know the cause of the debilitating disease.

Role of Immune System

Dr. Walker-Smith said it was possible that the decline of many childhood infections might allow children in the West to grow up without the vigorous development of their immune defense systems that such infections would ordinarily promote.

"One wonders whether that stimulation of the immune system, particularly in early childhood, may be advantageous later in life," he said.

Dr. Walker-Smith admitted that this is speculation, but he noted that the increase in the disease among children was real and there was evidence indicating that something in the modern Western environment or experience might be involved.

He said the theory was partly based on finding Crohn's disease in children of Indian and West Indian origin who had grown up in Britain. In India and the West Indies, he said, the disease is "very, very rare indeed."

The search for an environmental agent is difficult; so far the search for bacteria or viruses that might cause the disease has been unavailing, Dr. Walker-Smith said.

Research by the British scientist has shown that T-lymphocytes, white blood cells that are important in the immune defense system, may behave abnormally in the intestines of patients who suffer from the disease. He believes that this may contribute to the damage to the intestines that is characteristic of Crohn's disease.

Richard Moskowitz, M.D.
173 Mt. Auburn Street
Watertown, Massachusetts 02172

Alaska State Senate Health Subcommittee
c/o Sandy Mintz
1433 W. 13th Avenue
Anchorage, Alaska 99501

Dear Sir:

I am writing in support of the position paper of Sandy Mintz, and of Senate Bill 148, "An Act Relating to the Immunization of Minors."

I am a family physician and have been practising medicine for twenty-three years. During that time I have noticed that a wide variety of chronic diseases can be provoked, exacerbated, and even in some cases initiated by the various childhood vaccines in general use.

I am especially troubled by the fact that investigations of vaccine-related illness have generally been limited to <u>acute</u> complications occurring within thirty (30) days of the vaccine. My experience suggests that the vaccines act much more commonly as non-specific stressors of the immune system as a whole, such that the child becomes more susceptible to chronic responses generally, e.g., to chronic otitis media, allergies, asthma, and the like. In other words, in many cases the vaccines seem to favor illnesses that do not resolve themselves spontaneously, but continue to smolder or relapse for months and years at a time.

Requiring all children to be vaccinated with foreign proteins or live viruses clearly presupposes the moral and legal obligation to prove both that the corresponding natural diseases constitute a serious public health hazard, and that the vaccines are in no way detrimental to health. Furthermore, it implies full legal and financial liability for any illness or injury sustained by those vaccinated against their will.

Adequate investigation of vaccine-related illness will necessarily be prolonged and difficult. It will require following large numbers of both vaccinated and unvaccinated children for at least two decades, to determine any differences in overall health patterns, including IQ, school performance, and absenteeism, as well as in the incidence and severity of various chronic diseases (recurrent otitis media, asthma, epilepsy, behavior disorders, hyperactivity, etc.).

Until these studies are completed, it would be reckless indeed to continue routine childhood vaccination on a compulsory or statutory basis. I personally favor making all vaccines completely <u>optional</u>, i.e., making them freely available to all

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Hours by Appointment

who want them, and allowing parents to make the choice for their children, as in West Germany and many other countries. This practice will effectively reduce the liability of the state, if and when complications do occur. It will also create a sizeable control group of unvaccinated children for the long-term studies that urgently need to be done.

Nor do these children pose any threat to the rest of society. When children recover spontaneously from measles, mumps, and the rest, they will never again be susceptible to these diseases, no matter how many times they are re-exposed. We must face the fact that, if the vaccines are as effective as their proponents claim, unvaccinated children pose a threat only to themselves.

For all of these reasons, I urge you to support S. B. 148, and to make it as simple as possible for parents not to vaccinate their children. I have read the position paper of Sandy Mintz, and I believe that her proposals are well thought out, carefully researched, and clearly presented. If enacted, this law will be an important step forward, one that will bring Alaska abreast of the other states that have already acted to protect the free choice of their citizens in this matter. It deserves your full support.

Thank you.

Truly yours,

Richard Moskowitz, M. D.

ROBERT F. CATHCART III, M.D.
ALLERGY, ENVIRONMENTAL & ORTHOMOLECULAR MEDICINE
127 SECOND STREET, SUITE 3
LOS ALTOS, CALIFORNIA 94022
(415) 949-2822

February 12, 1990

Sandy Mintz
1433 West 13th Avenue
Anchorage, Alaska 99501

Dear Ms. Mintz:

Thank you for your POSITION PAPER ON SB148. I certainly support its postion. Reasonable people can certainly disagree about the value of any or all vaccines for particular children. This difference can range all the way from the use of smallpox vaccines in cases of eczema which everyone knows can be fatal to the possible objections that certain autoimmune diseases in later life may be caused by vaccinations in childhood. I think that the incidence of vaccinations in places that allow exceptions to vaccinations as you propose will allow the investigations of such concerns in the future without increaseng dangers of epidemics to either unvaccinated or vaccinated children.

I would suggest, in addition, that vaccinations be prohibited in children who at the time of vaccination are malnourished or have a cold or other infectious or "toxic" disease because the incidence of problems is greatly increased by any of these factors.

Sincerely,

Robert F. Cathcart, III, M.D.

RFC:omm

UNIVERSITY OF DUBLIN TRINITY COLLEGE DUBLIN 2 IRELAND

Department of Community Health

TRINITY 400

January 18, 1990

Ms. Sandy Mintz,
1433 West 13th Ave,
Anchorage, Alaska 99501,
USA

Dear Ms. Mintz,

thank you for letting me see your position paper on compulsory vaccination. It is a very thoughtful document and I support your argument.

With best wishes,
Yours sincerely,

Dr. Petr Skrabanek,
Lecturer in Community Health

MICHAEL A. WEINER, PH.D.

(University of California, Berkeley)

201 JAMAICA STREET

TIBURON, CALIFORNIA 94920

TELEPHONE: (415) 435-3304

FAX: (415) 435-2656

December 20,1990

Alaska State Senate Health Subcommittee
c/o Sandy Mintz
6981 Kincaid Road
Anchorage, Alaska 99502

To Whom It May Concern:

I am writing to lend my voice of support to the efforts of Sandy Mintz and others who are backing passage of Senate Bill # 148. "An Act Relating to the Immunization of Minors."

As a scientist trained in immunity and the author of numerous books, including "MAXIMUM IMMUNITY" (Houghton-Mifflin Co., Boston), I can safely say that many thousands of readers have advised me of the negative health effects of various childhood vaccines in general use. As the parent of two healthy children I can verify that the "P" portion of the common "DPT" vaccine induced severe fever in my son in 1970. The fever was at such a dangerous degree (106°degrees F) that we, as young parents, had to submerge our infant in an ice-cube bath in order to prevent brain damage and possibly death.

The evidence is clear that childhood vaccines do not benefit all children. In fact, as cited above, some children are severely hurt or killed by these "routine" injections. Therefore, why promulgate state-controlled murder by making it illegal for parents to elect <u>not</u> to have their children vaccinated with these questionable materials?

If I can be of further assistance in this or related matters please do not hesitate to call on me.

Sincerely,

Michael C Weiner

Michael A. Weiner,M.S.,M.A., Ph.D.,
Executive Director,
Alzheimer's Research Institute

MW:jac

Curriculum Vitae

MICHAEL A. WEINER, M.S., M.A., Ph.D.
201 Jamaica Street
Tiburon, CA 94920

EDUCATION

Queens College (CUNY)	B.S., 1963	(Biology)
University of Hawaii	M.S., 1970	(Ethno-botany)
University of Hawaii	M.A., 1972	(Medical Anthropology)
University of California, Berkeley	Ph.D., 1978	(Epidemiology & Nutrition) (In the School of Natural Resources)

TEACHING EXPERIENCE

University of Hawaii	1970-1972	Dept. of Biology
University of California, Santa Cruz	1976-1980	Environmental Sciences Dept. (Research)
Nassau College (SUNY)	1985-1987	Dept. of Biology

PRESENT RESPONSIBILITIES

Executive Director, Fund for Ethnic Medicine, Mill Valley, California

Director of Environmental & Scientific Affairs, Nature's Herbs Co., Orem, Utah (a TwinLab Co.)

Executive Director, Alzheimer's Research Institute, Mill Valley, California

RESEARCH GRANTS AND AWARDS

National Science Foundation,	1965-1966; renewed 1968-1969
Archbold Expeditions of the American Museum of Natural History	1969; renewed 1973
Hawaii Botanical Gardens Foundation	1971; renewed 1973
United States Public Health Service	1969
National Cancer Institute	1975-1976; 1980-1981
National Science Teachers Association	1976 ("Outstanding Science Book for Children")
The Asia Foundation	1981-1982
Estorick Foundation	1983-1984
National Endowment for the Humanities	1987
Estorick Foundation, London England	1988-1989-1990 (for the study of Alzheimer's disease and diet)
Japan Creativity Society, Tokyo, Japan	1989 (Prize for creative research and writings on environment and health)

(continued)

PUBLICATIONS

BOOKS:

Earth Medicine: Earth Foods: (American Indian Medicine)	(Macmillan, 1972)
Plant A Tree: A Working Guide To Regreening America	(Macmillan, 1975)
Man's Useful Plants (Narcotics & Other Addictive Plant Compounds)	(Macmillan, 1976)
Earth Medicine (revised edition)	(Macmillan, 1980)
Weiner's Herbal	(Stein & Day, 1980) (revised ed., 1990)
Homeopathic Medicine	(Bantam, 1982)
The Skeptical Nutritionist	(Macmillan, 1981)
Nutrition Against Aging	(Bantam, 1983)
Third World Medicine	(Government Press, Suva, 1984)
Maximum Immunity	(Houghton Mifflin, 1986) (also in Dutch, Danish, Norwegian, Italian, & French editions; Japanese and Chinese translations in progress)
The Complete Book of Homeopathy	(Avery Books, 1989)
Reducing the Risk of Alzheimer's	(Scarborough House, 1989)
Earth Medicine: Earth Foods (American Indian Medicine)	(Random House, 1991) (in press)
Rainforest Medicine	(Quantum Books, 1991) (in press)

ARTICLES:

Stomach Cancer in Japan: An Environmental Link	**Medical Hypothesis**; *20*: 357-358
The Legal & Health Effects of the Use of Dental Amalgams	**San Francisco Barrister**; Vol. 4(5): 10-15, June, 1985
Diet & the Immune Response	**Health Alert** Vol. No. 1, Winter, 1986
Heavy Metals Reduce Immunity	**Nutrition Health Review** No. 37, Winter, 1986
Aspartame May Impair Immunity	**Nutrition Health Review** No. 37, Winter, 1986
Genetics and Nutrient Needs	**Nutrition Health Review** No. 37, Spring, 1986
Omega – Three Fatty Acids & Hyperlipidemia (letter)	**New England Journal of Medicine** (Sept. 25, 1986)

(continued)

ARTICLES (continued):

Cholesterol in Foods Rich in Omega - Three Fatty Acids (reply to five letters)	**New England Journal of Medicine** (March 5, 1987)
Alzheimer's & Aluminum	**Longevity** *1*(7): 32, 1989
Alzheimer's, Aluminum and Non-Prescription Drugs	**Health & Nutrition Update** *4*(3): 7-9, 1989
Evidence Points to Aluminum's Link with Alzheimer's Disease (letter)	**New York Times** (Nov. 26, 1989)
Aluminum and Dietary Factors in Alzheimer's Disease	**Journal of Orthomolecular Medicine** *5*(2): 74-78, 1990
Herbs and the Immune System	**Herbal Healthline** *1*(1): 1-15, 1989
Herbs Allergy & Inflammation	**Herbal Healthline** *1*(2): 1-16, 1990
Herbs & Energy	**Herbal Healthline** *1*(3): 1-16, 1990
The Effects of Plutonium Seepage on Edible & Medicinal Plants in the Eastern Pacific	(Manuscript)

RECENT INVITED SPEAKING ENGAGEMENTS

Title of Presentation	**Organization, Place, & Date**
Rescuing Tropical Botanical Resources of the Future	NNFA (National Nutritional Food Assoc.) Las Vegas, NV, July 1989
Man's Useful Plants	EXPO EAST, Philadelphia, PA, 1989
Plant Resources of the Native American: A Vision of the Future	SOHO Convention (Southern Health Organization), Orlando, FL, December 1989
The Healing Wisdom of Earth's Medicines	SWHO Convention (Southwestern Health Organization) Dallas, TX, February 1990
Natural Remedies from Nature's Apothecary	Natural Foods Expo, Anaheim, CA, March 1990
Asian Herbal Medicine: A Response-Based Healing System	Malaysia, 3 city speaking tour (Kuala Lumpur, Ipo, Johor Baru), April 1990
Careers in Environmental Science	Earth Day, 1990, Loma Linda University
North American Botanical Resources: Medicines of the Future	Indianapolis, IN, June 1990
Herbal Remedies for Self-Treating Allergies	San Francisco Marriot, June 1990
In Search of the Vanishing Rainforest	NNFA (National Nutritional Food Assoc.) Boston, MA, July 1990

(continued)

RECENT INVITED SPEAKING ENGAGEMENTS (continued):

Environmental Action, 1990's Style	La Jolla, CA, Marriot, September 1990
160,000,000 Years Old and Dying: The Sarawak Rainforest	Rainforest Day Convention, San Francisco, CA October 1990
Environmental Realities: Can We Save the Malaysian Rainforest?	EXPO EAST Convention, Philadelphia, PA, November 1990
The World's Oldest Rainforest: Is It Nearly Extinct?	SOHO Convention, Orlando, FL, December 1990

In addition to the above, numerous appearances on radio and television programs on the above environmental issues.

REFERENCES

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YORK GASTROENTEROLOGY
JOANNE M. HATEM, M.D.
412 RATHTON ROAD • YORK, PA 17403
(717) 843-0965

June 6, 1990

Sandy Mintz
6981 Kincaid Road
Anchorage, Alaska 99502

Dear Mrs. Mintz,

I am writing to you in support of your effort to allow for philosophical objections to mandatory vaccination policies in your beautiful state of Alaska.

Unfortunately, the balance between individual good and common good seems to be lost in many of our present vaccine policies. It has become apparent to me, after developing a life threatening illness after a mandatory rubella vaccine, that the trust I had placed in those making immunization policies was unfounded. Having reviewed extensive documents from the FDA it is clear to me that the prelicensing studies done for the measles, mumps, and rubella vaccines is woefully inadequate. Many of these studies were performed under very suboptimal conditions in Ethiopia, Costa Rica and other parts of the Third World. The double standard appolied to vaccine licensing as compared to the more rigorous testing of pharmaceuticals in appalling.

The Centers for Disease Control and the FDA are inadequately evaluating adverse reactions, so the true risk of immunizations, even after decades of use, is not known. This is intolerable.

Healthy individuals, or their parents, should not be forced to have immunizations, especially where the risk is not known and the benefit is often theoretic. One unfortunate consequence of mandatory vaccine policies is the loss of incentive for industry to improve their products; another unfortunate consequence has been needless serious harm.

Since individuals have the option to choose vaccinatinoo for themselves or their children, unvaccinated individuals do not present a risk to the general population. There is no reason why immunizations must be mandatory--there is

every reason to provide parents with the information needed to make an informed decision.

With best wishes.

Sincerely,

Joanne Hatem, M.D.

YORK GASTROENTEROLOGY
JOANNE M. HATEM, M.D.
412 RATHTON ROAD / YORK, PA 17403
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Statement before the National Vaccine Advisory Committee
June 15, 1990

As a practicing physician and now as a patient, I am gravely concerned about the ethics of vaccine policies. Let me remind you, immunizations represent a unique aspect of clinical medicine where, in many cases, a committee decides and a law implements. No committee tells me which colon cancer patients to give chemotherapy, no law requires a patient to have this therapy. Underscoring a physician's relationship with patients is the medical tradition: do no harm, and the legal tradition: physicians are accountable.

At a minimum those agencies, committees, and individuals that determine vaccine policy must include with their recommendations the data upon which they are based, a reasonable estimate of risk, and, most important of all, an acceptable risk/benefit ratio for each vaccine and each clinical setting for which it is being recommended. A cookbook of recommendations without this information is an insult to physicians and a risk to the public.

It is not acceptable to vaccinate on theory alone and then squabble over whether a destroyed life is an adverse reaction or an adverse event.

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JOANNE M. HATEM, M.D.
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June 18, 1990

James Mason, M.D.
Assistant Secretary of Health
Hubert Humphrey Building
200 Independence Avenue
Washington, D. C. 20201

Dear Dr. Mason,

I attended the National Vaccine Advisory Committee meetings on June 14 and 15, 1990 and was very pleased to learn of your active involvement in immunization policy.

I am a practicing physician who has suffered ongoing serious reactions to a legally required rubella vaccine which I received at the beginnning of my fellowship in 1984. I am deeply concerned that vaccine recommendations are being made without adequate supporting data for both safety and efficacy. Priority must be given to determining appropriate risk/benefit ratios for all available vaccines. The medical community needs this data to make appropriate clinical decisions.

On June 14, but not June 15, Drs. Hinman and Orenstein presented data that at least 60% of the cases of measles in the present epidemic are due to vaccine failures. I was particularly disturbed by the recommendation of the CDC that children be revaccinated two or three additional times with MMR to achieve measles immunity. There is no study documenting the safety of this approach, and in fact there is very limited information on the safety of MMR in adults. Certainly, to expose measles susceptible college students to rubella vaccine, which has never been tested in adults and has recently been demonstrated to cause, in some individuals, chronic rubella viremia and devastating neurologic disease, is ridiculous.

On June 15, I read a brief statement ot the committee summarizing my concerns. I have enclosed a copy for your review.

I hope you will give consideration to these suggestions:

1. Appoint a clinician who is expert in the role of infectious agents in causing chronic disease.

2. Establish a multidisciplinary ethics committee to review all vaccine recommendations prior to implementation.

I hope these measures would achieve a better balance between the good and the harm that is done by immunization policy. It would be unfortunate if the lack of consideration given to risk were to undermine the great good that can be accomplished by judicious immunizations.

With best wishes.

Sincerely,

Joanne M. Hatem, M.D.

JMH:nec

SERAMMUNE PHYSICIANS LAB
Providers of the ELISA ACT
1830 Preston White Drive AMSA Building 2nd Floor Reston, VA 22091 703 758-2610 800 553-8470

June 1, 1990

Sandy Mintz
6981 Kincaid Road
Anchorage, Alaska 99502

Dear Ms. Mintz:

As my compliments, enclosed is a copy of Dr. Coulter's book.

I would be willing to testify as part of the medical profession , if the need arises.

Please contact me if I can be of any further assistance.

Sincerely,

Russell Jaffe, MD

Russell Jaffe, MD

Enclosure: 1

$14.95 MEDICINE

Physicians and Psychologists on

Vaccination, Social Violence, and Criminality

"...this thoroughly documented exposé of the dangers of childhood vaccinations will shock our complacent society. If Dr. Coulter is correct—and his evidence is as compelling as it is alarming—parents, children and civilization itself are paying dearly for our uncritical acceptance of inadequately tested medical "advances." This book will no doubt start an acrimonious but timely debate about the known benefits and hidden costs of childhood vaccination programs."

—**Bernard Rimland, Ph.D.**, Autism Society of America

"...a masterpiece; one of the most important works of several decades. It indicts present childhood vaccination programs as a major factor in immunologic and neurologic disorders in today's children. Evidence presented in these pages can no longer be ignored: we are long overdue a reassessment of current childhood immunization programs."

—**Harold E. Buttram, M.D.**

"Future generations may look upon us as an irresponsible group of sorcerers' apprentices, setting in motion processes difficult to reverse. That childhood vaccination is an overwhelmingly safe procedure is an article of faith in medicine, accepted by physicians and the public alike. Medical historian Harris Coulter shows that this assumption is not borne out by the evidence--citing data from the specialized literature and many parent interviews.

Coulter considers the relationship of vaccination to autism, hyperactivity, allergies, autoimmune diseases, and learning disabilities. He carries his argument into the social realm, suggesting a connection between neurologic damage and the present high level of criminality in American society. *Vaccination, Social Violence, and Criminality* will become a cornerstone in the ongoing debate about childhood vaccinations."

—**Russell Jaffe, M.D., Ph.D.**

ISBN 1-55643-084-1

North Atlantic Books
Berkeley, California
Center for Empirical Medicine
W[illegible] D.C.

VACCINATION
SOCIAL VIOLENCE AND CRIMINALITY

THE MEDICAL ASSAULT ON THE AMERICAN BRAIN

HARRIS L. COULTER

LEONARD A. SAGAN, M.D.
177 Toyon Road
Atherton, California 94025
(415) 323-4506

May 15, 1990

Sandy Mintz
6981 Kincaid Road
Anchorage, Alaska 99502

Dear Ms Mintz,

Thanks very much for your letter and the copy of your Ms.

I am really astonished at the highly competent and thorough review that you have conducted. It is a highly professional job, addressing all of the relevant medical and ethical issues. If it were shortened somewhat, it might well be submitted for publication in a medical journal. I shall certainly keep it in my files for reference.

