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Vaccine Realities That Big Pharma Doesn't Teach Us Doctors (or Our Patients). The Plight of "Vaccine Damaged Children"

And Why America's Mandated Over-vaccination Schedules are Unsafe and of Questionable Usefulness

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Global Research, November 30, 2018

Region: USA
Theme: Media Disinformation, Science and Medicine

"In 1986 a US law was passed that protected vaccine maker's from ever being sued in a a regular court regardless of how many babies or children were injured of killed from the aluminum, mercury (aka Thimerosal), formaldehyde, aborted fetal cells, deadly peanut byproducts, cells of pigs, cows, monkeys, dogs, insects, MSG (monosodium glutamate), ether and other toxins that make up normal vaccines. At that time 1 in 10,000 children had Autism. Children went from 7 vaccines to more than 70. Today as many as 1 in 25 boys over age 12 has autism-which is really a term to hide the real condition: vaccine-induced encephalitis (inflammation of the brain) and 1 in 5 high school kids have ADHD, Tourette's syndrome, epilepsy, asthma, diabetes and cancer has gone sky high. No vaccine is ever looked at for its ability to cause cancer-surely not the combination of vaccines and cancer is now the leading cause of death ion little children. There is a federal Vaccine court that has paid 3.3 BILLION dollars to families bright enough to learn the system and were able to prove that the autism was from the vaccines." — Shelley Tzorfas, author of Recovering Autism, ADHD, & Special Needs

Over the several decades since I really started studying vaccine issues in some depth – much too late for many of my vulnerable patients – I have come to see through the pervasive Big Pharma/Big Vaccine/Big Medicine propaganda that falsely and repeatedly asserted that all vaccines are safe, effective and necessary for the public health.

I have come to understand that my academic professors at the University of Minnesota Medical School that taught us naïve students about the alleged safety and alleged efficacy of mass vaccination campaigns had also been mis-taught by their own professors who probably only knew the historical myths about Jenner, cowpox and smallpox and the early myths about Salk and Sabin and their often failed, even disastrous experiments with polio vaccines

I suspect also that by the mid-1960s my professors were increasingly coming under the corrupting influence of the pharmaceutical industry and their Wall Street cronies that were recognizing the enormous corporate profits to be made by selling more and more dependency-inducing and increasingly expensive, patentable, synthetic drugs and vaccines. In fairness to my now-deceased professors, there were far fewer drugs and only a miniscule number of toxic vaccines available back then (1964 – 1968).

I last practiced family medicine in an under-served area of rural Minnesota about 20 years ago. Since then I have had more time and energy to understand how and why the academic doctors that wrote my med school text books also emphasized to us students – without corroborating evidence –that vaccines were always safe and effective. These textbook authors had also likely developed significant, undeclared conflicts of interest with the industries that provided the propaganda that made us easily-bamboozled student doctors into devoted life-long prescribers of their drugs and vaccines.

Of course, nothing was taught to us back then about the multiple toxic ingredients that are in every vaccine dose or the lack of proof of efficacy when cocktails of several combinations of vaccines (or drugs) are injected simultaneously into the tiny muscles of our infant and toddler-age patients. But students, particularly medical students, aren't known for questioning authority, especially if the authorities are esteemed and renowned (albeit often arrogant) professors. Most of us students weren't aware that most of our professors had never suffered through the trials of being a self-employed, primary-care physician that had to deal with normal members of the community.

These academics didn't explain to us med students (and perhaps they didn't understand it themselves) that the intentionally-deceptive "relative risk" statistics (as opposed to the more honest "absolute/actual risks") came from Big Pharma's statisticians and that those statistics consistently, intentionally and fraudulently over-rated the effectiveness and safety of their products. (Those products included not just their vaccines but also their dependency-inducing prescription drugs that frequently caused serious withdrawal effects that made stopping them both hard to do AND hazardous).

So we naive future teachers of our equally naïve – and easily bamboozleable – future patients have all been brainwashed into trusting the untrustworthy Big Pharma cartel and their "authoritative" propaganda that was so good for business. Most people tend to be obedient to the orders of authoritative folks and physicians and their patients are no different.

