February 18, 2015

Testimony to the Oregon Senate Health Committee: SB 442

Senators,

Thank you for your time. I am Sandra Ganey of Portland and I am representing myself and my family.

I am opposed to restricting vaccination choice and tying it to a child's education. We are all free to inject them, and we should all remain free to decline. To mandate vaccines is to tell parents we must risk injury or death of our child, however small, then deprive us of legal recourse in this country if something goes wrong. The Religious exemption is guaranteed in the U.S. Constitution's First Amendment. It is wrong to bully us and attack our civil liberties. If you care about Oregon's children, which you claim, you should first fix the 25% poverty rate, because malnourished children are the first to get sick. Health does not come from an injection, even Senator Hayward said herself that you can't fix everything with pills and procedures. I agree.

I have for you many documents attached to review as you wish.

Thank you for your time.

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PURPOSE: Universal newborn immunization with hepatitis B vaccine was recommended in 1991; however, safety findings are mixed. The Vaccine Safety Datalink Workgroup reported no association between hepatitis B vaccination at birth and febrile episodes or neurological adverse events. Other studies found positive associations between hepatitis B vaccination and ear infection, pharyngitis, and chronic arthritis; as well as receipt of early intervention/special education services (EIS); in probability samples of U.S. children. Children with autistic spectrum disorder (ASD) comprise a growing caseload for EIS. We evaluated the association between hepatitis B vaccination of male neonates and parental report of ASD.

METHODS: This cross-sectional study used U.S. probability samples obtained from National Health Interview Survey 1997-2002 datasets. Logistic regression modeling was used to estimate the effect of neonatal hepatitis B vaccination on ASD risk amongboys age 3-17 years with shot records, adjusted for race, maternal education, and two-parent household.

RESULTS:Boyswho received the hepatitis B vaccine during the first month of life had 2.94 greater odds for ASD (nZ31 of 7,486; OR Z 2.94; p Z 0.03; 95% CI Z 1.10, 7.90) compared to later- or unvaccinated boys.Non-Hispanicwhite boys were 61%less likely to haveASD(ORZ0.39; pZ0.04; 95% CIZ0.16, 0.94) relative to non-white boys.

CONCLUSION: **Findings suggest that U.S. male neonates vaccinated with hepatitis B vaccine had a 3-fold greater risk of ASD; risk was greatest for non-white boys.**

3. Do aluminum vaccine adjuvants contribute to the rising prevalence of autism?

J Inorg Biochem. 2011 Nov;105(11):1489-99. Epub 2011 Aug 23.
Tomljenovic L, Shaw CA.

Neural Dynamics Research Group, Department of Ophthalmology and Visual Sciences, University of British Columbia, 828 W. 10th Ave, Vancouver, BC, Canada V5Z 1L8.

Abstract
Autism spectrum disorders (ASD) are serious multisystem developmental disorders and an urgent global public health concern. Dysfunctional immunity and impaired brain function are core deficits in ASD. Aluminum (Al), the most commonly used vaccine adjuvant, is a demonstrated neurotoxin and a strong immune stimulator. Hence, adjuvant Al has the potential to induce neuroimmune disorders. When assessing adjuvant toxicity in children, two key points ought to be considered: (i) children should not be viewed as "small adults" as their unique physiology makes them much more vulnerable to toxic insults; and (ii) if exposure to Al from only few vaccines can lead to cognitive impairment and autoimmunity in adults, is it unreasonable to question whether the current pediatric schedules, often containing 18 Al adjuvanted vaccines, are safe for children? By applying Hill's criteria for establishing causality between exposure and outcome we investigated whether exposure to Al from vaccines could be contributing to the rise in ASD prevalence in the Western world. Our results show that: (i) children from countries with the highest ASD prevalence appear to have the highest exposure to Al from vaccines; (ii) the increase in exposure to Al adjuvants significantly correlates with the increase in ASD prevalence in the United States observed over the last two decades (Pearson r=0.92, p<0.0001); and (iii) a significant correlation exists between the amounts of Al administered to preschool children and the current prevalence of ASD in seven Western countries, particularly at 3-4months of age (Pearson r=0.89-0.94, p=0.0018-0.0248). **The application of the Hill's criteria to these data indicates that the correlation between Al in vaccines and ASD may be causal.** Because children represent a fraction of the population most at risk for complications following exposure to Al, a more rigorous evaluation of Al adjuvant safety seems warranted.