In my book, the Health of Nations, I do make the point that the importance of vaccination and immunization as factors contributing to the decline in mortality has been grossly exaggerated. You will find the evidence for that conclusion in the book, but the central point is that childhood diseases such as measles and diptheria persisted unabated until quite recently. What had changed was not the incidence of these diseases, but rather the risk of death in those with the disease (the case fatality rate).

I certainly agree with you that there may be unrecognized late effects of immunization which may occur years or decades later. There has been essentially no study of this issue. It may also be that the natural experience of childhood diseases may somehow stimulate the immune system and protect against other diseases. For example, when polio was common among children, it was observed that upper class children who presumably were protected against childhood diseases, were more susceptible to polio. It was also observed that children who had had tonsillectomies, and presumably were protected against tonsillitis, were more susceptible to polio.

You will also find in my book a reference to some research conducted in Germany relevant to the introduction of smallpox vaccination in Berlin, more than a hundred years ago. While the deaths from small pox disappeared, deaths from other diseases,

particularly gastrointestinal diseases, increased to an almost identical extent, so that death rates remained almost constant.

I think, however, that your most powerful argument is the libertarian view that individuals, including individual parents, should be permitted control over their own lives and those of their children unless the danger to those children (such as with child abuse) can be shown to be clearly harmful to the child or to others in the community.

These are difficult decisions as with parents who refuse to allow their children to be given life saving transfusions. When the benefits to the child are questionable, then the state should come down on the side of parental discretion. I think that you have very clearly made the point that in the case of immunization, the harm of state controlled intrusion into the family is greater than the benefits of immunization.

Your memory is correct; I was cited (rather harshly) in the Brodeur articles on non-ionizing radiation in the New Yorker. Because I am now so intensely involved in that area of research that I am afraid I shall not be able to testify on your behalf in the matter at hand.

Best wishes,

Leonard Sagan MD

Leonard Sagan, MD

Tel: 0983-752658

Ref:

Springwell,
High Down,
Totland,
Isle of Wight,
England, PO39 OHY.

14 March, 199-

Ms Sandy Mintz,
1433 West 13th Avenue,
Anchorage,
Alaska.

Dear Ms Mintz,

This is in answer to your letter about vaccination which was forwarded to me from the University of Glasgow. It arrived while I was away, hence the delay in replying. I have now retired from my university appointment, and my address is as above.

I agree that exemption on the lines suggested in your motion should be a matter of right for every parent or guardian on behalf of their child. Would you care to draft the kind of letter which you require and send it to me.

For additional support, I would suggest that you write to Mrs Barbara Fisher, Secretary of Distressed Parents Together (DPT!), 1571 Windbreak Drive, Alexandria, Va 22306. She has names of several physicians who are concerned about vaccinations.

Subject to hearing more about what you have in mir I shall be willing to testify in a teleconference

Yours sincerely,

Gordon T Stewart, M.D.

GORDON T STEWART.
MD,BSc,FRCP(G),FRCPATH,FFCM,FSS,LTM&H.

Emeritus Professor of Public Health, University of Glasgow, Glasgow UK.

DECLARATION OF PERSONAL STATUS IN RELATION TO SUBMISSIONS CONCERNING PERSONS WITH BRAIN DAMAGE FOLLOWING INJECTIONS OF PERTUSSIS VACCINE:
Whooping Cough and Pertussis Vaccine are far from being my main professional interest but, by coincidence and intention, I have some special experience of both, as follows:

I qualified in medicine (MB,ChB) in 1942. Since 1946, I have been especially interested in the epidemiology, diagnosis and control of infectious diseases, and have held junior and senior appointments which gave me experience in routine work, in teaching and in research in this field.

In 1950, while working at St Mary's Hospital, London, I helped to organise and coordinate an investigation of respiratory infections in children in Paddington, cooperatively with Dr REV Brimblecombe, under the supervision of Professors Robert Cruickshank and Donald Reid, with the support of the Medical Research Council. In parallel with this, I assisted in some of the work of the national trials of pertussis vaccines between 1949 and 1956.

From 1954 onward, I have held senior appointments in Britain and in the USA in which control of infectious disease, especially respiratory disease, featured as a main commitment. Before going to Glasgow in 1972 as Sutherland Professor of Public Health, I held the Watkins Chair of Epidemiology at Tulane University Medical Center in New Orleans and was a consultant in infectious diseases in two major Hospitals. I have served also as Visiting Professor in Karachi (1953-54), Cornell University Medical College, New York (1970-72) and in other Universities in the British Commonwealth, Africa and USA. I have acted as Consultant or Temporary Adviser to the World Health Organisation (1952 - 1986), New York City Dept of Health (1971-72), US Navy (Field Research Laboratory, Respiratory Diseases in Recruits, 1964 - 1969), and to various Health Authorities, Commercial Firms, Foundations and Charities. Since 1968, I have in publications and otherwise expressed increasing concern about the excessive reliance placed upon bio-technical methods for the control of certain infections and other diseases, and have endeavoured to focus more attention upon social and behavioural factors, notably those associated with inequality of health education and health maintenance. This is how I became from 1973 onward closely involved in the problems of whooping cough and pertussis vaccine. In this, as in some other major infections, I perceived vaccination as an inadequate method of control because risk might exceed benefit in some populations. I found reason for concern also in the lack of valid assessment and ethic in certain mass vaccination programmes.

In 1974, I initiated a 10 year continuing survey of whooping cough, of related infections and of the risk-benefit status of pertussis vaccines in Glasgow and elsewhere. At the request of the Committee on the Safety of Medicines, I

established a register and helped to assess over a thousand cases in which adverse effects of vaccines had been reported by parents, doctors and others (1977-81). I served as a member of the Advisory Panel on Suspected Adverse Reactions to Pertussis Vaccine (1977-81), of the Symposia on same organised by the National Institutes of Health and other Organisations in 1978 and 1984. My research during the period 1974 - 80, funded by the Chief Scientist, England & Wales, and the Greater Glasgow Health Board (1976 - 83), was reported to the Chief Scientist (1982, pv) and in publications (1976 - 84). During this time, I personally saw many cases of alleged adverse reactions and their families. Many problems were reported to me from overseas, and this is continuing (1989). I have maintained contact or cooperated with individuals and organisations in several European countries and in North America, as listed in my report to the DHSS; I have been and am still quite frequently asked to serve, formally and informally, as an adviser in enquiries about pertussis and other vaccines conducted by members of both Houses of Parliament, by medical and legal Tribunals, by the WHO and other international agencies, by the Law Society, by Courts, by Departments of Social Work, by Charities and by newspapers, radio and television programmes in Britain and overseas. My views on pertussis vaccine, and on certain other mass vaccination programmes, are admittedly controversial. I would submit that they are none the less relevant to the Test Case of Loveday v DHSS and Others, and to some wider aspects of assessment of quality of health care, and of medical injury, audit and compensation.

I have to declare a financial interest in so far as I have received fees and expenses from the Law Society, from Courts, from Solicitors and others for some of my services in matters concerning pertussis vaccines. Until my retirement in 1984, fees from the above were used for research expenses or remitted by me to the University of Glasgow or to Charities, as were all fees to date received from the Media, and certain cases that went to Court

In the course of my medical career, I have vaccinated thousands of persons, especially during war service in the Royal Navy and in my junior days, so I am familiar with the routine. I am also familiar with clinical aspects of whooping cough and of adverse reactions to vaccines. I have four children and seven grand-children. All four children received pertussis vaccine (without severe adverse results) but only one of the grand-children. All seven have received DT and OPV

17 May, 1990.

Signed .....

DR. MARK R. GEIER
MEDICAL/LEGAL CONSULTANT
14 REDGATE COURT
SILVER SPRING, MARYLAND 20904
(301) 384-0980

January 18, 1991

Sandy Mintz
6981 Kincade Road
Anchorage, Alaska 99502

Dear Ms. Mintz,

As per your request I am writing this letter to convey to you some of my opinions concerning DPT vaccination policy in the United States. I am a medical doctor licensed to practice in the state of Maryland, certified by the American Board of Medical Genetics and am a specialist in obstetrical genetics. I also hold a Ph.D. in genetics. Attached is to this letter is my Curriculum Vitae.

I have spent more than one thousand hours researching and reviewing medical and scientific literature on DPT vaccine, pertussis, the Bordetella pertussis organism, medical records of children who have sustained severe adverse reactions to DPT vaccine, depositions of expert medical and scientific witnesses retained by pharmaceutical companies and plaintiffs alike. I have attached a Table of Contents to my six large notebooks which contain the important materials concerning DPT on which I rely for my opinions.

I have been accepted as an expert witness on DPT vaccine injury in federal, state and Canadian courts. My expert testimony has been accepted in more than 30 hearings on Petition for Vaccine Compensation held before Special Masters of the United States Claims Court.

I was recently invited to address the National Academy of Sciences, Institute of Medicine, on the subject of toxins in DPT vaccine, the adverse reactions associated with these toxins, and the time frame within which the adverse reaction can be expected. A copy of the text of that presentation is attached.

I am familiar with the adverse reactions associated with DPT vaccine and specifically with the medical conditions commonly known and referred to as; pertussis vaccine induced encephalopathy; episodes of shock-collapse or hypotonic-hyporesponsive collapse, and residual seizure disorder.

It is my opinion that American parents currently have a difficult choice to make when it comes to whether or not their

children are to receive the DPT vaccination. On the one hand, there is a vaccine called DT, which omits the pertussis portion of the vaccine. This vaccine is far safer than the DPT vaccine, however, this vaccine does not protect against pertussis or whopping cough. On the other hand, it has been know for at least 60 years that wholecell pertussis vaccine, which is the only current form of pertussis vaccine used in the United States, does on occasion cause severe adverse reactions, including permanent neurological reactions and death. It is my feeling that it is very unfortunate that the United States still uses this old and unnecessarily dangerous form of pertussis vaccine. It has been known for many years that there is a safer form of vaccine called an acellular pertussis, which provides good protection against pertussis while removing most of the toxins that cause the adverse reactions. The adverse reaction are such a problem in DPT vaccines that the majority of children who receive the vaccine have at least some systemic reaction including significant fevers. However, faced with the choice, as American parents are, between this defective wholecell vaccine and no vaccination at all, it is my opinion that the benefits of the wholecell DPT vaccine outweigh the risk of the vaccine. Therefore, it is my opinion that parents should choose the wholecell vaccine rather omitting the pertussis portion of the vaccine. It is my hope the we as American parents will soon not have to make this terrible choice, and be allowed to utilize an acellular vaccine as has been available in Japan for approximately 10 years.

It is my opinion that in using the unfortunate and defective wholecell vaccine that physicians and other health care professionals should be extremely careful in following all the contra-indications which are known to exist for this vaccine. No child should receive this vaccine who has a previous personal history of any neurological problems. The vaccine should probably also be omitted in children who have a family history of neurological problems. No child should receive the vaccine who has had a severe reaction to a previous pertussis vaccine, and probably no child whose has a significant family history of severe pertussis vaccine reactions should be given this shot, in my opinion. For these children, it is my opinion, that they should receive the DT vaccine.

It is my opinion that due to dangerous nature of the wholecell DPT vaccine, that parents should be fully informed of the risks and benefits prior to making their decision, as to whether to receive the DPT or DT vaccine. Precedent for this decision, for the freedom to make this choice, is very wide in the international scene. For example in England parents are permitted to elect either the DPT or DT vaccine. In fact, there are a number of countries in which the pertussis vaccine is not generally used, including the countries of Sweden and Germany. The wholecell vaccine was dropped in the mid 70's in Japan as well. Some of the countries who have ceased to use the wholecell vaccine have had increases in the rate of whooping in their population. Other counties have not. It is my opinion that it is best not to take

this chance with American children and therefore, as I mentioned previously I would choose to use the wholecell vaccine. However, it is my opinion that the parents should be permitted a choice in whether or not their children are vaccinated with DPT or DT. There are some instances in which a society has a compelling interest in requiring vaccination, because unvaccinated individuals might be a threat to the rest of the population. It is my opinion that the individual selection of DT vs DPT is not a significant threat to the general population. My reasons for saying this are that the current wholecell DPT vaccine does not confer life long immunity. Furthermore, this vaccine cannot be given as a booster to children over the age of six. Therefore, there is a very large segment of our population which already is not immune to pertussis. These adults constitute a large reservoir for the pertussis organism. Adding a certain percentage of young children to this reservoir will not in my opinion significantly endanger the rest of the population anymore than it currently is. It is my hope that with the introduction of an acellular vaccine, that pertussis can be totally eliminated from the population by eliminating the pool of individuals who are not immune. However, since there is a large pool around already who lack immunity I do not feel a compelling case can be made that our society has a compelling reason to require pertussis vaccine against parental will.

It is my deepest hope that the problems with our wholecell vaccine will be eliminated by the general introduction of an acellular vaccines. Lederle Laboratories has announced in a press release that they are applying for an acellular vaccine similar to that used in Japan. However, the issue of parental choice in taking wholecell DPT still is important because it is not clear to me when and if such a product will actually become available to the general vs. population.

It is my opinion that forcing parents to use a potentiality dangerous product against their will, when it is not a significant threat to others in the population, is inappropriate and cannot be justified by simply saying that the wholecell pertussis vaccine efficacy outweighs its risk. Although, I do feel that its efficacy does outweigh its risk. Therefore, I think a reasonable current position for the government to take is (1) to do everything possible to make a safe acellular vaccine available as soon as possible for American children (2) until that occurs to have health care providers inform all parents of the risks and benefits of the vaccine, and (3) to allow those who want to do so to take the DT rather than the DPT that option. This is not the option that I have taken and I have indeed vaccinated my own son with DPT; however, it is not generally American policy to force people to take or restrain from taking products for their own good unless their action constitute a clear and present danger to the society as a whole. I don't think that is the case with the decision between DPT and DT.

If I can be of any further help to you in providing information or in any other way concerning this matter please feel free to contact me.

Sincerely,

Dr. Mark R. Geier

Mark R. Geier, MD, Ph.D.
Medical/Legal Consultant

Enclosures: as stated

CURRICULUM VITAE

Name	Mark Robin Geier	
Address	14 Redgate Court Silver Spring, MD 20905	
Date of Birth	May 3, 1948	
Place of Birth	Washington, D.C.	
Marital Status	Married (Anne Watson Geier) Son - David (born 10/02/80)	
Education	1970 B.S.	George Washington University, Washington, D.C.
	1970-1971	Graduate Student Dept. of Human Genetics and Development, Columbia University, N.Y.C., N.Y.
	1973	Ph.D. Genetics, George Washington University, Washington, D.C.
	1978	M.D. George Washington University, Washington, D.C.
Work Experience	1969-1970	Research (Student) at the National Institutes for Health
	1970-1971	NIH Traineeship at Columbia University, Department of Human Genetics and Development, N.Y.C.
	1971-1973	Research Geneticist, Laboratory of General and Comparative Biochemistry, NIMH, NIH
	1973-1974	Staff Fellow, Laboratory of General and Comparative Biochemistry, NIMH, NIH
	1974-1978	On Professional Staff Laboratory of General and Comparative Biochemistry NIMH, NIH

1978-1979 Intern and Fellow, Department of Obstetrics and Gynecology, The Johns Hopkins University Hospital, Baltimore

1979-1982 Assistant Professor, Department of Gynecology and Obstetrics, The Johns Hopkins School of Medicine, Baltimore

1980-1982 Guest worker Laboratory of General and Comparative Biochemistry, NIMH, NIH

State Licensure: Maryland, September 1979.

Board Certification: American Board of Medical Genetics, 1987

Other Positions:
1980-present Assoc. Prof. Psych. Dept. U.S.U.H.U.S., Bethesda, Md.
1980-present co-director of Genetic Consultants, Bethesda, MD.
1980-present Laboratory Director Molecular Medcine, Md.
1981-present Director of Institute of Immuno-Oncology and Genetics, Md.
1986-present President of Genetic Counselling and Research, Inc., T/A The Genetic Center Baltimore, Md.
1988-present Director of Genetics of Maryland Medical Laboratory, Inc. Baltimore, Md.
1989-present Member of the Substance Abuse and Doping Committee and the Sports Medicine and Science Committee of the U.S. Bobsled and Skeleton Federation (Olympic committee)

Professional Societies:
Sigma Psi
American Association for Advancement of Science
National Board of Medical Examiners, Diplomat
American Society of Human Genetics
Montgomery County Medical Society
American Fertility Society

Publications:

1. Merril, C.R. and Geier, M.: The effect of freezing and DEAE-D in spheroplast assays. Virology 42: 780-82 (1970).

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JOHN H. MENKES
1201 Park Way
Beverly Hills, Calif. 90210

January 20, 1991.

Ms. Sandy Mintz
6981 Kincaid Road
Anchorage, Alaska 99502

Dear Ms. Mintz:

In response to your recent letter, I can inform you that at the present time essentially all research which is being conducted on the side effects of vaccines is supported by the various drug houses producing the vaccine. In addition, when comparing risks to benefits, there is a tendency for physicians and scientists to overemphasize the risks of diseases such as whooping cough, and understate the risks of vaccination.

I trust this information will be of assistance to you.

Sincerely yours,

John H. Menkes, M.D.
Professor Emeritus of Neurology and Pediatrics
University of California, Los Angeles,
405 S. Beverly Drive, Suite 300
Beverly Hills, Ca. 90210
FAX (213) 277-6581

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Edward J. Linkner, M.D., Clinical Instructor, University of Michigan Medical School

"Randall Neustaedter's book is the most practical, useful book on immunizations from the viewpoint of alternative medicine written so far. I highly recommend it to all patients, parents, and physicians."

Roger Morrison, M.D., Co-founder, Hahnemann Medical Clinic; Instructor, Hahnemann College of Homeopathy

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Kenneth P. Stoller, M.D., Fellow of the American Academy of Pediatrics

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WASHINGTON, D.C. 20016

HARRIS L. COULTER, PH.D.
PRESIDENT

(202) 364-0898
(202) 362-3185

January 28, 1991

Chairman and Members
Health, Education, and Social Services
Committee
Alaska State Senate
Juneau, Alaska

Dear Sirs:

As the author of two books on the neurological effects of childhood vaccinations, I would like to support the Position Paper submitted to you by Ms. Sandy Mintz in April, 1989.*

I cannot add very much that is useful to what has already been stated very eloquently in that Position Paper other than to repeat a few facts which are well-known to physicians and neurologists but not always familiar to the non-medical public, namely:

-- The full extent of neurological damage from childhood vaccinations is not yet known. For example, prior to the publication in 1985 of DPT: A Shot in the Dark by myself and Barbara Fisher, the vaccine authorities would not admit that the whooping cough vaccine could cause death and held that the incidence of neurologic damage generally is infinitesimally small (1 in 350,000 children). But since the establishment in 1990 of a vaccine compensation system in the US Claims Court, Washington, DC, about 5000 cases have already been filed, one third of them for vaccine-caused death (usually diagnosed as "sudden infant death syndrome"). The more we dig into this issue, the worse the data become. So far we have just scratched the surface.

-- There is good evidence that some children are congenitally predisposed to a serious vaccine reaction. In other words, even if the vaccine is "safe" according to the FDA definition, some children could be killed or very seriously damaged by it (epilepsy, mental retardation, hyperactivity, learning disabilities).

-- There is greater awareness today that such childhood diseases as measles or mumps, even whooping cough, have beneficial effects in that they strengthen the child's immune system. Vaccinations, on the contrary, weaken the immune system and, when their effect wears off, leave the

adult even more vulnerable to a later attack of measles, mumps, or whooping cough.

Until all the evidence is in, I think it is unreasonable to force parents with strong contrary opinions to submit their children to the risks associated with these vaccines.

Thank you very much for your attention in this matter.

Very sincerely yours,

Harris L. Coulter, Ph.D.

*Harris L. Coulter and Barbara Loe Fisher, DPT: A Shot in the Dark. New York: Harcourt Brace Jovanovich, 1985. To be reprinted in 1991 by Avery Publishing Company, Garden City, Long Island, New York. Harris L. Coulter, Vaccination, Social Violence, and Criminality. Berkeley, California: North Atlantic Books, 1990.

HARRIS L. COULTER, PH.D.

