Shining a light on pertussis & DPT

standforhealthfreedom.com/blog/pertussis/

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The vaccine that closed the courthouse doors

Editor's note: The story behind the DPT shot and the removal of liability from vaccine manufacturers fills volumes. Here we endeavor to give you an overview and point you to the best resources for a deeper dive.

In 1985, a U.S. Senate committee with oversight on public health held a hearing to discuss a very serious and rapidly growing problem: how to handle the lawsuits being brought by Americans who were injured by vaccines. The issue became critical because the cost of the suits arising from childhood brain injury and death from the DPT (Diphtheria-Pertussis-Tetanus) shot became so large, in both number of cases filed and monies paid, that manufacturers were getting out of the business. Average claims collected by injured parties went from $10 million to $45.6 million in a decade and over 200 lawsuits had been filed.i By 1985, only Lederle was left as a manufacturer. The single-sourced vaccine price skyrocketed, with a doctor from Vermont informing the Senate that the state's annual cost to purchase the vaccine went from $3,000-$4,000 annually to $80,000 in just one year.ii

Many people dismiss the sudden explosion in lawsuits as a byproduct of growing public awareness of a connection between the DPT shot and sudden regression, injury, or death in children. Most notably, investigative journalist Leah Thompson revealed her findings after a year of research that "there has been a general void of information in the United States" about known dangers associated with the pertussis part of the vaccine. The report was called "DPT: Vaccine Roulette," and it would not be an exaggeration to say that reactions to the report were a huge step toward the creation of what we know as the "vaccine court."

After that report, which dropped into the stormy sea of cries for “tort reform” in many industries, Americans lost their constitutionally protected right to trial by jury when it comes to vaccines. Why?

To answer this question, we can look at the origins of the pertussis vaccine and how DTP became DTaP. We’ll also examine how American government insistence on vaccinating American children came at the expense of informed consent and parents’ access to justice when an “unavoidably unsafe” product devastates families with injury and death.

What is pertussis?

We know pertussis by its more common name: whooping cough. Through the mid-20th century, it was considered one of the deadliest diseases for the most vulnerable in a population.iii It was considered highly infectious with a death rate of 10% in children at the beginning of the 1900s as Americans moved from their rural homes into crowded, dirty cities.

Pertussis starts like a common cold, but it can linger for weeks or months, with a cough so bad it leaves a person desperately gasping for air between coughing fits, which sounds like a high-pitched wheezing, or “whoop.” However, it was well understood that secondary infections were commonly the cause of death. A popular book from the early 1900s used to promote allopathic medicine, the “Modern Home Medical Advisor,” noted, “As has been said, the chief danger from whooping cough is not from the disease itself, but from the secondary pneumonia and changes which may affect the heart and lungs.”iv

Just like diphtheria and tetanus, the illness is caused by a toxin secreted by bacteria. The Bordetella pertussis bacterium was first identified in 1906. It localizes in the lungs, but the toxin will circulate throughout the body and is known to weaken the blood-brain barrier and to cause neurological damage.v

Do we need a vaccine against pertussis?

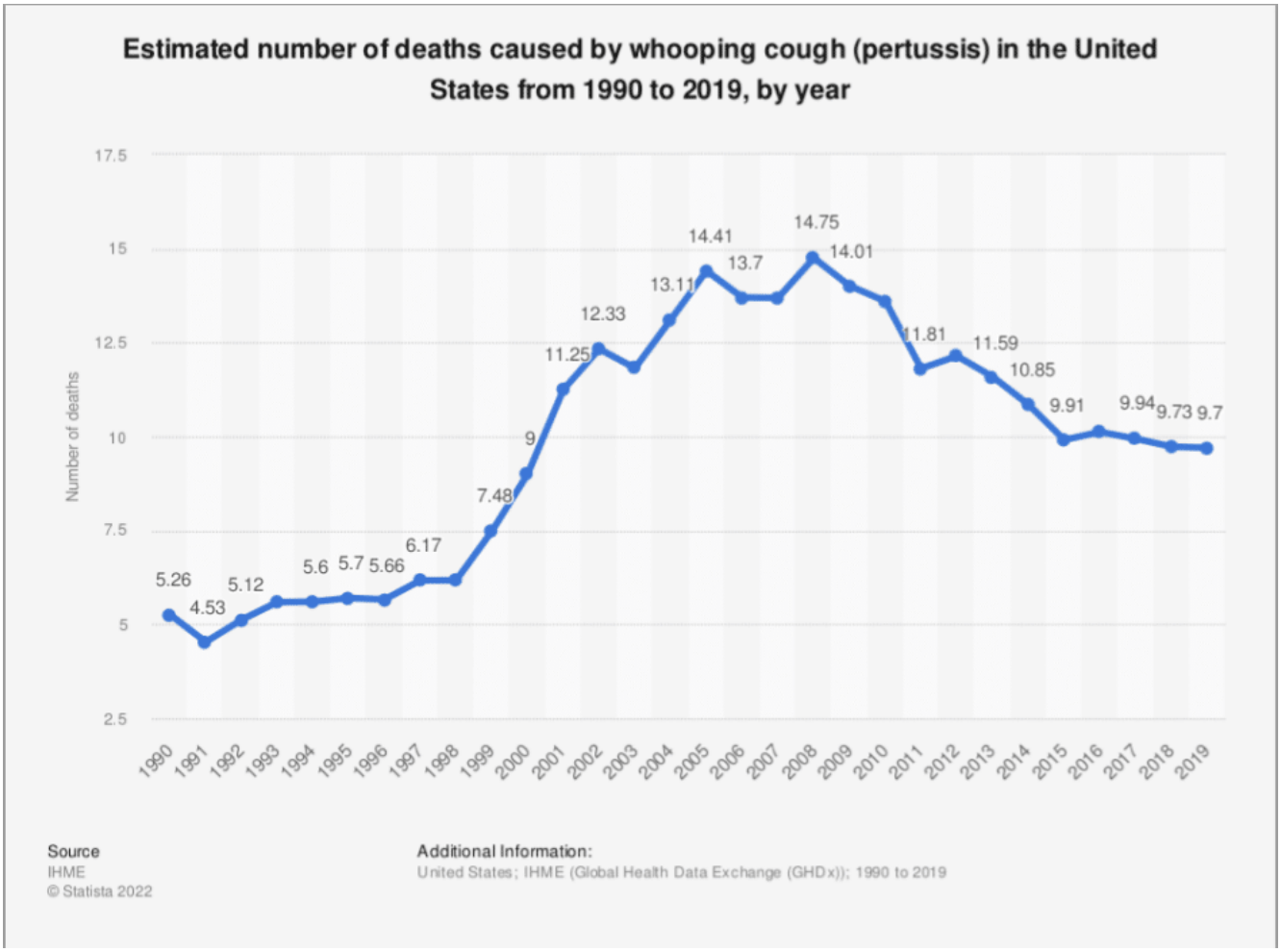
Many books and articles describe the decline in whooping cough deaths well before the vaccine came on the market in the 1940s. “Dissolving Illusions” reports, “From its peak in the 1800s, whooping cough deaths had declined by more than 99% before a vaccine was in widespread use.” The book, “A Shot in the Dark,” describes a “90% decline in the death rate was reported in America, in England, and in Sweden before a pertussis vaccine was used on a mass basis in the 1940s.” It goes on to state, “This decline in the death rate is not really surprising, since the same decline in mortality was occurring with other infectious diseases such as scarlet fever, measles, influenza, tuberculosis, and typhoid. All were formerly prevalent and lethal, and all declined as causes of death during the same period.”vi

As stated earlier, it was commonly accepted among medical practitioners that the reason for most deaths were secondary infections, rather than whooping cough itself. “A Shot in the Dark” further reports that the Wellcome Research Laboratories in England noted that whooping cough deaths declined even faster than other illnesses because of the advent of antibiotics.

Interestingly, historians Mark and David Geier stated, “The first challenge these researchers faced was to establish the efficacy of the vaccines produced, a task that was complicated by the fact that much of the older population was already immune to pertussis infection…”vii So many people had acquired natural immunity that it was hard to find people who would get sick for the tests.

The shot appears to have increased transmission

The book, “Miller’s Review of Critical Vaccine Studies” reports, “cases of whooping cough have increased throughout the world despite high vaccination rates against the disease.”viii In fact, a glance at the CDC’s reported annual cases since 1922 shows a complicated picture of many ups and downs. One can see a very long downward trend that hasn’t yet stabilized, with many surges and dips.ix And while numbers of cases may surge from time to time, death rates from pertussis have remained very low.



"Although health authorities often blame unvaccinated people for causing outbreaks of pertussis in vaccinated populations," explained Dr. Miller, "studies in this chapter [on Pertussis Mutations] demonstrate that pertussis vaccine was inadvertently designed to encourage evolutionary adaptation, which permitted virulent vaccine-resistant strains of pertussis to emerge." In other words, the vaccine is driving mutations that wouldn't have otherwise happened, which increases infection rates and therefore case counts. Where else have we seen this before? Look to 2021 for that answer.

Miller also summarizes studies that conclude it's possible for individuals vaccinated against pertussis to spread the disease to others through "asymptomatic transmission." One such study was conducted by researchers at the FDA's Center for Biologics Evaluation and Research (CBER — the agency department that evaluates vaccines for safety and efficacy). The results were published in 2014 in the "Proceedings of the National Academy of Sciences." Both Miller and authors of the vaccine science book "Turtles All the Way Down" describe the "surprising" study which showed that vaccinated baboons became asymptomatic carriers of pertussis, which could be transmitted to other baboons, while the baboons in the study with natural immunity did not get re-infected nor did they infect others.x This study, conducted by U.S. government scientists, seems to show the pertussis vaccine increasing transmission of the disease, rather than stopping it, as we are told vaccines are supposed to do. (Sound familiar? Again, look to 2021.)