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Abstract

Autoimmunity to the central nervous system (CNS), especially to myelin basic protein (MBP), may play a causal role in autism, a neurodevelopmental disorder. Because many autistic children harbor elevated levels of measles antibodies, we conducted a serological study of measles-mumps-rubella (MMR) and MBP autoantibodies. Using serum samples of 125 autistic children and 92 control children, antibodies were assayed by ELISA or immunoblotting methods. ELISA analysis showed a significant increase in the level of MMR antibodies in autistic children. Immunoblotting analysis revealed the presence of an unusual MMR antibody in 75 of 125 (60%) autistic sera but not in control sera. This antibody specifically detected a protein of 73-75 kD of MMR. This protein band, as analyzed with monoclonal antibodies, was immunopositive for measles hemagglutinin (HA) protein but not for measles nucleoprotein and rubella or mumps viral proteins. Thus the MMR antibody in autistic sera detected measles HA protein, which is unique to the measles subunit of the vaccine. Furthermore, over 90% of MMR antibody-positive autistic sera were also positive for MBP autoantibodies, suggesting a strong association between MMR and CNS autoimmunity in autism. Stemming from this evidence, we suggest that **an inappropriate antibody response to MMR, specifically the measles component thereof, might be related to pathogenesis of autism.**

6. Infection, vaccines and other environmental triggers of autoimmunity.

Autoimmunity. 2005 May;38(3):235-45.

Molina V, Shoenfeld Y., Department of Medicine B and The Center for Autoimmune Diseases, Sheba Medical Center, Tel-Hashomer, Israel.

Abstract
The etiology of autoimmune diseases is still not clear but genetic, immunological, hormonal and environmental factors are considered to be important triggers. Most often autoimmunity is not followed by clinical symptoms unless an additional event such as an environmental factor favors an overt expression. Many environmental factors are known to affect the immune system and may play a role as triggers of the autoimmune mosaic.Infections: bacterial, viral and parasitic infections are known to induce and exacerbate autoimmune diseases, mainly by the mechanism of molecular mimicry. This was studied for some syndromes as for the association between SLE and EBV infection, pediatric autoimmune neuropsychiatric disorders associated with streptococcal infection and more. Vaccines, in several reports were found to be temporally followed by a new onset of autoimmune diseases. The same mechanisms that act in infectious invasion of the host, apply equally to the host response to vaccination. It has been accepted for diphtheria and tetanus toxoid, polio and measles vaccines and GBS. Also this theory has been accepted for MMR vaccination and development of autoimmune thrombocytopenia, MS has been associated with HBV vaccination. Occupational and other chemical exposures are considered as triggers for autoimmunity. A debate still exists about the role of silicone implants in induction of scleroderma like disease.Not only foreign chemicals and agents have been associated with induction of autoimmunity, but also an intrinsic hormonal exposure, such as estrogens. This might explain the sexual dimorphism in autoimmunity.Better understanding of these environmental risk factors will likely lead to explanation of the mechanisms of onset and progression of autoimmune diseases and may lead to effective preventive involvement in specific high-risk groups. So by diagnosing a new patient with autoimmune disease a wide anamnesis

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Human & Experimental Toxicology
PMCID: PMC3170075

Infant mortality rates regressed against number of vaccine doses routinely given: Is there a biochemical or synergistic toxicity?

Neil Z Miller and Gary S Goldman

Abstract

The infant mortality rate (IMR) is one of the most important indicators of the socio-economic well-being and public health conditions of a country. The US childhood immunization schedule specifies 26 vaccine doses for infants aged less than 1 year—the most in the world—yet 33 nations have lower IMRs. Using linear regression, the immunization schedules of these 34 nations were examined and a correlation coefficient of $r = 0.70$ ($p < 0.0001$) was found between IMRs and the number of vaccine doses routinely given to infants. Nations were also grouped into five different vaccine dose ranges: 12–14, 15–17, 18–20, 21–23, and 24–26. The mean IMRs of all nations within each group were then calculated. Linear regression analysis of unweighted mean IMRs showed a high statistically significant correlation between increasing number of vaccine doses and increasing infant mortality rates, with $r = 0.992$ ($p = 0.0009$). Using the Tukey-Kramer test, statistically significant differences in mean IMRs were found between nations giving 12–14 vaccine doses and those giving 21–23, and 24–26 doses. A closer inspection of correlations between vaccine doses, biochemical or synergistic toxicity, and IMRs is essential.

