



**WHITE PAPER**  
**Briefing President-Elect Donald J. Trump On Vaccination Policy**  
**Vaccine Risks and Informed Consent**

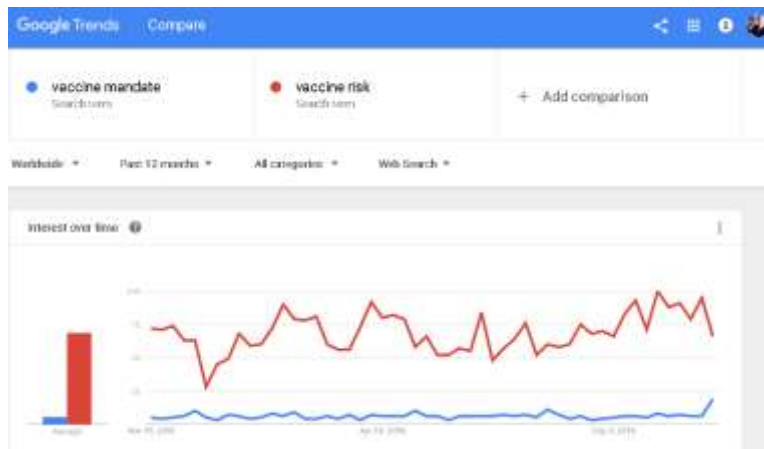
**INTRODUCTION**

**“The sky is blue, the science is settled, vaccines work.” Hillary Clinton**  
**“Whenever ‘The Science is Settled’ it has become a false dogma.**  
***Where there is Risk there must be Consent.*” Rima Laibow, M.D.**

**The Institute for Health Research and the Natural Solutions Foundation have prepared this private briefing dossier for the Trump Transition Team.<sup>1</sup>**

**Public policy issues regarding vaccination continue to attract strong public interest. President-Elect Trump has expressed a vigorous skepticism regarding the claims of the Pharmaceutical Industry regarding the safety and effectiveness of these drugs. His unsuccessful Presidential opponent has long been a strong proponent of mandatory mass vaccination. The relationship between autism and vaccination requires attention.**

**Google Trends indicates the strong continued interest in the issue.**



White Paper posted at: [http://drrimatruthreports.com/wp-content/uploads/Trump.Vax\\_.WhitePaper.11.11.16.pdf](http://drrimatruthreports.com/wp-content/uploads/Trump.Vax_.WhitePaper.11.11.16.pdf)

**This White Paper addresses two primary questions and offers Policy Recommendations:**

- 1. Are vaccines safe and effective? [Page 2]**
- 2. Do vaccine mandates violate the universal right of Informed Consent? [Page 22]**
- 3. Conclusions & Recommendations [Page 30]**

**Summary --This White Paper takes the following positions:**

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<sup>1</sup> Inspired by a discussion with people at Alex Jones' Infowars.



**WHITE PAPER**  
**Briefing President-Elect Donald J. Trump On Vaccination Policy**  
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**Vaccination, an uninsurable risk, has been declared by courts to be “unavoidably unsafe.”**

**Vaccine mandates impose unconstitutional conditions, violating the protected right of Informed Consent.**

**Policy Recommendations proposed by this White Paper:**

- [1] Stop all Federal Funding for vaccine mandates.**
- [2] Require that CDC Vaccine Committee members be free of all conflicts of interest; end pharmaceutical company tort liability exemption and the Vaccine Injury Compensation Program (VICP).**
- [3] Adopt the proposed Freedom of Informed Refusal of Medication (FIRM) Act.**
- [4] Encourage Alternatives to Vaccination: a Normal Immune System**

**SECTION ONE: VACCINE SAFETY**

**Decisions Flow Downstream**

**Decisions made by regulators flow downstream to public health officials, medical administrators and, ultimately, to the clinicians - physicians and other health professionals - who put those decisions into action.** Public health system-wide decision making, like clinical decision-making, while informed by both scientific and resource management considerations is, in the modern world, often predicated upon political and commercial decisions. The actual experience of health care providers is marginalized, leading, in the case of vaccination pseudo-science, to horrific outcomes, including mass infertility and extraordinary increases in preventable chronic diseases and medical conditions such as autism.

**Decision-Making: Vaccination**  
**Government Statistics Demonstrated That**  
**Hygiene, Sanitation and Better Nutrition**  
**Ended the Pandemic Diseases *Prior to Vaccination!***

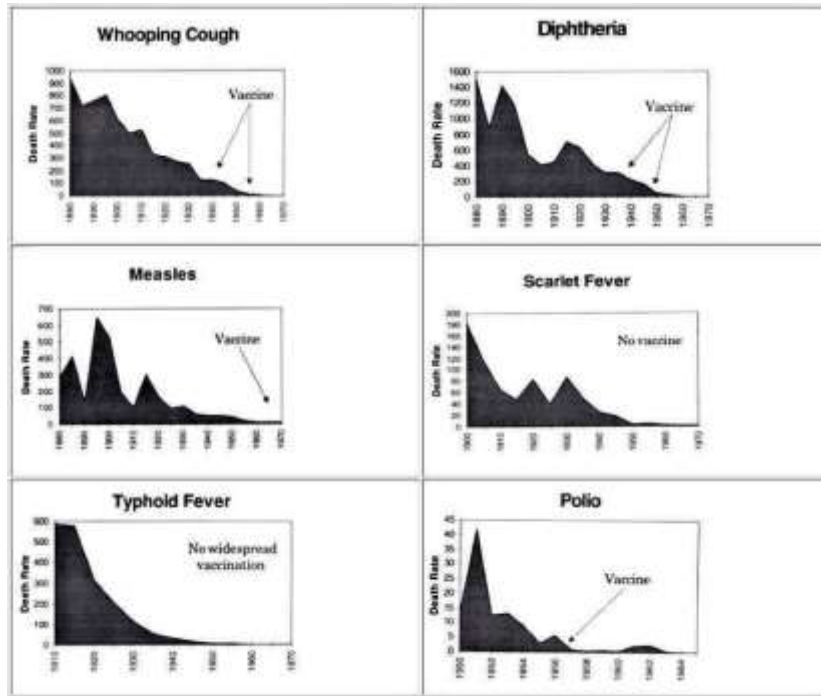
We illustrate the magnitude and gravity of the problem by examining in some detail the emotionally fraught subject of vaccines and vaccinations.

**Human survival moved along without vaccines for virtually our entire history on this planet.**

**WHITE PAPER**  
**Briefing President-Elect Donald J. Trump On Vaccination Policy**  
**Vaccine Risks and Informed Consent**

Happily, infectious disease incidence as well as morbidity and mortality consistently declined sharply and steadily as clean water, sufficient nourishing food and hygienic practices which promote general and specific health became widely available *prior* to the introduction of vaccines.

Because excellent government records were kept in Western Europe before they were available in North America, our discussion will lean heavily on those data. The influence of the United States’ “science”, regulatory practices and clinical programs looms so large around the world that it, too, is deeply illustrative of the point: enormous amounts of resources, including human ones, when Big Pharma controls regulation (and thereby clinical practice) rather than the reverse.



**Vaccines: Safe, Efficacious and Cost Effective?**

**As with any public health intervention, in order for vaccines to be considered as a meaningful public health measure, they must be safe, efficacious and cost effective. In fact, that standard is established by US statute.**

Few other public health interventions involve such vast amounts of money in or profit out to the purveyors of the innovation as vaccines *yet not one single vaccine which has ever been approved and deployed in the United States meets that level of proof on any of these parameters.*

Manufacturers and purveyors are assured of vast profits from a combination of government development and purchase grant support, total legal protection from tort liability (although vaccines share the status of “uninsurable risk” with only one other category of industrial activity: nuclear power plants), financial reward to the purveyors and financial reward through any “after-market”

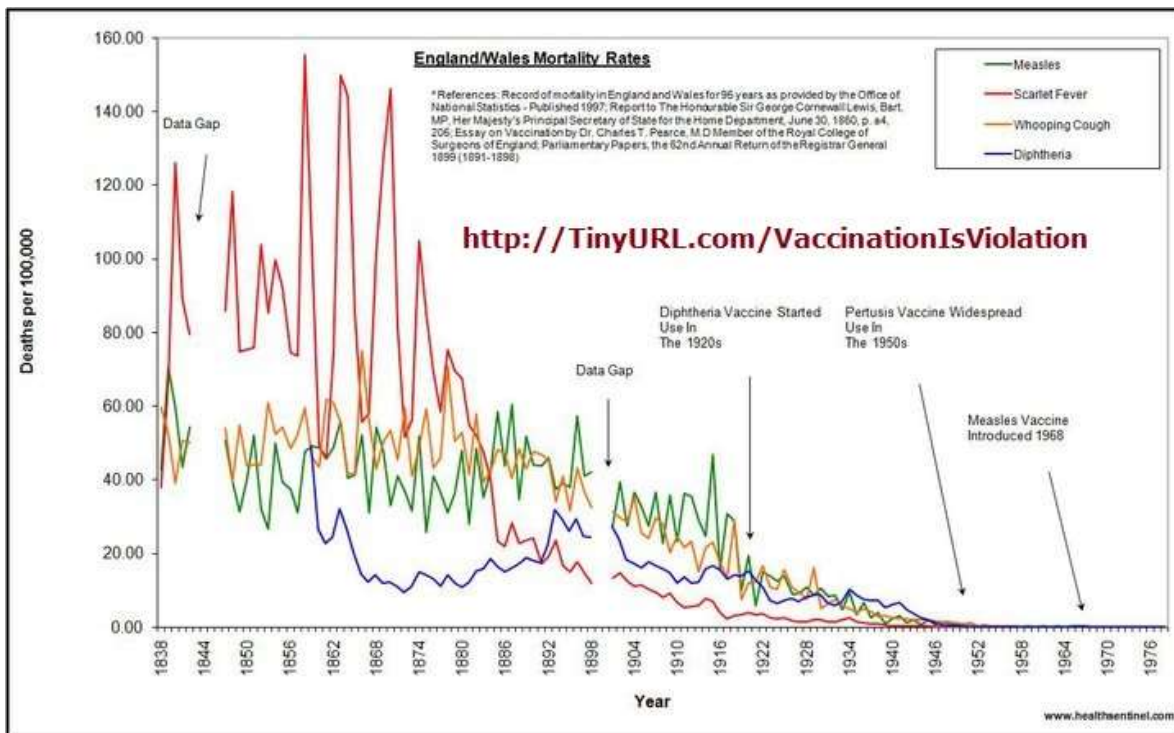
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**Briefing President-Elect Donald J. Trump On Vaccination Policy**  
**Vaccine Risks and Informed Consent**

benefits such as vaccine-related illnesses like leukemia and other cancers, infertility, autism, Alzheimer’s Disease, Diabetes, etc., which increase the pharmaceutical profit picture dramatically. Few other public health interventions have been the subject of such prolonged and intense professional and public relations brainwashing, leading to high tempers, righteous and wrathful indignation and a general substitution of passion for level-headed analysis on the part of regulators, journal editors, “medical ethicists” and reviewers and their downstream information recipients - doctors, other health professionals and the general public- around the topic.