And then, after we students finally finished our internships or residency programs, we were employed by various for-profit private medical practices, and we found out that our clinics could make a lot of money getting parents to bring their previously well babies in for their "well-baby exams" and their obligatory, periodic cocktails of "well-baby shots". It didn't occur to us rookie physicians at the time that the clinics made far less money than the vaccine makers and marketers did. We just went on guiltlessly and happily doing what we had learned in school – and we rarely questioned anything that we had been taught.

But most seriously, we students were never taught much immunology or even the basic science of how vaccines actually "work" while we were in med school. I myself only started trying to fully understand the little that I had been taught about vaccines after a close relative started having neurological issues after his 4 month well baby shots. (He was eventually diagnosed with Asperger's syndrome). It was only then that I finally started listening to and trusting the many anguished and justifiably distraught and angry parents whose vaccine-sickened or vaccine-killed children had unequivocally been neurologically damaged by their baby shots.

After hearing of the multitude of vaccine-damaged children, I have become more and more outraged over the fact that many of the parents – whose children and lives had been permanently devastated by vaccine injuries – have actually been fired from the previously-

trusted medical practices whose vaccines had injured their children.

The science of vaccine-induced neurotoxicity is actually quite understandable, even for laypeople – if they were ever taught the principles. It might even be easier for laypeople to learn than for indoctrinated physicians! I include a few of the principles in the last half of this column.

For example, it is easy for anybody to understand that until the year 2000, the highly neurotoxic mercury, in the form of Thimerosal, was commonly used in many vaccines as a preservative that was included in order to prevent bacterial overgrowth in the commonly-used, rubber-stoppered multiple-dose vials. Mercury is the 2nd most neurotoxic substance on the planet – right behind the highly radioactive element plutonium – and there is no known safe dose! The CDC, the AAP, the AMA and the media are correct in their admonitions to parents of children to have the kids avoid eating fish that might contain mercury but are to be condemned when they refuse to say anything about the mercury in vaccines. Mercury is still used in multidose influenza vaccine vials but, according to sources inside Big Pharma, trace amounts of it are still being found in other multidose, non-live virus vaccines as well.

In addition, solid microparticles of the known neurotoxic metal aluminum are used in many vaccines as an adjuvant. Particulate aluminum compounds are known to exaggerate immune responses when incubated with the intended viral particles in the vaccine solutions. The number of antibodies produced in response to an aluminum-containing vaccine are orders of magnitude greater than can be achieved with a vaccine that has no aluminum in it. Again, just like mercury, there is no known safe dose of aluminum when it is injected intramuscularly.

In addition, any of the live (albeit allegedly "attenuated") measles viruses that are in the MMR vaccines are known to be capable of causing low-grade viral encephalitis or non-infectious encephalopathies that are diagnosed as brain disorders such as learning disorders, autism, Asperger's disorder, ADHD, behavioral disorders, chronic headaches, epilepsy, allergies, asthma, narcolepsy, speech delays, low IQs, etc.

Vaccine-induced diseases are all, of course, "iatrogenic" disorders which are defined as "caused by doctors, doctor-prescribed drugs, vaccines or surgery". It is to be expected that any industry will try to downplay the toxic effects of its products in order to avoid legal liability and Big Medicine and Big Pharma are no different.

How many things could possibly go wrong when even a highly-skilled nurse tries to inject cocktails of liquids containing a multitude of potentially toxic synthetic chemicals into the tiny muscles of a neurologically-vulnerable infant. Failing to hit tiny muscles of an infant with a needle has to be fairly common in average medical clinics and probably accounts for the significant variability of vaccine efficacy that has frequently been found in pharmaceutical industry-sponsored studies.

But the Big Pharma cartels, the Big Medicine professional trade associations, the Big Pharma lobbyists and the Big Pharma-subsidized mainstream media voices easily out-spend, out-advertise and out-shout those of us who are trying to warn about the many dangers of the toxic substances that are in most vaccines.

One of the major reasons why vaccines may actually do more harm than good can be

understood if one understands that true immunity can only occur if both of the two essential aspects of immunity occur together.

Cellular/mucosal Immunity and Serological/humoral Immunity

Long-lasting or permanent immunity to any infectious disease is not achievable with vaccinations. Permanent immunity is ONLY achieved if there is exposure to – and at least a subclinical infection from – a wild-type virus or bacteria! Indeed, vaccinations can only cause short-lasting, partial immunity – hence the need for periodic booster shots for most vaccines to even achieve partial immunity. There are two essential realities that must go together if a person is to obtain full and long-lasting immunity to any infectious disease.

