THE CASE AGAINST IMMUNIZATIONS

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For the past ten years or so, I have felt a deep and growing compunction against giving routine immunizations to children. It began with the fundamental belief that people have the right to make that choice for themselves. Soon I discovered that I could no longer bring myself to give the injections even when the parents wished me to.

At bottom, I have always felt that the attempt to eradicate entire microbial species from the biosphere must inevitably upset the balance of nature in fundamental ways that we can as yet scarcely imagine. Such concerns loom ever larger as new vaccines continue to be developed, seemingly for no better reason than that we have the technical capacity to make them, and thereby to demonstrate our power, as a civilization, to manipulate the evolutionary process itself.

Purely from the viewpoint of our own species, even if we could be sure that the vaccines were harmless, the fact remains that they are *compulsory*, that all children are required to undergo them, without any sensitive regard for basic differences in individual susceptibility, to say nothing of the wishes of the parents or the children themselves.

Most people can readily accept the fact that, from time to time, certain laws may be necessary for the public good that some of us strongly disagree with. But the issue in this case involves nothing less than the introduction of foreign proteins or even live viruses into the bloodstream of entire populations.

For that reason alone, the public is surely entitled to convincing proof, beyond any reasonable doubt, that artificial immunization is in fact a safe and effective procedure, in no way injurious to health, and that the threat of the corresponding natural diseases remains sufficiently clear and urgent to warrant mass inoculation of everyone, even against their will if necessary.

Unfortunately, such proof has never been given; and, even if it could be, continuing to employ vaccines against diseases that are no longer prevalent or no longer dangerous hardly qualifies as an emergency.

Finally, even if such an emergency did exist, and artificial immunization could be shown to be an appropriate response to it, the decision would remain essentially a *political* one, involving issues of public health and safety that are far too important to be settled by any purely scientific or technical criteria, or indeed by *any* criteria less authoritative than the clearly articulated sense of the community about to be subjected to it.

For all of these reasons, I want to present the case against routine immunization as clearly and forcefully as I can. What I have to say is not quite a formal theory capable of rigorous proof or disproof. It is simply an

attempt to explain my own experience, a nexus of interrelated facts, observations, reflections, and hypotheses which, taken together, are more or less coherent and plausible and make intuitive sense to me.

I offer them to the public in part because the growing refusal of parents to vaccinate their children is so seldom articulated or taken seriously. The fact is that we have been taught to accept vaccination as sort of involuntary communion, a sacrament of our own participation in the unrestricted growth of scientific and industrial technology, utterly heedless of the long-term consequences to the health of our own species, let alone to the balance of nature as a whole. For that reason alone, the other side of the case urgently needs to be heard.

ARE THE VACCINES EFFECTIVE?

There is widespread agreement that the time period since the common vaccines were introduced has seen a remarkable decline in the incidence and severity of the corresponding natural infections. But the customary assumption that the decline is *attributable* to the vaccines remains unproven, and continues to be seriously questioned by eminent authorities in the field. The incidence and severity of whooping cough, for example, had already begun to decline precipitously long before the pertussis vaccine was introduced,[1] a fact which led the epidemiologist C. C. Dauer to remark, as far back as 1943: "If mortality [from pertussis] continues to decline at the same rate during the next 15 years, it will be extremely difficult to show statistically that [pertussis immunization] had any effect in reducing mortality from whooping cough."[2]

Much the same is true not only of diphtheria and tetanus, but also of TB, cholera, typhoid, and other common scourges of a bygone era, which began to disappear toward the end of the nineteenth century, perhaps partly in response to improvements in public health and sanitation, but in any case long before antibiotics, vaccines, or any specific medical measures designed to eradicate them.[3]

Reflections such as these led the great microbiologist René Dubos to observe that microbial diseases have their own natural history, independent of drugs and vaccines, in which asymptomatic infection and symbiosis are far more common than overt disease: "It is barely recognized, but nevertheless true, that animals and plants, as well as men, can live peacefully with their most notorious microbial enemies. The world is obsessed by the fact that poliomyelitis can kill and maim several thousand unfortunate victims every year. But more extraordinary is the fact that millions upon millions of young people become infected by polio viruses, yet suffer no harm from the infection. The dramatic episodes of conflict between men and microbes are what strike the mind. What is less readily apprehended is the more common fact that infection can occur without producing disease."[4]

The principal evidence that the vaccines are effective actually dates from

the more recent period, during which time the dreaded polio epidemics of the 1940s and 1950s have never reappeared in the developed countries, and measles, mumps, and rubella, which even a generation ago were among the commonest diseases of childhood, have become far less prevalent, at least in their classic acute forms, since the triple MMR vaccine was introduced into common use.

Yet how the vaccines actually accomplish these changes is not nearly as well understood as most people like to think it is. The disturbing possibility that they act in some other way than by producing a genuine immunity is suggested by the fact that the diseases in question have continued to break out even in highly immunized populations, and that in such cases the observed differences in incidence and severity between immunized and unimmunized persons have tended to be far less dramatic than expected, and in some cases not measurably significant at all.