**Part of the efficacy debate rests on the compelling argument that we are safer now from morbidity and mortality from infectious diseases since the introduction of vaccines. If that were true, there might be a reason to consider vaccination for the population. However, the facts belie this glib assumption since *every disease for which vaccines are used was in sharp decline as populations moved to modern sanitation and adequate food before the introduction of the disease specific vaccine* presenting an alleged prevention or remedy for it.**

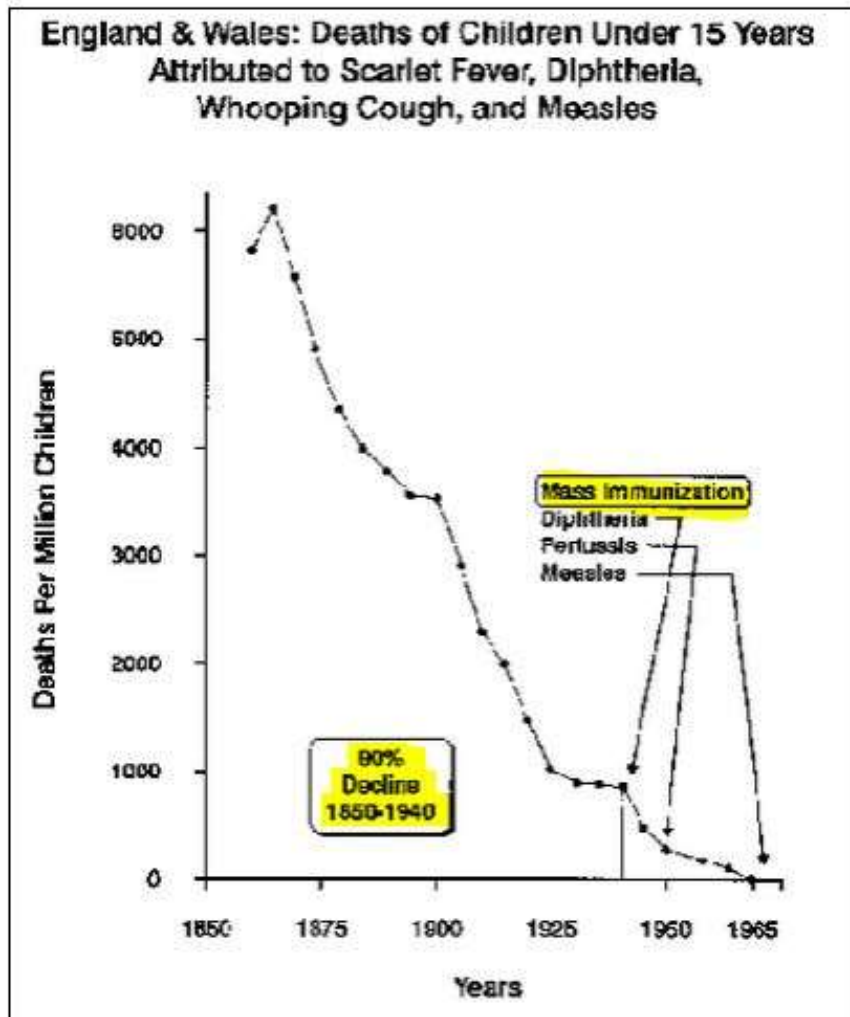
Consider the following examples:

**Overall Disease Incidence/ Vaccine Relationship**



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**Briefing President-Elect Donald J. Trump On Vaccination Policy**  
**Vaccine Risks and Informed Consent**

**Table 1: Deaths of Children Under 15 Years (England & Wales)**

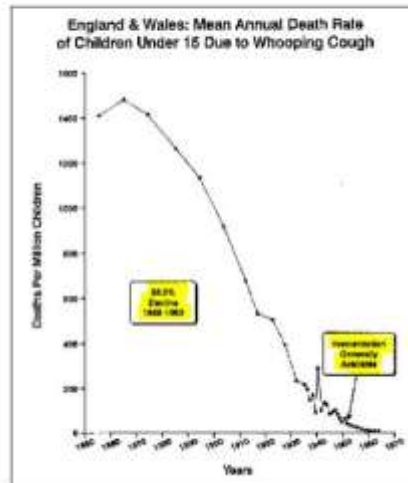


**In England and Wales child mortality declined by 90% from the combined infectious diseases of scarlet fever, diphtheria, whooping cough and measles during the 90 years from 1850 - 1940. The first vaccine made available for diphtheria was in the early 1940's, whereas the pertussis (whooping cough) vaccine became available in the early 1950's and the measles vaccine in the late 1960's (no vaccine was ever provided for scarlet fever).<sup>2</sup>**

<sup>2</sup> <http://www.whale.to/vaccines/decline1.html> citing [Immunization Graphs: Natural Infectious Disease Declines; Immunization Effectiveness; and Immunization Dangers Prepared by: Raymond Obomsawin Ph.D. 2009](#)

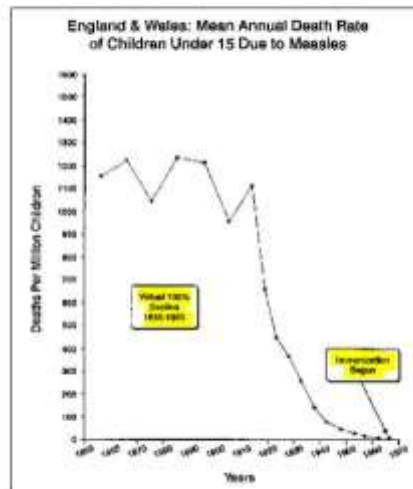
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**Briefing President-Elect Donald J. Trump On Vaccination Policy**  
**Vaccine Risks and Informed Consent**

Table II: Whooping Cough (England & Wales)



The annual pediatric death rate of children under age 15 from whooping cough in England and Wales declined by roughly 98.5% in the period covering 1868 to 1953, when the pertussis vaccine became generally available.<sup>3</sup>

Table III: Measles (England & Wales)



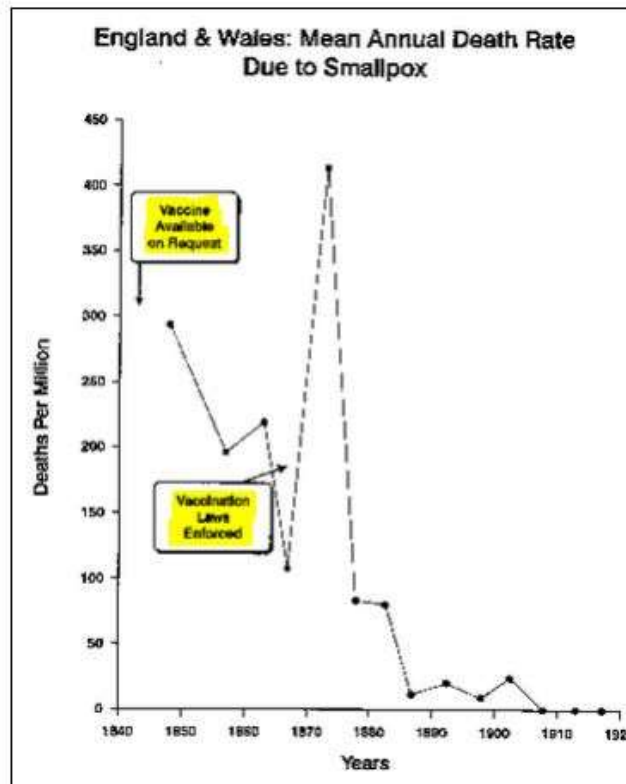
The annual death rate of children (under age 15) from measles in England and Wales declined

<sup>3</sup> <http://www.whale.to/vaccines/decline1.html> loc. cit.

**WHITE PAPER**  
**Briefing President-Elect Donald J. Trump On Vaccination Policy**  
**Vaccine Risks and Informed Consent**

from over 1,100 per million in the mid-nineteenth century, to virtually 0 by the mid 1960's prior to immunization.<sup>4</sup>

Table IV: Smallpox (England & Wales)



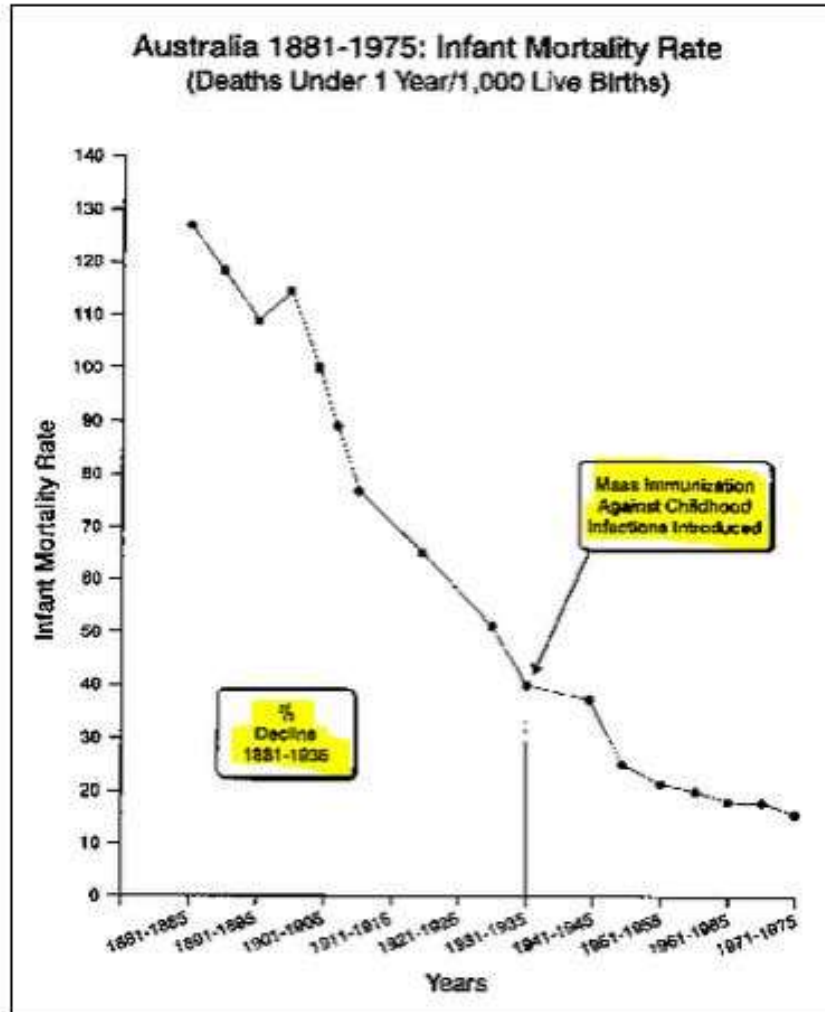
There was a continuing decline in the annual death rate from smallpox in England and Wales with a reduction in mortality of roughly 300 per million to virtually 0 in the 60 year period following the middle of the 19<sup>th</sup> century. This table further illustrates that the progressive rate of decline was severely disrupted—with a roughly 275% increase in mortality from the disease—occurring immediately after smallpox vaccination laws were enforced by the British government.<sup>5</sup>

<sup>4</sup> <http://www.whale.to/vaccines/decline1.html> loc. cit.