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WASHINGTON, D. C. 20016

CURRICULUM VITAE

Born: Baltimore, Maryland. October 8, 1932

Education: Milton Academy, Milton, Massachusetts, 1945-1950.
Yale University, 1950-1954. B.A., 1954. Major: Russian Studies
Harvard Law School, 1955-1956
Columbia University, 1954-1959. Department of Public Law and Government. M.A. 1961. Ph.D. 1969. Dissertation title: Political and Social Aspects of Nineteenth-Century Medicine in the United States: The Formation of the American Medical Association and its Struggle with the Homoeopathic and Eclectic Physicians
University of Moscow, USSR, Department of Economics, 1962-1963 (under the US-USSR Cultural Exchange Program)

Languages: Russian, French, German, Spanish, Serbocroatian, Hungarian

Family: wife -- Catherine Nebolsine Coulter (separated)
children -- Andrew, Elizabeth, Marian, Alexander

Organizations: American Institute of Homoeopathy
National Center for Homoeopathy
International Foundation for Homoeopathy
Liga Medicorum Homoeopathica Internationalis

Professional Experience: 1960-1963, United Nations, New York. Simultaneous interpreter -- Russian-English, French-English
1964-1966, U.S. Dept. of State. Interpreter and translator
1966-present. Self-employed writer, interpreter, translator, and consultant

Research interests: medical history and philosophy, homoeopathic medicine, childhood vaccinations, the controlled clinical trial

Grants: 1958 -- Ford Foundation Foreign Area Training Fellowship ($2500)
1977 -- writer's Grant from National Center for Homoeopathy, Washington, D.C. ($15,000)

Honors: 1985 -- Hahnemann Prize, from the Societe Royale Belge d'Homoeopathie
1990 -- Centenary Gold Medal, from the Academia Medico-Homeopatica de Barcelona

ge, United States, 1981

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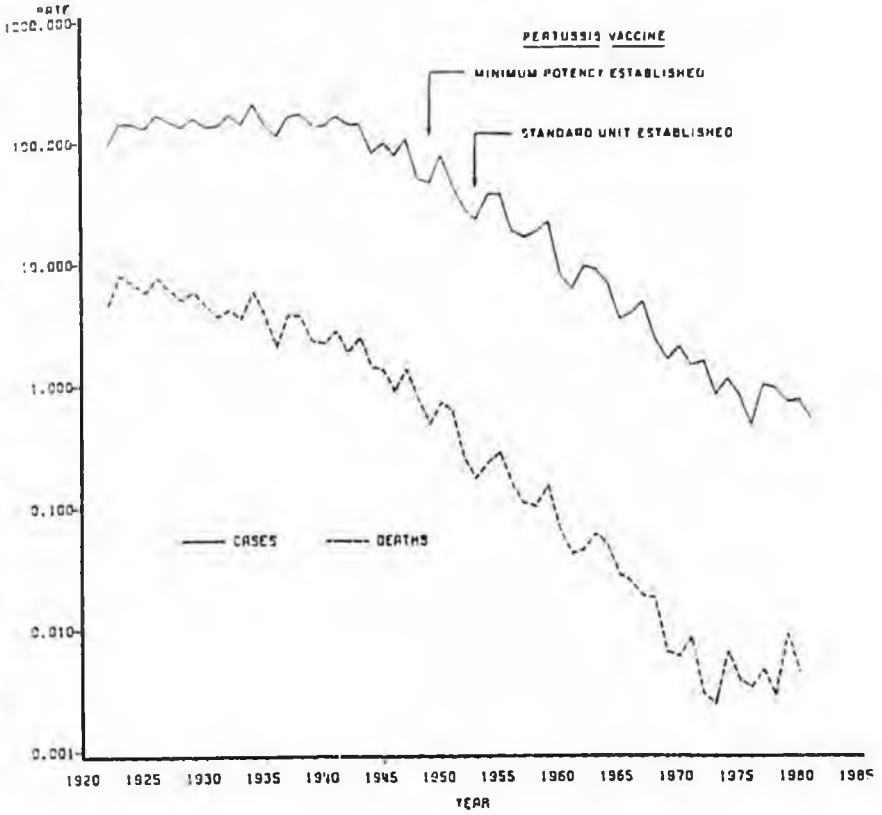
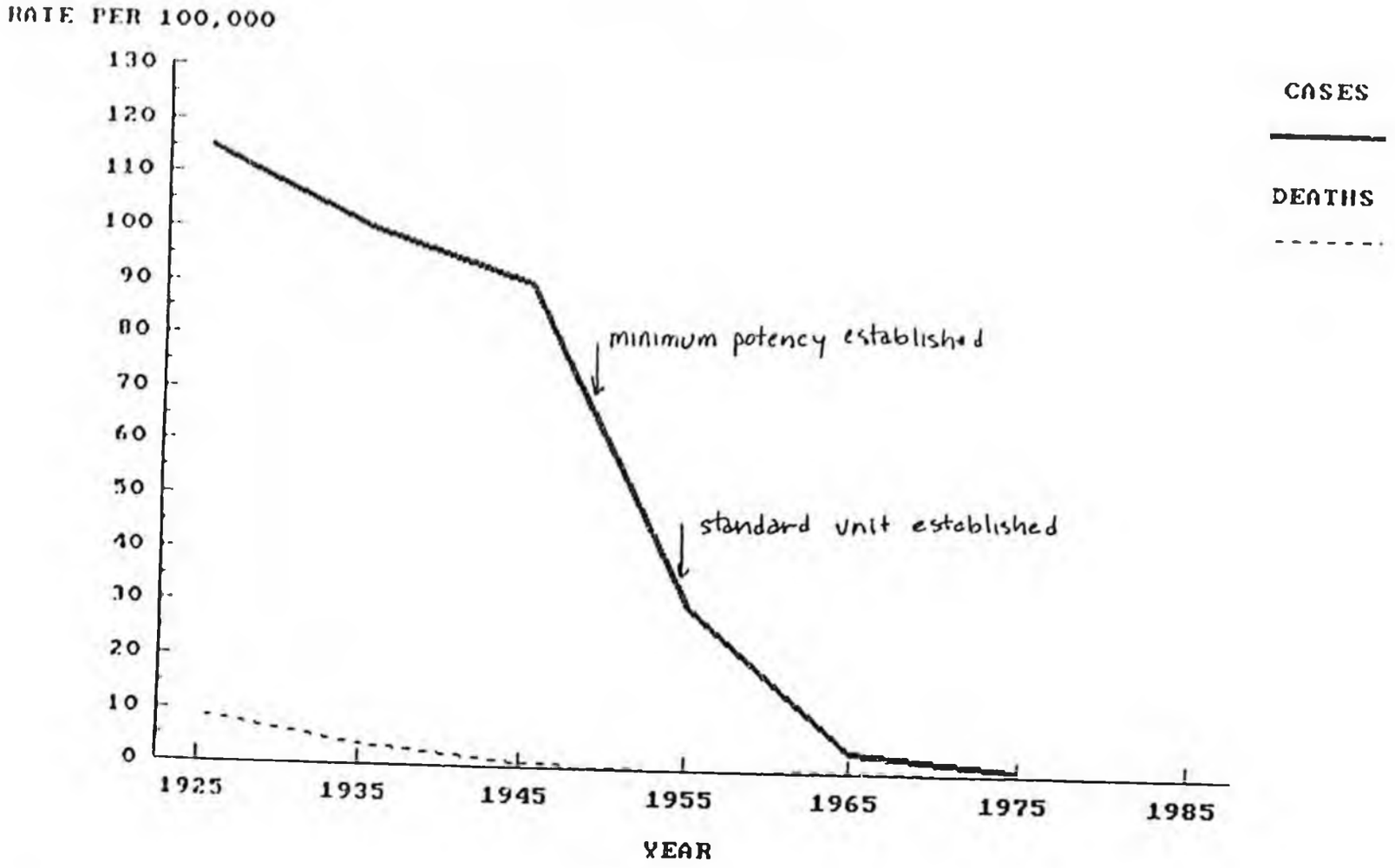
PERTUSSIS (Whooping cough)— Reported cases and deaths per 100,000 population, by year, United States, 1922-1981



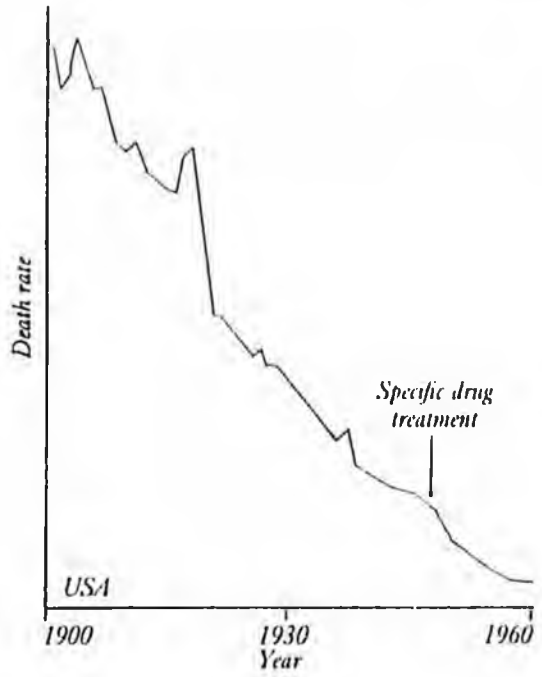
Bordetella pertussis vaccines were not uniform in potency before 1949 when minimum potency requirements were established. A standard unit of potency was adopted in 1953. Concurrently, the use of pertussis vaccine became widespread, and the rate of decrease in pertussis morbidity and mortality accelerated. In more recent years, however, the rate of decrease has been slower, with the preponderance of cases occurring in the < 1-year-old age group. For 1981, 62% of the cases with age reported were in this age group.

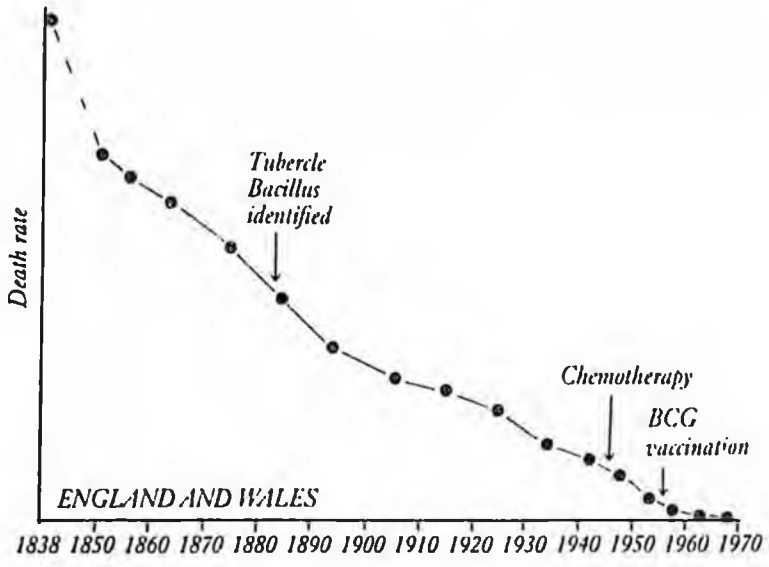
REVISED MMWR GRAPH SHOWING MORBIDITY AND MORTALITY FOR PERTUSSIS*



Graph originally found in MMWR 30:(54),1982.

* Approximate

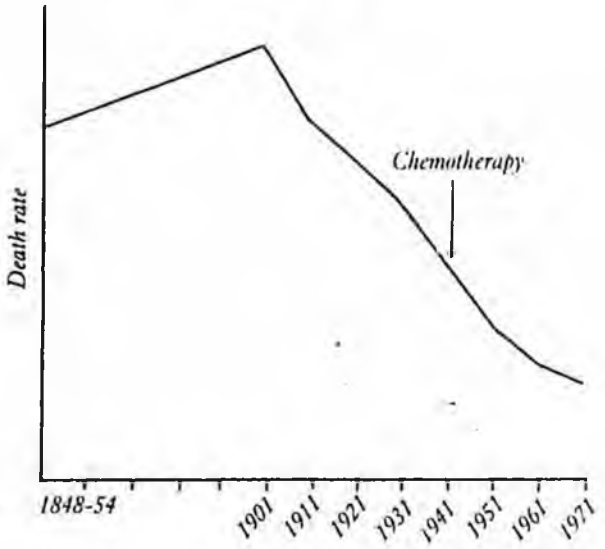




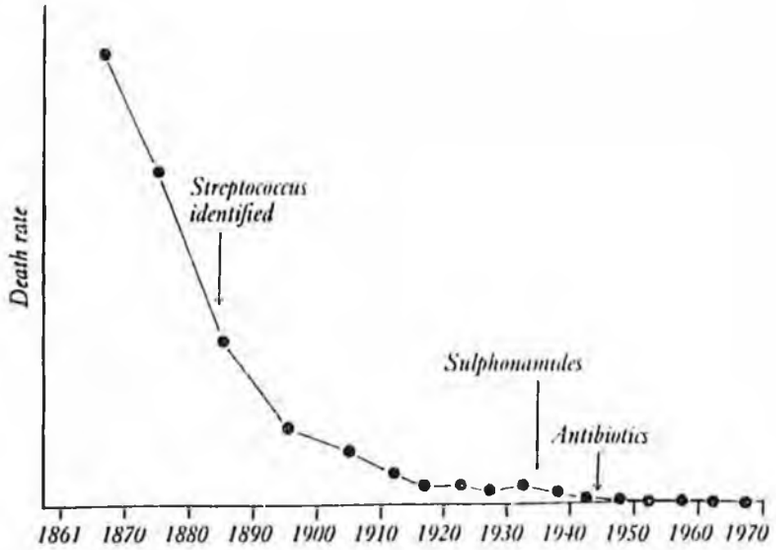
Tuberculosis in England, Wales and the USA

occurred in those vaccinated than in the placebo group![10] On the other hand, the Netherlands had the lowest death rate from respiratory TB for any European country in 1957-59 and 1967-69 despite having no national BCG programme.[6]

During the nineteenth century, pneumonia, bronchitis and influenza were all grouped together in national statistics. The introduction of antibiotics does not seem to have made an impact on the already declining death rate but this is hardly surprising because influenza and some cases of acute bronchitis are viral diseases for which antibiotics are ineffective. Although it is known from clinical experience that antibiotics can successfully treat pneumonia, statistics from 1900 both here and in the USA do not show a major change in the already declining death rate.[11] Since there are so many types of influenza virus, vaccines against one form may be useless against another and one study, involving 50,000 Post Office workers, showed that influenza vaccine had no impact on absenteeism.[12] But mass vaccination can sometimes prove dangerous and it was in 1976 that President Ford ordered the now infamous nationwide vaccination programme against swine flu. Eventually the project had to be abandoned because the vaccine was found to cause death and paralysis amongst the elderly.[10]



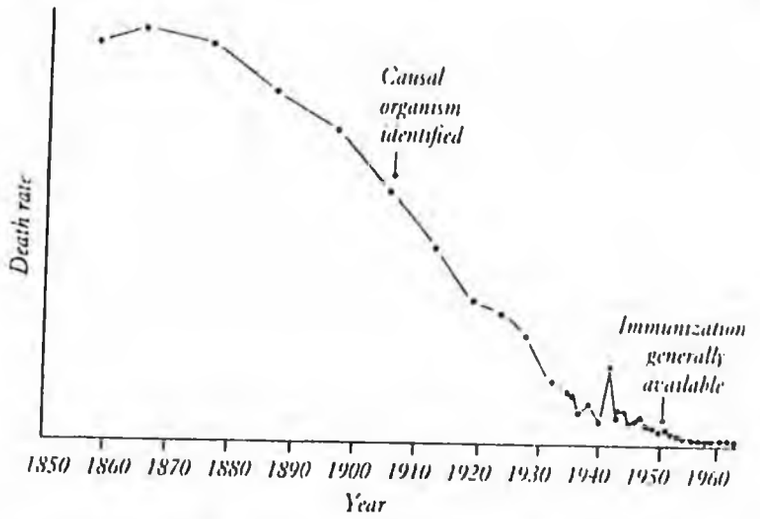
Bronchitis, pneumonia and influenza: death rates (standardized to 1901 population) for England and Wales



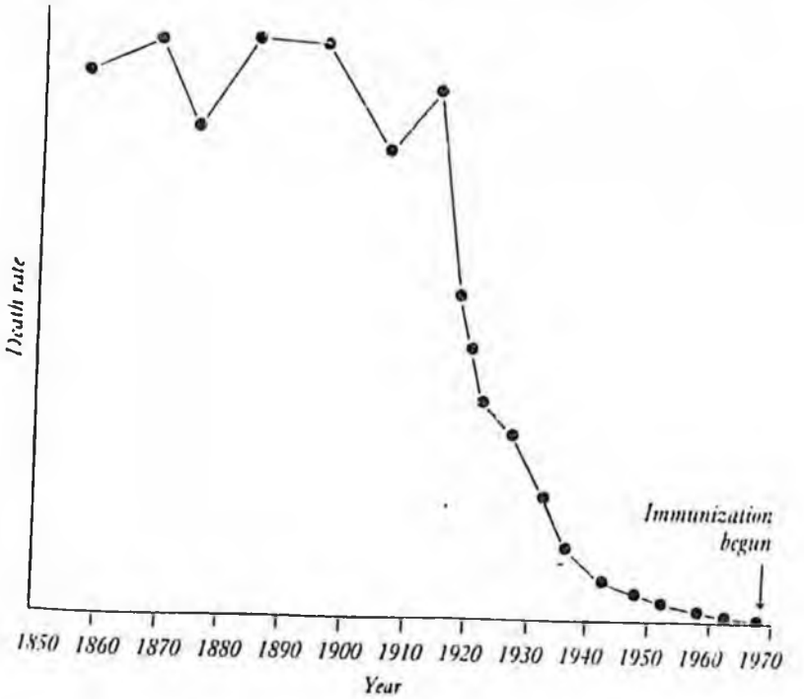
Scarlet fever: the mean annual death rate in children under 15 for England and Wales

Sadly pneumonia still claims many lives – 24,687 in England and Wales during 1984, and death rates for those aged 65 to 84 have risen sharply since the mid 1940s, despite the availability of antibiotics.[13]

Both scarlet fever and whooping cough have declined rapidly since the 1860s and 1870s and had fallen to comparatively low levels by the time antibiotics, and immunization against whooping cough, became available.[14] In the 1860s the death rate from whooping cough was about 1,372 per million children under 15. By 1901-10 it had fallen to 815, by 1921-30 to 405, and by 1940 to about 140 per million. In 1947-8 the rate had declined still further to 73 per million and by the time a nationwide vaccination programme was initiated in the late 1950s, the rate had fallen to around 5 per million children.[15] Since 1969 almost half the deaths have occurred in children under three months old[15] – before vaccination is commenced. In recent years the value and safety of the vaccine has been hotly disputed in the medical press and risks of brain damage between 1 in 750 and 1 in 100,000 children have been quoted.[16] In Glasgow Professor Gordon Stewart, a fierce critic of the vaccine, has found that a child's social class is three times more



Whooping cough: death rates of children under 15 for England and Wales.



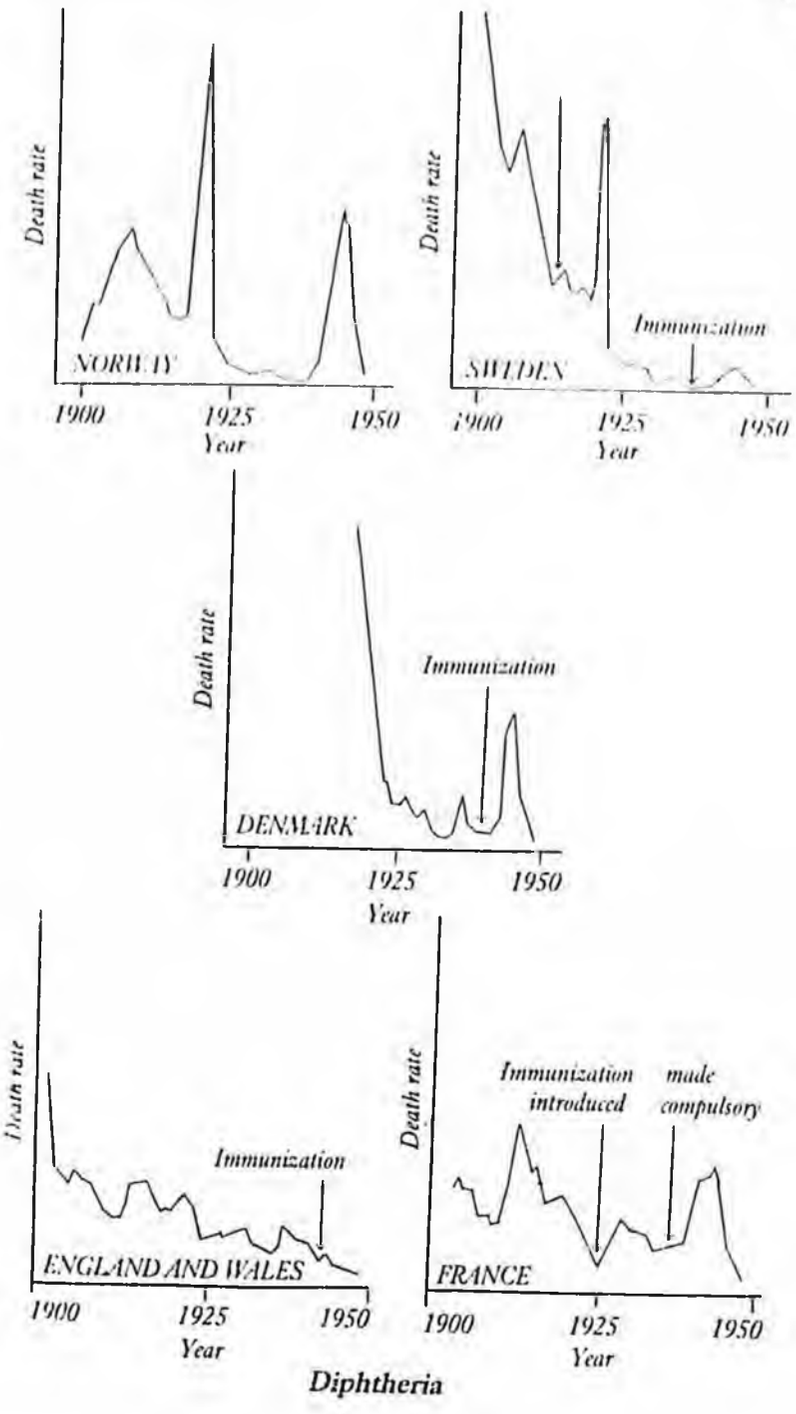
Measles: death rates of children under 15 for England and Wales

important than vaccination in influencing whooping cough outbreaks[17] – more evidence that poverty can cause disease. Other studies revealed that one third of whooping cough patients had previously been immunized![18] Routine use of the vaccine has been stopped in Sweden and West Germany without any rise in deaths or serious disease.[19]

Measles started to decline rapidly at the turn of the century and the death rate had reached very low levels by the time vaccination was introduced in 1968.[6]

In 1860 diphtheria accounted for well over 1,000 deaths per million children[20] but this had fallen sharply to an annual rate of around 400 between 1861 and 1870.[21] Although this fall was not associated with any specific therapy, later declines roughly coincided first with the introduction of horse antitoxin treatment (1894) and then by immunization (1940). Had mortality from other common childhood infections remained the same or increased during the same period, then it would be natural to assume that antitoxin and vaccination were mainly responsible for the fall in diphtheria deaths around 1900 and 1942. But deaths from whooping cough and measles did indeed decline over the same period without any treatment or immunization, suggesting other influences, such as an improved standard of living, may also have been at work with diphtheria. This is confirmed by figures from poorer countries where the death rate from diphtheria is 100 times higher.[22] And evidence taken from countries with a higher standard of living also shows that antitoxin and immunization could not have been solely responsible for the decline of diphtheria.