Interestingly, the CDC's Advisory Committee on Immunization Practices (ACIP) also acknowledged the strength of natural pertussis immunity in 1991, stating that children with documented recovery from pertussis did not need the vaccine.xi

Children who have recovered from pertussis

Children who have recovered from satisfactorily documented pertussis do not need pertussis vaccine. Satisfactory documentation includes recovery of *B. pertussis* on culture or typical symptoms and clinical course when epidemiologically linked to a culture-proven case, as may occur during outbreaks. When such confirmation of the diagnosis is lacking, DTP vaccination should be completed, because a presumed pertussis syndrome may have been caused by other *Bordetella* species, *Chlamydia*, or certain viruses.

Overall, “Miller’s Critical Review” summarizes 28 peer-reviewed publications on the topic of pertussis and its vaccine. The papers come from the likes of “Pediatrics, Emerging Infectious Disease,” the “New England Journal of Medicine,” “Vaccine,” the “Lancet” and many more. He concludes that “waning vaccine immunity, the evolutionary adaptation of B. pertussis to pertussis vaccinations, and the potential for vaccinated people to spread disease are important factors in the resurgence of whooping cough.”

The authors of “Turtles All the Way Down” conclude their review of decades of pertussis vaccine research like this:

“The scientific evidence clearly shows that health authorities’ long-time working assumption that the pertussis vaccine provides herd protection was mistaken and has led to decades of dissemination of misinformation, as well as guidelines that may have increased, rather than decreased, pertussis morbidity. The vaccine industry and health authorities, however, express neither regret nor remorse, or even acknowledge their past errors.”xii

Final 2019 Reports of Notifiable Diseases

https://wonder.cdc.gov/nndss/nndss_annual_tables_menu.asp

Reported Pertussis Cases

2018: **15,609** 2019: **18,617**

Reported Pertussis Cases and Percent Hospitalization by Age Group

Age	No. of Cases (% of total)	Age Inc /100,000	% Hospitalized by age**
< 6 mos	1447 (7.8)	76.5	40.9
6-11 mos	785 (4.2)	41.5	9.7
1-6 yrs	3889 (20.9)	16.3	2.4
7-10 yrs	2440 (13.1)	15.1	0.8
11-19 yrs	5673 (30.5)	15.0	1.1
20+ yrs	4380 (23.5)	1.8	7.7
Unknown Age	3 (0.0)	N/A	N/A
Total	**18,617 (100)**	**5.7***	**6.2**

*Total age incidence per 100,000 calculated from 18,614 cases with age reported.
**Age-specific proportion of cases that were hospitalized, calculated from those with a known hospitalization status.

Reported Pertussis Deaths

Age	Deaths*
Cases, aged < 1 yr	4
Cases, aged ≥ 1 yr	3
Total	**7†**

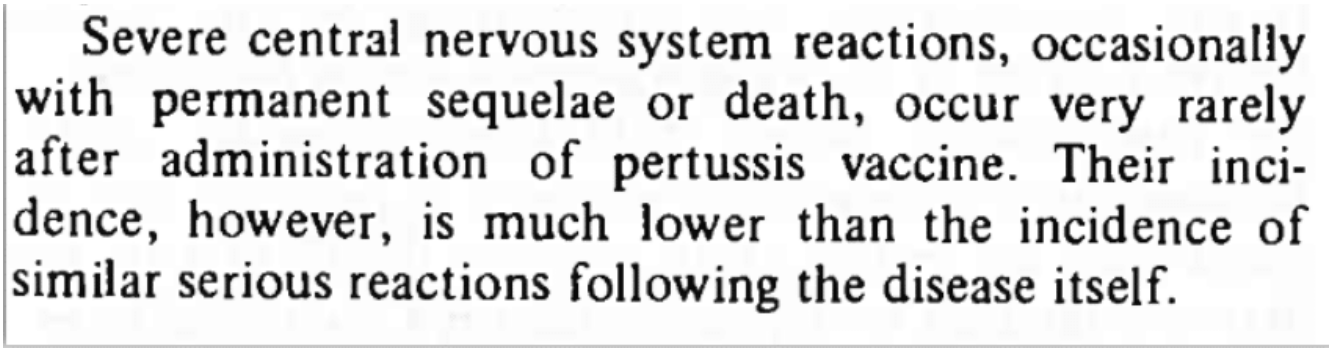
*Deaths reported through NNDSS to CDC.
†3 of the 7 deaths were female.

https://www.cdc.gov/pertussis/downloads/pertuss-surv-report-2019-508.pdf

Development, safety and evolution of the pertussis and combination vaccines The DTaP shot is one of the heaviest loads on the childhood vaccine schedule. The triple-dose shot is scheduled to be given six times before the age of 6, five of which happen before the age of 2 (including the prenatal shot).xiii The combination shot is also recommended every 10 years for adults, and in special circumstances like pregnancy, “cocooning” a new baby by ensuring every adult around them is up to date, and “wound management,” despite the CDC acknowledgement that the vaccine does not help the wound and instead is used for future prevention (discussed in our shot story about tetanus).xiv If the date of the last shot is unknown, the policy is to give a booster. Think about how many of these vaccines are being recommended over a lifetime, and how that number increases with a woman’s every pregnancy. Why?

The first childhood vaccine schedule compiled in 1969 by the ACIP explains, “The high mortality from pertussis in infancy is the major rationale for immunization early in life. … the incidence and mortality of pertussis decrease with age” and therefore the shot isn’t recommended after age 6 or entry into elementary school.xv The ACIP categorically states, “Pertussis immunization is effective in reducing both cases and deaths.”

In this very first schedule of recommendations, the ACIP acknowledged that brain damage and death could occur, which would have been observed after 25 years of “routine” administration. This risk is dismissed by saying it happens less frequently than the same risk after natural infections.


Severe central nervous system reactions, occasionally with permanent sequelae or death, occur very rarely after administration of pertussis vaccine. Their incidence, however, is much lower than the incidence of similar serious reactions following the disease itself.

This kind of dismissal can furrow the brow. Comparing the two risks does not diminish the fact that a risk exists, nor does it reveal how big the risk is. So, what is the risk of the vaccine?

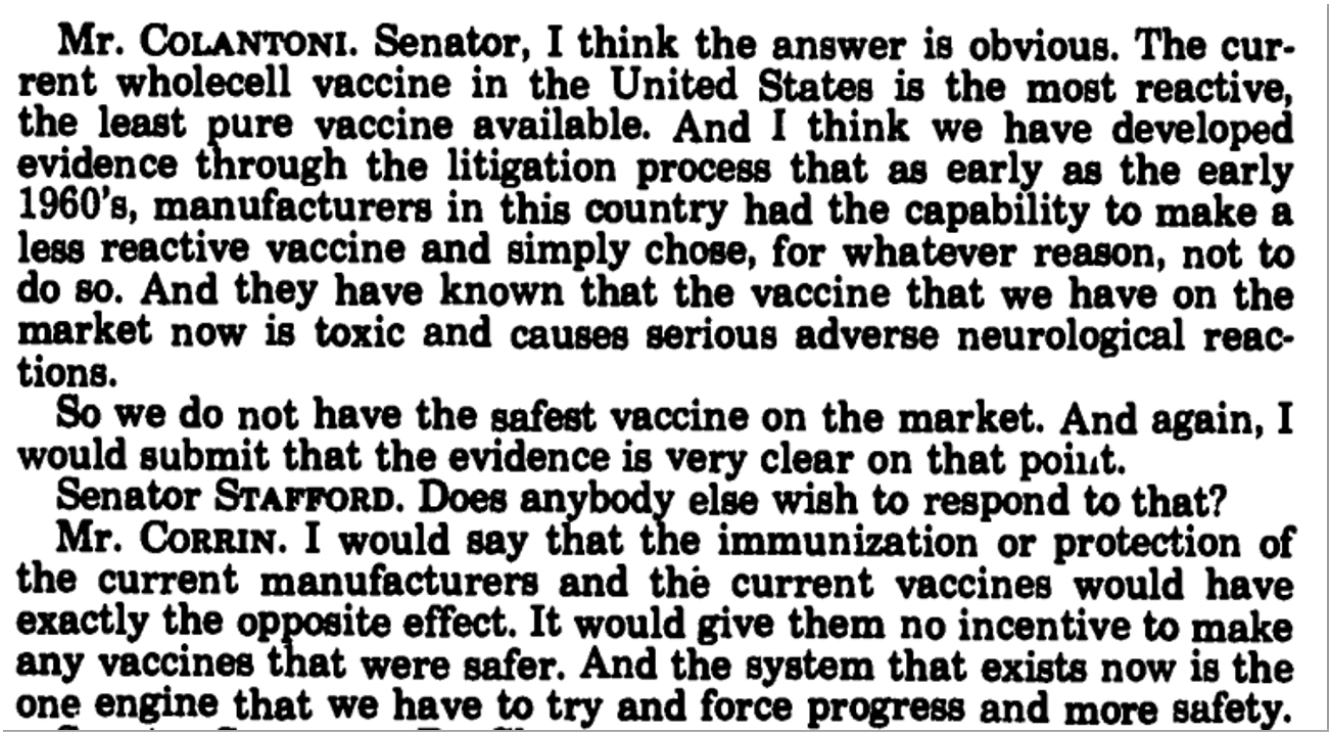
DTP, DTaP, TdaP, what's the difference?

What's the difference between the DTP and DTaP vaccines? Scientists may answer that question by explaining one is "whole" and the other is "parts" — the little "a" means "acellular" and indicates a shift from previously used "whole-cell" pertussis bacteria in the shot. Manufacturers would answer that with economics — the cost of producing DTP with whole cells was far less expensive than acellular.[xvi] Parents, and even some doctors, would answer that by saying the difference is how much your child risks brain damage or death from the vaccine.

The pertussis portion of the vaccine was initially made with whole-cell pertussis. It's similar to the polio vaccine invented by Jonas Salk in the sense that the suspected "germ" was isolated, grown, and "killed" with the theory it would be intact enough for recognition by the immune system but weakened so it wouldn't cause the recipient to get seriously ill.