<sup>5</sup> <http://www.whale.to/vaccines/decline1.html> loc. cit.

**WHITE PAPER**  
**Briefing President-Elect Donald J. Trump On Vaccination Policy**  
**Vaccine Risks and Informed Consent**

**Table V: Infant Mortality Rate (Australia)**



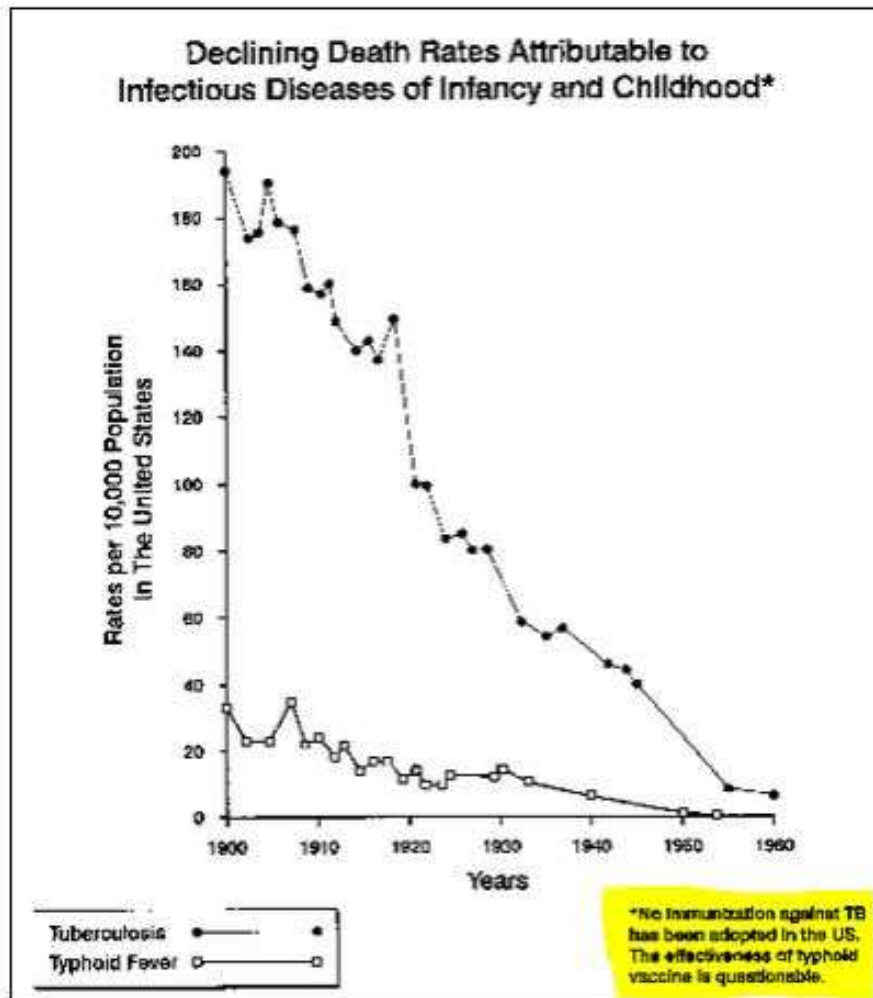
Approximately two thirds of the total decline in infant deaths from all childhood infectious diseases in Australia in the period covering 1881 to 1971 occurred before the introduction of mass immunization efforts.<sup>6</sup>

<sup>6</sup> <http://www.whale.to/vaccines/decline1.html> loc. cit.



**WHITE PAPER**  
**Briefing President-Elect Donald J. Trump On Vaccination Policy**  
**Vaccine Risks and Informed Consent**

**Table VI: Declining Death Rates (US)**

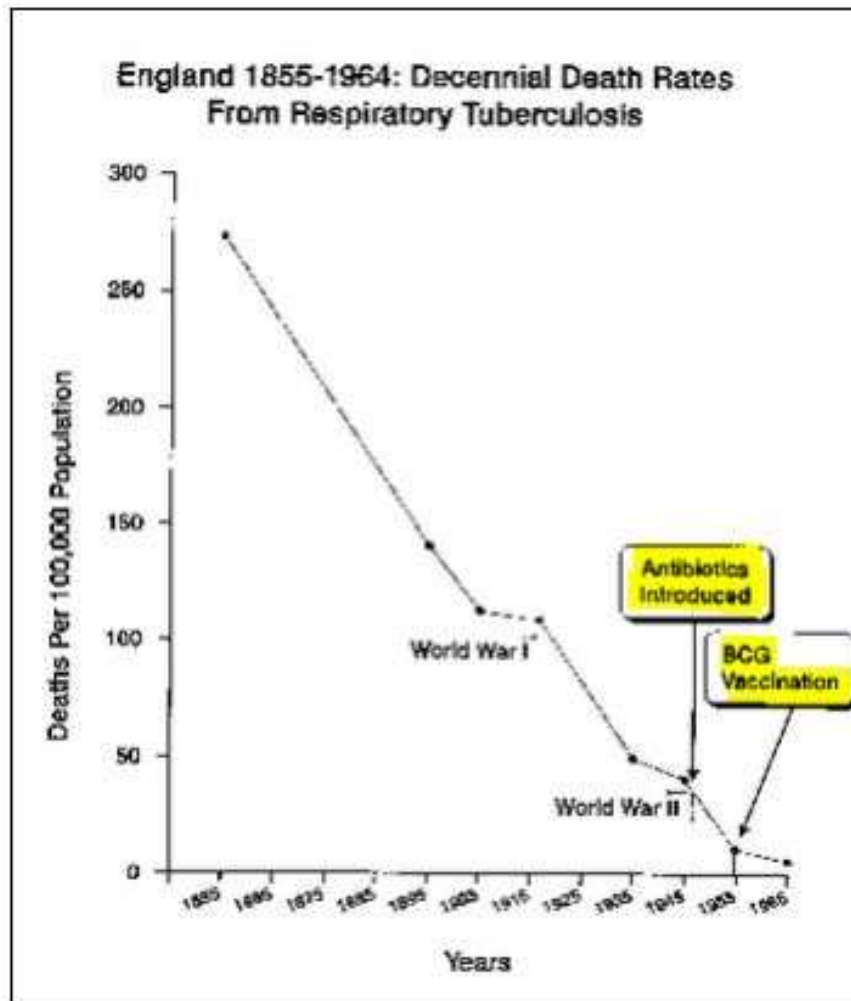


**In the United States—without benefit of any vaccine—the tuberculosis mortality rate underwent a drop of roughly 96% in the first 60 years of the 20<sup>th</sup> century and that in slightly less than the same time span (although the effectiveness of the vaccine has been seriously questioned by reputed scientists) mortality from typhoid vanished.<sup>7</sup>**

<sup>7</sup> <http://www.whale.to/vaccines/decline1.html> loc. cit.

**WHITE PAPER**  
**Briefing President-Elect Donald J. Trump On Vaccination Policy**  
**Vaccine Risks and Informed Consent**

**Table VII: Declining Death Rates (England)**



**Death rates from respiratory tuberculosis in England underwent a roughly 87% decline in the period between 1855 and 1947 when antibiotics first came into wide use. A further decline of nearly 93% by 1953 preceded the introduction of the BCG vaccine.<sup>8</sup>**

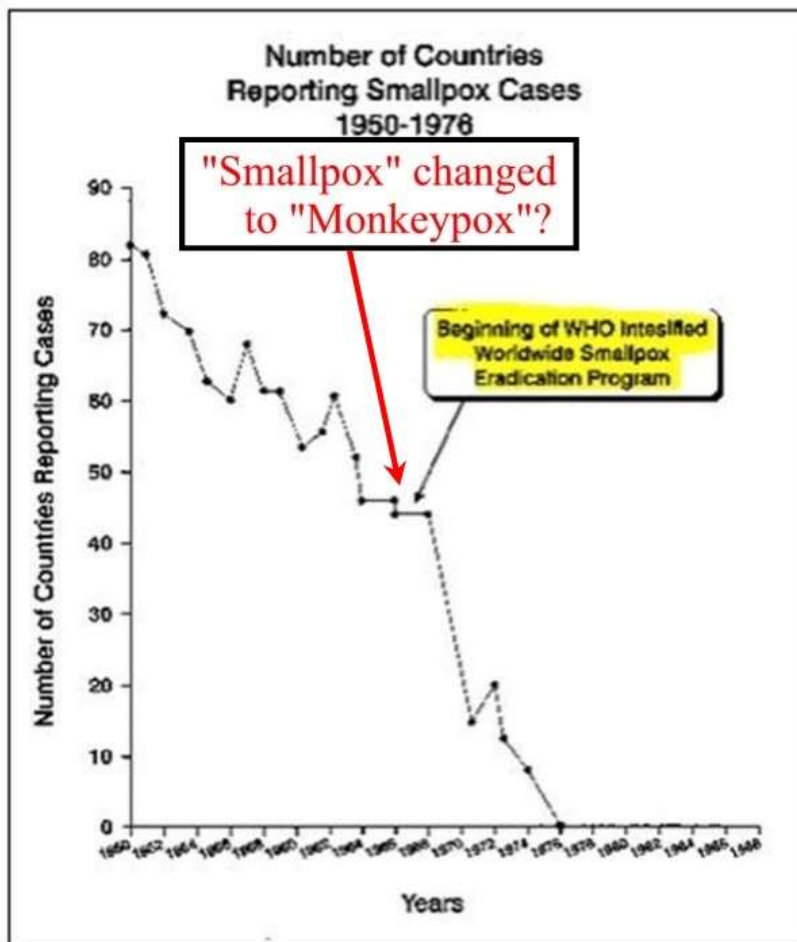
<sup>8</sup> <http://www.whale.to/vaccines/decline1.html> loc. cit.