Keywords: infant mortality rates, sudden infant death, SIDS, immunization schedules, childhood vaccines, drug toxicology, synergistic effects, linear regression model

Introduction

3 leading cause of death of babies in Oregon is SIDS.

USA - highest # of vaccines and highest infant mortality (ranked 34th out of 34 developed countries)

Methods and design

Infant mortality

The infant mortality rate is expressed as the number of infant deaths per 1000 live births. According to the US Central Intelligence Agency (CIA), which keeps accurate, up-to-date infant mortality statistics throughout the world, in 2009 there were 33 nations with better infant mortality rates than the United States (Table 1).[8] **The US infant mortality rate of 6.22 infant deaths per 1000 live births ranked 34th.**

Table 1.
2009 infant mortality rates, top 34 nations[8]

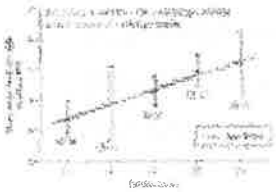
Rank	Country	IMR
1	Singapore	2.31
2	Sweden	2.75
3	Japan	2.79
4	Iceland	3.23
5	France	3.33
6	Finland	3.47
7	Norway	3.58
8	Malta	3.75
9	Andorra	3.76
10	Czech Republic	3.79
11	Germany	3.99
12	Switzerland	4.16

Immunization schedules and vaccine doses

A literature review was conducted to determine the immunization schedules for the United States and all 33 nations with better IMRs than the United States.[9,10] The total number of vaccine doses specified for infants aged less than 1 year was then determined for each country (Table 2). A vaccine dose is an exact amount of medicine or drug to be administered. The number of doses a child receives should not be confused with the number of 'vaccines' or 'injections' given. For example, DTaP is given as a single injection but contains three separate vaccines (for diphtheria, tetanus, and pertussis) totaling three vaccine doses.

Nations organized into groups

Nations were placed into the following five groups based on the number of vaccine doses they routinely give their infants: 12–14, 15–17, 18–20, 21–23,



2009 Mean infant mortality rates and mean number of vaccine doses (five categories). The one-way ANOVA using the Tukey-Kramer test yielded $F = 650$ with $p = 0.001$, indicating the five mean IMRs corresponding to the five defined dose categories are significantly different ($r^2 = 0.510$). Tukey's multiple comparison test found statistical significance in the differences between the mean IMRs of those nations giving 12–14 vaccine doses and (a) those giving 21–23 doses (1.61, 95% CI, 0.457–2.75) and (b) those giving 24–26 doses (1.83, 95% CI, 0.542–3.11).

Discussion

Basic necessities for infant survival

It is instructive to note that many developing nations require their infants to receive multiple vaccine doses and have national vaccine coverage rates (a percentage of the target population that has been vaccinated) of 90% or better, yet their IMRs are poor. For example, Gambia requires its infants to receive 22 vaccine doses during infancy and has a 91%–97% national vaccine coverage rate, yet its IMR is 68.8. Mongolia requires 22 vaccine doses during infancy, has a 95%–98% coverage rate, and an IMR of 39.9.[8,9] These examples appear to confirm that IMRs will remain high in nations that cannot provide clean water, proper nutrition, improved sanitation, and better access to health care. *As developing nations improve in all of these areas a critical threshold will eventually be reached where further reductions of the infant mortality rate will be difficult to achieve because most of the susceptible infants that could have been saved from these causes would have been saved.* Further reductions of the IMR must then be achieved in areas outside of these domains. As developing nations ascend to higher socio-economic living standards, a closer inspection of all factors contributing to infant deaths must be made.