So the difference is in the pertussis component of the vaccine — do they use the whole-cell bacteria or do they use bits of the bacteria? It turns out the whole-cell version is much more dangerous because the science behind the mechanism for infection wasn't completely understood and there were harmful toxins that were not inactivated when scientists believed they killed the cell. One paper, published in the "Journal of Infectious Disease" in 2014 described, "Many of the adverse reactions have been attributed to contaminating constituents and products of" the bacteria. In other words, the whole-cell vaccines could not be properly purified and the bacteria itself made harmful things the scientists didn't understand.

The disease progresses in two stages. First the bacteria localize in the lungs and respiratory tract, causing irritation and infection, then toxins are secreted by the bacteria.[xvii] Different strains release different toxins with different risk levels. Techniques using heat or formaldehyde-based chemicals to "inactivate" the virus are basically playing with fire because the goal is not to "kill" or "inactivate" everything there; the scientists must basically injure the "germ" enough so the body knows what it is but doesn't see it as a threat and mount a massive immune response. Imagine you're walking down the street and see someone sucker punch someone else. That victim is shocked, for sure, but are they down for the count? What if they have a hidden weapon or they know jiu jitsu or their friends are just around the corner? Perhaps a silly example, but it's a metaphor for what's happening in this fight against disease.



Mr. COLANTONI. Senator, I think the answer is obvious. The current wholecell vaccine in the United States is the most reactive, the least pure vaccine available. And I think we have developed evidence through the litigation process that as early as the early 1960's, manufacturers in this country had the capability to make a less reactive vaccine and simply chose, for whatever reason, not to do so. And they have known that the vaccine that we have on the market now is toxic and causes serious adverse neurological reactions.

So we do not have the safest vaccine on the market. And again, I would submit that the evidence is very clear on that point.

Senator STAFFORD. Does anybody else wish to respond to that?

Mr. CORRIN. I would say that the immunization or protection of the current manufacturers and the current vaccines would have exactly the opposite effect. It would give them no incentive to make any vaccines that were safer. And the system that exists now is the one engine that we have to try and force progress and more safety.

Parents were concerned about the risks of brain injury and death from the whole-cell vaccine, and in fact, entire countries paused or discontinued its use, especially in infants. Another version of the vaccine was created with just parts of the bacteria, along with certain added ingredients, and is referred to as acellular, which you see as the little “a” in the acronym.

In the tetanus, diphtheria, and pertussis combination shots, you can crack the code of what type of vaccine is being given by looking at capitalization and which letters are included. If you see lower case letters, it means is the shot contains a lower dose. Each of the doses have their own letter: t, d, or p (with the p sometimes preceeded by an “a” for acellular, or “w” for whole-cell. If the “a” isn’t there, you know it’s the whole-cell original formula). Clear as mud, right? Just as clear as the razzle-dazzle done to convince people they need these shots for our war on germs.

The risk and reward debate will rage on because if it doesn’t, doctors will stop recommending the shots and the precautionary principle will prevail. “DPT manufacturers also must use vague terms concerning the risk rate because there’s no reliable scientific data on which to base an accurate estimate.”[i] Patients are relying on their doctors to understand the risks as medical professionals. They rely on their medical opinion. How can doctors understand the risk if the manufacturers themselves do not?

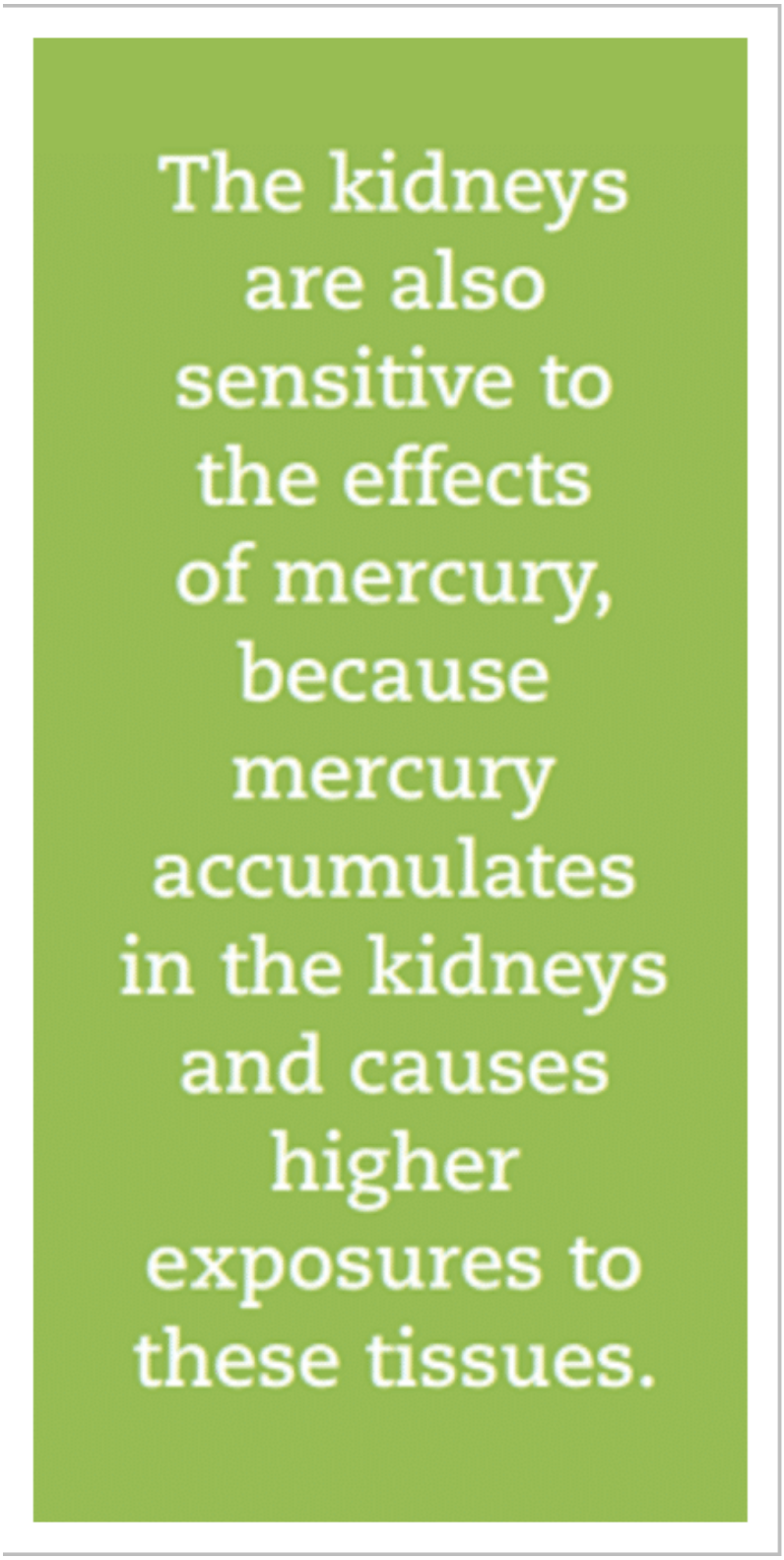
DPT ushered in the era of mercury in vaccines

The pertussis vaccine was combined with diphtheria and tetanus in the 1940s to create the combination shot DPT. Mercury (known as thimerosal) started making its way into vaccines either to “inactivate” or “kill” whole cells, or more commonly as a “preservative” to prevent contamination and enable multiple doses to be put into one combination shot.

Mercury is a poison. Have you ever read or watched “Alice in Wonderland”? Do you know why the hatter was mad? Mercury. It was used to soften the material to shape hats more easily.[ii] In the 1940s, the U.S. Public Health Service worked with states to prohibit the use of mercury by hat manufacturers, as neurological damage and insanity were well-known occupational hazards for those in the industry.[iii]

Mercury exposure levels are regulated and advised upon by no less than 10 federal agencies, along with the World Health Organization and other international organizations.[iv] Limits for mercury levels are described for foods, water, school, and work environments. A report to Congress informed Americans that, “The Food and Drug Administration (FDA) has declared that inorganic arsenic, lead, cadmium, and mercury are dangerous, particularly to infants and children.” They have “no established health benefit” and “lead to illness, impairment, and in high doses, death.” According to the FDA, “even low levels of harmful metals from individual food sources can sometimes add up to a level of concern.”[v] The FDA cautions that infants and children are at the greatest risk of harm from toxic heavy metal exposure.” Mercury exposure is associated with neurological, developmental, and kidney damage.[vi]

The CDC recommends that breastfeeding mothers limit their exposure to mercury found in the environment, workplaces, and diet.[vii] An entire sub-section of the CDC called the Agency for Toxic Substances and Disease Registry is dedicated to tracking, minimizing, and educating on the toxic effects of poisons such as mercury. The website describes the different types of mercury, noting they can all be toxic, and details where mercury has been or is used in products such as dental fillings, batteries, light bulbs, thermometers, paints, and pesticides.[viii] Notably absent from their list is the use of mercury in vaccines. Although thimerosal use in vaccines has been reduced, it is not prohibited, and is still found in some influenza vaccines in the U.S. and in other vaccines around the world (that could be provided by the U.S. to low-income countries).[ix]



https://www.atsdr.cdc.gov/sites/toxzine/mercury_toxzine.html#health_effects

Presidential candidate Robert Kennedy, Jr. has done extensive work uncovering the harms of mercury in vaccines. He revealed the extent of risk of harm that was known by federal agencies and scientists involved with vaccines as early as 2000 in an interview with Rolling Stone in 2005.[i] He described a quietly convened meeting that included top government officials from the U.S. and around the globe, held at a Methodist retreat center to keep it out of the public eye. It was a strategic policy meeting to

discuss a study done by CDC epidemiologist Tom Verstraeten that raised alarming concerns about the safety of childhood vaccines, including the risks of use of mercury. You can read the “the Simpsonwood documents” detailing the discussions of the meeting to learn the extent of the information that was hidden from the public, or a summary published by Children’s Health Defense. Kennedy also wrote a book exposing the dangers, “Thimerosal: Let the Science Speak,” published in 2015.