**WHITE PAPER**  
**Briefing President-Elect Donald J. Trump On Vaccination Policy**  
**Vaccine Risks and Informed Consent**

**Disease Eradication: Do the Stars Still Shine So Bright?**

What of the shining stars of vaccine-based public health, smallpox and polio eradication?

**Table VIII: Number of Countries Reporting Smallpox**



During the 17 year period preceding the WHO Smallpox Eradication Program, a progressive



**WHITE PAPER**  
**Briefing President-Elect Donald J. Trump On Vaccination Policy**  
**Vaccine Risks and Informed Consent**

**drop to nearly one half occurred in the number of countries reporting smallpox morbidity.<sup>9</sup>**  
**In the following years, reported small pox cases rapidly dropped to zero.**

*This graph is quite literally, unbelievable.* There is good reason for that: although the official line is clear, as the Center for Global Development summarizes:

“Health Condition: In 1966, there were approximately 10 to 15 million cases of smallpox in more than 50 countries, and 1.5 to 2 million people died of the disease each year. Smallpox has been eradicated from the globe, with no new cases reported since 1978....

“Impact: By 1977, the last endemic case of smallpox was recorded in Somalia. In May 1980, after two years of surveillance and searching, the World Health Assembly declared that smallpox was the first disease in history to have been eradicated....

Cost and Cost-Effectiveness: The annual cost of the smallpox campaign between 1967-1979 was US\$23 Million.<sup>10</sup> In total, international donors provided US\$98 Million, while US\$200 million came from the endemic countries. The US saves the total of all its contributions every 26 days because it does not have to vaccinate or treat the disease.”<sup>11</sup>

If the official line, that small pox had actually been eliminated, were true, then there are significant unintended negative consequences since that would mean that community immunity has been eliminated, too, with serious negative consequences. “Smallpox eradication had limited economic consequences but has left much of world’s population highly susceptible to zoonotic orthopoxviruses and to the use of smallpox as a biologic weapon.<sup>12</sup>

However, the official reality is much less clear. Smallpox was, in fact, never eradicated despite huge propaganda and financial expenditure to the contrary. Its name was changed to protect the guilty.

**Monkey Pox was first identified in humans in 1970. The two orthopoxviruses are 96.3% identical, although some differences do exist in their genomes.<sup>13</sup>**

Monkey pox and smallpox are clinically similar so that without sophisticated laboratory equipment, the discrimination between their causative pathogens is not possible and, following official pronouncements that smallpox has been eradicated the clinician was – and is- under informational and political pressure to “see”, and therefore diagnose, monkey pox, not smallpox.

Thus, cases of smallpox are now either intentionally or unintentionally misdiagnosed as monkey pox.

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<sup>9</sup> <http://www.whale.to/vaccines/decline1.html> loc. cit.

<sup>10</sup> Total cost not adjusted either for inflation or ancillary costs of adverse events, etc., \$2.76 billion in unadjusted US dollars.

<sup>11</sup> <http://www.cgdev.org/page/case-1-eradicating-smallpox>

<sup>12</sup> <http://www.ncbi.nlm.nih.gov/pubmed/10681974>

<sup>13</sup> <http://www.ncbi.nlm.nih.gov/pubmed/11734207>



**WHITE PAPER**  
**Briefing President-Elect Donald J. Trump On Vaccination Policy**  
**Vaccine Risks and Informed Consent**

Despite laboratory confirmation that smallpox cases persist, diagnostic reporting was altered to implicate monkey pox instead of the true pathogen, smallpox. Thus the smallpox eradication campaign continues to be presented as a resounding success when it was, in fact, no such thing.

The New England Journal of Medicine reported, “A joint team from the WHO and the Democratic Republic of the Congo visited the province of Kasai Oriental and concluded that 511 cases of suspected monkey pox had occurred between February 1996 and October 1997. **Laboratory studies have since revealed that a substantial proportion of the suspected cases were actually cases of varicella;**” [Emphasis added – REL]<sup>14</sup>

Thus, smallpox/monkey pox is a prime example of how regulatory decisions are misinformed by self-serving pseudo-science to the detriment of meaningful health care.

**What of Polio?**

Here is the official line from the CDC:

“Polio incidence has dropped more than 99 percent since the launch of global polio eradication efforts in 1988. According to global polio surveillance data from January 21, 2015, 356 polio cases have been reported to date in 2014 from Afghanistan, Cameroon, Equatorial Guinea, Ethiopia, Iraq, Nigeria, Pakistan, and Syria. So far in 2015, 1 case has been reported from Pakistan.

On March 27, 2014, Dr. Frieden<sup>15</sup> and senior CDC immunization staff were present when India, along with the other 10 countries of the South East Asia Region, was certified polio-free. The country was once considered the most complex challenge to achieving global polio eradication. Four of the six regions of the World Health Organization have been certified polio-free: the Americas (1994), Western Pacific (2000), Europe (2002) and South East Asia (2014). 80% of the world’s people now live in polio-free areas.

While no polio cases have been detected in India for more than three years, poliovirus transmission is ongoing in the three endemic countries – Afghanistan, Nigeria, and Pakistan.<sup>16</sup>

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<sup>14</sup> <http://www.nejm.org/doi/full/10.1056/NEJM199808203390811>

<sup>15</sup> Current Director of CDC

<sup>16</sup> <http://www.cdc.gov/polio/updates/>

**WHITE PAPER**  
**Briefing President-Elect Donald J. Trump On Vaccination Policy**  
**Vaccine Risks and Informed Consent**



Non Polio Acute Flaccid Paralysis (NPAFP) is characterized by weakness, paralysis and sudden onset in children under 15 years of age

The truth, which you in India know far better than the rest of the world, is that a “new” condition, Non-Polio Acute Flaccid Paralysis (NPAFP), has replaced polio as the diagnosis of choice following vaccination “against” polio and, in fact, **the incidence of NPAFP, which is twice as deadly as wild-type polio, has skyrocketed 12-fold BUT ONLY IN THOSE VACCINATED “AGAINST” POLIO.**<sup>17</sup>

**By 2012 it was clear that the \$8 Billion US polio eradication program had not only failed, it was a disastrous error causing incalculable human suffering and vast public health costs:**

“It is argued that getting poor countries to expend their scarce resources on an impossible dream over the last 10 years was unethical. Furthermore, while India has been polio-free for a year, there has been a huge increase in non-polio acute flaccid paralysis (NPAFP). In 2011, there were an extra 47,500 new cases of NPAFP. **Clinically indistinguishable from polio paralysis but twice as deadly, the incidence of NPAFP was directly proportional to doses of oral polio received.**”<sup>18</sup> [Emphasis added – REL]

**Keeping Up with the WHO/FDA/CDC Joneses**

Worse yet, the entire Indian polio eradication disaster was not even carried out because of India’s determination that the disease NEEDED to be eradicated. Professor William Muraskin, a specialist in international health policy and infectious disease, in *Polio Eradication and its discontents*, noted that the polio program was primarily designed to prove the fundamental usefulness of eradication as

<sup>17</sup> [http://www.naturalnews.com/035588\\_polio\\_vaccine\\_India\\_paralysis.html#](http://www.naturalnews.com/035588_polio_vaccine_India_paralysis.html#)

<sup>18</sup> <http://www.issuesinmedicaethics.org/index.php/ijme/article/view/110/1065>

**WHITE PAPER**  
**Briefing President-Elect Donald J. Trump On Vaccination Policy**  
**Vaccine Risks and Informed Consent**

a public health tool by the *Pan American Health Organisation* (PAHO) - the incubator of eradication campaigns<sup>19</sup>

An initial overseas grant of \$20 Million US launched the Indian Polio eradication program (“Pulse Plus”) in 1995<sup>20</sup> although public health experts in India felt that polio eradication was not the top priority for the country<sup>21</sup>.

In fact, in 1998, Dr T Jacob John wrote, “Today poliomyelitis is not the number one priority of public health in India. However, we must eradicate it for the sake of the rest of the world.”<sup>22</sup>

Keeping up with the CDC/WHO/FDA Joneses has had cataclysmic financial and human costs for India.

Having accepted the grant of \$20 million US, India had, by 2012, spent a hundred times as much<sup>23</sup>. What might she have accomplished with this vast sum of money were it wisely spent on meaningful health expenditures?



The oral polio vaccine is so easy to administer, even non-doctors can give it. Bill Gates administering the oral polio vaccine in India. 24

**In the 13 months before receiving its “Polio Free” status, 53,563 new cases of NPAFP were documented in India.**<sup>25</sup>

1. 19 Muraskin W. *Polio eradication and its discontents: an historian's journey through an international public health (un)civil war*. Hyderabad: Orient Blackswan. Forthcoming 2012 Aug.

20 Sathyamala C, Mittal O, Dasgupta R, Priya R. Polio eradication initiative in India: deconstructing the GPEI. *Int J Health Serv*. 2005;35:361-83.

21 <http://www.issuesinmedicalethics.org/index.php/ijme/article/view/110/1065>

22 John TJ. India's polio eradication efforts at the crossroads. *Indian Pediatr*. 1998;35:307-10.

23 <http://www.issuesinmedicalethics.org/index.php/ijme/article/view/110/1065>

24 <http://healthimpactnews.com/2014/the-vaccine-myth-of-polio-free-status-polio-vaccine-caused-53000-paralysis-victims-in-india-last-year/>



**WHITE PAPER**  
**Briefing President-Elect Donald J. Trump On Vaccination Policy**  
**Vaccine Risks and Informed Consent**

While the national rate of NPAFP in India is 13.7 per 100,000 children, where coverage is higher, the rate of NPAFP is correspondingly higher. 26,27

Polio vaccination coverage is highest in Uttar Pradesh and second highest in Bihar. The annualized NPAFP rate in Bihar is 21 per 100,000 and 34 per 100,000 children in Uttar Pradesh.28

**Vaccine manufacturers focus, incorrectly and, as we shall see, often disastrously, on the adaptive immune system (which they can manipulate and profit from) ignoring the vitally important innate immune system.**

“Worse, they wrongly claim that evidence of adaptive immunity based on “antibody titer” and/or other similar evidence can be used as a valid surrogate for proof that a given vaccination program provides disease protection to most of those inoculated with a given vaccine according to some fairly rigid, nationally recommended, vaccination schedule.” 29

The truth is that despite the gloss and puffery, claims of scientific validity for vaccine programs and schedules can neither be supported by science, by cost effectiveness nor by outcomes. In fact, mass vaccinations are a source not only of enormous profit for the companies and economic loss for the countries that support them, but they are a major preventable cause of suffering and death on a scale unprecedented except for armed hostile conflict.