In a recent British outbreak of whooping cough, for example, even fully immunized children contracted the disease in fairly large numbers, and the rates of serious complications and death were reduced only slightly.[5] In another recent outbreak of pertussis, 46 of the 85 fully immunized children studied eventually contracted the disease.[6]

In 1977, 34 new cases of measles were reported on the campus of UCLA, in a population that was supposedly 91 per cent immune, according to careful serological testing.[7] Another 20 cases of measles were reported in the Pecos, New Mexico area within a period of a few months in 1981, and 75 per cent of them had been fully immunized, some of them quite recently.[8] A survey of sixth-graders in a well-immunized urban community revealed that about 15 per cent of this age group are still susceptible to rubella, a figure essentially identical with that of the pre-vaccine era.[9]

Finally, although the overall incidence of typical acute measles in the U.S. has dropped sharply from about 400,000 cases annually in the early 1960s to about 30,000 cases by 1974-76, the death rate remained exactly the same;[10] and, with the peak incidence now occurring in adolescents and young adults, the risk of pneumonia and demonstrable liver abnormalities has actually increased substantially, according to one recent study, to well over 3 per cent and 2 per cent, respectively.[11]

The simplest way to explain these discrepancies would be to postulate that the vaccines confer only partial or temporary immunity, which sounds reasonable enough, given the fact that they are either live viruses rendered less virulent by serial passage in tissue culture, or bacteria or bacterial proteins that have been killed or denatured by heat, such that they can still elicit an antibody response but no longer initiate the full-blown disease.

Because the vaccine is a 'trick,' in the sense that it *simulates* the true or natural immune response developed in the course of recovering from the actual disease, it is certainly realistic to expect that such artificial immunity will in fact 'wear off' quite easily, and even require additional 'booster' doses

at regular intervals throughout life to maintain peak effectiveness.

Such an explanation would be disturbing enough for most people. Indeed, the basic fallacy inherent in it is painfully evident in the fact that there is no way to know how long this partial or temporary immunity will last in any given individual, or how often it will need to be restimulated, because the answers to these questions clearly depend on precisely the same individual variables that would have determined whether or how severely the same person, unvaccinated, would have contracted the disease in the first place.

In any case, a number of other observations suggest equally strongly that this simple explanation cannot be the correct one. In the first place, a number of investigators have shown that when a person vaccinated against the measles, for example, again becomes susceptible to it, even repeated booster doses will have little or no effect.[12]

In the second place, the vaccines do not act merely by producing pale or mild copies of the original disease; all of them also commonly produce a variety of symptoms of their own. Moreover, in some cases, these illnesses may be considerably more serious than the original disease, involving deeper structures, more vital organs, and less of a tendency to resolve spontaneously. Even more worrisome is the fact that they are almost always more difficult to recognize.

Thus, in a recent outbreak of mumps in supposedly immune school children, several developed atypical symptoms, such as anorexia, vomiting, and erythematous rashes, without any parotid involvement, and the diagnosis required extensive serological testing to rule out other concurrent diseases.[13] The snydrome of 'atypical measles' can be equally difficult to diagnose, even when it is thought of,[14] which suggests that it is often overlooked entirely. In some cases, atypical measles can be much more severe than the regnlar kind, with pneumonia, petechiae, edema, and severe pain,[15] and likewise often goes unsuspected.

In any case, it seems virtually certain that other vaccine-related syndromes will be described and identified, if only we take the trouble to look for them, and that the ones we are aware of so far represent only a very small part of the problem. But even these few make it less and less plausible to assume that the vaccines produce a normal, healthy immunity that lasts for some time but then *wears off*, leaving the patient miraculously unharmed and unaffected by the experience.

SOME PERSONAL EXPERIENCES WITH VACCINE-RELATED ILLNESS

I would like now to present a few of my own vaccine cases, both to give a sense of their variety and chronicity, and to show how difficult it can be to trace them, and also to begin to address the crucial question that is too seldom even asked, namely, how the vaccines actually *work*, i.e. what effects they do in fact produce in the human body.

My first case was that of an 8-month-old girl with recurrent fevers of unknown origin. I first saw her in January of 1977, a few weeks after her third such episode. These were brief, lasting 48 hours at most, but very intense, with the fever typically reaching 105°F. During the second episode, she was hospitalized for diagnostic evaluation, but her pediatrician found nothing out of the ordinary. Apart from these episodes, the child felt quite well, and appeared to be growing and developing normally.

I could get no further information from the mother, except for the fact that the episodes had occurred almost exactly one month apart; and, upon consulting her calendar, we learned that the first episode had come exactly one month after the last of her DPT injections, which had also been given at monthly intervals. At this point, the mother remembered that the child had had similar febrile episodes immediately after each injection, but that she had been instructed to ignore them, inasmuch as they are 'common reactions' to the vaccine. I therefore gave the child a single *oral* dose of dilute homoeopathic DPT vaccine; and I am happy to report that the child has remained well since, with no further episodes of any kind.

This case illustrates how homoeopathic remedies prepared from vaccines can be used for *diagnosis* as well as treatment of vaccine-related illnesses, which, no matter how strongly they are suspected, might otherwise be almost impossible to substantiate.

Secondly, because fever is the commonest known complication of the pertussis vaccine, and inasmuch as the child seemed quite well between the attacks, her response to the vaccine appeared to be a relatively strong and healthy one, disturbing because of its recurrence and periodicity, but in any case relatively simple to cure, as indeed it proved to be. But one cannot help wondering what happens to the vaccine in those tens of millions of children who show no obvious response to it at all.

Since that time, I have seen at least half a dozen cases of children with recurrent fevers of unknown origin, associated with a variety of other chronic complaints, chiefly irritability, temper tantrums, and increased susceptibility to colds, tonsillitis, and ear infections, which were similarly traceable to the pertussis vaccine, and which responded successfully to treatment with the homoeopathic DPT nosode. Indeed, I would have to say, on the basis of that experience, that the pertussis vaccine is probably one of the major causes of recurrent fevers of unknown origin in small children today.