For an easy way to ease into this topic, with its twists and turns in policy and science, you can listen to Kennedy explain how his environmental law practice led him to learn about hidden dangers in vaccines. No one can tell the story like he can.

This is a great clip to start learning about mercury in vaccines, because Kennedy contextualizes the complicated science and policy into relatable, real-world situations. If you have extra time, start around 9:25 to learn how he was reluctantly drawn into the research. Otherwise, start at 19:00 to learn how he saw through the false information being offered by federal agencies and manufacturers about the toxicity of mercury in vaccines. His mastery of the information combined with his unique position to understand the inner workings of politics is not to be missed.

Importantly, Kennedy describes how he stopped Paul Offit in his tracks when he caught him in a lie about the risks of mercury in vaccines. We are told that the mercury in vaccines (thimerosal) is different from the mercury found in the environment, which is true. The CDC states on their website that this form of mercury is quickly removed from the body. Kennedy explains that is not true. The scientists didn’t ask the right questions about where the mercury injected into a body went. He explains research that showed it doesn’t stay in the blood (and therefore looks like it leaves the body quickly) because it is able to cross the blood-brain barrier, accumulating in the brain instead. These are the types of questions that need to be asked when we’re told a vaccine is safe because “no evidence was found” to show risk. If you don’t look, you can honestly say you didn’t find something, but it doesn’t mean it isn’t there.

Timeline of development and policy

- **1906:** Bortadella pertussis bacteria discovered.
- **1914:** Pertussis vaccine made by six manufacturers, referred to as “new and non-official remedy” by American Medical Association (AMA).
- **1931:** The AMA removes pertussis vaccine from their list of remedies due to ineffectiveness.
- **1937:** Lederle Laboratories patents acellular pertussis vaccine.
- **1944:** S. Public Health Service Act passes, allowing federal government to regulate vaccines.
- **1947:** First published reports of irreversible brain damage from whole-cell vaccine.
- **1948:** Lederle replaces safer acellular vaccine with whole-cell DTP because of expense of testing efficacy under new federal laws.
- **1949:** NIH solidifies minimum requirements for concentration and potency for pertussis vaccines.
- **1960:** Merck markets acellular pertussis vaccine.
- **1963:** Merck replaces acellular with DTP.
- **1964:** Merck stops selling DPT, citing fear of lawsuits.
- **1968:** Quadrigen vaccine including DPT and killed polio withdrawn from market after “several successful lawsuits” showed the American public how dangerous the vaccine was and how costly manufacture of a dangerous product could be.
- **1974:** Germany withdraws recommendation of DPT shot.

- **1975:** Japan pauses DPT use after reported deaths, then reinstates only for children older than 2 years of age.
- **1979:** Sweden discontinues use of whole-cell pertussis vaccine.
- **1978:** S. government requires parents to sign “important information statement” about the risks of the vaccine.
- **1979:** The CDC links DPT lot to several SIDS deaths in Tennessee, prompting the FDA to recall the lots then reverses course and allows for their use after industry pressure.
- **1979:** The UK publishes results of three-year National Childhood Encephalopathy Study.
- **1981:** Japan creates acellular pertussis vaccine, prohibits use of whole-cell due to dangers.
- **1981:** Lederle loses lawsuit claiming DTP was “defective” and the company knew how to make a safer vaccine but put profits over people’s lives.
- **1982:** “DPT Vaccine Roulette” airs, creating awareness of the dangers of the vaccine.
- **1985:** Only one manufacturer, Lederle, continues making DPT because of the huge expense in government-required testing as well as the risk of litigation from injuries and death.
- **1985:** The Institute of Medicine (IOM) reports on adverse reactions to DPT shot, “gave the highest possible priority to switching from whole-cell pertussis vaccine [DPT] to acellular pertussis vaccine [DTaP] to prevent monetary loss and personal suffering.”[i]
- **1986:** National Childhood Vaccine Injury Act passes, creating the “vaccine court” and VAERS.
- **1990:** The IOM concludes whole-cell DPT causes acute encephalopathy (sudden brain swelling(.
- **1992:** The FDA approves DTaP for use in boosters after whole-cell administration first.
- **1993:** The IOM concludes whole-cell DPT causes permanent brain damage.
- **1996:** The FDA finally licenses DTaP for all doses on childhood schedule.

TABLE 3. Sudden infant deaths and DTP vaccination in public clinics, Tennessee, August 1977-March 1978 and August 1978-March 1979

Time period	Deaths		Immunized with DTP in public clinics		
	All deaths	2+ months-old	Total	Within 1 day	Within 2-7 days
1978-79	77	42	21	4	4
1977-78	74	41	11	0	2

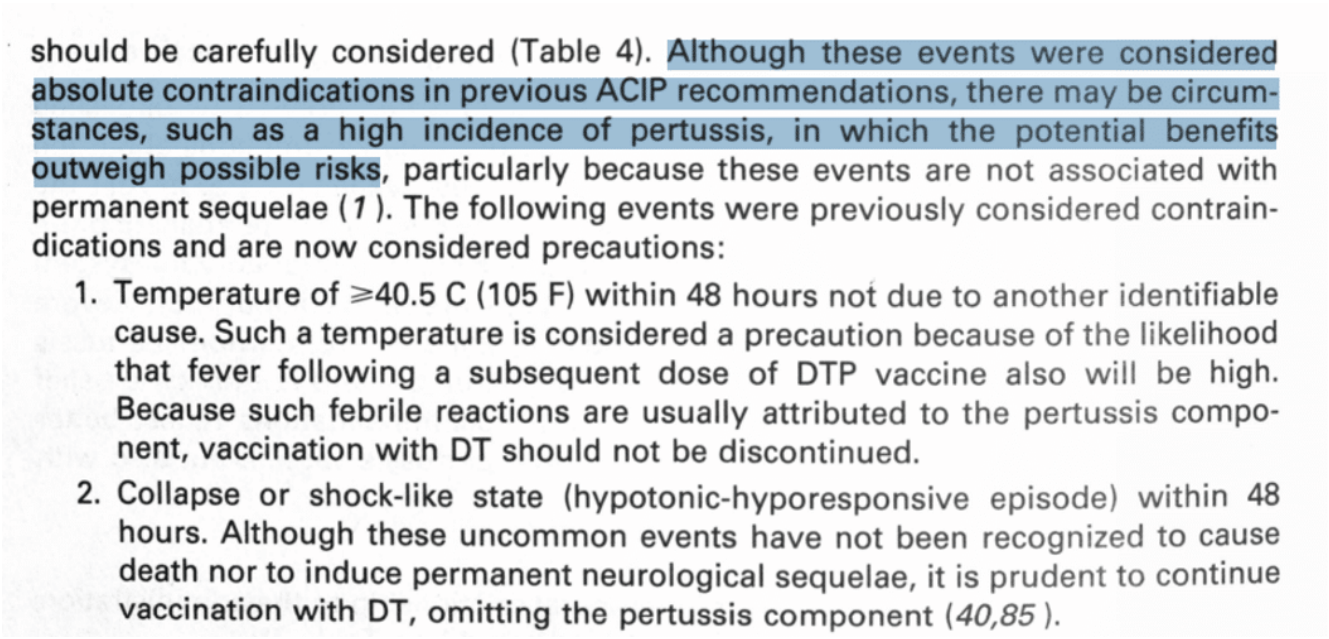
https://stacks.cdc.gov/view/cdc/1505

The interesting case of disappearing contraindications

Contraindications are “indications or symptoms which forbid the method of treatment usual in such cases.” In other words, they serve as smoke before the fire, telling a doctor the person’s risk of harm is greater than others’, and that individual is more likely to have a bad reaction. This is the reason vaccines are “unavoidably unsafe” because there is no way to categorically say no one would ever have a reaction to something.

Around the globe in the 1970s, parents were noticing serious reactions like brain damage and death after their children got DPT shots. Germany and Sweden withdrew the recommendation until something safer was available. Japan paused, then prohibited it for children under 2 years of age, then created and licensed a safer vaccine in 1981. But in the U.S., the ACIP and the CDC not only dismissed parents’ “anecdotal” concerns about injuries and death attributed to the vaccine, they *narrowed the medical contraindications that would trigger a medical exemption to the vaccine*.[i] This move made it

exponentially harder for parents to protect their children, because this government body of "experts" and authorities declared reactions that were considered "absolute contraindications in previous ACIP recommendations" were suddenly not as important as shots in arms.



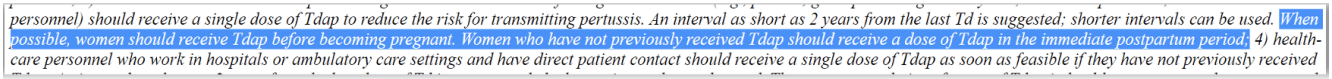
should be carefully considered (Table 4). Although these events were considered absolute contraindications in previous ACIP recommendations, there may be circumstances, such as a high incidence of pertussis, in which the potential benefits outweigh possible risks, particularly because these events are not associated with permanent sequelae (*1*). The following events were previously considered contraindications and are now considered precautions:

1. Temperature of ≥40.5 C (105 F) within 48 hours not due to another identifiable cause. Such a temperature is considered a precaution because of the likelihood that fever following a subsequent dose of DTP vaccine also will be high. Because such febrile reactions are usually attributed to the pertussis component, vaccination with DT should not be discontinued.
2. Collapse or shock-like state (hypotonic-hyporesponsive episode) within 48 hours. Although these uncommon events have not been recognized to cause death nor to induce permanent neurological sequelae, it is prudent to continue vaccination with DT, omitting the pertussis component (*40,85*).