These two essential factors are

> 1) cellular (aka mucosal) immunity, which only occurs if and when the nasal or respiratory mucosa (or bowel mucosa) is exposed to a virus or bacteria (which never happens with an intramuscularly injectable vaccine!) and
>
> 2) serological (aka humeral) immunity, which only occurs when the mucosal barrier is breached by the viral or bacterial antigen and the antigen gets into the bloodstream and comes in contact with the immunoglobulin-producing white blood cells.

Thus intramuscular vaccinations can never induce cellular immunity, which may be the most important factor in human immune systems. In addition, intramuscular vaccinations cannot be expected to induce normal serological immunity because infectious diseases are never caused by intramuscular exposure. Any immunological effect will thus be of uncertain strength and duration.

In addition, the intramuscularly-injected aluminum-adjuvanted vaccine or protein or DNA fragments are readily engulfed by phagocytes in the muscle and are capable of easily entering the central nervous system/brain (CNS) through the semi-permeable blood-brain barrier (which is more common in infants and children that adults)! Thus the brain can be poisoned with live viruses or toxic substances such as aluminum or mercury.

The aluminum adjuvant is also known to form immune-stimulating fragments that can cause a hyper-immune response and therefore vaccine-induced autoimmune disorders, an increasingly common cause of chronic disorders in childhood.

Why most physicians and patients have become so thoroughly convinced that vaccinations are effective is not just because of the massive propaganda from Big Pharma and Big Medicine that repeatedly supports that notion, but also because of the relative rarity of the infectious diseases that the vaccines allegedly prevent. See the list below for a multitude of examples regarding that reality.

As just one example of the uselessness of vaccinating all pediatric patients with, for example, a mumps vaccine, is the fact that in the United States, only 6,000 cases of mumps were reported annually in recent years, most cases of which were in vaccinated individuals, which equates to the exceedingly rare incidence of 3 cases per 100,000 population! And yet the CDC and the AAP (American Academy of Pediatrics) mandate several doses of the live mumps virus-containing MMR vaccine for every pre-school child in America. Which means

that for every child partially protected from the benign parotid gland infection there will be tens of thousands of children that will be unnecessarily vaccinated. Those patients will receive no benefit, will have to pay the substantial fees, will be unnecessarily exposed to the many toxic ingredients of the vaccine and will be at risk of developing a vaccine-induced autoimmune disorder that could last a life-time.

A second example is the aluminum-adjuvanted Pneumovax shot and the fact that as few as 2 cases of invasive pneumococcal pneumonia occur annually in the US per 100,000 population. That means that 99.99% of the patients getting the Pneumovax shot will get no benefit but will also be at risk of suffering the considerable adverse effects from the neurotoxic aluminum. In addition, there are many strains of pneumococcal bacteria that are not targeted in the vaccine.

Other examples abound (see further below).

Would any rational person, whose physician did his duty and fully informed his patient about the risks (as physicians are supposed to do), accept the expense and the risks of being injected with aluminum-containing vaccines if the risk of getting pneumococcal pneumonia was so extremely low?

Here are some sobering statistics that should give pause to anybody considering exposing themselves to unnecessary toxins for little or no benefit.

Commonly-mandated Childhood Vaccines and the Incidence of the Diseases they are Supposed to Prevent

- DTaP: Diphtheria is non-existent in the US population
- DTaP: Tetanus is rare in the US population

DTaP

Pertussis (Bordetella pertussis – aka “whooping cough”) has an incidence of 55.2 cases per 100,000 infants less than 12 months of age; (98.2 cases per 100,000 6 month-old infants or younger).

The incidence of pertussis has actually been gradually increasing since the early 1980s. A total of 25,827 cases was reported in 2004, the largest number since 1959. The reasons for the increase are not clear. A total of 27,550 pertussis cases and 27 pertussis-related deaths were reported in 2010. Case counts for 2012 have surpassed 2010, with 48,277 pertussis cases, with 13 deaths in infants (provisional).