My second case was that of a 9½-month-old girl, who presented acutely with a fever of 105°F, and very few other symptoms. Like the first, this child had had two similar episodes previously, but at irregular intervals; and the parents, who felt ambivalent about vaccinations in general, had given her only one dose of the DPT vaccine so far, although the first episode occurred a few weeks afterwards.

I first saw the child in June of 1978. The fever remained high and unremitting for 48 hours, despite the usual acute remedies and supportive

measures. A CBC revealed a white count of 32,100 per cu. mm, with 43 per cent lymphocytes, 11 per cent monocytes, 25 per cent neutrophils (many with toxic granulations), 20 per cent bands (also with toxic granulations), and 1 per cent metamyelocytes and other immature forms. When I asked a pediatrician about these findings, 'pertussis' was his immediate reply. After a single oral dose of homoeopathic DPT vaccine, the fever came down abruptly within a few hours, and the child has remained well since.

This case was disturbing mainly because of the hematological abnormalities, which were in the leukemoid range, together with the absence of any cough or distinctive respiratory symptoms, which suggested that introducing the vaccine directly into the blood may actually promote deeper or more systemic pathology than allowing the pertussis organism to set up typical symptoms of local inflammation at the normal portal of entry.

The third case was a 5-year-old boy with chronic lymphocytic leukemia, whom I happened to see in August of 1978, while visiting an old friend and teacher, a family physician with over 40 years' experience. Well out of earshot of either the boy or his parents, he told me that the leukemia had first appeared following a DPT vaccination, and that, although he had treated the child successfully with natural remedies on two previous occasions, with shrinking of the liver and spleen to approximately normal size, and dramatic improvement in the blood picture, full relapse had occurred soon after each successive DPT booster.

The idea that vaccinations might also be implicated in some cases of childhood leukemia was shocking enough in itself, but it also completed the line of reasoning opened up by the previous case. For leukemia is a cancerous process of the blood and the blood-forming organs, the liver, the spleen, the lymph nodes, and the bone marrow, which are also the basic anatomical units of the immune system. Insofar as the vaccines are capable of producing serious complications at all, the blood and the immune organs would certainly be the logical place to begin looking for them.

But perhaps even more shocking to me is the fact that the boy's own physician dared not communicate his suspicion of vaccine-related illness to the parents, let alone to the general public. It was this case that convinced me, once and for all, of the need for serious, public discussion of our collected experiences with vaccine-related illness, precisely because rigorous experimental proof will require years of investigation and a firm public commitment that has not even been made yet.

I will now present two cases from my limited experience with MMR vaccine.

In December of 1980 I saw a 3-year-old boy with a 4-week history of loss of appetite, stomach aches, indigestion, and swollen glands. The stomach pains were quite severe, and often accompanied by belching, flatulence, and explosive diarrhea. The nose was also congested, and the lower eyelids were quite red. The mother also reported some unusual be-

havior changes, such as extreme untidiness, 'wild' and 'noisy' playing, and waking at 2 a.m. to get into bed with the parents.

The physical examination was unremarkable except for some large, tender left posterior auricular and suboccipital nodes, and marked enlargement of the tonsils. I then learned that the child had received the MMR vaccine in October, about 2 weeks before the onset of symptoms, with no apparent reaction to it at the time. I gave the child a single dose of the homoeopathic rubella vaccine, and the symptoms promptly disappeared within 48 hours.

In April 1981, the parents brought him back for a slight fever, and another 3-week history of intermittent pain in and behind the right ear, stuffy nose, etc. On examination, the whole right side of the face appeared to be swollen, especially the cheek and the angle of the jaw. The right eye was red and injected. He responded well to acute homoeopathic remedies, and has remained well since.

This boy was typical of my rubella vaccine cases. At an interval of a few weeks after the MMR vaccine, which is about the same as the normal incubation period of rubella, a rather nondescript illness develops, which becomes subacute and rather more severe than rubella in the same age group, with, e.g. abdominal or joint pains and marked adenopathy, but no rash. Usually the diagnosis is suspected because of the characteristic posterior auricular and suboccipital nodes, and confirmed by a favourable response to the homoeopathic rubella nosode.

As I read over this case, I am struck by the possibility that his second illness, and especially the parotid enlargement, may have represented continuing activity of the mumps component of the vaccine, inasmuch as I did not have the triple MMR nosode, but only those derived from the individual components. We must therefore also consider the probability that a variety of 'mixed' or composite syndromes may occur, representing the patient's responses to two or all three of the vaccine components, either simultaneously or over time.

In April of 1981 I first saw a 4-year-old boy for bilateral chronic enlargement of the posterior auricular nodes, which were also occasionally tender. The mother had noticed the swelling for about one year, during which time he had become more susceptible to various upper respiratory infections, none of them especially severe. The mother had also noticed recurrent parotid swelling at irregular intervals over the same time period, which began shortly after the MMR vaccine was given at the age of 3.

At the time of the first visit, the child was not ill; and, because the mother was about 2 months pregnant at the time, I elected to observe the child and do nothing if possible until the pregnancy was over. He did develop a mild laryngitis in the last trimester, which responded well to bed rest and simple homoeopathic remedies.

In April of 1982, he came down with acute bronchitis. I noticed that

the posterior auricular nodes were once again swollen and tender, and I decided to give him the homoeopathic rubella nosode at that point. The cough promptly subsided, and the nodes regressed in size and were no longer tender. Two weeks later, however, he returned with a noticeably hard, tender swelling on the outside of the right cheek, near the angle of the jaw, and some pain on chewing or opening the mouth. A single dose of the homoeopathic mumps nosode was given, and the child has been well since.