Tdap recommended for pregnant women to prevent infant cases

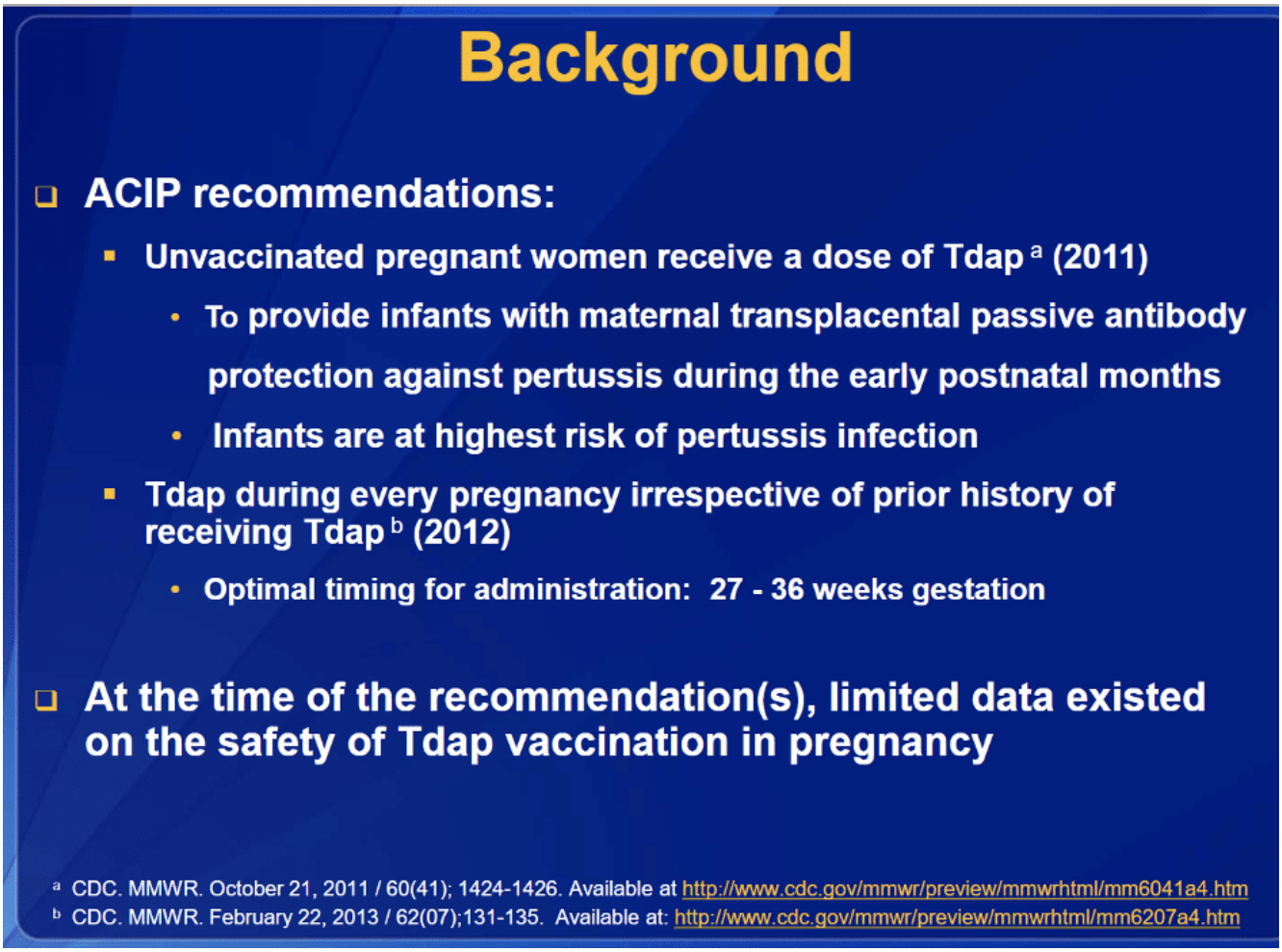
As of 1991, the CDC's position was "[r]outine vaccination against pertussis is not currently recommended for persons [greater than or equal to] 7 years of age," but since adults "are a major reservoir for transmission of pertussis," booster recommendations may have been on the horizon.[i] Tetanus shots were recommended alone or with diphtheria, which is relevant because no additional studies were done once pertussis was added to the mix and recommended.

In 2006, the FDA licensed Tdap for use in adults, but the CDC cautioned women to get the shot before or immediately after pregnancy.[ii] Pregnant women were specifically excluded from the vaccine trials.



personnel) should receive a single dose of Tdap to reduce the risk for transmitting pertussis. An interval as short as 2 years from the last Td is suggested; shorter intervals can be used. When possible, women should receive Tdap before becoming pregnant. Women who have not previously received Tdap should receive a dose of Tdap in the immediate postpartum period; 4) health-care personnel who work in hospitals or ambulatory care settings and have direct patient contact should receive a single dose of Tdap as soon as feasible if they have not previously received

In 2011, ACIP changed course and chose to recommend the Tdap for unvaccinated pregnant women. That recommendation quickly ballooned the next year to a recommendation for a shot during *each* pregnancy.



https://stacks.cdc.gov/view/cdc/60673

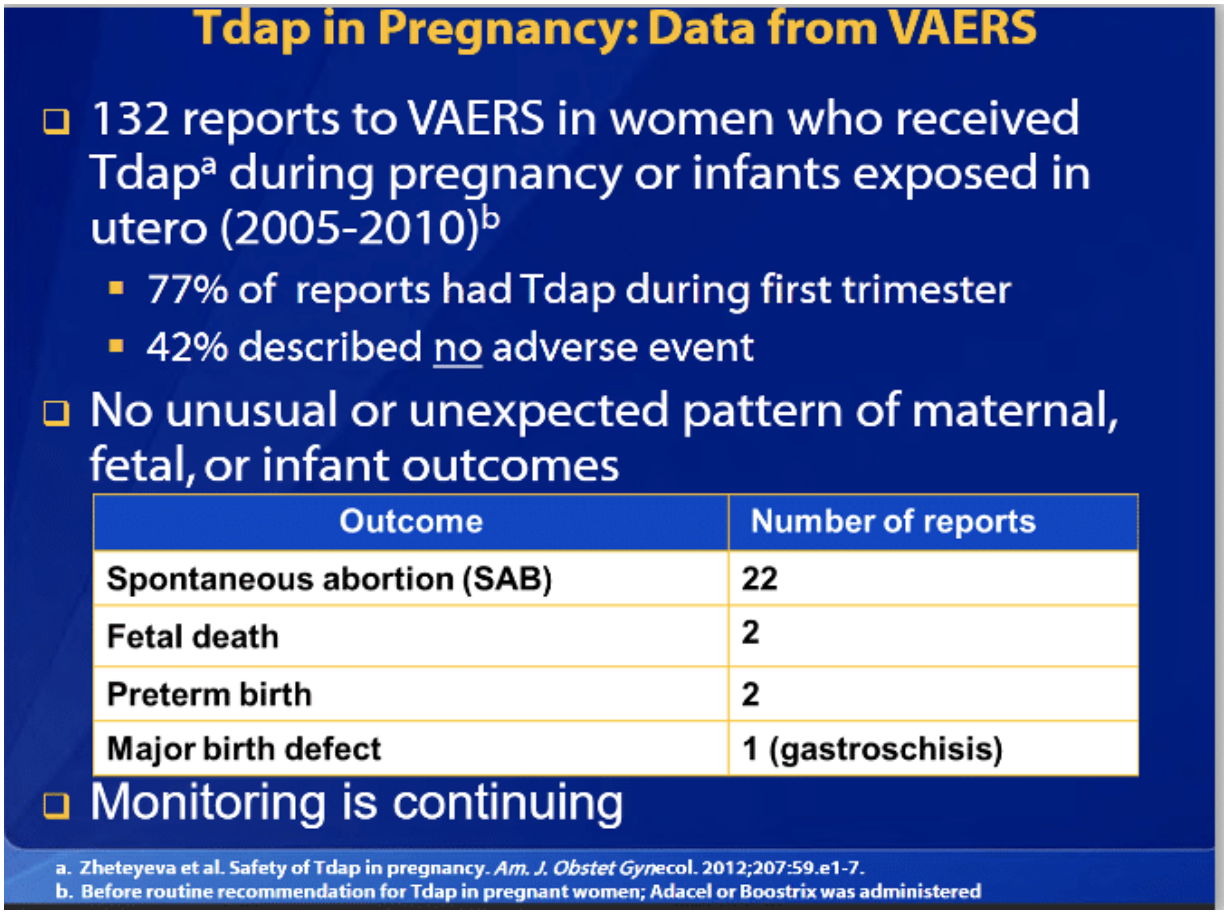
In 2012, the CDC reported a "pertussis resurgence, with record-breaking numbers of cases,"[i] and the ACIP seized the opportunity to shift their recommendation for pertussis vaccination in pregnancy from getting up to date with a booster, to recommending Tdap for every pregnancy in a woman's lifetime. The justification was the rapidly waning immunity from the vaccine during a surge of case counts. It was noted that "there was an opportunity to present this similarly to the 2009 pandemic influenza recommendation," which saw an increase in vaccine uptake during pregnancy. "As the influenza experience has illustrated, provider recommendation is the best predictor of getting pregnant women vaccinated."