In his Presidential address to the British Association for the Advancement of Science, Professor Porter described how the value of antitoxin treatment has never been accepted generally[23] and perhaps this is not surprising because controlled clinical trials were never carried out.[24] As a result there are virtually no statistics proving that antitoxin actually works on human beings.[25] The apparent fall in the case-fatality rate (the number of deaths expressed as a fraction of the total number contracting the disease) may well have been caused by new diagnostic methods. Bacterial analysis, introduced at about the same time as antitoxin, meant that mild cases of the disease, previously classified as something else, were now included in statistics, which automatically lowered the overall case-fatality rate.[26] And despite the availability of antitoxin since the 1890s, several

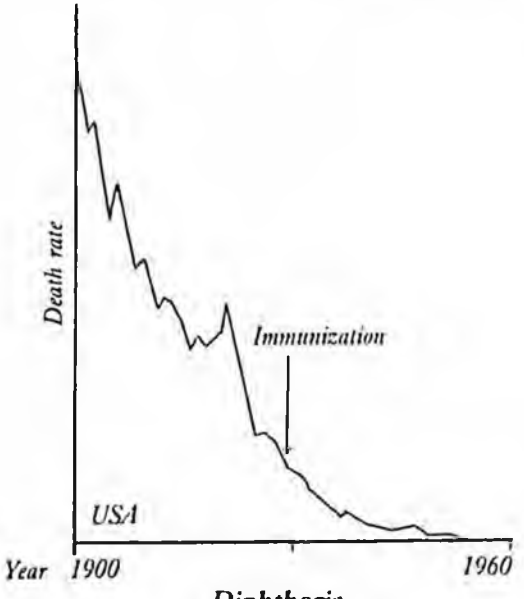


Diphtheria

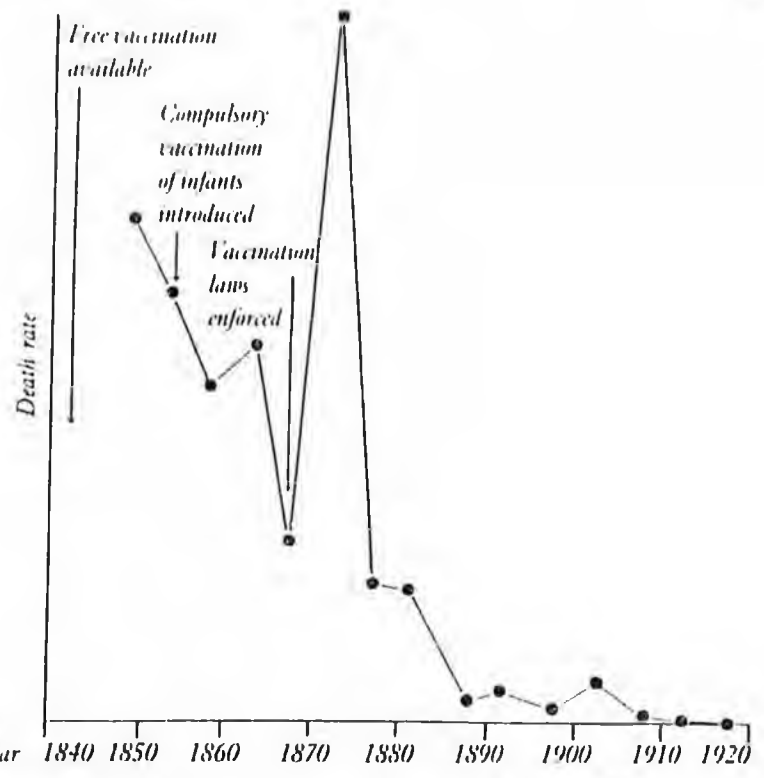
countries have experienced an increased death rate in the early years of this century.[27] In Berlin during the 1920s a severe outbreak of diphtheria led to high case-fatality rates despite large doses of antitoxin being given at an early stage. Debating these findings at the Berlin Medical Society, Professor Friedberger argued that the apparently favourable results following the introduction of antitoxin in the 1890s were really due to a natural decline in the severity of the disease.[28]

Figures for America show that immunization against diphtheria did not produce any detectable change in the death rate, which had already steeply declined.[24] Furthermore diphtheria was gradually declining in Massachusetts, Michigan and New York from about 1880, well before the introduction of antitoxin, let alone vaccination. Studies have also shown that parallels between the number of children immunized and the decline in mortality do not hold for every region in the USA,[24] suggesting that other factors, such as improvements in living standards, are crucially important.

In countries with a high standard of living, such as Denmark, Sweden and Norway, deaths from diphtheria declined rapidly without any vaccination.[29] That is, until World War II when several countries in Western Europe had greatly increased rates. In Denmark, immunization did not begin until 1941, but in



Diphtheria



Smallpox: death rates for England and Wales

Copenhagen, despite 95% of children being inoculated, there was an astonishing increase from 41 cases in 1942 to 1,754 cases in 1944![30] In Norway the disease had rapidly declined and virtually disappeared by 1939 when only 18 cases per million were recorded.[31] It was only after the German occupation in World War II that immunization was introduced, coincidentally with an enormous rise in diphtheria. And, despite immunization, diphtheria had shown a remarkable rise in Germany both before and during the Second World War. Increased overcrowding, a general lowering of hygienic standards and a lack of resistance because of poor food supply seem largely responsible.[31]

Evidence like this, taken from the experience of other countries shows that antitoxin and immunization could not have been solely, or even mainly, responsible for the decline of diphtheria in Britain.

Although the contribution of smallpox to the overall decline in

Britain's death rate between the 1850s and 1970s was relatively small, this is the one major disease for which vaccination was available before 1900. The medical historian Creighton considered vaccination against the disease useless but this is not a generally accepted view. Nevertheless, a recent analysis of the decline of smallpox in London concluded that vaccination could never have been solely responsible.

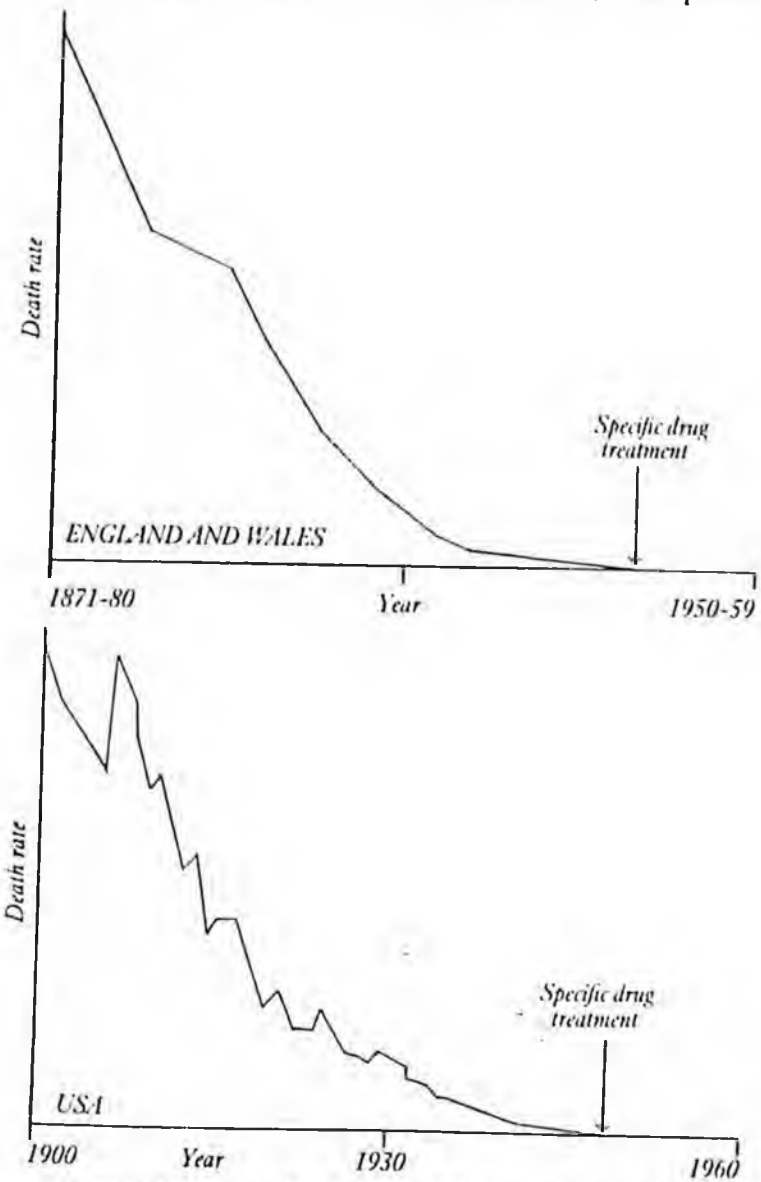
> 'The history of smallpox in the later years of the nineteenth century does not support the contention that vaccination was fully or finally responsible for the eventual disappearance of the disease in Britain. It was in these years, in fact, that there was developed the system for control of the disease that became the basis of the successful modern campaign for its eradication.'
>
> *Medical History*, 1983[32]

The 'system' included the establishment of port sanitary authorities to avoid the disease being imported from abroad, isolation of patients and thorough cleansing of their homes. In fact the Royal Commission on Smallpox and Fever Hospitals traced the beginnings of the decline to the 1780s although Jenner's method of vaccination was not even published until 1798. By the time Jenner's vaccine was being introduced, between 1801 and 1810, the death rate had already fallen from 500 to 200 per 100,000 of the population.[32] Even then vaccine uptake was not great – hence the subsequent Acts of Parliament attempting to enforce the practice. Compulsory vaccination was introduced in 1852 but by then mortality had fallen to 40 per 100,000. Between 1871 and 1880, the period when compulsory vaccination was legally enforced, the death rate leapt from 28 to 46 per 100,000.[32] Worldwide, the elimination of smallpox has been attributed to isolation of contacts, education and mass vaccination.[33]

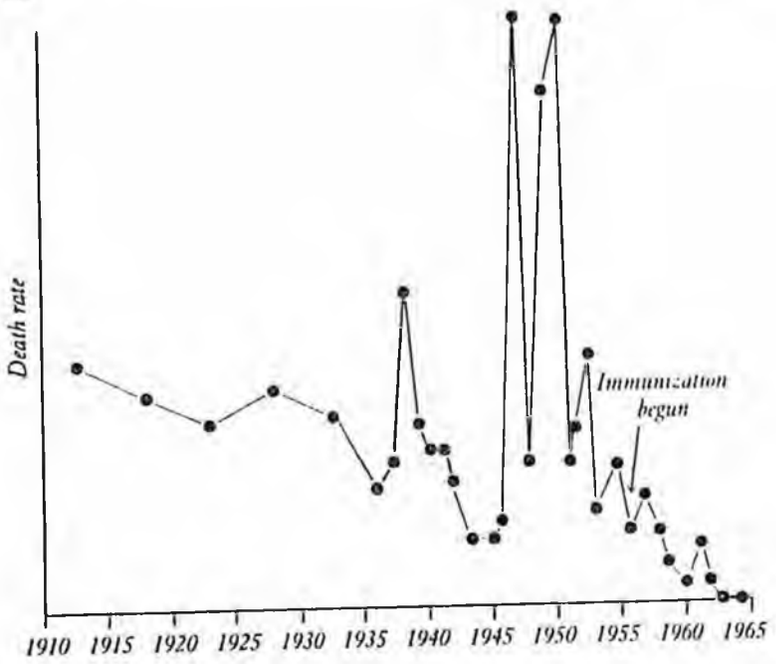
It is often thought that Edward Jenner developed the first protection against smallpox but inoculation against the disease had been practised in India since ancient times and in China since 1063.[2] In 1718 Lady Wortley Montague, wife of the British Ambassador to Turkey, introduced inoculation against smallpox into this country. Small amounts of material from the pustules of those suffering from a mild form of the disease were administered nasally or inoculated into those seeking protection, immunity being conferred against dangerous attacks. The

method was sometimes hazardous although risks could be reduced by making the fluid less virulent.

Jenner's subsequent 'discovery' of vaccination was really based on the chance observation that milkmaids, infected with cowpox from lesions on the udders of cows, were protected



Typhoid Fever in England and Wales and the USA



Poliomyelitis: the mean annual death rate for children under 15 for England and Wales

main reasons being a rising standard of living of which the most important feature was a better diet, improvements in hygiene, and a favourable trend in the relationship between some microbes and the human host. McKeown concludes that therapy made no contribution and the effect of immunization was restricted to smallpox, a disease that accounted for only about one twentieth of the reduction of the death rate. For the twentieth century McKeown lists improved nutrition and better hygiene as by far the most important influences, with therapy and immunization playing a relatively minor role. In the United States where Shattuck had performed the same vital role as Chadwick in Britain, researchers John and Sonja McKinlay found that for ten common infectious diseases (TB, scarlet fever, influenza, pneumonia, diphtheria, whooping cough, measles, smallpox, typhoid and poliomyelitis), medical measures only accounted for between 1 and 3.5 per cent of the decline in mortality since 1900.

> 'In general, medical measures (both chemotherapeutic and prophylactic) appear to have contributed little to the overall decline in mortality in the United States since about 1900 – having in many instances been introduced several decades after a marked decline had already set in and having no detectable influence in most instances. More specifically, with reference to those five conditions (influenza, pneumonia, diphtheria, whooping cough and poliomyelitis) for which the decline in mortality appears substantial after the point of intervention – and on the unlikely assumption that all of this decline is attributable to the intervention – it is estimated that at most 3.5 per cent of the total decline in mortality since 1900 could be ascribed to medical measures introduced for the diseases described here.'[9]

Even traditional medical sources such as the *Lancet* acknowledge that '. . . public health legislation and related measures have probably done more than all the advances of scientific medicine to promote the well-being of the community in Britain and in most other countries.'[40].

But if affluent Western societies have largely eradicated the infectious epidemics, life is not so good in poorer countries. People in the Third World now suffer from the same communicable diseases that were widespread in developed nations during the nineteenth century. Many illnesses are transmitted by food and water contaminated by disease organisms from human and animal excreta. They include diarrhoeal disease, amoebic and bacterial dysentery, typhoid, cholera, polio and infectious hepatitis.[41] Fewer than one in five people in the Third World can obtain clean water. Lack of a clean water supply, and the breeding of mosquitoes and flies in stagnant water, have been connected with 80 per cent of disease in the world.[33] Indeed the World Health Organisation estimate that 25 million people die every year because they do not have clean water and sanitation. Poverty is another major cause of ill health leading to malnutrition and a lowered resistance to infection: the death rates from whooping cough and measles are 300 and 55 times higher respectively in poorer countries.[22] The Third World poor almost always live in overcrowded conditions which accelerates the spread of disease. Whilst modern drugs can tackle many of these infections, they are powerless to break the cycle of disease if the environment remains unhealthy. As Oxfam point out, disease that is rooted in poverty can only be prevented by an onslaught on poverty and inequality.[41] In

the words of the Tanzanian Food and Nutrition Council,[42] a '. . . society that is perpetuating malnutrition cannot be treated with medicine. It has to develop and be restructured in such a way that all its members are ascertained all their basic human needs.' So the prescription for better health in Third World countries is the same as that which worked so effectively in developed nations like the UK: improve nutrition, hygiene and sanitation and living and working conditions. Even tropical diseases like malaria can be effectively controlled through public health measures, that is by draining swamps or treating water so mosquitoes cannot breed.[33]

The evidence shows that society's control of infectious disease rests primarily on efficient public health services and a good standard of living and the dramatic increase in life-expectancy since the early 1800s can be directly traced to these sources. Medical measures clearly played only a relatively small part and later on, in Chapter 5, we will see how little even these owed to experiments on animals. None of this is an argument against *properly conducted* medical research, but it does show that the major influences on our health are outside the scope of laboratory experiments. As medical historian Brian Inglis concludes:

> 'The chief credit for the conquest of the destructive epidemics . . . ought to have been given to the social reformers who had campaigned for purer water, better sewage disposal and improved living standards. It had been their efforts, rather than the achievement of the medical scientists, which had been chiefly responsible for the reduction in mortality from infectious diseases.'[43]

1 A. M. Ramsay and R. T. Emond, *Infectious Diseases* (Heinemann, 1967)
2 R. Sand, *The Advance to Social Medicine* (Staples Press, 1952)
3 Professor R. Watt in reference 2
4 Reproduced in *Animal Liberation*, P. Singer (Thorsons Publishing Group, 1983)
5 Reproduced in reference 2
6 T. McKeown, *The Role of Medicine* (Blackwell 1979)
7 F. Grundy, *Preventive Medicine & Public Health* (H. K. Lewis, 1964)
8 On the state of the Public Health, 1979 (DHSS, 1980)
9 J. B. McKinlay & S. McKinlay, *Health & Society*, 405-428, 1977 (Millbank Memorial Fund)
10 M. Weitz, *Health Shock* (Hamlyn, 1982)
11 In England and Wales, reference 6; in the United States, reference 9

12 R. Smith, *Lancet*, 330, 10 August, 1974
13 See reference 82 in Chapter 2
14 T. McKeown and C. R. Lowe, *An Introduction to Social Medicine* (Blackwell Scientific Publications, 1976)
15 *BMJ*, 1208, April 9, 1983
16 For instance, G. T. Stewart, *BMJ*, 1263, 24 April, 1982, together with reference 19.
17 W. R. Bassili and G. T. Stewart, *Lancet*, 471-473, 28 February, 1976
18 T. T. Salmi, et al, *Lancet*, 811-812, 25 October, 1975
19 *Times*, 8 September, 1982
20 W. H. Parry, *Communicable Diseases* (Hodder & Stoughton, 1979)
21 MRC Special Report Series, no. 247, 1943
22 *Lancet*, 632, 14 September, 1974
23 Presidential address by R. R. Porter at the Swansea Meeting of the British Association for the Advancement of Science, 3 September, 1971
24 H. F. Dowling, *Fighting Infection* (Harvard University Press, 1977)
25 A. B. Christie, *Infectious Diseases* (Churchill Livingstone, 1980)
26 C. S. Singer and E. A. Underwood, *A Short History of Medicine* (Clarendon Press, 1962)
27 For example, H. J. Parish's *Victory with Vaccines* (Churchill Livingstone, 1968) describes how antitoxin was widely used in Germany and France by 1895-1900. Yet in the early years of the twentieth century death rates for diphtheria showed a huge rise. See also graph for Sweden.
28 *Lancet*, 598, 14 August, 1931
29 Diphtheria graphs plotted using statistics from *Epidemiological & Vital Statistics Report*, 92-111, Volume 4, 1951 (WHO). According to Sweden's National Central Bureau of Statistics, vaccination was '. . .introduced in 1939 but not used to a greater extent until 1943' (letter from G. Karlström, 12 August, 1986.) According to the *BMJ*, 614, 3 November, 1945, immunization had not been carried out in Norway before World War II because it '. . . had not been considered necessary'
30 *Lancet*, 915, 20 December, 1947
31 *Lancet*, 628, 11 November, 1944
32 A. Hardey, *Medical History*, 111-128, volume 27, 1983
33 The Wellcome Museum of the History of Medicine (Science Museum, London, November 1986)
34 See Chapter 5
35 L. Hayflick, *Laboratory Practice*, 58-62, volume 19, 1970
36 Typhoid decline in England and Wales: graph plotted using data from *Registrar General's Statistical Review*, 1970 (HMSO, 1972); for United States, see reference 24
37 For declining death rates from polio see graph (reference 14). Reference 1 indicates that the total number of cases had fallen from around 10,000 in 1950 to just over 3,000 by 1956
38 *Lancet*, 1223-1231, 15 December, 1956
39 Conclusion reproduced in reference 9. See also references 6 and 14
40 *Lancet*, 354-355, 12 August, 1978
41 D. Melrose, *Bitter Pills* (Oxfam, 1982)
42 Reproduced in reference 41
43 B. Inglis, *Diseases of Civilization* (Paladin Books, 1983)