In this case also, we see the subacute pattern of the disease, with a strong tendency to chronicity and increased susceptibility to weaker, low-grade responses, in contrast to the vigorous, acute responses typically associated with diseases like the measles and the mumps when acquired naturally.

HOW DO THE VACCINES WORK?

It is dangerously misleading, and, indeed, the exact opposite of the truth to claim that a vaccine makes us 'immune' or *protects* us against an acute disease, if in fact it only drives the disease deeper into the interior and causes us to harbor it *chronically*, with the result that our responses to it become progressively weaker, and show less and less tendency to heal or resolve themselves spontaneously.

What I propose, then, is simply to investigate as thoroughly and objectively as we can how the vaccines actually *work* inside the human body, and to begin by paying attention to the implications of what we already know. In particular, I would like to consider in detail the process of falling ill with and recovering from a typical acute disease, such as the measles, in contrast with what we can observe following the administration of the measles vaccine.

We all know that measles is primarily a virus of the respiratory tract, both because it is inhaled by susceptible persons upon contact with infected droplets in the air, and because these droplets are produced by the coughing and sneezing of a person with the disease.

Once inhaled by a susceptible person, the measles virus then undergoes a long period of silent multiplication, first in the tonsils, adenoids, and accessory lymphoid tissues of the nasopharynx; later in the regional lymph nodes of the head and neck; and eventually, several days later, it passes into the blood and enters the spleen, the liver, the thymus, and the bone marrow, the 'visceral' organs of the immune system.[16] Throughout this incubation period, which lasts from 10 to 14 days, the patient usually feels quite well, and experiences few or no symptoms.[17]

By the time that the first symptoms of measles appear, circulating antibodies are already detectable in the blood, and the height of the symptomatology coincides with the peak of the antibody response.[18] In other words, the 'illness' is simply the definitive effort of the immune system to clear the virus from the blood. Equally noteworthy is the fact that the virus is elimi-

nated by sneezing and coughing, i.e. via the same route through which it entered in the first place.

It is evident that the process of *mounting* an acute illness like the measles, no less than recovering from it, involves a general mobilization of the entire immune system, including inflammation of the previously sensitized tissues at the portal of entry, activation of leukocytes and macrophages, liberation of the serum complement system, and a host of other mechanisms, of which the production of circulating antibody is only one, and by no means the most important.

Such a splendid outpouring leaves little doubt that such illnesses are in fact the decisive experiences in the normal physiologic maturation of the immune system as a whole in the life of a healthy child. For not only will the child who recovers from the measles never again be susceptible to it;[19] such an experience also cannot fail to prepare the individual to respond even more promptly and effectively to any infections he may acquire in the future. The ability to mount a vigorous acute response to organisms of this type must therefore be reckoned among the most fundamental requirements of general health and well-being.

In contrast, when an artificially attenuated virus such as measles is injected directly into the blood, bypassing the normal portal of entry, at most a brief inflammatory reaction may be noted at the injection site, or in the regional lymph nodes; but there is no incubation period of local contact at the normal portal of entry, and consequently very little possibility of eliminating the virus via the same route.

Even more important is the fact that the virus has been artificially 'attenuated,' so that it will no longer initiate a generalized inflammatory response, or indeed any of the nonspecific defense mechanisms that help us to respond to infection generally. By 'tricking' the body in this fashion, we have accomplished what the entire immune system seems to have evolved in order to prevent: we have placed the virus directly into the blood, and given it free and immediate access to the major immune organs and tissues, without any obvious way of getting rid of it.

The result is, indeed, the production of circulating antibodies against the virus, which can be measured in the blood; but the antibody response now occurs as an isolated technical feat, without any generalized inflammatory response, or any noticeable improvement in the general health of the organism. Exactly the opposite, in fact: the price that we have to pay for those antibodies is the persistence of virus elements in the blood for prolonged periods of time, perhaps permanently, which in turn presupposes a systematic weakening of our ability to mount an effective response not only to measles, but also to other acute infections as well.

Far from producing a genuine immunity, then, the vaccines may act by actually interfering with or *suppressing* the immune response as a whole, in much the same way that radiation, chemotherapy, and corticosteroids and

other anti-inflammatory drugs do. Artificial immunization focuses on *antibody production,* a single aspect of the immune process, and disarticulates it and allows it to stand for the whole, in much the same way as chemical suppression of an elevated blood pressure is accepted as a valid substitute for a genuine *cure* of the patient whose blood pressure has risen. Worst of all, by making it difficult or impossible to mount a vigorous, acute response to infection, artificial immunization substitutes for it a much weaker, *chronic* response, with little or no tendency to heal itself spontaneously.