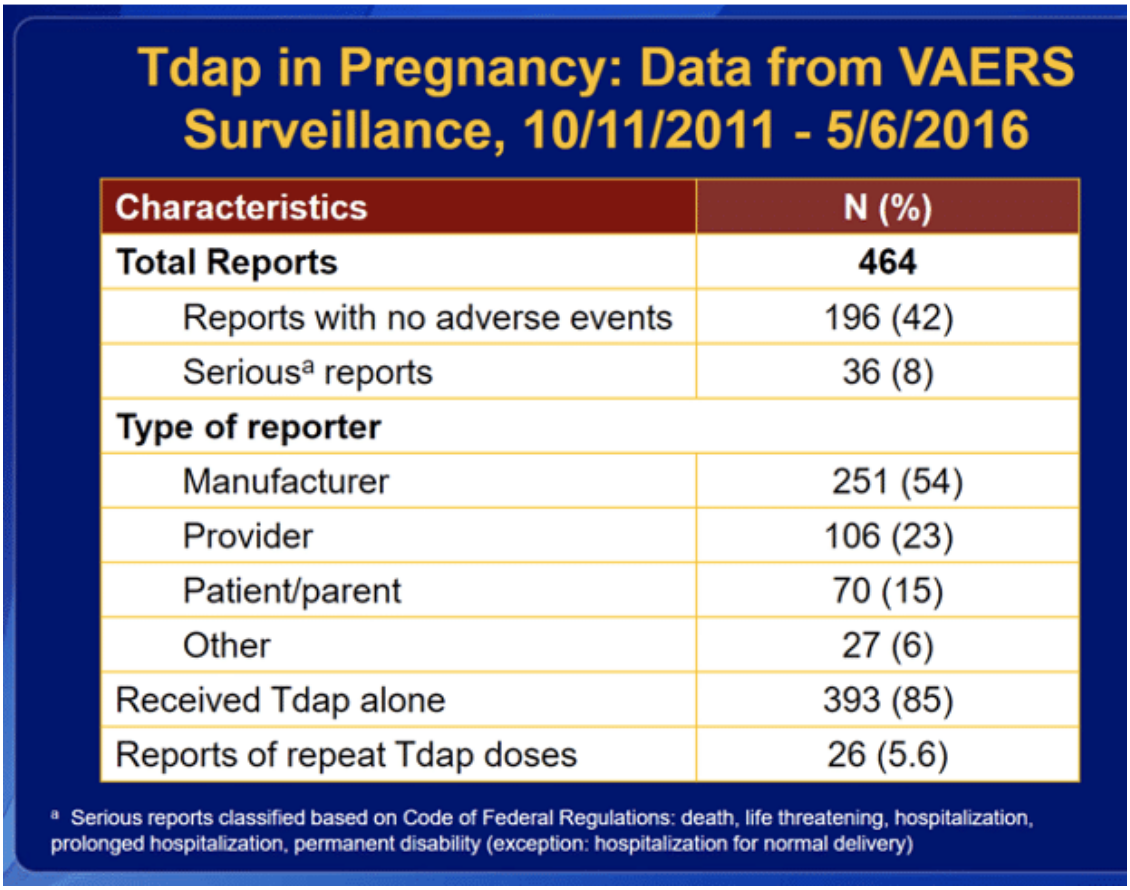
It was noted that the National Vaccine Advisory Committee, the National Foundation for Infectious Diseases, the CDC, ACOG, and other partners were "working to remove barriers to maternal immunization." One ACIP member believed low uptake was because of "provider hesitancy, not pregnant women hesitancy." She opined that pregnant women would opt for sore arms and possible adverse reactions themselves, "versus a hospitalized or dead baby." Her comments are summarized for the record: "Pregnant women will choose to be vaccinated, even if they are not highly educated."

ACIP members voted for this change, despite a lack of actual evidence that it would work to protect infants. In other words, they guessed. One member observed, "There are no direct data to substantiate that the strategy of vaccinating during pregnancy is preventing hospitalizations or death in newborns."

The panel concluded it was “acceptably safe” based on their perception that other tetanus vaccines, without a pertussis component, “have been used extensively in pregnant women and no evidence indicates that administering [tetanus alone or with diphtheria] during pregnancy” would cause developmental defects in unborn babies. It was noted that there was no data about adverse reactions following more than one dose.

“In essence,” the panel concluded, “the working group wished for more data pertaining to the theoretical concerns on severe adverse events but felt that this was not a reason to deter them from making a recommendation for Tdap for every pregnancy or to limit the number of doses.





Tdap in Pregnancy: Data from VAERS Surveillance, 10/11/2011 - 5/6/2016

Characteristics	N (%)
Total Reports	**464**
Reports with no adverse events	196 (42)
Serious[a] reports	36 (8)
Type of reporter	
Manufacturer	251 (54)
Provider	106 (23)
Patient/parent	70 (15)
Other	27 (6)
Received Tdap alone	393 (85)
Reports of repeat Tdap doses	26 (5.6)

[a] Serious reports classified based on Code of Federal Regulations: death, life threatening, hospitalization, prolonged hospitalization, permanent disability (exception: hospitalization for normal delivery)

There was a concern that the recommendation would be an "off-label" use, meaning the FDA had not evaluated the safety and efficacy of the use of Tdap beyond one single use in a nonpregnant adult. You would think the concern would focus on safety and efficacy, but that's not the ACIP's job. Their job is to make recommendations. If the vaccine is being used off-label, there was concern it wouldn't be paid for by health insurance, creating an access problem. As there were representatives at the meeting from America's Health Insurance Plans (AHIP), as well as Medicare and Medicaid, the panel was assured both private and public insurance would pay.

Does natural pertussis infection in childhood protect the next generation?

Published evidence reveals, **"[w]idespread pertussis outbreaks in children may reduce the risk of pertussis in infants when those children become parents."[i]** (Emphasis added). A paper published in "Vaccine" in 2021 explored the effect of outbreaks on future risk of infant death for the next generation. The authors noted that outbreaks in 2012 and other years resulted in infant deaths for those who were not yet of vaccination age (under 6 months). "As a result, in the last few years, recommendations for immunization in pregnancy have been introduced in several countries." The authors point out that the "immunological imprint" of outbreaks should be factored into the modeling and policymaking regarding boosters.

The propaganda of pertussis

Generally, we have social agreements about drugs and other products that are harmful. Cigarette smoking used to be fashionable, with even doctors promoting their favorite brands. But social consensus changed on the acceptability of smoking after a massive lawsuit brought against tobacco

industry leaders revealed information about the harms and dangers of cigarettes that had been deliberately hidden from the public.

Many people ask why doctors didn't know this.

One of the tactics used by the tobacco industry to conceal evidence that smoking caused cancer, lung disease, deaths, and more, was the creation of a false debate about the safety of the product. Tobacco leaders created and funded scientific research that was designed to publish statistics and peer reviewed papers taking the position that cigarettes were not dangerous. By occupying the field of "science," people of letters had debates.

Another tactic used was to apply the massive arm-twisting power the tobacco industry had with their advertising dollars. Cigarette advertisements were allowed only in print. The companies that sold tobacco also sold basic staple products for American households, like tomato sauce and toilet paper. If a publication wanted to run an article questioning the safety of cigarettes, they would also run the very real risk of losing their profits altogether, as *all* advertising dollars would be pulled for products that went well beyond cigarettes. Staying silent on the topic silenced debate and left Americans in the dark about dangers, which was exactly what the industry wanted so people would feel safe to buy their product.

These techniques were not limited to the tobacco industry. We've also learned that Coca-cola and other "Big Sugar" peddlers also created false debate about sugar and health, to keep public perception of their product positive or positively confused, which kept profits rolling in at the expense of the health of Americans.

You may remember a "big bad wolf" commercial that was made to scare older Americans into getting a booster or risk spreading pertussis to their infant grandchildren. It started out by saying "There's something out there," while tense music played in the background and a car zoomed along a grey winter landscape.

Fear is a powerful motivator. Governments know it. Marketers know it. But most people underestimate its potency. Interestingly, there's a class action lawsuit in federal court right now claiming this was false advertising that prompted older Americans to take a shot they wouldn't have otherwise gotten. Despite knowing that the Boostrix vaccine would not stop the possibility of transmission of pertussis to infants, the manufacturer played on the public's fear to get shots in arms.[i]

Dr. Suzanne Humphries and researcher Roman Bystrianyk noted in their book "Dissolving Illusions," that the CDC and many medical doctors openly use fear as a way to increase vaccine uptake. We saw that in the ACIP discussion about the Tdap for pregnancy when one member graphically said pregnant women would get the shot once they saw the choice as vaccine or "dead baby." Humphries and Bystrianyk state, "Portraying disease as severe, whether it is or not, is admittedly done because it helps to increase vaccine uptake." The book cites a CDC power point presentation from 2004 that promotes influenza vaccines with this tactic and points out it happens with pertussis as well.[ii] "If whooping cough was perceived as a less severe disease, it might have a negative effect on vaccination uptake. If more people understood that the incidence of whooping cough has increased with increasing vaccines, bacterial resistance is emerging, and there is a nontoxic treatment available, surely vaccine uptake would decline further."

The book quotes a published article from the federal National Vaccine Advisory Committee from 1998:

“Collaboration and cooperation of government agencies, such as NIH, CDC, FDA, USAID, DOD, large vaccine companies, small research companies, and academia are essential to continue success and fulfill the promise of recent advances in science and technology.

Threats to any part of the delicate vaccine research and development network jeopardize the rapid development and supply of new lifesaving and life-enhancing vaccines for the American people.”[iii]

The fact that “messaging” about vaccines is a part of the discussion at all at the level of government health policy, and the subject of discussion and publication among doctors speaks for itself. If a product works and is safe, we would not need to use fear to bully people into taking it.

“Doctors do not receive unbiased information in medical school or during their careers. In order for doctors to learn the full truth, they have to seek it and then deal with the resultant cognitive dissonance. It is very difficult to continue practicing medicine under conventional dictates once that truth is accepted.”[iv]

Finally, doctors are invested financially, emotionally, and psychologically in the products they use, prescribe, and promote. They’ve spent hundreds of thousands of dollars on their education, and untold grueling hours studying, researching, and learning through the ritual of residency. To be initiated into the profession, they swear to abide by ethical codes. (Interestingly, the Hippocratic Oath is not used universally,[v] and does not include the well-known phrase “first, do no harm,” as explained on the Harvard Health Blog in 2020.[vi])

“Dissolving Illusions” notes that “Most medical experts continued to ignore these reports and insisted that the vaccine only rarely led to neurologic problems. To them, any encephalopathy was thought to be a mere coincidence that would have occurred even without the vaccine. Most authorities concluded that permanent brain damage as a result of DTP was a myth. **As had occurred with smallpox vaccine years earlier, there was a medical bias against admitting that a heavily promoted medical procedure was actually harmful**.” (emphasis added).