Crossing the socio-economic threshold

It appears that at a certain stage in nations' movement up the socio-economic scale—after the basic necessities for infant survival (proper nutrition, sanitation, clean water, and access to health care) have been met—a counter-intuitive relationship occurs between the number of vaccines given to infants

high number of vaccine doses and have relatively high infant mortality rates. These nations should take a closer look at their infant death tables to determine if some fatalities are possibly related to vaccines though reclassified as other causes. Of course, all SUID categories should be re-inspected. Other ICD categories may be related to vaccines as well. For example, a new live-virus orally administered vaccine against rotavirus-induced diarrhea—Rotarix®—was licensed by the European Medicine Agency in 2006 and approved by the US Food and Drug Administration (FDA) in 2008. However, in a clinical study that evaluated the safety of the Rotarix vaccine, *vaccinated babies died at a higher rate than non-vaccinated babies*—mainly due to a statistically significant increase in pneumonia-related fatalities.30 (One biologically plausible explanation is that natural rotavirus infection might have a protective effect against respiratory infection.)31 Although these fatalities appear to be vaccine related and raise a nation's infant mortality rate, medical certifiers are likely to misclassify these deaths as pneumonia.

Several additional ICD categories are possible candidates for incorrect infant death classifications: unspecified viral diseases, diseases of the blood, septicemia, diseases of the nervous system, anoxic brain damage, other diseases of the nervous system, diseases of the respiratory system, influenza, and unspecified diseases of the respiratory system. All of these selected causes may be repositories of vaccine-related infant deaths reclassified as common fatalities. All nations—rich and poor, industrialized and developing—have an obligation to determine whether their immunization schedules are achieving their desired goals. Progress on reducing infant mortality rates should include monitoring vaccine schedules and medical certification practices to ascertain whether vaccine-related infant deaths are being reclassified as ordinary mortality in the ICD.

How many infants can be saved with an improved IMR?

Slight improvements in IMRs can make a substantial difference. In 2009, there were approximately 4.5 million live births and 28,000 infant deaths in the United States, resulting in an infant mortality rate of 6.22/1000. If health authorities can find a way to reduce the rate by 1/1000 (16%), the United States would rise in international rank from 34th to 31st and about 4500 infants would be saved.Go to:

Limitations of study and potential confounding factors

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Vaccinated children should stay home from school for two weeks until they're not shedding live virus.

280 references
live virus vaccine shedding

The Emerging Risks of Live Virus & Virus Vectored Vaccines: Vaccine Strain Virus Infection, Shedding & Transmission

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U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

Claims Filed and Compensated or Dismissed by Vaccine [1]

February 2015

Vaccines Listed in Claims as Reported by Petitioners

Vaccine(s)	Filed			Compensated	Dismissed
	Injury	Death	Total		
DT	69	9	78	24	51
DTaP	374	80	454	179	203
DTaP-Hep B-IPV	62	24	86	30	34
DTaP-HIB	10	1	11	4	3
DTaP-IPV-HIB	24	16	40	6	11
DTP	3,286	696	3,982	1,270	2,706
DTP-HIB	20	8	28	4	21
Hep A-Hep B	18	0	18	9	2
Hep B-HIB	8	0	8	4	3
Hepatitis A (Hep A)	65	5	70	27	20
Hepatitis B (Hep B)	618	54	672	241	363
HIB	25	3	28	12	14
HPV	255	12	267	73	85
Influenza	1,704	84	1,788	985	155
IPV	264	14	278	8	267
Measles	143	19	162	55	107
Meningococcal	40	2	42	27	4
MMR	890	57	947	367	502
MMR-Varicella	30	1	31	15	8
MR	15	0	15	6	9
Mumps	10	0	10	1	9
Nonqualified	85	9	94	1	87
OPV	280	28	308	158	150
Pertussis	4	3	7	2	5
Pneumococcal Conjugate	41	5	46	10	26
Rotavirus	65	1	66	39	17
Rubella	190	4	194	70	123
Td	183	3	186	106	64
Tdap	227	1	228	106	12
Tetanus	97	2	99	43	37
Unspecified	5,411	8	5,419	4	4,749
Varicella	78	7	85	51	20
Grand Total	**14,591**	**1,156**	**15,747**	**3,937**	**9,867**

413 in Oregon

Clearly the vaccines aren't as effective as claimed, nor is the concept of herd immunity – which is debunked and decimated here and here -- supported unequivocally by the epidemiological evidence.