Moverover, adequate models already exist for predicting and explaining what sorts of chronic disease are likely to result from the chronic, long-term persistence of viruses and other foreign proteins within the cells of the immune system. It has long been known that live viruses, for example, are capable of surviving or remaining latent within the host cells for years, without continually provoking acute disease. They do so simply by attaching their own genetic material as an extra particle or 'episome' to the genome of the host cell, and replicating along with it, which allows the host cell to continue its own nomal functions for the most part, but imposes on it additional instructions for the synthesis of viral proteins.[20]

Latent viruses of this type have already been implicated in three distinct types of chronic disease, namely, (1) *recurrent or episodic acute diseases,* such as herpes, shingles, warts, etc.;[21] (2) *'slow-virus' diseases,* i.e. subacute or chronic, progressive, often fatal conditions, such as kuru, Creuzfeldt-Jakob disease, subacute sclerosing panencephalitis (SSPE), and possibly Guillain-Barre syndrome;[22] and (3) *tumors,* both benign and malignant.[23]

In any case, the latent virus survives as a clearly 'foreign' element within the cell, which means that the immune system must continue to try to make antibodies against it, insofar as it can still respond to it at all. Because the virus is now permanently incorporated within the genetic material of the cell, these antibodies will now have to be directed against the cell itself.

The persistence of live viruses or other foreign antigens within the cells of the host therefore cannot fail to provoke *auto-immune* phenomena, because destroying the infected cells is now the only possible way that this constant antigenic challenge can be removed from the body. Since routine vaccination introduces live viruses and other highly antigenic material into the blood of virtually every living person, it is difficult to escape the conclusion that a significant harvest of auto-immune diseases most automatically result.

Sir Macfarlane Burnet has observed that the components of the immune system all function as if they were collectively designed to help the organism to discriminate 'self' from 'non-self,' i.e. to help us to recognize and tolerate our own cells, and to identify and eliminate foreign or extraneous substances as completely as possible.[24] This concept is exemplified not only by the acute response to infection, but also by the rejection of transplanted tissues, or

'homografts,' both of which result in the complete and permanent removal of the offending substance from the body.

If Burnet is correct, then latent viruses, auto-immune phenomena, and cancer would seem to represent different aspects of the same basic dilemma, which the immune system can neither escape nor resolve. For all of them presuppose a certain degree of *chronic immune failure*, a state in which it becomes difficult or impossible for the body either to recognize its own cells as unambiguously its own, or to eliminate its parasites as unequivocally foreign.

In the case of the attenuated measles virus, it is not difficult to imagine that introducing it directly into the blood would continue to provoke an antibody response for a considerable period of time, which is doubtless the whole point of giving the vaccine; but that eventually, as the virus succeeded in attaining a state of latency within the cell, the antibody response would wane, both because circulating antibodies cannot normally cross the cell membrane, and because they are also powerful immunosuppressive agents in their own right.[25]

The effect of circulating antibody will thereafter be mainly to keep the virus *within* the cell, i.e. to continue to prevent any acute inflammatory response, until eventually, perhaps under circumstances of accumulated stress or emergency, this precarious balance breaks down, antibodies begin to be produced in large quantities against the cells themselves, and frank auto-immune phenomena of necrosis and tissue destruction supervene. Latent viruses, in this sense, are like biological time bombs, set to explode at an indeterminate time in the future.[26]

Auto-immune diseases have always seemed obscure, aberrant, and bizarre, because it is not intuitively obvious why the body should suddenly begin to attack and destroy its own tissues. They make a lot more sense, and, indeed, must be reckoned as 'healthy,' if destroying the chronically infected cells is the only possible way of eliminating an even more serious threat to life, namely, the persistence of the foreign antigenic challenge within the cells of the host.

Tumor formation could then be understood as simply a more advanced stage of chronic immune failure, according to the same model. For, as long as the host is subjected to enormous and unremitting pressure to make antibodies against itself, that response will automatically tend to become less and less effective.

Eventually, under stress of this magnitude, the auto-immune mechanism could easily break-down to the point that the chronically infected and genetically transformed cells, no longer clearly 'self or 'non-self,' begin to free themselves from the normal restraints of 'histocompatibility' within the architecture of the surrounding cells, and begin to multiply autonomously at their expense.

A tumor could then be described as 'benign' insofar as the breakdown

of histocompatibility remains strictly localized to the tissue of origin, and 'malignant,' insofar as it begins to spread to other cell types, tissues, and organs, even in more remote areas. Malignancy might simply represent the reactivation of the virus from its latent phase into a more acute mode, albeit with less inflammation and more tissue destruction than the original wild-type infection.

If what I am saying turns out to be true, then what we have done by artificial immunization is essentially to trade off our acute, epidemic diseases of the past century for the weaker and far less curable chronic diseases of the present, with their amortizable suffering and disability. In doing so, we have also opened up limitless evolutionary possibilities for the future of ongoing *in vivo* genetic recombination within the cells of the race.

THE INDIVIDUAL VACCINES RECONSIDERED

I want next to consider each of the vaccines on an individual basis, in relation to the infectious diseases from which they are derived.

The MMR is composed of attenuated live measles, mumps, and rubella viruses, administered in a single intramuscular injection at about 15 months of age. Subsequent re-immunization is no longer recommended, except for young women of childbearing age, in whom the risk of congenital rubella syndrome (CRS) is thought to warrant it, even though the effectiveness of re-immunization is questionable at best.

Prior to the vaccine era, measles, mumps, and rubella were reckoned among the routine childhood diseases, which most school-children contracted before the age of puberty, and from which nearly all recovered, with permanent, lifelong immunity, and no complications or sequelae.