The problem? Parents rely on doctors to think critically and have the best information. But we have evidence that shows us the government will use fear to motivate more shots and will hide information that would decrease shots.

This very point came up in 1985 when lawmakers were deciding what to do about the rapidly increasing costs in life and in dollars resulting from injuries from DPT vaccines. They had already seen a number of manufacturers fold after similar litigation from polio vaccines. Their priority was to continue the vaccine program, but as they relied on private companies to manufacture them, the government had to make sure the companies would make a profit. The only way to do that was to remove the possibility of lawsuits.

The federal government held many hearings on the matter. One focused on “whether approval by the federal government means that a vaccine is, in effect, as safe as it could be.”[vii]

Dissatisfied Parents Together and the 1986 Act

When a child is injured by a vaccine, what happens next?

Who holds responsibility for the care of that child and the expense of that care?

Who should?

In the U.S., parents are told vaccines are “safe and effective.” We are told vaccine injuries are one in a million. We are told we must vaccinate our children for the good of all children — the “greater good.”

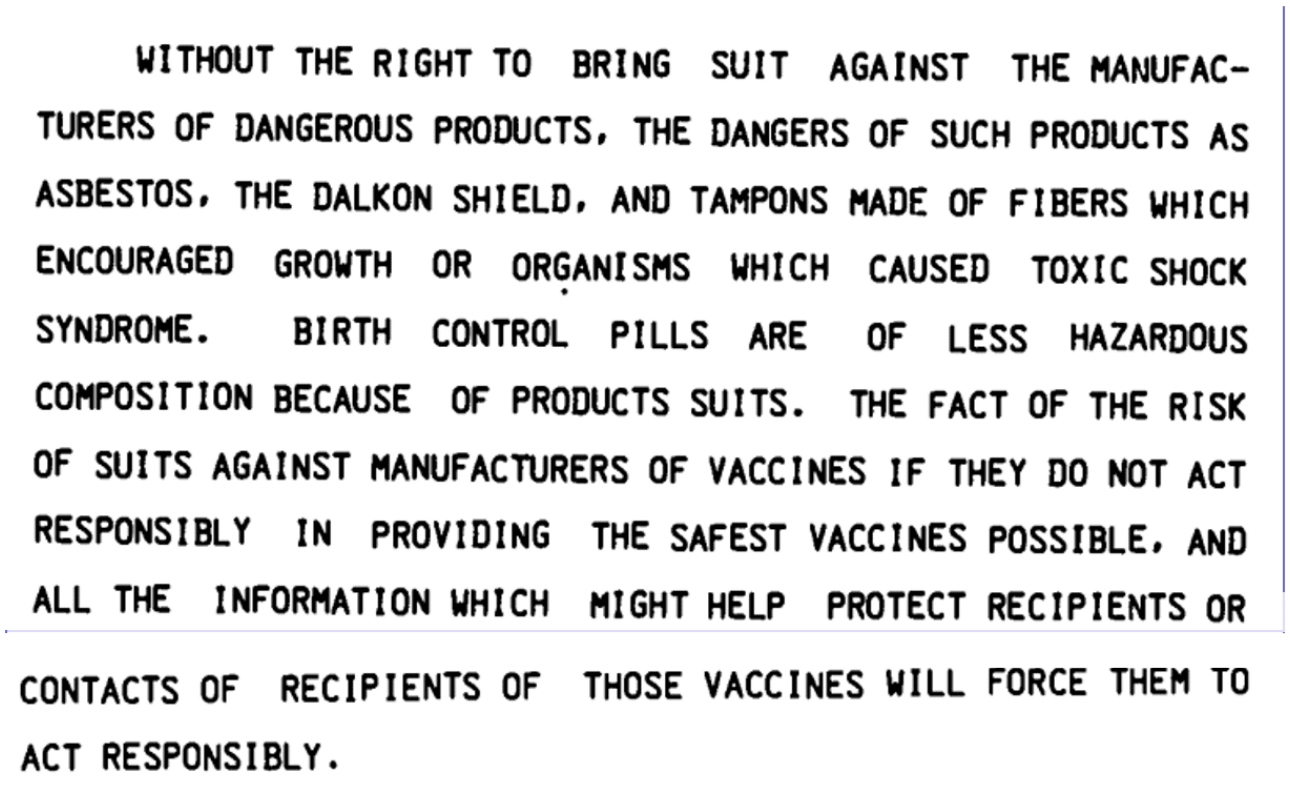
“It never crossed my mind that a vaccine that was supposed to keep healthy children healthy, would ever, in a million years, be able to brain damage or kill them.” Barbara Loe Fisher co-founder of National Vaccine Information Center, made this declaration in a recent documentary, “1986 The Act.”

Before 1986, parents answered that question by suing vaccine manufacturers. And they won. They won over and over again. Companies went out of business or dropped the vaccine product from their portfolio.

Why is trial by jury so important that it was enshrined in the Bill of Rights as the Seventh Amendment? The court system is the last bastion of freedom in our democratic republic. It is essential to our “free market” as well. When a product is so dangerous that the cost of compensating people who are injured eclipses the profits, that unsafe product will be pulled from the market. This is exactly what was happening with vaccines. The “unavoidably unsafe” products were unprofitable and unsustainable to produce because of how much they cost. The system was working. And then it was crippled.

What happens to informed consent when parents aren’t given all the information they need, risks are sugar coated, and we’re convinced we’ll harm others if we don’t go along?

One of the greatest harms of the vaccine court is everything is done under seal. The public can get raw statistics from HRSA about how many cases have been filed, how many compensated, and how much money has been awarded. However, in this no-fault system, neither the company nor the government are held accountable for anything and the public cannot read opinions or gain access to expert witness reports.


WITHOUT THE RIGHT TO BRING SUIT AGAINST THE MANUFAC-
TURERS OF DANGEROUS PRODUCTS, THE DANGERS OF SUCH PRODUCTS AS
ASBESTOS, THE DALKON SHIELD, AND TAMPONS MADE OF FIBERS WHICH
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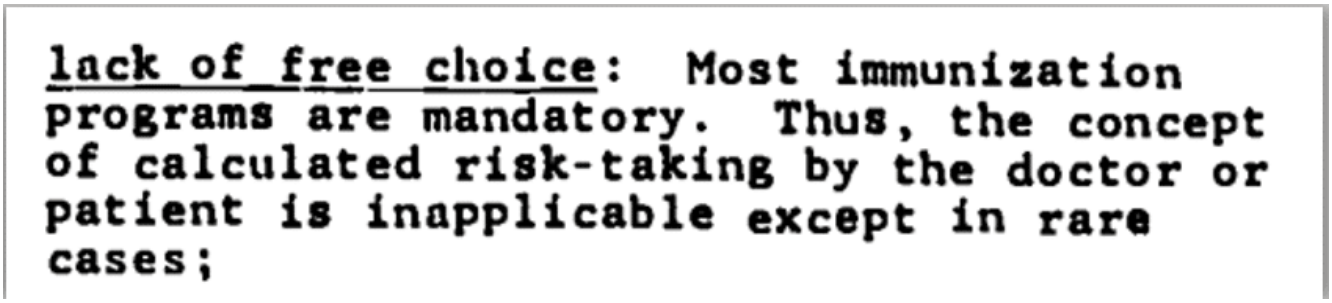
OF SUITS AGAINST MANUFACTURERS OF VACCINES IF THEY DO NOT ACT
RESPONSIBLY IN PROVIDING THE SAFEST VACCINES POSSIBLE, AND
ALL THE INFORMATION WHICH MIGHT HELP PROTECT RECIPIENTS OR
CONTACTS OF RECIPIENTS OF THOSE VACCINES WILL FORCE THEM TO
ACT RESPONSIBLY.

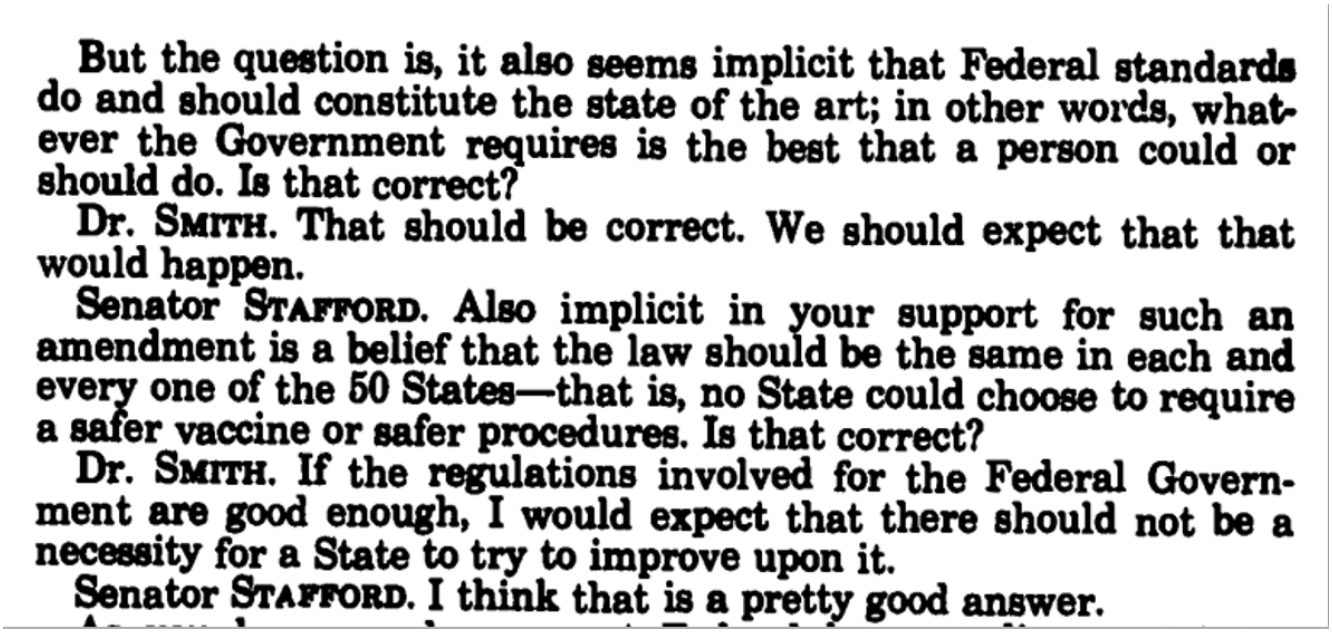
Congress acknowledged that there was a “lack of free choice” when it came to vaccines because of school and other mandates.[i] “Thus, the concept of calculated risk-taking by the doctor or patient is inapplicable except in rare cases.” In other words, our lawmakers acknowledged that parents are not able to give informed consent to vaccines because of mandates.



lack of free choice: Most immunization programs are mandatory. Thus, the concept of calculated risk-taking by the doctor or patient is inapplicable except in rare cases;

There was much discussion about the fact that the pertussis combination vaccines could either be done quickly or they could be done safely, but not both. The safer vaccine was, of course, more expensive and time-consuming to produce. (It makes one think of Albert Sabin’s objections to the killed polio injection vaccine that ended up injuring many, while he toiled away at an oral vaccine that was ultimately accepted as safer and more effective.)