Since the US experience is the one that I know best, and since the US syringe print on world vaccine policies and profits is so enormous, let me take a moment to provide some details of that system.

In the US, vaccines are regulated as drugs<sup>30</sup> which are declared to be safe as required by statute<sup>31</sup> which stipulates “The Secretary shall approve a biologics license application on the basis of a

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25 <http://healthimpactnews.com/2014/the-vaccine-myth-of-polio-free-status-polio-vaccine-caused-53000-paralysis-victims-in-india-last-year/>

26 Puliye J, Vashisht N, Sreenivas V. Trends In Non-polio Acute Flaccid Paralysis Incidence In India. WebmedCentral *plus* PAEDIATRICS 1970;-39(1):WMCPLS0035

27 NPAFP increased with the OPV doses used. ( $R^2=32.1\%$ ;  $P2=62.5$ ). Per capita income of the state, female literacy and overall literacy showed negative correlation with NPAFP. This disappeared in a multivariable analysis when the number of doses of OPV was considered. On multiple regression analysis, the number of OPV doses was the only factor that showed a positive correlation with the NPAFP rate. NPAFP in UP and Bihar decreased in 2012 coinciding with a reduction in OPV administered. Puliye J, Vashisht N, Sreenivas V. Trends In Non-polio Acute Flaccid Paralysis Incidence In India. WebmedCentral *plus* PAEDIATRICS 1970;-39(1):WMCPLS0035

28 <http://www.livemint.com/Politics/XS6vPor5jFX3vKkaE7Ri6H/India-to-get-polio-free-status-amid-rise-in-acute-flaccid-pa.html>

29 [http://dr-king.com/docs/20130501\\_Vaccines\\_The\\_Safest\\_of\\_Medicines\\_or\\_the\\_Biggest\\_Liequstn\\_e\\_b.pdf](http://dr-king.com/docs/20130501_Vaccines_The_Safest_of_Medicines_or_the_Biggest_Liequstn_e_b.pdf)

30 42 U.S.C. § 262(j)

Application of Federal Food, Drug, and Cosmetic Act The Federal Food, Drug, and Cosmetic Act [21 U.S.C. 301 et seq.] applies to a biological product subject to regulation under this section, except that a product for which a license





**WHITE PAPER**  
**Briefing President-Elect Donald J. Trump On Vaccination Policy**  
**Vaccine Risks and Informed Consent**

demonstration that the biological product that is the subject of the application **is safe, pure, and potent**; and ...”[Emphasis added – REL]

**Critical to the issue, of course, is what “safety” means. FDA relies on the following definition of safely, “... the relative freedom from harmful effect to persons affected, directly or indirectly, by a product when prudently administered, taking into consideration the character of the product in relation to the condition of the recipient at the time”<sup>32</sup>**

Despite the clear statutory requirement for safety, potency and purity imposed on the regulatory agencies, these requirements are consistently not met and, in fact, vaccines are routinely recommended by the Center for Disease Control’s Advisory Committee on Immunization Practices (ACIP) even when there is no evidence that any vaccine approved and deployed by the US meets the applicable requirements for safety NOR that it prevents the disease in question from developing in fully vaccinated populations.

Even when vaccines have been shown to fail to provide any protection for those who are fully vaccinated, as in the case of pertussis and influenza<sup>33</sup>, or viral influenza<sup>34</sup> the policy of policy makers is to add more doses of the ineffective vaccine without regard to any parameters of cost to the public as so-called “booster shots” so that even if the initial vaccination program were cost-effective, the addition of any booster clearly renders it much less cost-effective or, more often, non-cost-effective.<sup>35</sup>

Additional segments of the population are brought under the vaccination schedule banner and exposed to unsafe and unnecessary vaccinations. The population, including pregnant women, the elderly and babies, provide market support to manufacturers for vaccines while vaccines provide immune and toxic assaults to the population.

Physicians and public health officials generally rely upon and trust the legality and logic of the recommendations handed down from central authorities without examining the basis, or lack thereof, upon which those recommendations rest.

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has been approved under subsection (a) shall not be required to have an approved application under section 505 of such Act [21 U.S.C. 355]

31 42 U.S.C. § 262(a)(1)(C)(i)(I), emphasis added, “... (C) The Secretary shall approve a biologics license application - (i) on the basis of a demonstration that - (I) the biological product that is the subject of the application is safe, pure, and potent; and ...”

32 Title 21 of the United States Code of Federal Regulations (see, 21 C.F.R. § 600.3(p))

33 [http://drking.com/docs/120806\\_PGKDrftRevu\\_Anti\\_vaccineMovementCausesTheWorstWhoopingCoughEpidemicIn70Yrs\\_fnlr2b.pdf](http://drking.com/docs/120806_PGKDrftRevu_Anti_vaccineMovementCausesTheWorstWhoopingCoughEpidemicIn70Yrs_fnlr2b.pdf)

34 “Influenza Vaccine: Review of Effectiveness of the U.S. Immunization Program, and Policy Considerations” by Geier DA, King PG, Geier MR).

35 [http://dr-king.com/docs/110128\\_DrftRevuNonCostEffectivenessOfVaxProgrmForN\\_MeningitidisAnd\\_b.pdf](http://dr-king.com/docs/110128_DrftRevuNonCostEffectivenessOfVaxProgrmForN_MeningitidisAnd_b.pdf)



**WHITE PAPER**  
**Briefing President-Elect Donald J. Trump On Vaccination Policy**  
**Vaccine Risks and Informed Consent**

Physicians and public health officials generally rely upon and trust the legality and logic of the recommendations handed down from central authorities without examining the basis, or lack thereof, upon which those recommendations rest. The medical profession must consider its responsibility when faced with unscientific, political and profit-driven health decision-making. Physicians are trained to believe that they have a sacred calling to Do No Harm and to offer hope and help to the sick and suffering. What if reliance upon official pronouncements instead of clinically-informed medical judgment violates the responsibilities of that sacred trust?

**It must be added that among the beneficiaries of increased immunization schedules, at least in the United States, is the United States itself. Since the US government receives \$0.75 per dose of influenza vaccine purchased, under the current recommendation levels, the US government will receive about \$100Million US for administration of the influenza vaccine, which it has admitted has virtually *no* clinical benefit.<sup>36</sup>**

The CDC's recommendations for people who develop influenza after vaccination is then to take one of 3 dangerous failed or unproven antivirals.<sup>37</sup>

The litany of illogic at disastrous cost continues with each vaccine program we examine closely.

The exceptionally gifted scholar, Dr. Paul G. King, PhD<sup>38</sup>, upon whose work I draw extensively, makes the point excruciatingly clearly in his analysis of the costly and dangerous commercially driven, but scientifically barren, case of chicken pox vaccine:

“For the chickenpox disease, the initial criteria used to justify recommending the Merck Varivax® live-virus vaccine for Alphaherpes varicella zoster virus, medically termed as “varicella zoster virus” or “VZV”, were: a) one dose would provide lifetime ‘immunity’ to those who were vaccinated, b) there would be no serious adverse effects from the vaccine, and c) the added medical costs of the vaccination program would be offset by the reduced societal costs (if lost work time) incurred when parents cared for their sick children. When the actual experience showed that one-dose protected less than 60% of those inoculated from getting chickenpox within a couple of years after being vaccinated, the protection provided was not lifetime, and the costs from the excess shingles (medically called “herpes zoster”) cases caused by the reactivation of the latent Alphaherpes varicella zoster virus sequestered in the body’s root ganglia greatly exceeded the societal child-care costs “saved”, sound medical science would require that this vaccination program be halted because it failed to meet all of the key criteria used to justify its approval. Instead, the CDC simply ignored the sound science and added a second dose of Varivax to its recommendations as well as, for elderly most at risk of shingles, a shingles vaccine (Merck’s Zostavax®) for those over 60 years of age. Even after widespread administration of the second dose of the Varivax vaccine, no more than 80% of those doubly inoculated develop “adequate” anti-body titers,

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<sup>36</sup> <http://www.today.com/video/today/56803874#56803874>

<sup>37</sup> Oseltamivir, zanamivir or peramivir

<sup>38</sup> <http://dr-king.com/> provides a treasure trove of publications detailing aspects of this issue with exquisite



**WHITE PAPER**  
**Briefing President-Elect Donald J. Trump On Vaccination Policy**  
**Vaccine Risks and Informed Consent**

the vaccine provides protection that does not last more than 5 years in most who are vaccinated, the excess costs from the added shingles cases in the elderly now exceed US\$ 700 million annually and, though once rare, shingles cases in children have become increasingly common. Scientifically, the Varivax vaccine is a clear failure; it is a vaccine that does not provide long-term, much less lifetime, disease protection from chickenpox; it is a vaccination program that has clearly increased the harm to children and adults caused by the increases in shingles cases it has caused; and, when the serious adverse reactions and deaths attributable to the vaccine and the increased shingles treatment costs are considered, the annual increased medical costs exceed US\$ 1billion (1,000 million) annually.

Yet CDC still recommends this failed vaccine program.”<sup>39,40</sup>

In determining whether a given vaccination program can be cost-effective, the following factors must be considered:

- a) All of the costs of the vaccination program
- b) The estimated number of disease cases prevented, and
- c) The estimated number of deaths from the disease for which the vaccine is claimed to be somewhat protective for some period of time.