But they were not always so harmless. Measles, in particular, can be a devastating disease when a population encounters it for the first time. Its importation from Spain, for instance, undoubtedly contributed to Cortez' conquest of the great Aztec Empire; whole villages were carried off by epidemics of measles and smallpox, leaving only a small remnant of cowed, superstitious warriors to face the bearded *conquistadores* from across the sea.[27] In more recent outbreaks among isolated, primitive peoples, the case fatality rate from measles averaged 20 to 30 per cent.[28]

In both these so-called virgin-soil epidemics, not only measles but also polio and many other similar diseases take their highest toll of death and serious complications among adolescents and young adults, healthy and vigorous people in the prime of life, and leave relatively unharmed the group of school-age children before the age of puberty.[29]

This means that the evolution of a disease such as measles from a dreaded killer to an ordinary disease of childhood presupposes the development of nonspecific or 'herd' immunity in young children, such that, when they are finally exposed to the disease, it activates defense mechanisms

already prepared and in place, resulting in the long incubation period and the usually benign, self-limited course described above.

Under these circumstances, the rationale for wanting to vaccinate young children against measles is limited to the fact that a very small number of deaths and serious complications have continued to occur, chiefly pneumonia, encephalitis, and the rare but dreaded subacute sclerosing panencephalitis (SSPE), a slow-virus disease with a reported incidence of 1 per 100,000 cases.[30] Pneumonia, by far the commonest complication, is usually benign and self-limited, event without treatment;[31] and, even in those rare cases in which bacterial pneumonia supervenes, adequate treatment is currently available.

By all accounts, then, the death rate from wild-type measles is very low, the incidence of serious sequelae is insignificant, and the general benefit to the child who recovers from the disease, and to his contacts and descendants, is very great. Consequently, even if the measles vaccine could be shown to reduce the risk of death or serious complications from the disease, it still could not justify the high probability of auto-immune diseases, cancer, and whatever else may result from the propagation of latent measles virus in human tissue culture for life.

Ironically, what the measles vaccine certainly has done is to reverse the historical or evolutionary process to the extent that measles is once again a disease of adolescents and young adults,[32] with a correspondingly higher incidence of pneumonia and other complications, and a general tendency to be a more serious and disabling disease than it usually is in younger children.

As for the claim that the vaccine has helped to eliminate measles, encephalitis, I myself, in my own relatively small general practice, have already seen two children with major seizure disorders which the parents clearly ascribed to the measles vaccine, although they would never have been able to prove the connection in a court of law, and never even considered the possibility of compensation.

Such cases therefore never make the official statistics, and are accordingly omitted from conventional surveys of the problem. Merely injecting the virus into the blood would naturally favor a higher incidence of deep or visceral complications affecting the lungs, liver, and brain, for which the measles virus has a known affinity.

The case for immunizing against mumps and rubella seems *a fortiori* even more tenuous, for exactly the same reasons. Mumps is also essentially a benign, self-limited disease in children before the age of puberty, and recovery from a single attack confers lifelong immunity. The principal complication is meningoencephalitis, mild or subclinical forms of which are relatively common, although the death rate is extremely low,[33] and sequelae are rare.

The mumps vaccine is prepared and administered in much the same

way as the measles, usually in the same injection; and the dangers associated with it are likewise comparable. Again like the measles, mumps too is fast becoming a disease of adolescents and young adults,[34] age groups which tolerate the disease much less well. The chief complication is acute epididymo-orchitis, which occurs in 30 to 40 per cent of the males affected past the age of puberty, and usually results in atrophy of the testicle on the affected side;[35] but it also shows a strong tendency to attack the ovary and the pancreas.

For all of these reasons, the greatest favor we could do for our children would be to expose them all to the measles and mumps when they are young, which would not only protect them against contracting more serious forms of these diseases when they grow older, but would also greatly assist in their immunological maturation with minimal risk. I need hardly add that this is very close to the actual evolution of these diseases before the MMR vaccine was introduced.

The same discrepancy is evident in the case of rubella, or German measles, which in young children is a disease so mild that it frequently escapes detection,[36] but in older children and adults not infrequently produces arthritis, purpura, and other severe, systemic signs.[37] The main impetus for the development of the vaccine was certainly the recognition of the congenital rubella syndrome (CRS), resulting from damage to the developing embryo *in utero* during the first trimester of pregnancy,[38] and the relatively high incidence of CRS traceable to the rubella outbreak of 1964.

But here again, we have an almost entirely benign, self-limited disease transformed by the vaccine into a considerably less benign disease of adolescents and young adults of reproductive age, which is, ironically, the group that most needs to be protected against it. Moreover, as with measles and mumps, the simplest and most effective way to prevent CRS would be to expose everybody to rubella in elementary school; re-infection does sometimes occur after recovery from rubella, but much less commonly than after vaccination.[39]

The equation looks somewhat different for the diphtheria and tetanus vaccines. First of all, both diphtheria and tetanus are serious, sometimes fatal diseases, even under the best of treatment; this is especially true of tetanus, which still carries a mortality of close to 50 per cent.

Furthermore, these vaccines are not made from living diphtheria and tetanus organisms, but only from certain toxins elaborated by them; these poisonous substances are still highly antigenic, even after being inactivated by heat. Diphtheria and tetanus toxoids therefore do not protect against infection *per se*, but only against the systemic action of the original poisons, in the absence of which both infections are of minor importance clinically.

Consequently, it is easy to understand why parents might want their children protected against diphtheria and tetanus, if safe and effective protection were available. Moreover, both vaccines have been in use for a long

time, and the reported incidence of serious problems has remained very low, so that there has never been much public outcry against them.

On the other hand, both diseases are quite readily controlled by simple sanitary measures and careful attention to wound hygiene; and, in any case, both have been steadily disappearing from the developing countries, since long before the vaccines were introduced.