The failure of vaccine-induced antibody titers to protect against 'vaccine preventable disease' may make more sense when you consider the antibody-based theory of vaccine efficacy – a fundamental tenet of vaccinology/immunology – was recently called into question: Study Calls Into Question Primary Justification for Vaccines. Injecting aluminum and other highly immunotoxic adjuvants into the body in order to stimulate elevated antibody titers does not in and of itself guarantee their affinity for the antigen they are supposed to be protecting you against. To the contrary, It is much like saying *you have improved the overall health of the beehive by kicking it with your boot to stir its* angry residents and getting them to sting (and hence die) the closest thing around them. We highly suggest you obtain a copy of Tetyana Obukhanych's layperson oriented book Vaccine Illusion (she is a Ph.D. in immunology from Rockefeller University, New York, NY) to learn the almost universally repressed truth about the dangers and ineffectiveness of vaccines.

In 2005, the Regional Committee of WHO Western Pacific Region established 2012 as the target date for the complete regional elimination of measles, and the Chinese Ministry of Health initiated mandatory measles vaccination to accomplish this. A year later, in 2006, China set a goal of accelerating the progress of eliminating measles by 2012, striving to keep measles incidence below 0.1 per 100,000, and then developed a *series of vaccination strategies to execute these goals.*

And yet, despite the full and near universal implementation of multi-dose vaccines, measles, mumps and rubella outbreaks continued to afflict those receiving them:

"Measles outbreaks continued in 2008, with 12782 cases reported, which translated to 252.61 per million of the population. From 2009 to 2011, the incidence of measles remained high at 3.14–17.2 per million of the population. Similarly, the incidence of mumps increased from 394.32 to 558.26 per million of the population in 2007 and 2008, respectively. Finally, the reported cases of rubella increased from 3284 to 4284 in 2007 and 2011, respectively, representing a 30.45% increase or an increase from 65.94 to 78.71 per million of the population. Therefore, the elimination of measles and control of *mumps and rubella are urgent public health priorities in local regions.*"[1]

certified the accuracy of applications filed with the FDA, (ix) falsely certified compliance with the terms of the CDC purchase contract, (x) engaged in the fraud and concealment describe herein for the purpose of illegally monopolizing the U.S. market for mumps vaccine, (xi) mislabeled, misbranded, and falsely certified its mumps vaccine, and (xii) engaged in the other acts described herein to conceal the diminished efficacy of the vaccine the government was purchasing."

These fraudulent activities, say the whistleblowers, were designed to produce test results that would meet the FDA's requirement that the mumps vaccine was 95 per cent effective. To the whistleblowers' delight, the judge dismissed Merck's objections to the case proceeding, finding the whistleblowers had plausible grounds on all of the claims lodged against Merck.

If the whistleblowers win, it would represent more than a moral victory (they repeatedly tried to stop Merck while still in its employ). Under the False Claims Act, the whistleblowers would receive a share -- likely 25 per cent to 30 per cent -- of the amount the government recovers. Previous settlements involving extensive fraud by pharmaceutical companies under the False Claims Act have run into the hundreds of millions of dollars, and in some cases such as against GlaxoSmithKline and Pfizer, into the billions.

The second court case, Chatom Primary Care v. Merck & Co. relies on the same whistleblower evidence. This class action suit claims damages because Merck had fraudulently monopolized the mumps market. Doctors and medical practices in the suit would be able to obtain compensation for having been sold an overpriced monopolized product, and a defective one to boot, in that the mumps vaccine wasn't effective (indeed, the suit alleged that Merck expected outbreaks to occur and, as predicted, they did -- mumps epidemics occurred in 2006 in a highly vaccinated population and again in 2009-2010).

"Plaintiffs have argued sufficient facts to sustain a claim for proximate causation, detailing the significant barriers that other companies would face to enter the mumps vaccine market," the court ruled.