During 2001–2003, the highest average annual pertussis incidence was among infants younger than 1 year of age (55.2 cases per 100,000 population), and particularly among children younger than 6 months of age (98.2 per 100,000 population). In 2002, 24% of all reported cases were in this age group. However, in recent years, adolescents (11–18 years of age) and adults (19 years and older) have accounted for an increasing proportion of cases. During 2001–2003, the annual incidence of pertussis among persons aged 10–19 years increased from 5.5 per 100,000 in 2001, to 6.7 per 100,000 in 2002, and 10.9 per 100,000 in 2003.

Hepatitis B

Hepatitis B vaccine is a synthetic, non-infectious vaccine. The incidence of Hepatitis B is 2.1 cases per 100,000 population. The vaccine used to contain thimerosal (mercury) as a preservativeand now contains aluminum as an adjuvant.

Based on data from CDC, the incidence of acute hepatitis B in the United States has declined steadily since the late 1980s. Between 1987 and 2004, the incidence of acute hepatitis B was recently reported by the CDC to be 2.1 per 100,000(6,212 cases reported).

Pneumovax

As few as 2 cases of invasive pneumococcal pneumonia occur annually per 100,000 population. It contains an aluminum adjuvant.

CDC reported dramatic declines in invasive pneumococcal disease among children less than 5 years old. Overall, invasive pneumococcal disease decreased from 100 cases per 100,000 people in 1998 to 9 cases per 100,000 in 2015. Invasive pneumococcal disease caused by the 13 serotypes covered by PCV13 decreased from 91 cases per 100,000 people in 1998 to 2 cases per 100,000people in 2015.

Hemophilus influenza b (Hib) vaccine

The incidence of Hib infection is as low as 0.08 cases per 100,000 in children younger than 5 years of age.

In the United States, Hib disease is uncommon. In 2015, the incidence of invasive Hib disease was 0.08 cases per 100,000 in children younger than 5 years of age. It occurs primarily in under-immunized children and in infants too young to have completed the primary immunization series.

In 2015, the incidence of non-b *H. influenzae* invasive disease was 1.3 per 100,000 in children younger than 5 years of age.

Non-typeable *H. influenzae*, *for which there is no vaccine*, now causes the majority of invasive *H. influenzae* disease in all age groups. In 2015, the incidence of invasive non-typeable *H. influenzae* disease was 7 cases per 100,000 in children younger than 5 years of age and 2 cases per 100,000 in adults 65 years of age and older.

MMR (Measles)

The MMR vaccine contains live (although allegedly attenuated) viruses and therefore contains no mercury. In the US, the incidence of measles is approximately 2 cases per million population.

The incidence of measles has remained below one case per million since 1997, except in 2014, when 667 measles cases were reported, representing a reported incidence of 2.08 cases per million.

MMR (Mumps)

In the US, the incidence of mumps is less than 3 cases per 100,000 population.

In the United States, approximately 6,000 cases of mumps were reported annually in recent years (3 cases per 100,000 population).

MMR (Rubella)

In the US, the incidence of rubella (German measles) is less than 0.5 cases per 100,000 population.

The largest annual number of cases of rubella in the United States was in 1969, when 58 cases were reported per 100,000 population. In 1983, fewer than 1,000 cases per year were reported in the United States (less than 0.5 cases per 100,000 population).

Varicella (Chicken Pox)

The chicken pox vaccine is a live virus vaccine. The incidence of wild-type chicken pox is highly variable and not reportable.

Influenza

Flu viruses have 100 – 200 different strains and therefore influenza has an unpredictable and variable incidence. 80% of what is commonly diagnosed as "vaccine-preventable" influenza is actually "Influenza-Like Illnesses" (ILI) for which there is no vaccine. The commonly over-promoted annual influenza vaccines that come in multiple-dose vials contain the neurotoxic preservative mercury (thimerosal).

Neurotoxic aluminum adjuvants hyper-stimulate immune responses to whatever protein molecules (look up the critically important concept of "Molecular Mimicry") come to be attached, explaining the large number of vaccine-induced autoimmune (hyperimmune) disorders that are increasingly occurring in fully-vaccinated populations.

Aluminum adjuvants are used in the following vaccines:

- DTaP (diphtheria/Tetanus/ Pertussis (whooping cough);
- Hepatitis A;
- Hepatitis B;
- Haemophilus influenza type b;
- Meningococcus; and
- Pneumococcal vaccines.

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http://duluthreader.com/search?search_term=Duty+to+Warn&p=2;

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