In general, for a preventive (prophylactic) vaccination to be cost-effective:

- a) The disease itself must be common (endemic) and have a significant (>10%) mortality rate in those with a clinical case of the disease (e.g., measles in children)
- b) The vaccine must be highly effective (providing true disease protection to more than 90% of those who are inoculated for their “lifetime”)
- c) The vaccine, its administration costs, and its adverse-event costs must be sufficiently low so that the projected average cost savings from vaccination are significantly more than the average disease case-associated costs, and
- d) The serious adverse reactions (death, permanent disability and life-threatening events) caused by the vaccine must be significantly rarer than those caused by the disease before the vaccine approval and the other vaccination-associated costs (e.g., emergency room visits, hospitalizations and extended hospitalizations) must be sufficiently low so that their population costs are some small fraction of the population administration costs and, collectively, are much less than the costs associated with the disease in the absence of any effective vaccine

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<sup>39</sup>[http://dr-king.com/docs/20130501\\_Vaccines\\_The\\_Safest\\_of\\_Medicines\\_or\\_the\\_Biggest\\_Liequstn\\_e\\_b.pdf](http://dr-king.com/docs/20130501_Vaccines_The_Safest_of_Medicines_or_the_Biggest_Liequstn_e_b.pdf)

<sup>40</sup> Goldman GS, King PG. *Review of the United States universal varicella vaccination program: Herpes zoster incidence rates, cost-effectiveness, and vaccine efficacy based primarily on the Antelope Valley Varicella Active Surveillance Project data.* **Vaccine** 2013 Mar 25; 31(13): 1680-1694, online May 31, 2012



**WHITE PAPER**  
**Briefing President-Elect Donald J. Trump On Vaccination Policy**  
**Vaccine Risks and Informed Consent**

Unfortunately, the requirement that a vaccination program must be truly cost-effective when all of the preceding costs are considered is consistently ignored.<sup>41</sup>

Tragically, in the United States, in the current vaccine approval process, the submitter of the application is allowed to:

- a) Make unsubstantiated claims of vaccine effectiveness based on anti-body titer
- b) Ignore the costs of the adverse events associated with vaccination
- c) Make unproven claims as to the level of disease protection provided and the duration of the protection provided by the vaccination series proposed and
- d) Using all of the preceding devices, define the cost of any vaccination program in a manner that justifies the list price proposed by the manufacturer for the vaccine.<sup>42</sup>

The US The Advisory Committee on Immunization Practice (ACIP) to the Centers for Disease Control and Protection (CDC), apparently acting as a rubber stamp for the vaccine makers, simply presumes that the projections offered by the approved vaccine’s manufacturer or the researchers whom they have given grants or have otherwise hired are valid and, before (in the case of the now-withdrawn Wyeth RotaShield® rotavirus vaccine), or soon after, approval (in the case of the meningococcal meningitis vaccines (Sanofi’s Menomune® and Menactra®, and Novartis’ MenVeo®) and the HPV vaccines (Merck’s Gardasil® and GlaxoSmithKline’s Cervarix®) simply adds the vaccines to the recommended vaccination schedule without any long-term study of:

- a) The in-use performance of the vaccine and
- b) The delayed-adverse-reaction profile for the vaccine.

Then, as mentioned, after the vaccine fails, it is not removed from the schedule: more shots are added as “boosters”, courtesy of the.<sup>43</sup>

**Case in point: One Dose Meningococcal Meningitis Vaccination Program**

With the preceding realities in mind, let us consider the cost-effectiveness of the original “one dose” meningococcal meningitis vaccination program for children ages 11- or 12- years old, or 13 to 18 years of age if they missed the vaccination at age 11 or 12, and a second dose to college freshman living in dormitories, with the understanding that the ACIP now recommends a second dose to all children at age 16 because the claimed but unsubstantiated 10-year protection interval used to get the vaccines approved has been found to be overly optimistic. An equally unsubstantiated 5-year period of protection is now being claimed.<sup>44</sup>

Calculations are based on:

- a. Cost per dose, at least \$15045

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<sup>41</sup> [http://dr-king.com/docs/110128\\_DrftRevuNonCostEffectivenessOfVaxProgrmForN\\_MeningitidisAnd\\_b.pdf](http://dr-king.com/docs/110128_DrftRevuNonCostEffectivenessOfVaxProgrmForN_MeningitidisAnd_b.pdf)

<sup>42</sup> Ibid

<sup>43</sup> Ibid

<sup>44</sup> Ibid

<sup>45</sup> This probably underestimates the cost significantly



**WHITE PAPER**  
**Briefing President-Elect Donald J. Trump On Vaccination Policy**  
**Vaccine Risks and Informed Consent**

- b. Minimum number in population segment requiring vaccination, at least 4,000,000 per year since approval granted January 2004
- c. Maximum effectiveness estimated at 85% (unsubstantiated) by manufacturers for the recommended vaccines
- d. Average **maximum** disease 0.67 strain-prevalence fraction for the covered strains, means that with a 100% coverage rate, the mass vaccination program would
  - a. Prevent less than 57% of the disease cases seen annually in the US
  - b. Would have an average cost in excess of \$600,000,000 per year<sup>46</sup>
  - c. Ignore the second shot costs for college students.

The cost for the United States mass meningococcal program significantly exceeds \$1 Billion US. Before Menactra was approved in 2004 and added to the vaccination schedule, there were 1,360 cases of meningococcal meningitis. By 2008 with 41.8% of the children between 13 and 18 vaccinated, there were 1170 cases, or a maximum of 190 cases less at an apparent **cost of about \$1.4 Million US per prevented case.** [Emphasis added – REL]

Generous estimates suggest that since approximately 10% of diagnosed cases die, **the cost per each of the 19 “prevented deaths” would be about \$14 Million US.** [Emphasis added – REL]

However since by 2010 CDC only claimed about 9 lives saved through this program, **the cost per saved life was about \$30 Million US.**<sup>47</sup> [Emphasis added – REL]

Interestingly, however, the while the press rallies around mass vaccinations and vast numbers of children and young adults are inoculated with the meningococcal meningitis vaccine, the **reported cases have continued to decline dramatically in both the vaccinated and the unvaccinated** [Emphasis added – REL] so that by 2010, the number of cases was at its lowest point in 67 years.

It is clear, even before any other associated costs are considered, although they must be, that there is no justification on the basis of either massive public health impact or economic cost effectiveness for this massive vaccination campaign. [Emphasis added – REL]

But any meaningful calculation of the real costs of a public health program must also include the costs of adverse consequences of the program, both in human and in financial terms.

**The US Vaccine Adverse Event Reporting System, VAERS<sup>48</sup>, is a voluntary reporting option which is widely believed to capture between 1 and 10% of the relevant episodes of short term vaccine-related adverse events.**

Using the most conservative figures, we will multiply the VAERS data by 10 assuming an exceedingly generous 10% capture instead of the more realistic 1-2% capture rate.

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<sup>46</sup> Ibid

<sup>47</sup> : [http://www.fiercepharma.com/story/cdcpanel-backs-additional-vax-doses/2010-10-28?utm\\_medium=nl&utm\\_source=internal](http://www.fiercepharma.com/story/cdcpanel-backs-additional-vax-doses/2010-10-28?utm_medium=nl&utm_source=internal)

<sup>48</sup> <http://www.cdc.gov/vaccinesafety/Activities/vaers.html>



**WHITE PAPER**  
**Briefing President-Elect Donald J. Trump On Vaccination Policy**  
**Vaccine Risks and Informed Consent**

From January 2005 through 2010, about 7,095 adverse events for children in the age range in which vaccines for N. meningitides were part of the ACIP schedule. These VAERS reports included:

- 20 deaths reported in VAERS
- 98 life-threatening adverse events
- 49 cases of permanent disability
- 3007 hospitalizations
- 19 extended hospitalizations
- 2,412 emergency-room visits

As Dr. Paul G. King, PhD, points out

“On this basis, to save less than 130 N. meningitides infections and the CDC’s about “9” deaths annually, the current ‘one dose’ vaccination program at an uptake level of about 70 % probably annually causes in excess of 66 deaths, 161 permanent disabilities, 312 life threatening events, 1,006 hospitalizations, 63 extended hospitalizations and 7,900 emergency room visits”<sup>49</sup> [Emphasis added – REL]

**Whether considering the enormous public health burden, the human burden or the staggering economic burden, it is clear that this program is neither justified nor supportable except to those whose commercial interests are at stake.**

**SECTION TWO: THE UNIVERSAL RIGHT TO INFORMED CONSENT**

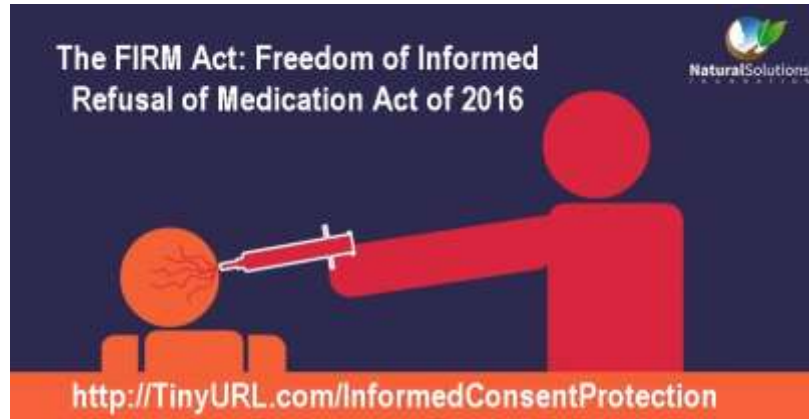
In order to vindicate International Humanitarian Law regarding Informed Consent to any and all medical interventions, including vaccination, even during any declared local, national or international Health Emergency, the right to refuse any vaccination must be respected, whether that refusal is grounded in philosophical, medical, religious or no reasons at all.

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<sup>49</sup> [http://dr-king.com/docs/110128\\_DrftRevuNonCostEffectivenessOfVaxProgrmForN\\_MeningitidisAnd\\_b.pdf](http://dr-king.com/docs/110128_DrftRevuNonCostEffectivenessOfVaxProgrmForN_MeningitidisAnd_b.pdf)



**WHITE PAPER**  
**Briefing President-Elect Donald J. Trump On Vaccination Policy**  
**Vaccine Risks and Informed Consent**



- Point One: The Legal Basis for Informed Consent***
- Point Two: Legitimate Government Regulation***
- Point Three: International Law Protects Informed Consent***
- Point Four: The Right Must Be Asserted to Be Protected***
- Point Five: The Right May Not Be Defeated by Unconstitutional Conditions***

***Point One: The Bill of Rights’ Speech, Privacy and Association Rights are the Basis for Informed Consent.***

Implementing the general law as applied to the protection of human life is mandated, in the instance of vaccination, by the United States Supreme Court, which held that the courts “are not without power...” regarding vaccination in the case of *Jacobson vs Commonwealth of Massachusetts*<sup>[1]</sup>.

In 1914, Judge (later Supreme Court Justice) Benjamin Cardozo validated the concept of voluntary consent when he noted that every human being has a right to decide what shall be done with his or her body, deeming medical intervention without Informed Consent an unlawful trespass:

*“Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault for which he is liable in damages.”*<sup>[2]</sup>

Federal Regulation acknowledges Informed Consent for formal Institutional Review Board (IRB – required for FDA approved medical experiments) overseeing experimentation.<sup>[3]</sup> The recognition of the application of Informed Consent during the less formal “final stage” of experimentation on drugs (including vaccines) released to the public is not adequately implemented by law or regulation, “...Phase 4 trials are conducted after a product is already approved and on the market to find out more about the treatment’s long-term risks...”<sup>[4]</sup>



**WHITE PAPER**  
**Briefing President-Elect Donald J. Trump On Vaccination Policy**  
**Vaccine Risks and Informed Consent**

With regard to all communications about health care decisions, the members of the public have the right to make informed consent decisions, even if a decision may be considered a “bad” decision by the Government. The Supreme Court indicated, in *Thompson v Western States*[5]:

“We have previously rejected the notion that the Government has an interest in preventing the dissemination of truthful commercial information in order to prevent members of the public from making bad decisions with the information.”