Throughout the hearing, it was pointed out that Americans are trusting the government to keep them safe, especially in a situation where they’re expected to give up their choice in the matter.



But the question is, it also seems implicit that Federal standards do and should constitute the state of the art; in other words, whatever the Government requires is the best that a person could or should do. Is that correct?

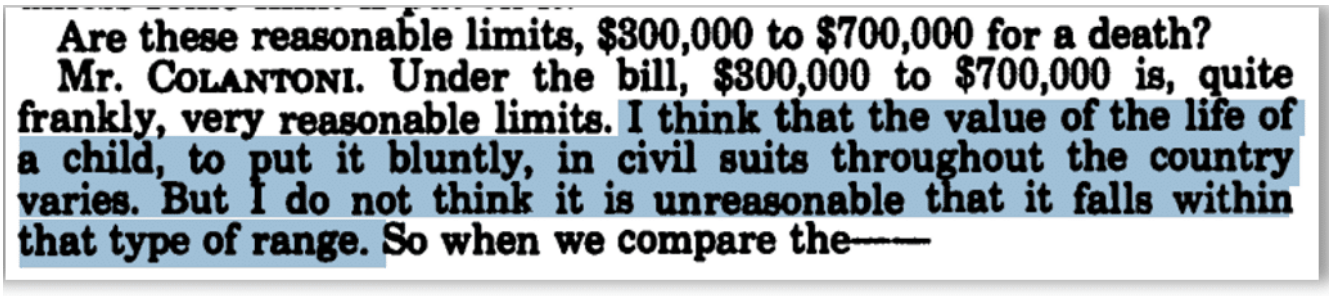
Dr. SMITH. That should be correct. We should expect that that would happen.

Senator STAFFORD. Also implicit in your support for such an amendment is a belief that the law should be the same in each and every one of the 50 States—that is, no State could choose to require a safer vaccine or safer procedures. Is that correct?

Dr. SMITH. If the regulations involved for the Federal Government are good enough, I would expect that there should not be a necessity for a State to try to improve upon it.

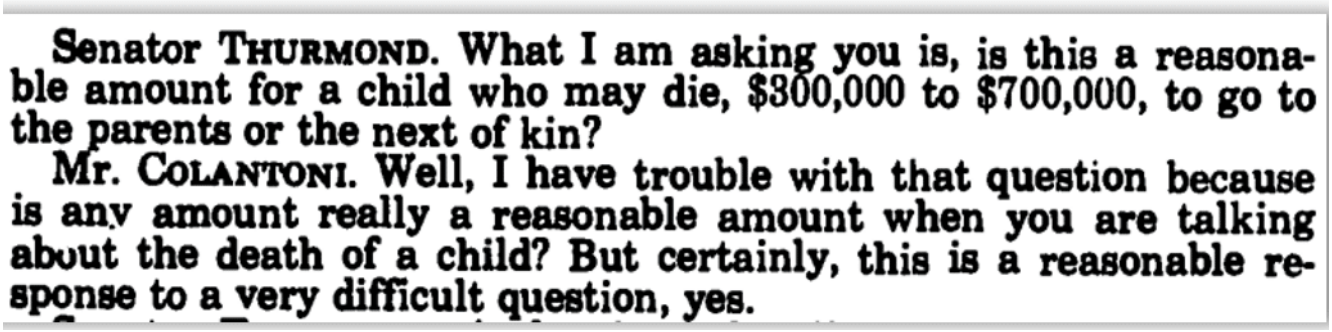
Senator STAFFORD. I think that is a pretty good answer.

One way the lawmakers wanted to lower costs associated with the vaccine when harm happened was to cap the payments made to families when their children died from the vaccine.



Are these reasonable limits, $300,000 to $700,000 for a death?

Mr. COLANTONI. Under the bill, $300,000 to $700,000 is, quite frankly, very reasonable limits. I think that the value of the life of a child, to put it bluntly, in civil suits throughout the country varies. But I do not think it is unreasonable that it falls within that type of range. So when we compare the——



Senator THURMOND. What I am asking you is, is this a reasonable amount for a child who may die, $300,000 to $700,000, to go to the parents or the next of kin?

Mr. COLANTONI. Well, I have trouble with that question because is any amount really a reasonable amount when you are talking about the death of a child? But certainly, this is a reasonable response to a very difficult question, yes.

Source 1: 1985 Senate Hearing on how best to compensate victims of vaccine injury (which ultimately led to the 1986 Act that created "Vaccine Court." https://files.eric.ed.gov/fulltext/ED273589.pdf

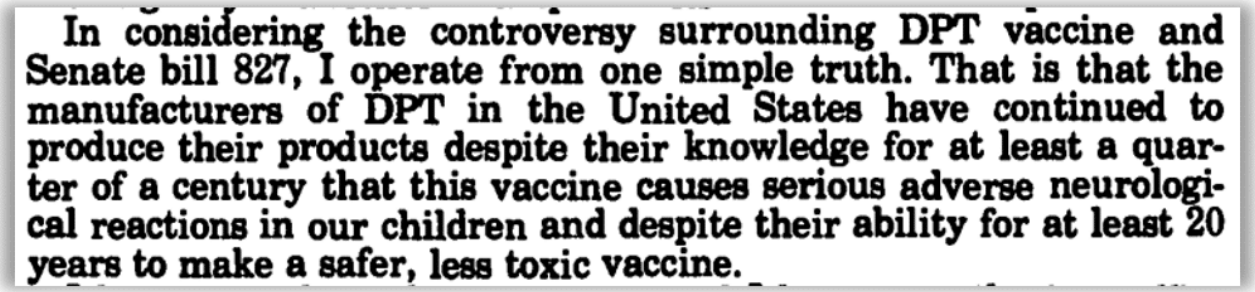
Congress ultimately decided to lower the value of the life of a child to $250,000, which is the statutory limit to an award that can be made to the family of a child who has died because of a vaccine.

Conclusion

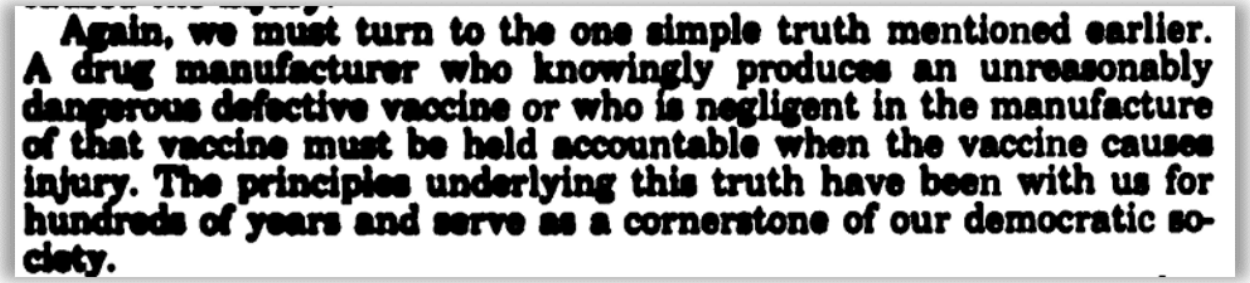
Given the fact that this triple-shot is recommended for pregnant women and for our youngest children *five* times before a child's second birthday, we can assume it is one of the most thoroughly tested and vetted and safe vaccines on the schedule, right?

History tells a different story.

One attorney who offered testimony at the 1985 congressional hearing noted above summed up the situation this way:



In considering the controversy surrounding DPT vaccine and Senate bill 827, I operate from one simple truth. That is that the manufacturers of DPT in the United States have continued to produce their products despite their knowledge for at least a quarter of a century that this vaccine causes serious adverse neurological reactions in our children and despite their ability for at least 20 years to make a safer, less toxic vaccine.



Again, we must turn to the one simple truth mentioned earlier. A drug manufacturer who knowingly produces an unreasonably dangerous defective vaccine or who is negligent in the manufacture of that vaccine must be held accountable when the vaccine causes injury. The principles underlying this truth have been with us for hundreds of years and serve as a cornerstone of our democratic society.

Steps you can take

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Step One: Keep the spotlight on free speech. Our U.S. House of Representatives is exposing the corruption that ran rampant in COVID policy. Our petition to support them in their fight to protect speech (and, by proxy, informed consent) is at 16,899 signatures at publication of this article. Can you help us make it to 20,000 to let our lawmakers know we are standing with them? Please sign and share!

Sign the petition
N

Step Two: We at Stand for Health Freedom are so grateful to be able to bring you content and action items that can help America protect health freedom. But we can't do it without you. Please consider a donation so we can ramp up and amplify the health freedom message! Your dollars will fund the shots series like you read above, a new podcast, and boots on the ground to protect health freedom at home in individual states (which is where health decisions should stay). Thank you! (Pssst — sharing is free! Please share our work widely to keep shining a light on health freedom.)

Donate today

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