Diphtheria now occurs sporadically in the United States, often in areas with significant reservoirs of unvaccinated children. But the claim that the vaccine is protective is once again belied by the fact that, when the disease does break out, the supposedly susceptible children are in fact no more likely to develop clinical diphtheria than their fully immunized contacts. In a 1969 outbreak in Chicago, for example, the Board of Health reported that 25 per cent of the cases had been fully immunized, and that another 12 per cent had received one or more doses of the vaccine and showed serological evidence of full immunity; another 18 per cent had been partly immunized, according to the same criteria.[40]

So, once again, we are faced with the probability that what the diphtheria toxoid has produced is not a genuine immunity to diphtheria at all, but rather some sort of chronic immune *tolerance* to it, by harboring highly antigenic residues somewhere within the cells of the immune *system*, presumably with long term suppressive effects on the immune mechanism generally.

This suspicion is further aggravated by the fact that all of the DPT vaccines are alum-precipitated and preserved with thiomersal, an organomercury derivative, to prevent them from being metabolized too rapidly, so that the antigenic challenge will continue for as long as possible. The fact is that we do not know and have never even attempted to discover what actually becomes of these foreign substances, once they are inside the human body.

Exactly the same problems complicate the record of the tetanus vaccine, which almost certainly has had at least some impact in reducing the incidence of tetanus in its classic acute form, yet presumably also survives for years or even decades as a potent foreign antigen within the body, with long-term effects on the immune system and elsewhere that are literally incalculable.

Whooping cough, much like diphtheria and tetanus, began to decline as a serious epidemiological threat long before the vaccine was introduced. Moreover, the vaccine has not been particularly effective, even according to its proponents; and the incidence of known side-effects is disturbingly high.

The power of the pertussis vaccine to damage the central nervous system, for example, has received growing attention since Stewart and his colleagues reported an alarmingly high incidence of encephalopathy and severe convulsive disorders in British children that were traceable to the vaccine.[41] My own cases, a few of which were reported above, suggest that hematological disturbances may be even more prevalent, and that, in any

case, the *known* complications almost certainly represent a small fraction of the total.

In any case, the pertussis vaccine has become controversial even in the United States, where medical opinion has remained almost unanimous in favor of immunizations generally; and several countries, such as West Germany, have discontinued routine pertussis vaccination entirely.[42]

Pertussis is also extremely variable clinically, ranging in severity from asymptomatic, mild, or inapparent infections, which are quite common actually, to very rare cases in young infants less than 5 months of age, in whom the mortality is said to reach 40 per cent.[43] Indeed, the disease is rarely fatal or even that serious in children over a year old, and antibiotics have very little to do with the outcome.[44]

A good deal of the pressure to immunize at the present time thus seems to be attributable to the higher death rate in very young infants, which has led to the terrifying practice of giving this most clearly dangerous of the vaccines to infants at 2 months of age, when their mothers' milk would normally have protected them from all infections about as well as it can ever be done,[45] and the effect on the still developing blood and nervous system could be catastrophic.

For all of these reasons, the practice of routine pertussis immunization should be discontinued as quickly as possible, and more studies done to assess and compensate the damage that it has already done.

Poliomyelitis and the polio vaccines present an entirely different situation. The standard Sabin vaccine is trivalent, consisting of attenuated, live polioviruses of each of the three strains associated with poliomyelitis; but it is administered orally, in much the same way as the infection is acquired in nature. The oral or non-injectable route, which leaves the recipient free to develop a natural immunity at the normal portal of entry, i.e. the GI tract, would therefore appear to represent a considerable safety factor.

On the other hand, the wild-type poliovirus produces no symptoms whatsoever in other 90 per cent of the people who contact it, even under epidemic conditions;[46] and, of those people who do come down with recognizable clinical disease, perhaps only 1 or 2 per cent ever progress to the full-blown neurological picture of poliomyelitis, with its characteristic lesions in the anterior horn cells of the spinal cord or medulla oblongata.[47]

Poliomyelitis thus presupposes peculiar conditions of susceptibility in the host, even a specific *anatomical* susceptibility, since, even under epidemic conditions, the virulence of the poliovirus is so low, and the number of cases resulting in death or permanent disability was always remarkably small.[48]

Given the fact that the poliovirus was ubiquitous before the vaccine was introduced, and could be found routinely in samples of city sewage wherever it was looked for,[49] it is evident that effective, natural immunity to poliovirus was already as close to being universal as it can ever be, and *a fortiori* no artificial substitute could ever equal or even approximate that

result. Indeed, because the virulence of the poliovirus was so low to begin with, it is difficult to see what further attenuation of it could possibly accomplish, other than to abate as well the full vigor of the natural immune response to it.

For the fact remains that even the attenuated virus is still alive, and the people who were anatomically susceptible to it before are still susceptible to it now. This means, of course, that at least *some* of these same people will develop paralytic polio from the vaccine[50] and that the others may still be harboring the virus in latent form, perhaps within those same cells.

The only obvious advantage of giving the vaccine, then, would be to introduce the population to the virus when they are still infants, and the virulence is normally lowest anyway;[51] and even this benefit could be more than offset by the danger of weakening the immune response, as we have seen. In any case, the whole matter is clearly one of enormous complexity, and illustrates only too well the hidden dangers and miscalculations that are inherent in the virtually irresistible attempt to beat nature at her own game, to eliminate a problem that cannot be eliminated, i.e. the susceptibility to disease itself.

So even in the case of the polio vaccine, which appears to be about as safe as any vaccine ever *can* be, the same fundamental dilemma remains. Perhaps the day will come when we can face the consequences of deliberately feeding live polioviruses to every living infant, and admit that we should have left well enough alone, and addressed ourselves to the art of healing the sick when we have to, rather than to the technology of eradicating the *possibility* of sickness, when we don't have to, and can't possibly succeed in any case.