The third whistleblower -- a senior CDC scientist named William Thompson -- only indirectly blew the whistle on Merck. He more blew

Morgan VerKamp LLC

NEWS

August 27, 2014 Press Release, "Statement of William W. Thompson, Ph.D., Regarding the 2004 Article Examining the Possibility of a Relationship Between MMR Vaccine and Autism"

CDC

FOR IMMEDIATE RELEASE-AUGUST 27,2014

STATEMENT OF WILLIAM W. THOMPSON, Ph.D., REGARDING THE 2004 ARTICLE EXAMINING THE POSSIBILITY OF A RELATIONSHIP BETWEEN MMR VACCINE AND AUTISM

My name is William Thompson. I am a Senior Scientist with the Centers for Disease Control and Prevention, where I have worked since 1998.

I regret that my coauthors and I omitted statistically significant information in our 2004 article published in the journal *Pediatrics*. The omitted data suggested that African American males who received the MMR vaccine before age 36 months were at increased risk for autism. Decisions were made regarding which findings to report after the data were collected, and I believe that the final study protocol was not followed.

I want to be absolutely clear that I believe vaccines have saved and continue to save countless lives. I would never suggest that any parent avoid vaccinating children of any race. Vaccines prevent serious diseases, and the risks associated with their administration are vastly outweighed by their individual and societal benefits.

My concern has been the decision to omit relevant findings in a particular study for a particular sub group for a particular vaccine. There have always been recognized risks for vaccination and I believe it is the responsibility of the CDC to properly convey the risks associated with receipt of those vaccines.

I have had many discussions with Dr. Brian Hooker over the last 10 months regarding studies the CDC has carried out regarding vaccines and neurodevelopmental outcomes including autism spectrum disorders. I share his beliefthat CDC decision-making and analyses should be transparent. I was not, however, aware that he was recording any of our conversations, nor was I given any choice regarding whether my name would be made public or my voice would be put on the Internet.

I am grateful for the many supportive e-mails that I have received over the last several days. I will not be answering further questions at this time. I am providing information to Congressman William Posey, and of course will continue to cooperate with Congress. I have also offered to assist with reanalysis of the study data or development of further studies. For the time being, however, I am focused on my job and my family.

Reasonable scientists can and do differ in their interpretation of information. I will do everything I can to assist any unbiased and objective scientists inside or outside the CDC to analyze data collected by the CDC or other public organizations for the purpose of understanding whether vaccines are associated with an increased risk of autism. There are still more questions than answers, and I appreciate that so many families are looking for answers from the scientific community.

My colleagues and supervisors at the CDC have been entirely professional since this matter

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Fugitive Profiles

POUL THORSEN

13 counts fraud
9 counts money laundering

Principal Investigator
autism-vaccine program

1 From approximately February 2004 until February 2010, Poul Thorsen executed a scheme to steal grant money awarded by the Centers for Disease Control and Prevention (CDC). CDC had awarded grant money to Denmark for research involving infant disabilities, autism, genetic disorders, and fetal alcohol syndrome. CDC awarded the grant to fund studies of the relationship between autism and the exposure to vaccines, the relationship between cerebral palsy and infection during pregnancy, and the relationship between developmental outcomes and *fetal alcohol exposure*.

2 Thorsen worked as a visiting scientist at CDC, Division of Birth Defects and Developmental Disabilities, before the grant was awarded.

3 The initial grant was awarded to the Danish Medical Research Council. In approximately 2007, a second grant was awarded to the Danish Agency for Science, Technology, and Innovation. Both agencies are governmental agencies in Denmark. The research was done by the Aarhaus University and Odense University Hospital in Denmark.

4 Thorsen allegedly diverted over $1 million of the CDC grant money to his own personal bank account. Thorsen submitted fraudulent invoices on CDC letterhead to medical facilities assisting in the research for reimbursement of

GlaxoSmithKline fined $490m by China for bribery - BBC Business

China has fined UK pharmaceuticals firm GlaxoSmithKline $490m (£297m) after a court found it guilty of bribery.

The record penalty follows allegations the drug giant paid out bribes to doctors and hospitals in order to have their products promoted.

The court gave GSK's former head of Chinese operations, Mark Reilly, a suspended three-year prison sentence and he is set to be deported.