The United States is bound to observe the Nuremberg Code by virtue of the Subsequent Nuremberg Trials[7] and subsequent exacting of justice through penalties, including the death penalty. The Geneva Conventions (the international treaties that govern humanitarian requirements) [8] require that the United States be bound by these international humanitarian principles. Thus the United States is treaty-bound to implement fully Informed Consent.



**Forced Vaxx is a Crime Against Humanity**

**The Nuremberg Code on Medical Ethics**

“...voluntary consent ...is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, **without the intervention of any element of force, fraud, deceit, duress, over-reaching, or other ulterior form of constraint or coercion;** and should have sufficient knowledge and comprehension of the elements of the subject matter involved, as to enable him to make an understanding and enlightened decision.” <http://www.hhs.gov/ohrp/archive/nurcode.html>

<http://tinyurl.com/vaccinationSviolation>

Even in an emergency situation the Government Agencies involved must take a pro-active role in the full implementation of Informed Consent without “the intervention of any element of force, fraud, deceit, duress, over-reaching, or other ulterior form of constraint or coercion...”[9]

The public has a right to know, and the governments on the federal and state levels have an obligation to provide, clear information regarding the Informed Consent, to the end that government approvals, requirements, mandates and recommendations are understood to be subject to the Right of Informed Consent. Intervention by the courts must vindicate this Right.

**Point Two: Legitimate Government Regulation**

**Government Agencies have No Legitimate Interest in  
Promoting FDA-Approved Vaccination Mandates in Violation of Informed Consent.**

In the case of *State v Biggs* (46 SE Reporter 401, 1903) the North Carolina Supreme Court dealt with a person who was advising people as to diet, and administering massage, baths and physical culture. In the *Biggs* case, the defendant “advertised himself as a ‘nonmedical physician’ ... [and] held himself out to the public to cure disease by ‘a system of drugless healing’ ...” p.401.





**WHITE PAPER**  
**Briefing President-Elect Donald J. Trump On Vaccination Policy**  
**Vaccine Risks and Informed Consent**

That Court held that there could be no “state system of healing” p.402 and while “Those who wish to be treated by practitioners of medicine and surgery had the guaranty that such practitioners had been duly examined... those who had faith in treatment by methods not included in the ‘practice of medicine and surgery’ as usually understood, had reserved to them the right to practice their faith and be treated, if they chose, by those who openly and avowedly did not use either surgery or drugs in the treatment of diseases...” p.402.

**There is no compelling government interest in controlling people associating together for the improvement of their well-being.**

The North Carolina Supreme Court concluded, nearly a century ago in *State v Biggs, supra.*, at p.405:

*“Medicine is an experimental, not an exact science. All the law can do is to regulate and safeguard the use of powerful and dangerous remedies, like the knife and drugs, but it cannot forbid dispensing with them. When the Master, who was himself called the Good Physician, was told that other than his followers were casting out devils and curing diseases, he said, ‘Forbid them not.’” (p.405).*

FDA approved drugs, including vaccines, remain in an experimental state, which the FDA calls “Phase 4” of the clinical trials system.[\[10\]](#)

Unless affirmatively and effectively asserted an individual’s Fundamental Right to Informed Consent, the legal ability to resist unwanted medical interventions, such as vaccines and other invasive techniques, may be ignored by the medical system under government directive. Based on the ancient legal principle that “silence is acquiescence”[\[11\]](#) martial law or medical emergency authorities may presume that you consent to even experimental medical interventions, as we saw imposed by WHO dictum during the 2014 Ebola Panic[\[12\]](#). The same is true of medical practice in “ordinary times”.

After the horrors of the Second World War, including the murder and abuse of millions with the complicity of the “health care” authorities of various warring parties, the international community developed conventions and declarations to the end that “Never Again!” would – or could – the health system or health professionals be used to harm either individuals or whole populations. Those prohibitions and protections remain binding today.

A key element in the international protections secured by the Allied Victory and subsequent codification of health-related international law was recognition that no person could be forced to accept any medical intervention that was contrary to conscience and that all medical interventions were to be carried out only with fully informed [and therefore meaningfully willing] consent.

**WHITE PAPER**  
**Briefing President-Elect Donald J. Trump On Vaccination Policy**  
**Vaccine Risks and Informed Consent**

This has been international law for millennia, starting with the Hippocratic Oath in which doctors swore “*I will take care that [my patients] suffer no hurt or damage*” and

“*Nor shall any man’s entreaty prevail upon me to administer poison to anyone...*”<sup>[13]</sup>

**THE STORY OF RAGGEDY ANN**

*Back in 1915, Raggedy Ann stood for grief and a medical controversy that cost a little girl her life. Marcella Gruelle, daughter of children’s author Johnny Gruelle, died after receiving a smallpox vaccination without her parents’ consent. After Marcella’s death, Raggedy Ann became a symbol for the anti-vaccination movement.*

<http://DrRimaTruthReports.com/AdvanceVaccineDirective/>



**ASSERT YOUR  
RIGHT TO  
INFORMED  
CONSENT!**

***Point Three: International Law Protects the Right of Informed Consent***

Among the Post World War II protective codifications were the Universal Declaration of Rights, Geneva Declaration<sup>[14]</sup>and the Nuremberg Code which state, concerning the rights of all human beings and the obligation for ethical action by health personnel:

“Everyone has the right to life, liberty and security of person... No one shall be subjected to ... inhuman or degrading treatment ... Everyone is entitled in full equality to a fair and public hearing by an independent and impartial tribunal, in the determination of his rights... No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence...”<sup>[15]</sup>



**WHITE PAPER**  
**Briefing President-Elect Donald J. Trump On Vaccination Policy**  
**Vaccine Risks and Informed Consent**

“I WILL NOT USE my medical knowledge to violate human rights and civil liberties, even under threat...”[16]

“The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, over-reaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved, as to enable him to make an understanding and enlightened decision.”[17]

This salutary development of international law has continued with international standards promulgated, such as the UNESCO Universal Bioethics Declaration [18] about which it has been said:

Even apart from article 7 of the ICCPR, ethical requirements for informed consent before medical or scientific treatment probably constitute international law as involving “general principles of law” under article 38 (1) (c) of the *Statute of the International Court of Justice*. The reference to “civilized nations” in this context could well introduce an ethical requirement to such evaluations that many contemporary developed nations may fail.[19]

**Defining Informed Consent**

[www.DrRimaTruthReports.com/AdvanceVaccineDirective](http://www.DrRimaTruthReports.com/AdvanceVaccineDirective)



**Natural Solutions**  
FOUNDATION  
**Advance Vaccine Directive**

Your RIGHT to Informed Consent: Established by the Nuremburg Trials  
Reaffirmed by the US Supreme Court in 2013



**YOU HAVE A GUARANTEED  
INFORMED CONSENT RIGHT TO BE FREE FROM**  
“...the intervention of any element of force, fraud, deceit,  
duress, over-reaching, or other ulterior form of constraint or coercion...”  
Geneva Convention, other binding International Law Treaties

“Informed consent is a process for getting permission before conducting a healthcare intervention on a person... In the United Kingdom and countries such as Malaysia and Singapore, informed consent in medical procedures requires proof as to the standard of care to expect as a recognized standard of acceptable professional practice (the Bolam Test), that is, what risks would a medical



**WHITE PAPER**  
**Briefing President-Elect Donald J. Trump On Vaccination Policy**  
**Vaccine Risks and Informed Consent**

professional usually disclose in the circumstances (see Loss of right in English law). Arguably, this is “sufficient consent” rather than “informed consent.” ... Medicine in the United States, Australia, and Canada take a more patient-centric approach to “informed consent.” Informed consent in these jurisdictions requires doctors to disclose significant risks, as well as risks of particular importance to that patient. This approach combines an objective (the reasonable patient) and subjective (this particular patient) approach.”<sup>[20]</sup>

***Point Four: The Right Must Be Asserted to Be Preserved***

Where there is no recognition of the legal duty to obtain informed consent, the individual or guardian *must* assert the Right or it may unlawfully assumed or deemed to have been waived. International Humanitarian Law is clear: without clear, affirmative, memorialized informed consent, it must be concluded that Informed Consent has been withheld.

The essential importance of asserting the Right to preserve it is shown by the 2013 US Supreme Court case of *Missouri vs McNeely*, where the warrantless extraction of blood was ruled illegal as the defendant “refused to consent.” Had McNeely remained silent, the blood test would have been allowed.<sup>[21]</sup>

The Court opined,

*Even a “...diminished expectation of privacy does not diminish the... **privacy interest in preventing a government agent from piercing the... skin.** And though a blood test conducted in a medical setting by trained personnel is less intrusive than other bodily invasions, **this Court has never retreated from its recognition that any compelled intrusion into the human body implicates significant, constitutionally protected privacy interests ...**” (page 15; emphasis added).*

If the removal of blood “implicates significant, constitutionally protected privacy interests...” it is fair to assume that other invasive medical techniques including the introduction of vaccine toxins into the body that have been held to be “unavoidably unsafe”<sup>[22]</sup> will also give rise to such concerns.

The Constitution of the United States recognizes certain Rights held by people and delegates certain limited Powers to the government. Without clear respect for those Rights, the judicial system and the administration of government will fail to protect the truly fundamental interests of civil society, including the Right to Informed Consent.

An earlier Supreme Court understood this, when in 1905 in *Jacobson v Massachusetts*, the Court declared the judicial power to extend to protecting people from forced vaccination.



**WHITE PAPER**  
**Briefing President-Elect Donald J. Trump On Vaccination Policy**  
**Vaccine Risks and Informed Consent**

While giving due deference to the State authorities, the Supreme Court reserved for the Federal Courts the right to intervene in matters where health and life may be at stake:

*“...if it be apparent or can be shown with reasonable certainty that he is not at the time a fit subject of vaccination or that vaccination, by reason of his then condition, would seriously impair his health or probably cause his death.” [Emphasis added.][23]*

In a regime of verbal obfuscation of fundamental Right, only the clear assertion of the Right will prevent degradation of the Right “by a thousand (bureaucratic) cuts...” If McNeely had not engaged in protected speech stating he did not consent, the taking of his blood would probably have been allowed.

The question then becomes, “How is one to effectively assert the Right to Informed Consent, enshrined in International Humanitarian Law, for oneself and those over whom one has guardianship?” Thus, there is a need for strong Statutory and Regulatory protections for the Right, whether exercised by Advanced Medical Directive or otherwise, in situations that do not involve a formal IRB.