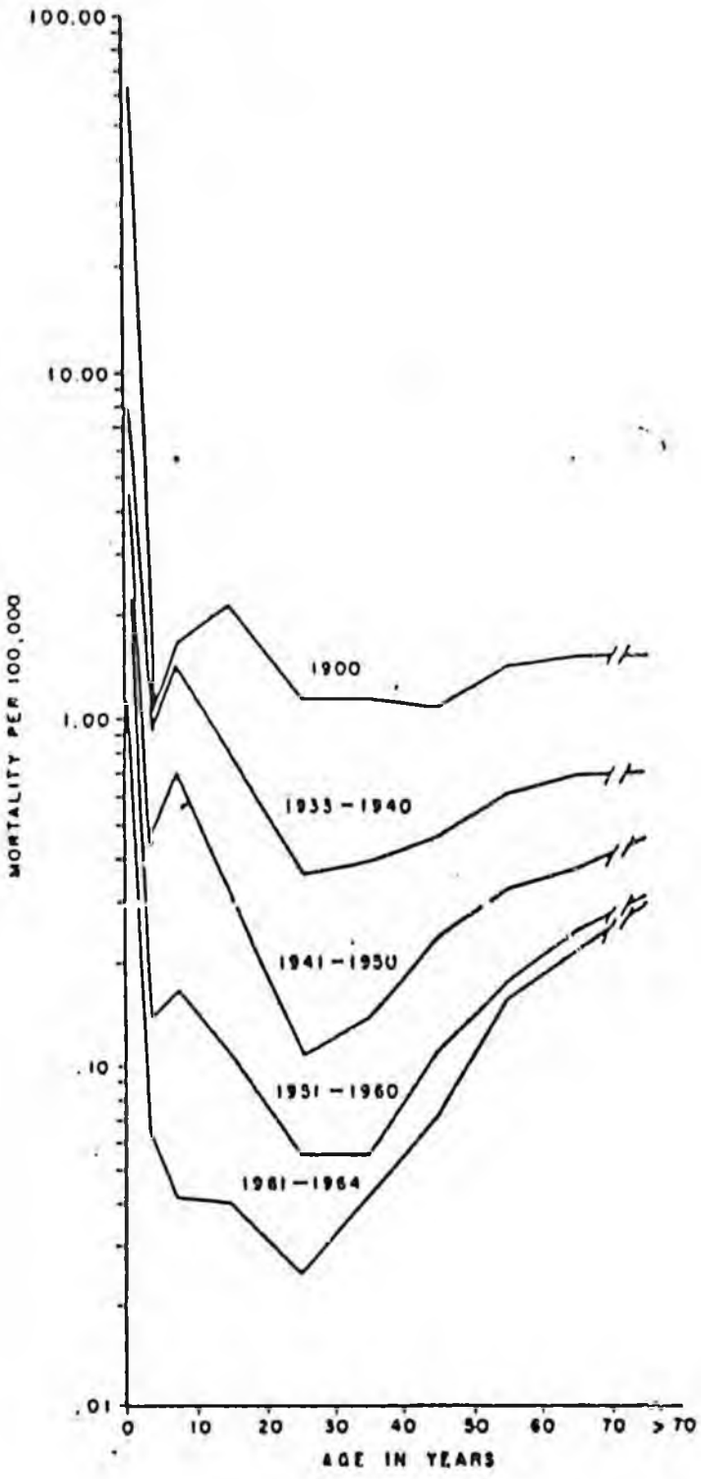
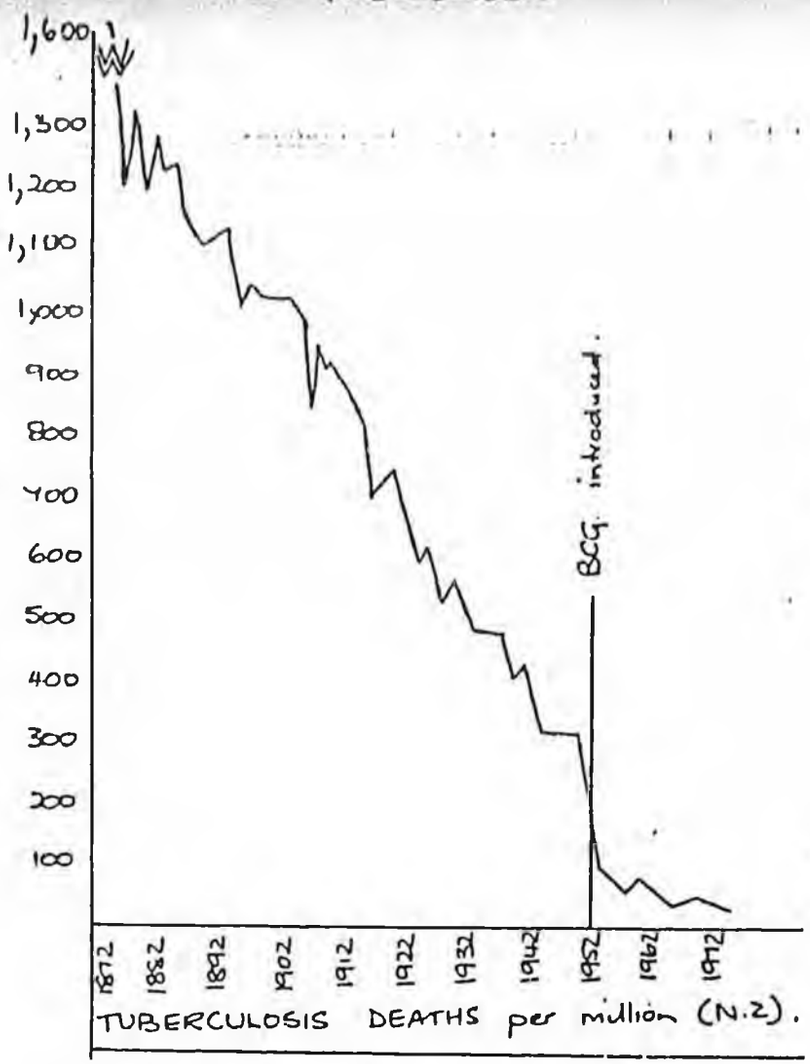


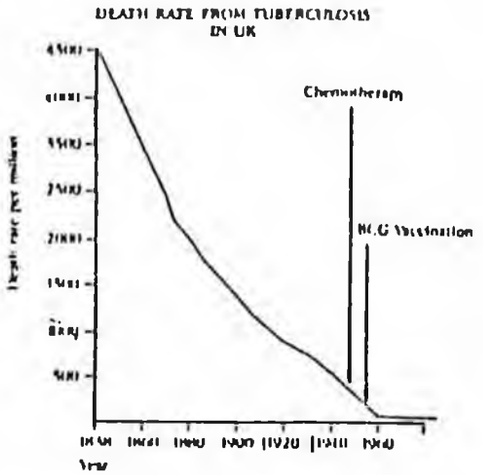
FIGURE 2. *Average Annual Tetanus Mortality Rates, According to Age Group, United States, 1900 and 1933-1964.*

Tetanus

Vaccine used only after 2nd W. War



U.K.
Tuberculosis



Introduction

The prevalence of tuberculosis in Great Britain has declined dramatically over the last hundred years. It is now largely confined to particular high risk groups, such as the single homeless [1,2]. Although tuberculosis is a treatable disease, it has proved difficult to eradicate among the homeless; attendance at mass radiography is notoriously poor [3,4], and the initiation and continuation of effective treatment of the homeless is particularly unsuccessful [5,6]

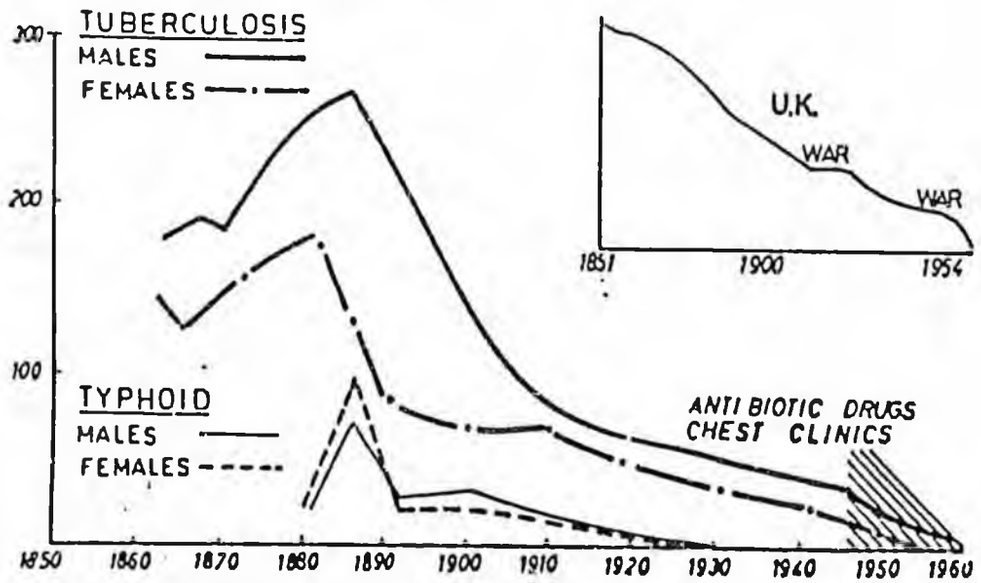
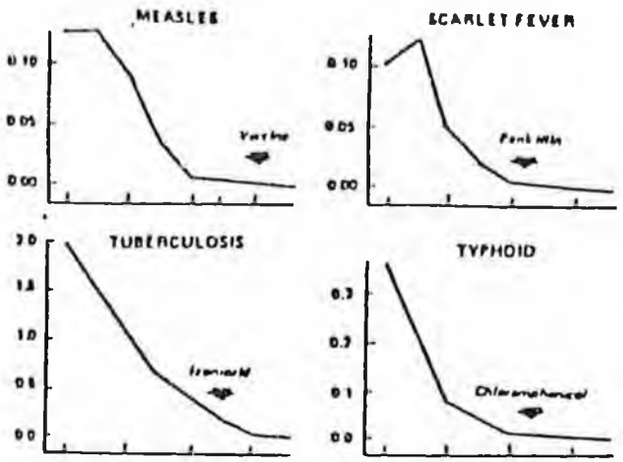


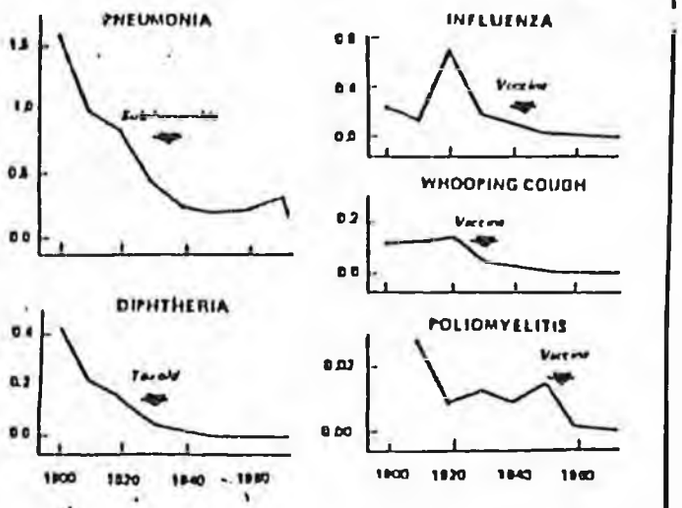
Fig. 19. Deaths from tuberculosis and typhoid all ages per 100,000 population, Australia, 1850–1960. (Graph by H. Silverstone, Department of Social and Preventive Medicine, University of Queensland. Data from H. O. Lancaster and others.)

Australia, Tuberculosis.

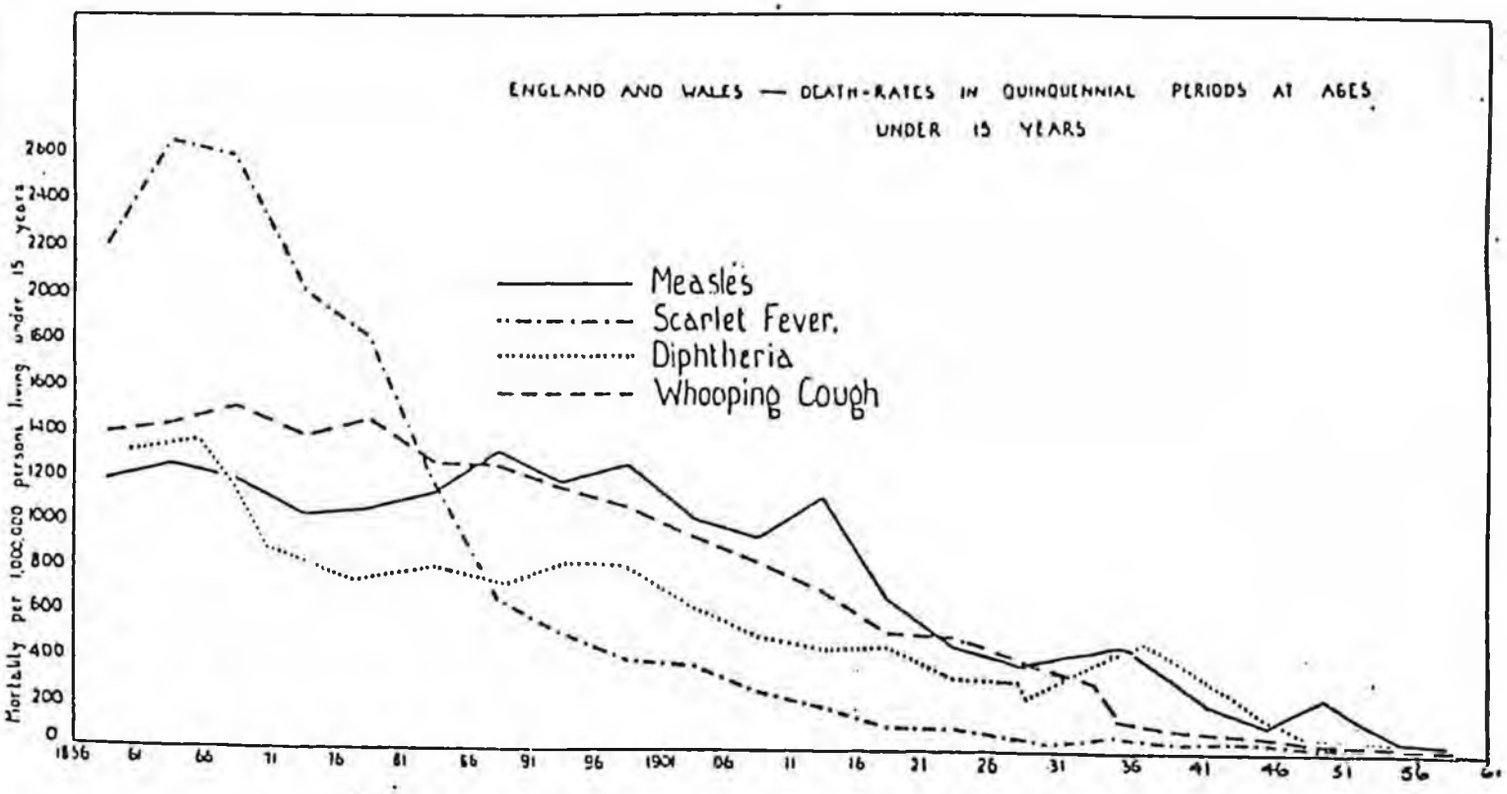
Journal of the Royal College of Physicians of London Vol. 22 No. 1 January 1988

THE FALL IN THE STANDARDIZED DEATH RATE (PER 1,000 POPULATION) FOR NINE COMMON INFECTIOUS DISEASES IN RELATION TO SPECIFIC MEDICAL MEASURES, FOR THE UNITED STATES, 1900-1977.





From "Contribution of Medical Measures to Mortality Decline", by John B. McKinlay and Sonja M. McKinlay.



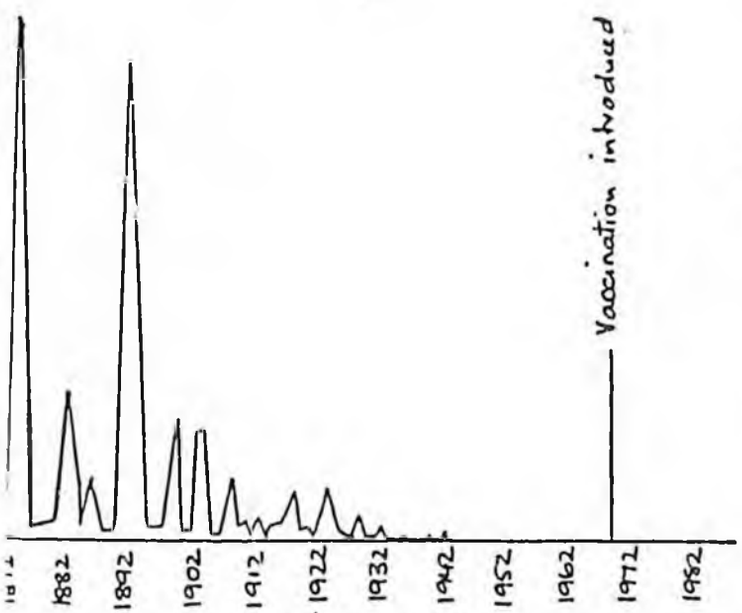
USA. Decline: measles, scarlet fever, T.B., Typhoid, pneumonia, influenza, Diphtheria, polio, whooping cough.
1900 - 1977.