VACCINATION AND THE PATH OF MEDICAL TECHNOLOGY

In conclusion, I want to go back to the beginning, to the essentially political aspects of vaccination, that oblige us all to reason and deliberate together about matters of common concern, and to reach a clear decision about how we choose to live. I have stated my own views regarding the safety and effectiveness of the vaccines, and I hope that others of differing views will do the same.

That is why I am deeply troubled by the atmosphere of fanaticism with which the vaccines are imposed on the public, and serious discussion of them is ignored or stifled by the medical authorities, as if the question had already been settled definitively and for all time. In the words of Sir Macfarlane Burnet: It is our pride that in a civilized country the only infectious diseases which anyone is likely to suffer are either trivial or easily cured by available drugs. The diseases that killed in the past have in one way or another been rendered impotent, and, in the process, general principles of control have been developed which should be applicable to any unexpected outbreak in the future.[52]

Quite apart from the truth of these claims, they exemplify the smugness and self-righteousness of a profession and a society that worships its own ability to manipulate and control the processes of nature itself. That is why, as Robert Mendelsohn has said, "We are quick to pull the trigger, but slow to examine the consequences of our actions."[53]

Indeed, one would have to say, *methodically* slow. In 1978, for example, the American Academy of Pediatrics, which had been charged by Congress with responsibility to formulate guidelines for Federal compensation of vaccination-related injuries, issued the following eligibility restrictions:

(1) Compensation should be made available to any child or young person under the age of 18 years, or a contact of such person of any age, who suffers a major reaction to a vaccine mandated for school entry or continuation in school in his or her state of residence.

(2) *Such a reaction should have been previously recognized as a possible consequence of the vaccine given.*

(3) *Such a reaction should have occurred no more than 30 days following the immunization.*[54]

These restrictions would automatically exclude all of the chronic diseases, or indeed anything other than the very few adverse reactions that have so far been identified, which clearly represent only a tiny fraction of the problem.

Still less can either the government or the medical establishment be considered ignorant of the possibility that lurks in every parent's mind and heart, namely, that the vaccines cause cancer and other chronic diseases. Precisely that possibility was raised by Prof. Robert Simpson of Rutgers in a 1976 seminar for science writers, sponsored by the American Cancer Society: Immunization programs against flu, measles, mumps, polio, and so forth, may actually be seeding humans with RNA to form latent proviruses in cells throughout the body. These latent proviruses could be molecules in search of diseases; when activated, under proper conditions, they could cause a variety of diseases, including rheumatoid arthritis, multiple sclerosis, systemic lupus erythematosus, Parkinson's disease, and perhaps cancer.[55]

Unfortunately, this is the sort of warning that very few people are willing or able to hear at this point, least of all the American Cancer Society or the American Academy of Pediatrics. The fact is, as Dubos points out, that all of us still want to believe in the miracle, regardless of the evidence: The faith in the magical power of drugs often blunts the critical senses, and comes close at times to a mass hysteria, involving scientists and laymen alike. Men want miracles as much today as in the past. If they do not join one of the newer cults, they satisfy this need by worshiping at the altar of modern science. This faith in the magical power of drugs is not new. It helped to give medicine the authority of a priesthood, and to recreate the glamor of ancient mysteries.[56]

The idea of eradicating measles or polio has come to seem attractive to us, simply because the power of medical science makes it seem technically *possible;* we worship every victory of technology over nature, just as the bullfight celebrates the triumph of human intelligence over the brute beast.

That is why we do not begrudge the drug companies their enormous profits, and gladly volunteer our own bodies and those of our children for their latest experiments. Vaccination is essentially a religious sacrament of our own participation in the miracle, a veritable *auto-da-fé* in the name of modern civilization itself.

Nobody in his right mind would seriously entertain the idea that, if we could somehow eliminate, one by one, measles and polio and all the known diseases of mankind, we would be any the healthier for it, or that other even more serious diseases would not quickly take their place.

Still less would a rational being suppose that the illnesses from which he suffered were entities somehow separable from the patients who suffer them, and that, with the appropriate chemical or surgical sacrament, this separation can literally be carried out.

Yet these are precisely the 'miracles' we are taught to believe in, and the idolatries to which we aspire. We prefer to forget the older and simpler truths, that the propensity or susceptibility to illness is deeply rooted in our biological nature, and that the phenomena of disease are the expression of our own life energy, trying to overcome whatever it is trying to overcome, trying, in short, to *heal* itself.

The myth that we can find technical solutions for all human ailments seems attractive at first, precisely because it by-passes the problem of healing, which is a genuine miracle in the sense that it can always *fail* to occur. We are all genuinely at risk of illness and death at every moment; no amount of technology can change that. Yet the mission of technical medicine is precisely to try to change that: to stand at all times in the front lines against disease, and to attack and destroy it whenever and wherever it shows itself.

That is why, with all due respect, I cannot have faith in the miracles or accept the sacraments of Merck, Sharp, and Dohme and the Center for Disease Control. I prefer to stay with the miracle of life itself, which has given us illness and disease, but also the arts of medicine and healing, through which we can acknowledge and experience our pain and our vulnerability, and sometimes, with the grace of God and the help of our fellow men, an awareness of health and well-being that transcends all boundaries. That is *my* religion; and, while I would willingly share it, I would not *force* it on anyone.

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