Other GSK executives have also been given suspended jail sentences. The guilty verdict was delivered after a one-day trial at a court in Changsha, according to the Xinhua news agency.

Chinese authorities first announced they were investigating GSK in July last year, in what has become the biggest corruption scandal to hit a foreign firm in years. The company was accused of having made an estimated $150m in illegal profits

GSK said it had "published a statement of apology to the Chinese government and its people".

"Reaching a conclusion in the investigation of our Chinese business is important, but this has been a deeply disappointing matter for GSK," said chief executive Sir Andrew Witty in a statement.

"We have and will continue to learn from this. GSK has been in China for close to a hundred years and we remain fully committed to the country and its people," he said.

"We will also continue to invest directly in the country to support the government's health care reform agenda and long-term plans for economic growth."

Mick Cooper, analyst at Edison Investment Research in London, said: "GlaxoSmithKline will hope that this will draw a line under events in China, but it will take time for its Chinese commercial operations to recover."

AAPS

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FACT SHEET ON MANDATORY VACCINES

- AAPS does not oppose vaccines. AAPS has never taken an anti-vaccine position, although opponents have tried to paint that picture. AAPS has only attempted to halt government or school districts from blanket vaccine mandates that violate parental informed consent.

- 42 states have mandatory vaccine policies, and many children are required 22 shots by first grade.

- According to government statistics, children under the age of 14 are three times more likely to suffer adverse effects -- including death -- following the hepatitis B vaccine than to catch the disease itself.

- The Centers for Disease Control admits that the reported number of adverse effects of vaccines is probably only 10% of actual adverse effects.

- The Physician's Desk Reference cites adverse reactions to the hepatitis B in less than 1 percent. However, if more than 70 million American children receive the vaccine, that means more than 700,000 children are likely to suffer adverse reactions.

- Children are a very low risk group for hepatitis B. Primary risk factors are dependent on lifestyle, i.e. multiple sex partners, drug abuse or an occupation with exposure to blood.

- Rampant conflicts of interest in the approval process has been the subject of several Congressional hearings, and a recent Congressional report concluded that the pharmaceutical industry has indeed exerted undue influence on mandatory vaccine legislation toward its own financial interests.

- The vaccine approval process has also been contaminated by flawed or incomplete clinical trials, and government officials have chosen to ignore negative results. For example, the CDC was forced to withdraw its recommendation of the rotavirus vaccine within one year of approval. Yet public documents obtained by AAPS show that the CDC was aware of alarmingly high intussuception rates months before the vaccine was approved and recommended.

- Mandatory vaccines violate the medical ethic of informed consent. A case could also be made that mandates for vaccines by school districts and legislatures is the de facto practice of medicine without a license.

- The CDC's own "Guide to Contraindications to Childhood Vaccination" warns that when assessing children's common symptoms, "if any one of them is a contraindication, DO NOT VACCINATE" [caps added]. And yet, under legislated mandates, the vaccines are still required.

Opinion 9.133 Routine Universal Immunization of Physicians

As professionals committed to promoting the welfare of individual patients and the health of the public and to safeguarding their own and their colleagues' well-being, physicians have an ethical responsibility to take appropriate measures to prevent the spread of infectious disease in health care settings. Conscientious participation in routine infection control practices, such as hand washing and respiratory precautions is a basic expectation of the profession. In some situations, however, routine infection control is not sufficient to protect the interests of patients, the public, and fellow health care workers.

In the context of a highly transmissible disease that poses significant medical risk for vulnerable patients or colleagues, or threatens the availability of the health care workforce, particularly a disease that has potential to become epidemic or pandemic, and for which there is an available, safe, and effective vaccine, physicians have an obligation to:

(a) Accept immunization absent a recognized medical, religious, or philosophic reason to not be immunized.

(b) Accept a decision of the medical staff leadership or health care institution, or other appropriate authority to adjust practice activities if not immunized (e.g., wear masks or refrain from direct patient care). It may be appropriate in some circumstances to inform patients about immunization status. (I, II)

Issued June 2011 based on the report "Routine Universal Immunization of Physicians for Vaccine-Preventable Disease," adopted November 2010.

In other words, doctors are obligated to accept immunization, unless they have "a recognized medical, religious or philosophical reason" not to.