UK Decline measles, scarlet fever, Diphtheria, whooping cough.
1856 - 1961

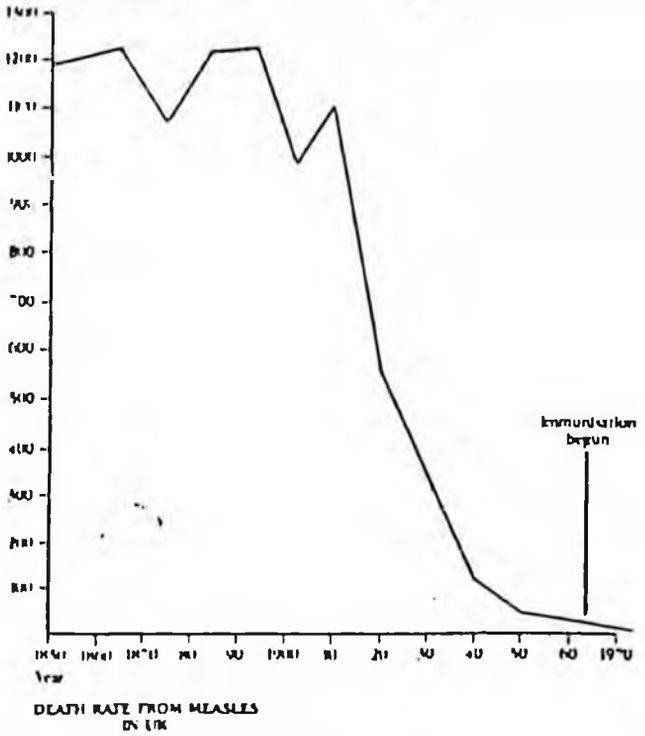
New Zealand

Measles

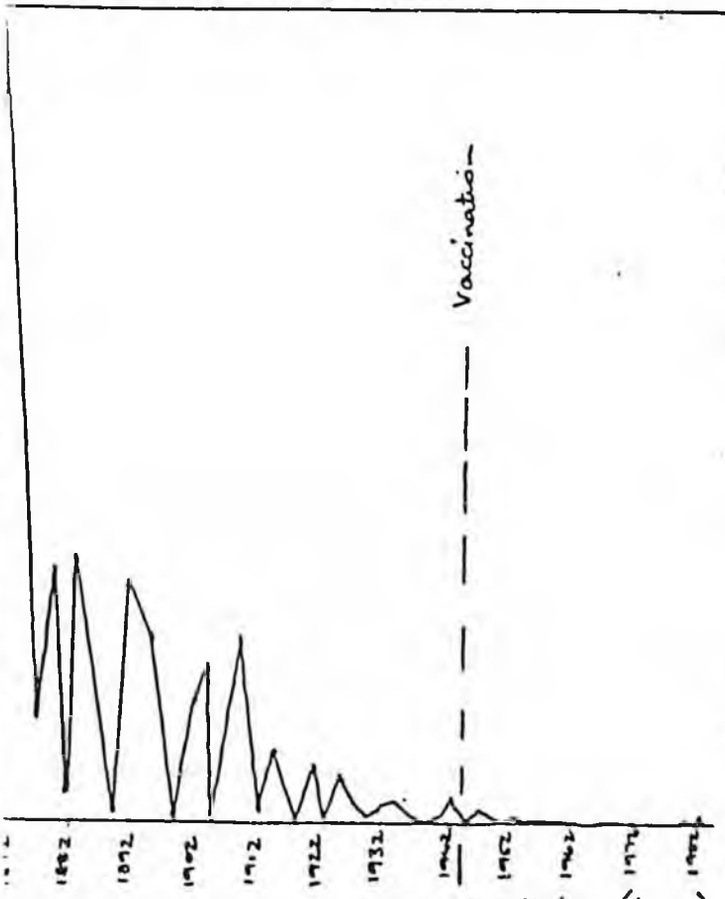
United Kingdom



MEASLES Deaths per million (N.Z)



DEATH RATE FROM MEASLES IN UK



WHOOPING COUGH. DEATHS per million (N.Z)

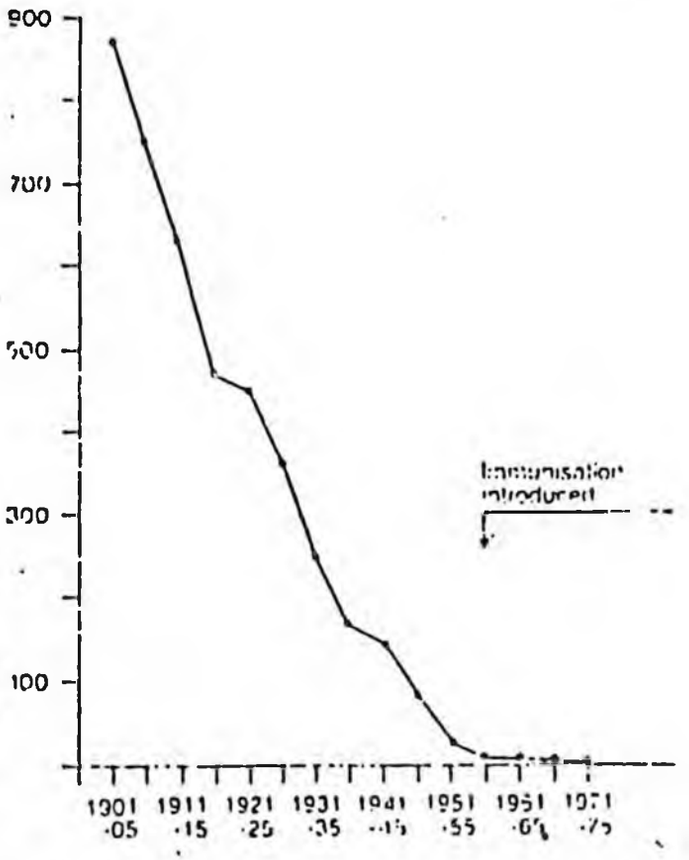


Fig. 3 Deaths from whooping cough per million children under 15 years of age. (UK)

Whooping Cough.

Whooping Cough.

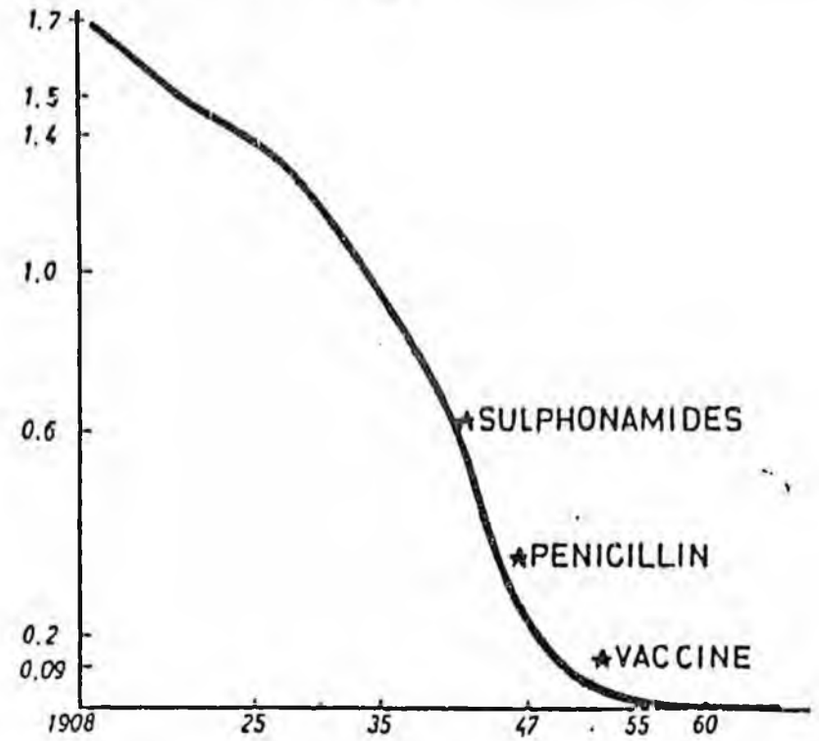


Fig. 17. Deaths from pertussis in first year per 1,000 live births per annum, males, Australia, 1908–60. (Graph by H. Silverstone, Department of Social and Preventive Medicine, University of Queensland. Data from H. O. Lancaster.)

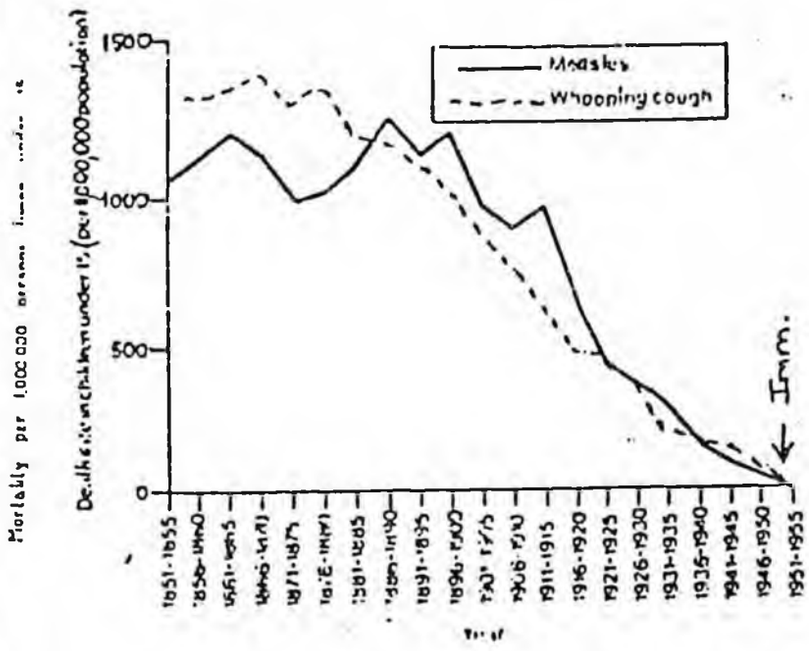


Fig. 2 Decline in deaths from whooping cough and measles (England and Wales). (Reg. Gen. Stats)

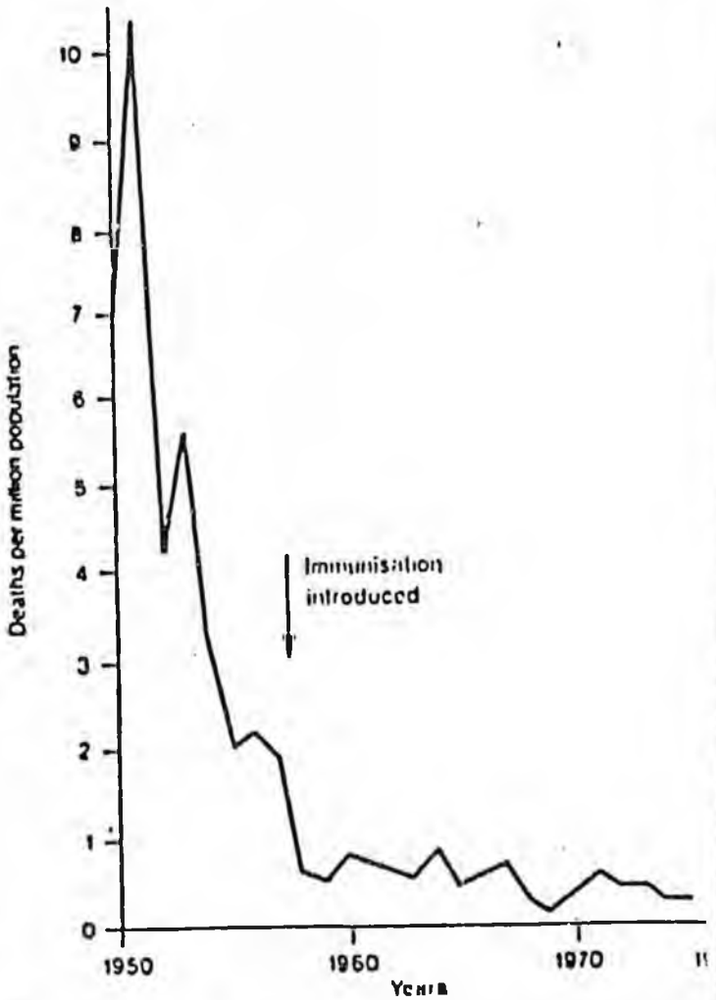
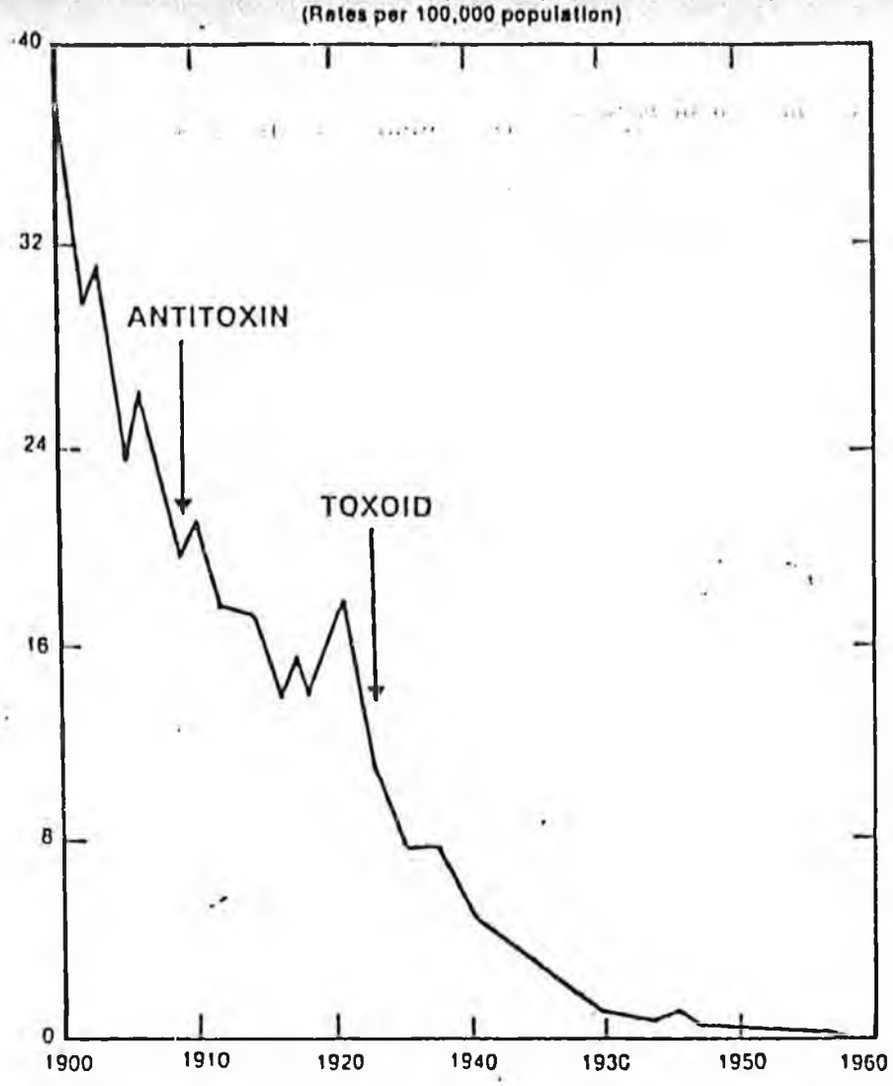


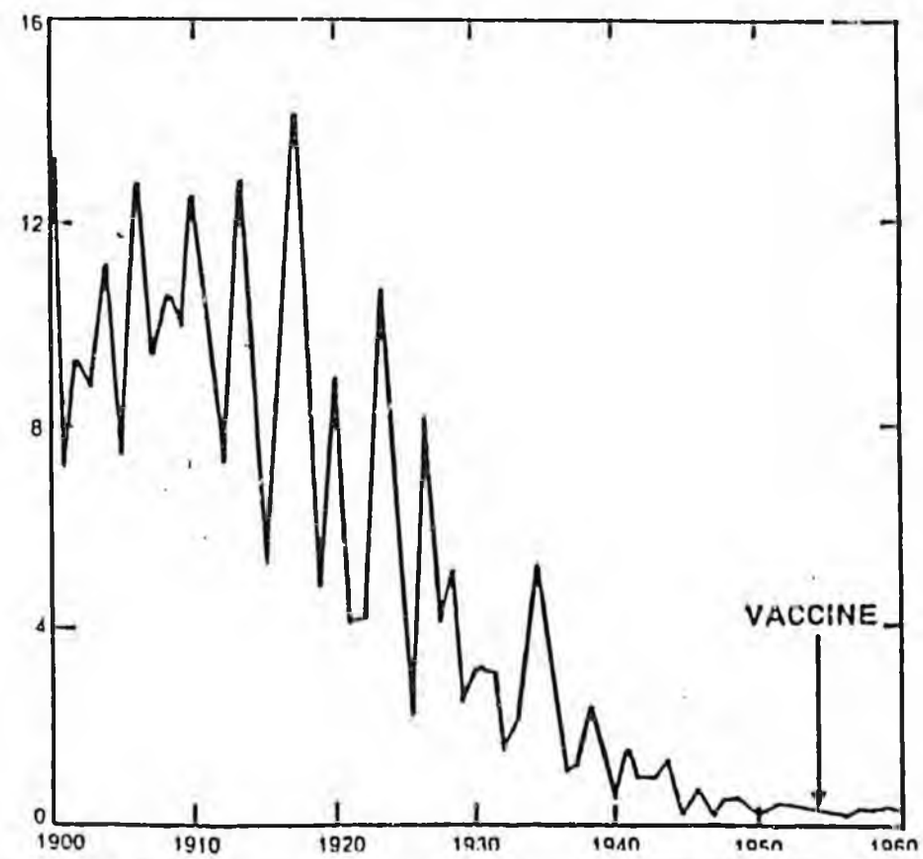
Fig. 4 Whooping cough deaths per million population, England and Wales: 1950 to 1976.

DEATH-REGISTRATIONS STATES, 1900-32, & UNITED STATES, 1933-60
(Rates per 100,000 population)



1900-60.
Vital Stats of USA in DHEW - USPHS No 1677, 1968.

FIGURE 2
DEATH RATES FOR MEASLES:
DEATH-REGISTRATION STATES, 1900-32, & UNITED STATES, 1933-60
(Rates per 100,000 population)

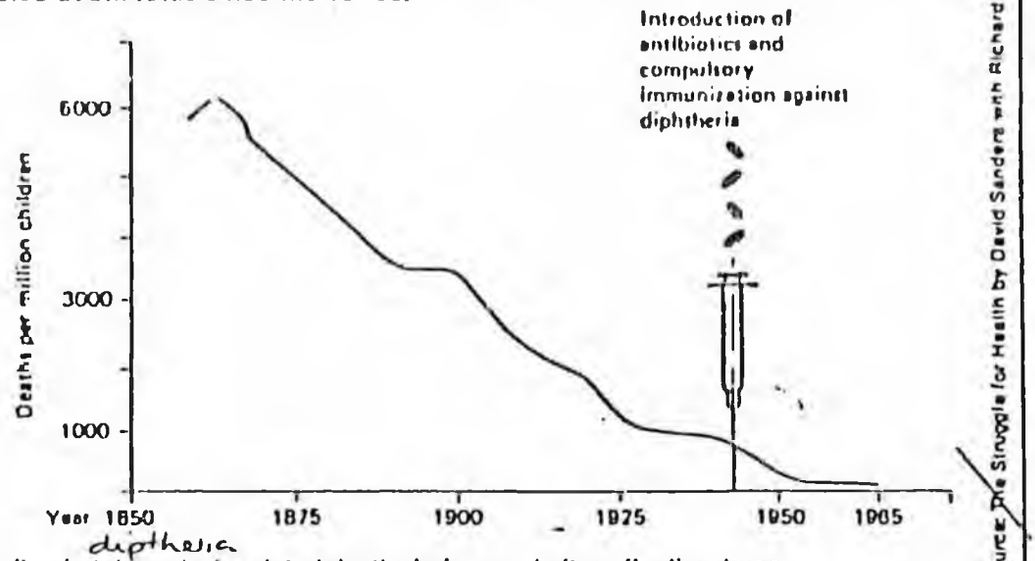


Measles
US

Diphtheria — England and Wales.

Decline in infectious diseases in the industrialized world

Substantial health improvements have occurred mainly due to better public sanitation, housing and nutrition. Medical intervention has only significantly affected death rates since the 1940s.



Source: The Struggle for Health by David Sanders with Richard Carver

diptheria

Decline in ~~tuberculosis~~ related deaths before and after effective drugs treatment introduced, England and Wales

Nov. 1986.
"New Internationalist"

The fundamental causes of ill-health are beyond the control of doctors and their drugs. Yet recognizing this would mean questioning the validity of expensive medical care. It is not in the interests of the medical profession to be examining or confronting the social roots of illness. Anyway, they are not trained to be social workers or revolutionaries. They are trained to be scientists.

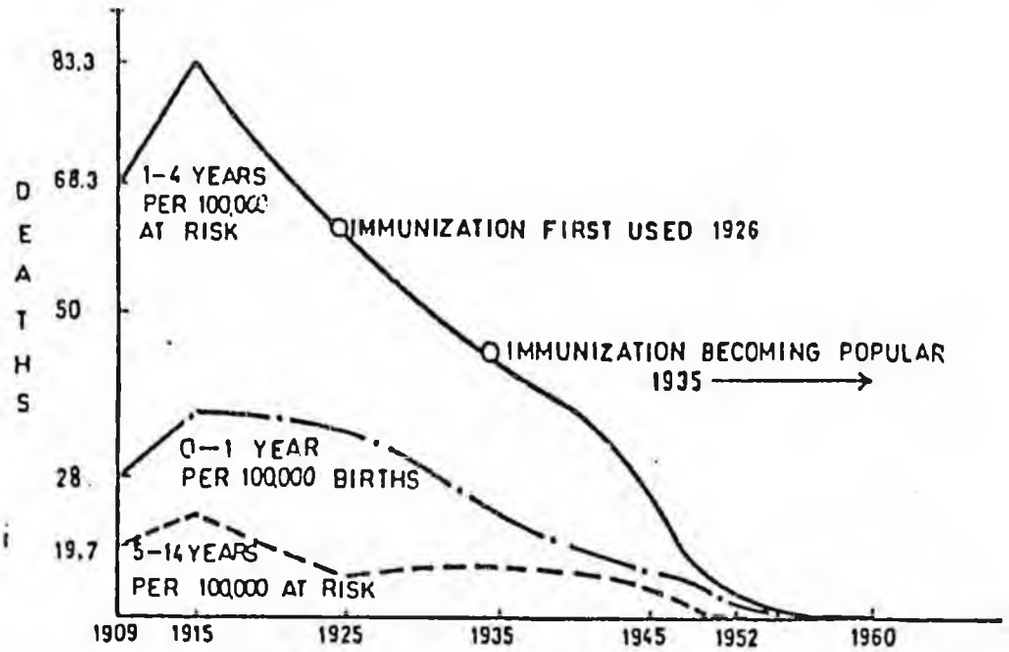


Fig. 18. Deaths from diphtheria, males, Australia, 1909–60. (Graph by H. Silverstone, Department of Social and Preventive Medicine, University of Queensland. Data from H. O. Lancaster.)

Diphtheria (males) Australia

NVIC FINDS DOCTORS ARE REFUSING TO REPORT VACCINE REACTIONS

After following up on 21 of the many severe vaccine reactions reported to the National Vaccine Information Center (NVIC) in 1990, the NVIC found that doctors are refusing to report reactions to state and federal health authorities as is required by Public Law 99-660 (*The National Childhood Vaccine Injury Act of 1986*). The Center discovered that pediatricians are refusing to report reactions because they are being told by vaccine policymakers in the Centers for Disease Control (CDC) and American Academy of Pediatrics (AAP) that the pertussis vaccine does not cause permanent brain damage and death.

Responding to an increasing number of reports of reactions leading to death and permanent injury following DPT vaccinations, Ann Millan, NVIC Director of Administration, contacted 21 parents who had written NVIC telling of their child's suspected DPT reactions and asking if there was any kind of federal reporting system. She learned that 18 out of the 21 doctors who gave the vaccines, refused to report reactions and the majority refused to give parents the manufacturer's name and lot number when requested by the Center, despite the legal requirement to do both.

In most cases, the doctors often justified their lack of reporting the vaccine reactions, and subsequent deaths and injuries, by claiming the DPT shot had nothing to do with the child's death or injury. The doctors often cited information given out by the CDC and AAP that the vaccine is completely safe as proof. All but a few of the 21 reactions were eventually reported by the parents themselves to the Food and Drug Administration (FDA) or CDC, but only after five months of assistance from the NVIC.

"The behavior of these doctors toward parents, who were only trying to have their child's reactions reported to health authorities, is not only professionally irresponsible but is also inexcusable," said Mrs. Millan. "These mothers and fathers were trying to cope with what had happened to their children and, at the same time, had to make repeated phone calls to their doctors and beg them to provide the vaccine manufacturer's name and lot number. Some of the doctors told parents they 'forgot' to record the information, others gave parents false manufacturer's names and lot numbers, and one parent had to retain a lawyer to obtain the information. After five months, all but a few of the 21 reactions were reported by the parents themselves to the proper government agencies."

After finally obtaining identifying information about the DPT vaccine associated with the 21 reactions, the NVIC discovered that two seizures and two deaths were reported to have followed receipt of DPT vaccine from Lederle Lots 256-957/959/960/965; one death and two seizures involved DPT vaccine from Connaught Lot 0B11061; and two seizures and one reaction involved vaccine from Connaught Lot number 8F01010.

Formal Protest Lodged

In a September 16 report to the National Vaccine Advisory Committee (NVAC), a federal vaccine policy advisory committee established under Public Law 99-660 and administered in the Department of Health and Human Services, NVAC committee member Barbara Loe Fisher, Executive Vice President of the National Vaccine Information Center, asked, "How many more deaths and injuries following vaccination occur each day and are never acknowledged or reported by physicians?" She asserted that the government's new adverse reaction reporting system is "a cruel joke" and will remain useless if doctors continue to refuse to report reactions. "There will be no way to draw scientifically valid conclusions about the relationship between vaccine reactions and long term consequences unless physicians abandon their biased attitude that there is no "cause and effect" and obey the law by reporting vaccine reactions without having to be coerced by parents and the National Vaccine Information Center," said Ms. Fisher.

Blaiming the lack of reaction reporting on the CDC and AAP for sending out a "no cause and effect" message to public and private pediatricians, she suggested the solution to physicians refusing to obey the law is to urge Congress to pass legislation applying legal sanctions against doctors who fail to report vaccine reactions or keep vaccination records.

Ms. Fisher asked the FDA to answer questions about whether the FDA has (1) looked at the production records of the lots associated with the 21 vaccine reactions the Center documented to determine whether there are any especially toxic pertussis batches that are causing the DPT lots to be highly reactive; (2) follow up to determine how many reactions, injuries and deaths have been associated nationwide with these lots; or (3) recalled one or more of the lots.

The FDA has still not made a formal reply to these questions.

(A copy of the 16-page report submitted to the Committee can be obtained for $3 from the NVIC.)

L.A. Times: 3-24-90

UCLA Researcher to Clarify Ties to Drug Manufacturer

Medicine: Journal will follow doctor's editorial on vaccines with statement that he is a paid consultant to a firm that makes them.

By JANNY SCOTT
TIMES MEDICAL WRITER

A prominent UCLA researcher, who wrote an editorial dismissing the likelihood of neurological illness from pertussis vaccines, will publish a clarification noting that he omitted mentioning he is a paid consultant to a vaccine manufacturer.

Dr. James D. Cherry, a professor of pediatrics, agreed to the clarification after the Journal of the American Medical Assn. learned that he failed to make the kind of financial disclosure required of journal authors since last October.

"Dr. Cherry's financial disclosure was incomplete, and we will be publishing his statement of clarification in the next available issue of JAMA," John Hammarley, science news editor for the American Medical Assn., said Thursday.

Cherry, a longtime vaccine researcher, is a consultant to Lederle Laboratories, one of two U.S. manufacturers of the diphtheria-tetanus-pertussis (DTP) vaccine. He has also received hundreds of thousands of dollars worth of research grants from Lederle and other firms.

In the editorial, published Friday in the journal, Cherry endorsed the conclusions of a paper published elsewhere in the issue in which researchers at Vanderbilt University studied 38,000 vaccinated children and found no increased risk of seizures. One of the authors of that paper also failed to disclose his ties to Lederle.

Cherry said he chose not to mention his ties to Lederle in the disclosure statement he submitted to the journal. In an interview Thursday, he said he believed such a disclosure was not necessary since the editorial concerned DTP vaccines in general, not one in particular.

"This particular editorial relates in no way to a specific manufacturer, it relates to pertussis vaccine," Cherry said. "Anybody who has done any research in fields like this has done contract studies with various companies.

"When I signed this thing, I actually thought about it, and I read it sort of carefully because I know this is a sensitive area," he said. "As it turns out, I did think about this. I thought this is generic, not really specific."

The issue arose this week when a reporter for a Boston television station learned of Cherry's ties to Lederle and his failure to declare them. The reporter, with WHDH-TV, contacted Cherry, who says he then contacted the journal.

Since October, the journal has required all authors to identify "any affiliation or financial involvement that may be considered a conflict of interest."

Disclosed information may or may not be published along with the author's paper.

Dr. Edward A. Mortimer Jr., a co-author of the Vanderbilt paper, acknowledged Thursday that he, too, failed to disclose he is a paid consultant to Lederle. As with Cherry, he said Lederle pays his university, and the money goes back into research, not into his pocket.

Mortimer, whose case has not been brought before the JAMA editorial board, pointed out that most experts in the field have ties to companies. He said the U.S. Food and Drug Administration had recommended that Lederle enlist academic researchers as vaccine consultants.

THE NATIONAL VACCINE INFORMATION CENTER

Dissatisfied Parents Together (DPT)
128 Branch Road, Vienna VA 22180
(703) 938-DPT3

Contact: Barbara Loe Fisher
703-938-DPT3

for release after May 13, 1990

PARENT GROUP CHARGES IOM VACCINE STUDY COMMITTEE BIAS - CALLS ON HHS AND CONGRESS TO ACT

WASHINGTON, D.C. -- Dissatsified Parents Together (DPT), a national organization representing vaccine injured children and their parents, is calling on the Secretary of Health and Human Services (HHS) to stop funding a vaccine study being conducted by a committee appointed by the Institute of Medicine (IOM) until apparent conflict of interest issues in the committee can be resolved.

The parent group charges that the IOM Committee to Review the Adverse Consequences of Pertussis and Rubella Vaccines is not impartial, pointing out that committee member Marie Griffin, M.D., is financially supported by Burroughs Wellcome, one of the largest pertussis vaccine manufacturers in the world. The parent group is calling for Griffin's resignation and asking Congress to conduct an independent assessment of the IOM study procedures and conflict of interest issue.

The IOM review of the scientific literature associating the pertussis and rubella vaccines with permanent brain damage and

-more-

death is being funded by HHS under the National Childhood Vaccine Injury Act of 1986. The vaccine injury legislation set up a no-fault compensation system for individuals who died or were permanently injured by mandated childhood vaccines.

DPT, which operates the National Vaccine Information Center and was a major supporter of the vaccine injury legislation, publicly asked the IOM to respond to a list of questions about the committee members' possible bias at a January 10 IOM workshop. A major question was whether any of the committee members received grant money or other financial support from vaccine manufacturers. In a recent IOM letter to DPT, the IOM did not answer the question, citing the need for "confidentiality."

"Public money is being spent on this study and the public has a right to know if committee members may be biased," said DPT spokesman Jeff Schwartz. "Although one committee member has already been removed for apparent conflict of interest, the IOM has failed to adequately respond to the problem. This is a critical scientific examination of the link between several mandated vaccines and death and brain damage - a link which has been established in the medical literature for decades and which helps document the need for the federal vaccine injury compensation system. Unless IOM commmittee members are truly impartial and the review is conducted properly, the public will have no reason to have confidence in their findings."

Griffin is a Burroughs Wellcome Scholar in Pharmaco-epidemiology at Vanderbilt University. She was the principal author of a pertussis vaccine risk study recently published in the Journal of the American Medical Association (JAMA), which disputed the link between the pertussis vaccine and permanent damage.

Her study prompted JAMA to publish an editorial calling for an end to the federal vaccine injury compensation system on the grounds that the pertussis vaccine does not cause permanent brain damage. The author of the editorial, James Cherry, M.D., of UCLA, is a paid consultant for Lederle Laboratories, the largest American manufacturer of pertussis vaccine. Cherry, who also has obtained large research grants from Lederle, failed to disclose his financial ties to the drug company to JAMA readers.

The federal vaccine injury compensation system, which is administered in the U.S. Claims Court in Washington, D.C., has awarded more than $30 million in 60 cases of vaccine injury and death. The majority of the cases involved the pertussis vaccine.

November 12, 1987

SUMMARY OF SEVERE ADVERSE REACTIONS TO STATE MANDATED IMMUNIZATIONS

Data collected by: Dissatisfied Parents Together, Alaska Chapter

Dates of survey: October 1986-October 1987

Method used: Alaska "DPT" vaccine adverse reaction questionnaire

Number of subjects (reactions) - 25: 24 DPT
1 MMR

Range of survey: State of Alaska

1- College, AK.	1- Anchorage, AK.
1- Gustavis, AK.	1- Anchor Point, AK.
1- Sterling, AK.	1- Homer, AK.
4- Kenai, AK.	3- Fairbanks, AK.
2- Juneau, AK.	7- Soldotna, AK.
1- Palmer, AK.	2- Kasilof, AK.

Ages of subjects at date of response:

2- 4 months	1- 4 years
1- 6 months	2- 5 years
1-10 months	3- 6 years
1- 14 months	1- 8 years
1- 18 months	1- 17 years
5- 2 years	1- 20 years
4- 3 years	1- 23 years

Return to: Dissatisfied Parents Together
Box 1746
Soldotna, AK 99669
Shannon Kohler 262-3825

DPT SHOT REACTION QUESTIONNAIRE

Directions: Please place an "X" before the answer(s) you select or fill in the spaces when appropriate.

1. Before your child received his DPT shot(s), did a health professional inform you of the possible serious reactions to the shot?

   5 Yes (1) 19 No (2) 1 Don't Know (3)

2. Did the health professional who gave your child the DPT shot(s) tell you to look for and report severe reactions such as a high temperature, excessive crying or high pitched screaming, excessive sleepiness, etc.?

   6 Yes (1) 18 No (2) 1 Don't Know (3)

3. Before giving your child the DPT shot(s) did a health professional tell you when the shot should not be given (i.e. if the child has an active infection or a fever, if the child reacted severely to a previous DPT shot, etc.)?

   6 Yes (1) 16 No (2) 3 Don't Know (3)

4. Did you sign a consent form containing information about the DPT shot and its possible reactions before your child received his DPT shot?

   2 Yes (1) 15 No (2) 8 Don't Know (3)

5. Before your child received his DPT shot(s), did a health professional question you about your family's and your child's medical history?

   ____ Yes (1) 23 No (2) 2 Don't Know (3)

6. Do you believe your child reacted severely to any of his DPT shots? (Answer yes only if the reaction was more serious than a low fever, mild crying, or slight redness or puffiness around the site of the shot)

   25 Yes (1) ____ No (2) ____ Don't Know (3)

If you answered yes to question #6, please answer the rest of the questionnaire. If you answered no to question #6, skip the rest of the questions and fill in your name, address and telephone number at the end of the questionnaire.

7. After the DPT shot that caused your child to react severely, did he have:

   most children had more than one symptom of reaction

   4 convulsions (1)
   16 fever of more than 103 degrees (2)
   13 excessive crying or high pitched screaming for long periods (3)
   6 extreme sleepiness (4)
   ____ collapse or shock (5)
   5 loss of muscle control (temporary or pemanent paralysis) (6)
   ____ death (7) 1-nerve damage deafness 2-permanent partial paralysis
   ____ other (please explain) 1-severe allergies & eczema 1-chronic cold sores 1-severe congestion 1-whooping-like cough (8) 1-limping 1-severe swelling of arm 1-severe leg swelling 1-severe swelling of glands in head

8. How long after the shot did the reaction begin to occur?

24 Within 24 hours after the shot (1)
1 24-48 hours after the shot (2)
___ 2 days - 7 days after the shot (3)
___ 1 week - 2 weeks after the shot (4)
___ more than 2 weeks after the shot (5)

9. After which DPT shot did your child react severely? Some children reacted to more than 1 shot

15 First shot (1)
4 Second shot (2)
3 Third shot (3)
2 Fourth shot (4)
___ Fifth shot (5)
1 all shots

10. How old was your child when he was given the DPT shot that caused the severe reaction?

8 2-3 months old (1)
6 4-5 months old (2)
4 6-7 months old (3)
3 8-12 months old (4)
1 13-18 months old (5)
1 19-24 months old (6)
___ 25 months - 3 years old (7)
___ over 3 years old (8)
1 all
1 Dont Know

11. How old is your child now?

See 1st page attachment

12. Did you report your child's severe reaction to the DPT shot to a health professional?

21 Yes (1) 4 No (2) ___ Don't Know (3)

13. If you did not report your child's severe reaction to the DPT shot, was it because you were not aware that the reaction was serious and should have been reported?

4 Yes (1) No ___ (2) ___ Don't Know (3)

*14. If you did report your child's severe reaction to the DPT shot to a health professional, did that person report your child's severe reaction orally or in writing to: NO: 10

___ drug manufacturer (1)
___ federal government (2)
3 state health department (3)
___ any local health agency (4)
8 Don't Know (5) none of these parents had an official MSAEFI form completed

15. Was your child's severe reaction to the DPT shot written on his medical record?

6 Yes (1) 8 No (2) 11 Don't Know (3)

16. After your child reacted severely to a DPT shot, was he given another shot that contained the pertussis vaccine?

6 Yes (1) 17 No (2) 1 Don't Know (3) 1 n/a mmr shot

17. Was your child mentally and physically normal before he received the DPT shot to which he reacted severely?

25 Yes (1) ___ No (2) ___ Don't Know (3)

18. Prior to the DPT shot to which your child reacted severely, did your child have a history of convulsions or neurologic disease?

____ Yes (1) 24 No (2) 1 Don't knows

19. Does your family have a history of convulsions or neurologic disease?

1 Yes (1) 23 No (2) 1 Don't Know (3)

20. Did you or your husband ever have whooping cough?

1 Yes (1) 22 No (2) 2 Don't Know (3)

21. Is there a significant history of allergies in your family or has your child ever been diagnosed as having allergies?

9 Yes (1) 12 No (2) 4 Don't Know (3)

22. If your child has allergies, were the allergies apparent before or after the DPT shot to which he reacted severely?

3 Before (1) 5 After (2) N/A 17

23. At the time your child had a severe reaction to the DPT shot, was he primarily bottle-fed?

9 Yes (1) 11 No (2) 5 Both

24. Has your child had a continuing physical or mental health problem since the DPT shot that caused the severe reaction?

12 Yes (1) 12 No (2) 1 dont know yet

If you answered yes to question #24, please answer the rest of the questions.

25. Is your child now:

1 experiencing motor delay
____ mentally retarded (1)

4 physicially handicapped (2)

3 experiencing convulsions (3)

4 exhibiting learning difficulties (4)

____ in an institution (5)

____ other (please explain) 1-nerve damage deafness 1-epilepsy 2-permanent partial paralysis 1-speech problem 2-cerebral palsy 1-severe allergies (6)

26. Has a physician confirmed your belief that your child's present health problems were caused by the DPT shot?

7 Yes (1) 7 No (2)

27. Has your child required special medical treatment, medicine, hospitalization, or therapy since the DPT shot that caused the severe reaction?

11 Yes (1) 14 No (2)

28. The cost of your child's special medical treatment is estimated to have been:

1 Under $2,000
10 $2,000 - $7,000
____ $7,000 - $12,000
____ $12,000 - $20,000 (4)
____ $20,000 - $40,000 (5)
____ Over $40,000 (6)

29. Please feel free to use the back of this page to tell us your story of what happened to your child as a result of his severe reaction to a DPT shot. Try to be as specific as possible, giving names, dates, and places.

Name: See next page for Emergency Treatment Information

Address: _____

Telephone Numbers: _____ (home) _____ (work)

Date: _____

+ visit to emergency room

2 telephone contact only

B) 2nd parent
C) 3rd parent
D) 4th parent
E) 5th parent
F) 6th parent

30. Emergency room treatment of adverse reaction, if applicable

a) What hospital did you go to?
a) Central Pen Gen. Hospital
B) Kenai Emergency medical Clinic
c) Central Peninsula Gen Hospital
D) Tanana Alaska
e) Central Pen. Gen. Hospital
f) Homer South Peninsula General Hospital

b) Did you call the emergency room?
5 yes a) B) C) D) e) 1 no f)

c) Did you go to the emergency room?
4 yes a) B) D) f) 2 no c) e)

d) How were you treated? (if more room needed, use back of sheet)
a) told not to worry; give cold bath & tylenol
B) O.K.
C) told not to worry; give cold bath & tylenol
D) hospital did not even record visit
e) give cold bath & tylenol
f) good

e) Were you advised to tell your doctor of reaction?
___ yes 6 no a) B) C) D) e) f)

f) Were you advised to tell Health Dept. of reaction?
___ yes 6 no a) B) C) D) e) f)

31. Was your child hospitalized?
1 yes f) 5 no a) B) C) D) e)

a) Where? Homer South Peninsula General Hospital

b) For how long? 3 days

c) How was reaction treated? not treated as vaccine reaction

VACCINE INJURY COMPENSATION PROGRAM

Status Report as of April 5, 1990

TOTAL NUMBER OF PETITIONS FILED: 263

Vaccine	Number Filed
DT	3
DTP	216
MMR	15
Rubella	4
Measles	6
OPV	13
IPV	5
Smallpox	1

10/1/88

Pre-legislation cases filed:	254
Post-legislation cases filed:	9

TOTAL NUMBER OF AWARDS: 60

TOTAL $ OF AWARDS: $31.5 Million

RANGE OF AWARDS: $86,000 - 2.8 Million

MEAN OF AWARDS: $550,967.00**

**3 out of the 60 awards were for attorney fees/costs only--the petitioner received no award. These awards were not included when calculating the mean.

WRC-TV4 NBC Television Stations Division
National Broadcasting Company, Inc.
4001 Nebraska Avenue, N.W.
Washington, D.C. 20016 202-885-4000

TRANSCRIPT

DPT: VACCINE ROULETTE

BROADCAST

APRIL 19, 1982

8:00-9:00 PM

WRC TV

WASHINGTON, D. C.

PARTICIPANTS

Dr. Robert Mendelsohn
Pediatrician, Author

Dr. Edward Mortimer
American Academy of Pediatrics

Dr. Gordon Stewart
British Epidemiologist

Dr. John Robbins
FDA, Bureau of Biologics

Marge Grant
Scott's Mother

Jim Grant
Scott's Father

Dr. Larry Baraff, UCLA
Whooping Cough Researcher

Dr. Alan Hinman
Centers for Disease Control

Dr. Bobby Young
Microbiologist

Evelyn Gaugert
Polly's Mother

Dr. Jerome Murphy
Pediatric Neurologist

Conley Yankovich
Abra's Father

Emily Yankovich
Abra's Mother

Gail Browne
Reynaldo's Mother

Lorenzo Browne
Reynaldo's Father

Alan McDowell
Chicago Attorney

Monty Preiser
West Virginia Attorney

Barbara Syska
Silver Spring

Lea Thompson
NewsCenter Four

THOMPSON DPT. The initials stand for Diptheria, Pertussis, Tetanus. Three diseases against which every child is vaccinated.

For more than a year we have been investigating the "P", the Pertussis part of the vaccine. What we have found are serious questions about the safety and effectiveness of the shot.

The overriding policy of the medical establishment has been to aggressively promote the use of the vaccine. But it has been anything but aggressive in dealing with the consequences. While there has been active study and debate in other countries on this subject, there has been a general void of information in the United States.

Our objective in the next hour is to provide enough information so that there can be an informed discussion about this important subject. It affects every single family in America.

It's a fact of life. All children must get four DPT shots to go to school. Shots we are told will keep our children healthy. Shots we are told will protect every child from a dread disease: Pertussis. It's Whooping Cough. But the DPT shot can also damage to a devastating degree.

MENDELSOHN It's probably the poorest and most dangerous vaccine that we now have.

MORTIMER The benefits of the vaccine, in my view, far outweigh the risks.

STEWART I believe that the risk of damage from the vaccine is now greater than the risk of damage from the disease.

ROBBINS Despite its limitations, Whooping Cough vaccine is something that should be given to children.

THOMPSON — Since 1933, studies have shown that the Whooping Cough or Pertussis vaccine causes brain damage. The controversy isn't really over the fact that it happens, but how often it happens, and whether it happens often enough to deem the vaccine more dangerous than the disease itself.

You don't have to ask the Grants of Beaver Dam, Wisconsin that question.

SCOTT GRANT
AGE: 21
REACTION: Harsh cry, infantile spasms
Severely Disabled and retarded

MARGE GRANT — We had a child up to 4 months of age that was developing beautifully well. The doctor explained that he was giving Scott his first DPT shot. Between 12 and 14 hours he gave an outburst of a very hard cry. What we learned later were infantile spasms, it was determined at the Mayo Clinic after a group of doctors conferred and indicated that it was indeed the DPT shots that injured Scott. I went home and cried, Jim cried. We couldn't believe that we could possibly have such a black future.

JIM GRANT — I had to start into business for myself. I had to be near the home all the time in regards to helping lift him, care for him and take care of his many needs. It is quite a big job. We have not had a vacation in 21 years. We simply can't go away. It's impossible to go away.

THOMPSON — It's important to remember, however, most children who get the DPT shot have minor reactions like swollen arms or fussiness. But there are more serious reactions that doctors should be watching for and worrying about.

The Pediatric Redbook, written by the American Academy of Pediatrics, lists high fever, collapse, shock-like collapse, unconsolable crying, convulsions and brain damage as reactions to the DPT vaccine. Those complications are associated with varying degrees of retardation ranging from severe brain damage...like Scott's, to learning disabilities which may never be connected to the shot.

The Physicians Desk Reference, prepared by manufacturers, says the "P" part of the vaccine is a possible link to Sudden Infant Death Syndrome.

This is for sure, the Whooping Cough, or Pertussis vaccine, is the most unstable, least reliable vaccine we give our children.

Dr. Gordon Stewart, epidemiologist and pediatrician Univ. of Glasgow, Scotland. A member of the British government's Committee on the Safety of Medicines.

STEWART — Pertussis vaccine is a crude brew...literally...of those bacteria and all their growth products.

THOMPSON — Dr. Robert Mendelsohn of Chicago, author, lecturer, and former head of Pediatrics Departments at the University of Illinois Medical School and the Michael Reese Hospital in Chicago.

MENDELSOHN — The statistics of this country are wrong, and that the danger is far greater than any doctors here have ever been willing to admit.

THOMPSON — Dr. Larry Baraff of the UCLA Medical Center in Los Angeles. He did a study of reactions to the Whooping Cough vaccine.

BARAFF — I don't think that this is the type of vaccine that would be produced today. If this vaccine were produced in 1980 instead of in the 1930's and 40's, there'd be a different type of technology available and we would make a more purified vaccine.

THOMPSON — The Bureau of Biologics bacterial program, it's part of the Food and Drug Administration, exists to make sure our bacterial vaccines are effective and safe.

Dr. John Robbins, head of that program, conceded the vaccine is not perfect, but...

ROBBINS — Much more is to be gained by immunizing the children with the current vaccines with its limitations, than by allowing our children to be exposed to contracting Pertussis.

THOMPSON — Dr. Edward Mortimer of Case Western Reserve Univ. here in Cleveland, Ohio, is considered by the government to be a leading expert in the field of childhood disease, especially Whooping Cough and its vaccine.

He has served on numerous FDA panels and speaks as well for the American Academy of Pediatrics.

MORTIMER — Whooping Cough is a bacterial disease. It's a disease that goes on for a long time. Some people used to call it "100 day fever", even though there isn't much fever associated with it. Two weeks of minor respiratory symptoms with the beginning cough, followed by two weeks of an increasing cough with the characteristic whoop (whoop) like that. At the end of the coughing spell, the poor kid often vomits. That child essentially ends up retaining little or no nutrition. With the damage to the lining of the bronchial tubes, the child is much more susceptible to pneumonia, and they incur lack of oxygen during the coughing spells. And in a young baby with a developing brain, lack of oxygen isn't necessarily a very good thing. The disease itself, for reasons that are not entirely clear, sometimes produces what is called encephalopathy--brain damage.

THOMPSON — Dr. Alan Hinman, chief of the immunization division at the Centers for Disease Control in Atlanta.

HINMAN — For the individual who has Whooping Cough it is a serious disease. It certainly is not as fatal a disease as it was in the 30's nor is it as common.

THOMPSON — In fact, Whooping Cough in this country is almost gone. There are less than 2,000 cases a year. During the 1930's, though, Whooping Cough struck over 195,000 people. 4800 people died from the disease annually. Then, the disease plummeted. By the early 50's when the vaccine was in mass usage, the cases of Whooping Cough were down to 37,000 and 270 deaths. Today, with cases under 2,000, there are an average of about 9 deaths a year, almost all in tiny infants.

As you can see, the disease was already in decline before the vaccine was widely used, and there are a number of reasons for that...

MORTIMER — Better nutrition maybe, maybe better means of handling these kids when they got in the hospital. Maybe a change in the organism. That is not unknown.

THOMPSON — Dr. Bobby Young, a microbiologist. For 12 years he studied and researched vaccines at both the Bureau of Biologics and the Univ. of Maryland. He told us before his death last summer he believed the disease is now easily treated.

YOUNG — These days when we have bacterial antibiotics, when we have chemotherapy, death from pertussis is a relatively rare event.

STEWART — When children die of Whooping Cough it is because they are disadvantaged in some other way...a completely well child doesn't often die of Whooping Cough.

End of Segment

STEWART — In this country and in the United Kingdom Whooping Cough has not been a killing disease for a very long time.

THOMPSON — In 1974, the majority of British parents quit using the DPT shot. In the process of researching this story, we were told over and over again by US officials that the result was a major epidemic and that hundreds of thousands of people suffered and hundreds of people died.

THOMPSON (Interview) — From what you know, the situation in England is that there are more deaths and more hospitalizations now that they are not giving the vaccine.

HINMAN — That's correct.

STEWART — The death rate in the height of that so called epidemic to which a lot of attention has been drawn by your government here, the death rate was the lowest ever. And in Scotland, for example, the hospital admissions continued to fall.

THOMPSON — Dr. Stewart is correct. According to official United Kingdom government figures, here is what happened. The British people became convinced that the vaccine was worse than the disease in 1974 and use of the vaccine dropped from about 80% acceptance to about 30% acceptance. There was an epidemic in 1978. It was not hundreds of thousands of cases, though. In fact at the peak of the epidemic, it was 66,000 cases. Twelve people died.

In 1980, when vaccine acceptance was running about 40%, 21,200 people got Whooping Cough, six people died. In Great Britain, where the shot was once mandated, parents must now ask for it to get it...it is their choice.

DOCTOR Have you thought about the Whooping Cough injection?

MOTHER I have, but I've decided I don't want it.

DOCTOR Why is that?

MOTHER I just think she could be that one in a million that something might happen to. So I just decided to leave it out.

DOCTOR And your other two children didn't have it either.

MOTHER They didn't have it, no.

THOMPSON In this country parents can't say no.

POLLY GAUGERT
AGE 7
REACTION: Fever, convulsions
Undontrolled seizures and Brain Damage

MRS. GAUGERT I said, maybe she should not have this shot. Because it seems to me she's just not quite herself. And he checked her all over, and said, "well, she looks OK to me" and then he gave her the shot. And the next following morning when I was feeding her, she went into a gran mal seizure, which, of course, I didn't know what was happening. I though she was dying in my arms--is what it amounted to.

MURPHY She has seizures, probably one every five or ten minutes.

THOMPSON Polly's neurologist, Dr. Jerome Murphy, until recently head of Pediatric Neurology at Milwaukee Children's Hospital

MURPHY — She has injured herself frequently from these. A very cute little girl, unfortunately has to wear a helmet to prevent any more serious head injuries. I call it a post pertussis encephalopathy. I presently follow four children at least that I know of that the neurologic illness that started shortly after a DPT immunization. All four children have delay in their development and have seizures.

THOMPSON (Interview) — Is her condition permanent?

MURPHY — I doubt she will ever resolve her seizures disorder. I hope that as she grows older we'll be able to control them better. As far as her delay in learning, I think that's a permanent problem.

THOMPSON — The Food and Drug Administration and the Centers for Disease Control have long contended that children like Scott and Polly may not be DPT victims...that it may be a coincidence that they convulsed right after the shot. The government feels their convulsions might have happened anyway. Dr. Murphy disagrees...

MURPHY — There's just overwhelming data that there's an association. I think it's average for the...for Pediatric Neurologists to see such cases. I knew it has influenced many pediatric neurologists not to have their children immunized with Pertussis.

THOMPSON — Serious reactions from the polio vaccine...one in four to five million children...and measles and mumps vaccine.. one in a million, are almost unknown. Serious reactions from the Whooping Cough vaccine are common. It could be as low as one in every 700 children.

Medical knowledge about severe reactions from the Whooping Cough vaccine goes all the way back to the early 30's... report after report has been published in medical journals since then. In 1948 two American doctors reported on case histories of many children who had been brain damaged or died from DPT vaccines in Boston. The following year another doctor surveyed pediatricians throughout the country and found still more. Those studies have been forgotten.

THOMPSON Between 1955 and 1958 Dr. Justus Strom surveyed over 200,000 children who got shots in 64 hospitals and clinics in Sweden. Then he looked at the previous ten years of Whooping Cough disease in Sweden. He found three times more brain damage and disorder caused by the vaccine than caused by the disease. He was strongly criticized, so he did another study. The two studies combined show a rate of destructive brain damage or death in one out of every 46,000 children who get the DPT shot.

The Swedish government has now stopped recommending the DPT vaccine. It feels the disease is now mild and the vaccine too reactive. So far, there has been no epidemic in Sweden.

West German studies determined the rate of serious brain damage from the "P" part of the DPT shot to be about one in every 39,000 children. The West German government stopped recommending the shot.

A study shows with only 10% of parents requesting that their children be vaccinated with the Pertussis Whooping Cough vaccine...that there has been no epidemic and no rise in deaths from the disease in West Germany.

Great Britain has done two studies on the Whooping Cough vaccine. The Committee on Safety of Medicines on which Dr. Gordon Stewart served determined one of every 53,000 children vaccinated was severely brain damaged...the National Childhood Encephalopathy study in England determined the rate at about one in every 100,000 children. However, that study only considered children who had convulsions and they had to last more than 30 minutes.

MORTIMER When one has convulsions that last longer than a minute or two, one is much more apt to be dealing with some underlying brain disease.

STEWART The only part of the study they really endorse is the one that supports the conclusions that they'd already formed.

THOMPSON (Interview) But they sponsored yours as well.

STEWART They sponsored ours, and then when ours came up with different conclusions, they more or less disowned it.

THOMPSON It is the National Childhood Encephalopathy study and its rate of one in 100,000 children seriously damaged, that the British government, the US medical community and the US government recognize.

It was American doctors who first alerted the government to reactions back in 1936, but it was not until after British press reports caused people to quit using the vaccine in the United Kingdom that our government decided to take a look. Forty-two years had gone by between the first warning and the time the US government decided to commission its first study.

It was done by Dr. Larry Baraff of the UCLA Medical center.

BARAFF Because the Food and Drug Administration was concerned that this sort of public panic might spread to the United States they wanted to document that the vaccine was in fact safe and not associated with severe consequences.

THOMPSON The UCLA study found more reaction than had ever been seen before. The study estimates that as many as one in every 13 children had persistent or high pitched crying after the shot.

YOUNG This may be indicative of brain damage in the recipient child.

THOMPSON Also, the study estimates one in every 700 children had a convulsion or went into shock.

MURPHY — In most cases it's a single spell, it does not recur, and the child does very well thereafter. But there are many children in whom there is a persistent neurologic deficit.

THOMPSON — Even though it is well known some of the reactions children had in the UCLA study can cause brain damage, there has been no follow-up to find if any of those children suffered long term problems. Why? Because after nearly a half a century of waiting for answers, the only study commissioned in this country ran out of money. Neither the FDA nor the doctors involved have plans to pursue the matter.

THOMPSON (Interview) — This is the only real study that the government has done on the DPT shot in 40 years and you're saying you don't have enough money to go back and check on those children who had reactions.

ROBBINS — The funds for contractual agreements...there are just no funds within the FDA for that now.

THOMPSON (Interview) — They were only follwed for 48 hours. There is some reason to believe that some children develop complications after that. It seems that you have them in your grasp. Wouldn't you like to know what happened to them?

ROBBINS — I think so...sure...it's just not the only thing that's been cut back unfortunately.

HINMAN — Well, one has to be concerned about studies that are fairly careful studies that show rates substantially more frequent than what has previously been reported. I think, however, one also has to take into account the fact that this is one study.

THOMPSON (Interview) Do you know of any other studies which are going to be done to hopefully get to the bottom of all this?

HINMAN I do not know of other studies underway at the present time.

THOMPSON Two children died that were in the UCLA study. They weren't considered as being DPT related.

ROBBINS The deaths that were reported in that study were SIDS. And the association between SIDS and the Whooping Cough vaccination, when we saw the data were just no more than occur by chance itself.

THOMPSON Dr. Hinman at CDC is not that sure.

HINMAN The bottom line is that one cannot be certain that DPT vaccination in some circumstances does not trigger Sudden Infant Death.

BARAFF But the data we have to date suggests that there might be an association.

THOMPSON Even when the Physicians Desk Reference written by manufacturers lists a possible connection between DTP and SIDS deaths, the man in charge of finding out says...

ROBBINS There is no evidence for anything other than a coincidental association.

YOUNG — I was employed at the Bureau of Biologics for several years, and it is my opinion that they very much do not wish to know adverse reactions.

THOMPSON (Interview) — Why?

YOUNG — This will complicate their lives...considerably.

THOMPSON — It is difficult to come up with a definitive answer as to how many children are being severely damaged or are dying from the DPT vaccine. There have been a lot of studies, but no one has ever searched out victims.

However, in the United Kingdom there is a compensation program. In England children may receive compensation if they are 80% disabled and can prove to the government that they were damaged by a vaccine. Dr. Stewart says just under 600 DPT victims have collected. He correlates that to one in every 25,000 children given the shot.

One in every 25,000 children in the US would mean 272 children are being severely disabled and retarded every year.

Dr. Robbins of the FDA just doesn't believe it.

ROBBINS — If these numbers did occur I would be alarmed...I don't know what we would do about it... But I don't think we are having that many cases.

THOMPSON (Interview) — It is possible that there could be more reactions in the United Kingdom than there would be in the United States?

ROBBINS — It is possible...but not probable.

YOUNG — You know, we start off with healthy infants, and we pop 'em not once, but three or four times with a vaccine...the probability of causing damage is the same each time. My greatest fear is that very few of them escape some kind of neurological damage out of this.

THOMPSON (Interview) — You really believe that?

YOUNG — I really believe it. I mean, if the child isn't frankly rendered a vegetable and yet has a fever... and a very large fraction of the children have fever from it, also a large fraction have the screaming syndrome which is surely an irritation of the central nervous system. You add all of this up...how many infants that are receiving this are in some way damaged by the vaccine and how can you prove that they haven't been, or that they have been. All of them are vaccinated.

End of 2nd Segment

Beginning of 3rd Segment

THOMPSON — The major reason we don't know how many children are being damaged by the "P" part of the DPT vaccine is because doctors don't report reactions. The governemnt medical schools and the medical community have done a good job informing doctors of the need for the vaccine. But from what we've found, many are not aware of the risks and the reactiors from the shots.

ABRA YANKOVICH
AGE 2
REACTION: Stopped breathing, seizures
Severely disabled and retarded

MRS. YANKOVICH — When she was four months old she...on the same day she had her vaccination she had her first seizure. She was shaking, and she was turning blue, and she appeared to have breathing problems. By the time we got her to the emergency room she was OK, and we told the doctor that she had had her vaccination that day. Could anything, could that be a link there. He said, "No, she probably was just choking. Just take her home and she'll be fine." But two weeks later she went into a gran mal seizure. She was very near dying.

THOMPSON — The Yankovich's who live in Kenosha, Wisconsin, said they knew it was the DPT shot that damaged Abra, but it wasn't until they found pediatric neurologist, Dr. Gordon Millichap in Chicago, that it was confirmed.

MRS. YANKOVICH — He realized right away that it was the DPT.

MR. YANKOVICH — Dr. Millichap told us about the shot and his feelings about the shot, especially the pertussis in the vaccination. And he said, personally, he wouldn't even give that to his dog.

THOMPSON — They also went to the Mayo Clinic in Rochester, Minn.

MRS. YANKOVICH — Our pediatrician told the doctor the story about Abra. He said that she had seizures stemming from the DPT shot and the doctor interrupted him and said, "Yes, we know exactly what you're talking about. Send her up."

Mr. YANKOVICH — She'll have good days and she'll have bad days. She'll experience hundreds of seizures in a day. And some days we're blessed with only one or two seizures.

MRS. YANKOVICH — She's a joy to be around because she's such a sweet natured girl, but we've been told that she probably will never walk on her own, and she probably will never talk.

THOMPSON — Emily and Conley Yankovich have been close friends with Gail and Lorenzo Browne for some years. They don't live very far from each other in Kenosha. Knowing of Abra's reaction, Gail was very apprehensive when she took her son Reynaldo to the pediatrician for his DPT shot.

MRS. BROWNE — I asked the doctor what the odds are of our child having a similar reaction. And he said that I didn't have anything really to worry about...

REYNALDO BROWNE
AGE 20 months
REACTION: Convulsions
Controlled seizures

MRS. BROWNE — Then he went into a convulsion, and I thought, "Oh, no, not Abra again". And the doctors told us that he just had an ear infection and there was really nothing for us to be upset about. The pediatrician didn't want to admit that the shot was any problem.

THOMPSON — But now Reynaldo's doctor admits he is a victim of DPT. His treatment has been expensive.

MR. BROWNE — We're so far behind because of the expense that we have. All our savings is gone.

MRS. BROWNE — And eventually I just ended up going back to work part time to make the ends meet. We don't know if he'll learn to talk, or what he'll be like as he grows older. It's hard to look forward to even think about another child is the farthest thing from my mind.

TECMPSON The Yankovich's, the Browne's, all the families we have talked to are angry, bitter and frustrated. They say doctors, manufacturers, and the government do not want to admit they exist. Of all the cases we have come to know, only one was reported to the manufacturer and the government. It was Reynaldo Browne, and it was only because Gail Browne forced her doctor to do it.

MRS. BROWNE I wanted them to have accurate records because to me they told me one in 70,000 children react. We had our son and Abra in a town that has not much more than 70,000 people in it. So I thought those figures are obviously not correct figures.

MRS. SCOTT I did a survey of all our immediate physicians in the area in Madison. I didn't get one that said "I record adverse reactions". As far as the reporting in this country is concerned, it is a disgrace, because it just simply isn't done.

TECMPSON It is here at the Centers for Disease Control in Atlanta, Georgia, that all information about the disease and vaccine reactions is stored and analyzed. The problem almost everyone agrees, including the CDC itself, is that the reporting system for vaccine reactions does not work. Part of the problem is a lack of knowledge.

MRS. BROWNE When they would bring the interns on their tours and tell them what was wrong with each child and they would get to Reynaldo, the student doctors would look at each other and say, "I didn't know that could happen."

THOMPSON And there's another reason that keeps doctors from reporting.

BARAFF Physicians in this day and age are always concerned about law suits.

THOMPSON — More and more families of DPT victims are deciding to sue...not only doctors, but manufacturers and the government.

Alan McDowell, an attorney in Chicago, represents a number of them.

MCDOWELL — Some institutions I've seen in this state and in some other states, that I have spoken to certain administrators at those hospitals or at those institutions, who have indicated that they do have children there as a result of the DPT vaccine...brain damaged children.

THOMPSON (Interview) — Do you think some children have been damaged by the DPT shot and their parents don't even know it?

MCDOWELL — Absolutely, I don't think the parents would be aware of it, and normally the pediatrician, or whoever the doctor, or GP, wouldn't tell them.

THOMPSON (Interview) — Do you think doctors are reporting reactions?

MORTIMER — NO

THOMPSON (Interview) — Why not?

MORTIMER — Legally it's not reportable.

THOMPSON — Do you think doctors are warning patients about the risks?

MORTIMER — No.