Access to the AVD Card Here: <http://drimatruthreports.com/advancevaccinedirective>  
Regulatory Petition to FDA Here: <http://tinyurl.com/InformedConsentPetition>  
FIRM Act - Model Protective Law Here: <http://tinyurl.com/InformedConsentProtection>



***Point Five: Government Action Imposes an Unconstitutional Condition on the Constitutionally Protected Right to Informed Consent***



**WHITE PAPER**  
**Briefing President-Elect Donald J. Trump On Vaccination Policy**  
**Vaccine Risks and Informed Consent**

The well-established law of Unconstitutional Conditions has particular relevance in the case before any Court wherein a party is faced with the harsh choice of vaccinating the child or having the child banned from the public benefit of public education, required by law for all children. Any law, regulation or policy imposing school vaccine mandates where the parent is faced with denying his or her own expressed beliefs or preferences (beliefs thereby protected under the First Amendment) or denying the child access to public education, is an action “under color of law” that forces coerced consent..

*This is precisely the type of duress condemned by the Nuremberg Code.*

It is also clearly conditioning the acceptance of a public benefit on the surrender of a right.

The law of Unconstitutional Conditions is well-represented in the jurisprudence of the United States Supreme Court and the Courts it oversees.

We do not pretend to more expertise on the issue than the Court’s own pronouncements.

The Supreme Court first mentions the phrase in *Doyle v. Continental Ins. Co.*, 94 U.S. 535, 543 (1876) (Badley, J., dissenting) “*Though the State may have the [police] power... it has no power to impose unconstitutional conditions...*”

In *Frost v Railroad Commission*, 271 U.S. 583,594 (1925) the Court held it “would be a palpable incongruity to strike down an act of state legislation which, by words of express divestment seeks to strip the citizen of rights guaranteed by the federal Constitution, but to uphold an act by which the same result is accomplished under the guise of a surrender of a right in exchange for a valuable privilege which the state threatens otherwise to withhold... it may not impose conditions which require the relinquishment of constitutional rights.”

More recently the Court applied the principle to First Amendment speech rights arising from expressive association issues directly in point here where First Amendment protected religious expressive association is involved. In *Speiser v Randall*, 357 U.S. 513, 526 (1958)

*“In practical operation, therefore, this procedural device must necessarily produce a result the State could not command directly. It can only result in a deterrence of speech which the Constitution makes free.”*

And finally, of particular note is the statement in *Perry v Sindermann*, 408 U.S. 593, 597 (1972):

*“...this court has made it clear that even though a person has no ‘right’ to a valuable governmental benefit and even though the government may deny him the benefit for any number of reasons, there are some reasons upon which the government may not rely. It may not deny a benefit to a person on a basis that infringes his constitutionally protected*



**WHITE PAPER**  
**Briefing President-Elect Donald J. Trump On Vaccination Policy**  
**Vaccine Risks and Informed Consent**

*interests – especially, his interest in freedom of speech. For if the government could deny a benefit to a person because of his constitutionally protected speech or associations, his exercise of those freedoms would in effect be penalized and inhibited. This would allow the government to “produce a result which (it) could not command directly.”*

**CONCLUSION**

**It was not random, but for good reason, that the Founders grouped together in the First Amendment Religious Liberty, Speech, Assembly and Petition Rights. Rather, these stated Rights have been held by the Supreme Court to be, together, “expressive association.”**



**We consider meaningful Informed Consent to be the *sine qua non* of humane health care required by International Humanitarian Law. Truly, no free person should be forced to consent to mandated medical interventions.**

There can hardly be a more fundamental or central freedom issue than whether agents of government, or persons acting under color of state law, as are those who act to abrogate conscientious objections to mandated vaccines, can force a free and competent adult (or a child under the protection of such adult) to receive any medical treatment. That the treatment may be vaccination, which is not merely experimental and (sic) preventative but uninsurable and, according to many courts, “unavoidably unsafe” gives greater emphasis to the unconscionable personal



**WHITE PAPER**  
**Briefing President-Elect Donald J. Trump On Vaccination Policy**  
**Vaccine Risks and Informed Consent**

sacrifice the individual is mandated to make. Such a mandate is inconsistent with status as a free person, rather than a slave. No free society can tolerate any such imposition.

“Liberty is to the collective body what health is to every individual body. Without health no pleasure can be tasted by man; without liberty, no happiness can be enjoyed by society.” – Thomas Jefferson<sup>[24]</sup>

**SUMMARY AND RECOMMENDATIONS**

**This White Paper addresses two primary questions and offers Policy Recommendations:**

- 1. Are vaccines safe and effective? [Page 2]**
- 2. Do vaccine mandates violate the universal right of Informed Consent? [Page 23]**
- 3. Conclusions [Page 31]**

**The positions this Paper takes are, in summary:**

**Vaccination is an uninsurable risk that has been declared by courts to be  
“unavoidably unsafe.”  
Vaccine mandates impose unconstitutional conditions, violating Informed Consent.**

**The Policy Recommendations proposed in this Paper are:**

**Stop all Federal Funding for vaccine mandates.  
Require that CDC Vaccine Committee members be free of all conflicts of interest; end  
pharmaceutical company tort liability exemption and the Vaccine Injury  
Compensation Program (VICP).  
Adopt the proposed FIRM Act, Freedom of Informed Refusal of Medication Act.  
Encourage Alternatives to Vaccination: a Normal Immune System**

**RECOMMENDATIONS**

Clearly, a solution to the problems of infectious diseases is urgently needed which is cost effective in financial *and* in human terms.

**[Recommendation #1] Regarding the vaccines themselves, the solution is simple: remember the First Rule of humane medicine: Do No Harm. *Vaccination is Violation.* Mandated vaccine programs must be abolished. All medical, philosophical and religious conscientious objections to vaccination must be honored.**

**[Recommendation #2] The effective mechanism to accomplish this policy goal is the FIRM Act which establishes a Federal Cause of Action to protect the universal right to Informed**





**WHITE PAPER**  
**Briefing President-Elect Donald J. Trump On Vaccination Policy**  
**Vaccine Risks and Informed Consent**

**Consent.** Courts would be empowered to issue injunctions to protect fundamental personal privacy rights with regard to any mandated medication.

More about the FIRM Act here: <http://drrimatruthreports.com/support-the-firm-act-freedom-of-informed-refusal-of-medication-act/>

**[Recommendation #3] Forbid conflicts of interest in the CDC; end pharmaceutical company tort liability exemption and the government injury compensation program that has paid out over \$3 billion in tax money.** The tort exemption violates our right to petition government for redress of grievances and guarantees illicit drug company vaccine profits. The conflicts of interest in the CDCs committee system for “recommending” vaccines have become so blatant that self-interested members no longer have to recuse themselves, but must merely reveal their interests when voting. One well-known physician voted to recommend a vaccine in which he had an interest, resulting in tens of millions in personal profit. See, for example: <http://www.ageofautism.com/2009/02/voting-himself-rich-cdc-vaccine-adviser-made-29-million-or-more-after-using-role-to-create-market.html>

Assuming that vaccines provided protection, there would be no need for concern among the vaccinated when they came into contact with the unvaccinated. If they do not work, there is no justification for forcing them on anyone – or indeed, for that matter, for giving them to anyone.

**[Recommendation #4] Find alternatives to Vaccination.** The solution for preventing infections and mitigating risk must be inexpensive, active against every pathogen of any type, easily obtained, robust to temperature extremes, stable at ambient temperature, totally non-toxic so that whatever immunological or nutritional state the recipient is in, there is no toxic impact for even the most vulnerable, self-sterilizing, acceptable to take or use, simple to dose with a very large safety margin to prevent accidental overdose.

There is, to our knowledge, one and only one substance which meets those criteria and it is, in fact, manufactured here in India as well as other countries, which can be used as a safe, inexpensive and effective nutritional support for immune system function.

The substance is called Nano Silver 10 PPM and it meets, and exceeds the requirements set forth above.

It has been tested and reviewed in more than 1000 formal safety and efficacy studies and has an unparalleled record of such significant immune system support and safety that it can be safely given to everyone in the community whatever their age, gender, nutritional or immunological status.

It stands to reason, after all, that if the immune system can respond quickly and efficiently to every pathogen’s challenge, then there is no need for vaccines at all.

**Basic principles of Science and of Justice tell us that Vaccination is an uninsurable risk that is unavoidably unsafe. It must be the Public Policy of the United States Public Health System to end reliance on vaccines and reposition public health efforts at reinforcing hygiene, sanitation and better nutrition: the real weapons in the war against pandemic disease. At the same time**



**WHITE PAPER**  
**Briefing President-Elect Donald J. Trump On Vaccination Policy**  
**Vaccine Risks and Informed Consent**

**it should be the Public Policy of the United States to fully support the universal right of Informed Consent. *Where there is risk there must be consent.***

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This White Paper is posted at:

[http://drrimatruthreports.com/wp-content/uploads/Trump.Vax\\_.WhitePaper.11.11.16.pdf](http://drrimatruthreports.com/wp-content/uploads/Trump.Vax_.WhitePaper.11.11.16.pdf)

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PS: We recommend Mary Holland's spirited defense of Informed Consent here:

<https://www.youtube.com/watch?v=gyRR-srQeVE&feature=youtu.be>



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Vaccination is an uninsurable risk; vaccines are unavoidably unsafe.



**WHITE PAPER**  
**Briefing President-Elect Donald J. Trump On Vaccination Policy**  
**Vaccine Risks and Informed Consent**

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- [1] *Jacobson v. Commonwealth of Massachusetts*, 197 U.S. 11 (1905)  
[2] *Schloendorff v. Society of New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914)  
[3] <http://www.fda.gov/RegulatoryInformation/Guidances/ucm126431.htm>  
[4] <http://www.fda.gov/Drugs/ResourcesForYou/Consumers/ucm143531.htm>  
[5] *Thompson v. Western States Medical Center* – 01-344, decided on April 29, 2002 – 535 U.S. 357)  
[6] omitted  
[7] [http://en.wikipedia.org/wiki/Subsequent\\_Nuremberg\\_trials](http://en.wikipedia.org/wiki/Subsequent_Nuremberg_trials)  
[8] [https://en.wikipedia.org/wiki/Geneva\\_Conventions](https://en.wikipedia.org/wiki/Geneva_Conventions)  
[9] <http://www.hhs.gov/ohrp/archive/nurcode.html>  
[10] “Phase 4 trials are conducted after a product is already approved and on the market to find out more about the treatment’s long-term risks, benefits, and optimal use, or to test the product in different populations of people, such as children.” Downloaded July 8, 2015: <http://www.fda.gov/Drugs/ResourcesForYou/Consumers/ucm143531.htm>  
[11] “*qui tacet consentire videtur*” – “Thus, silence gives consent.” Sometimes accompanied by the proviso “*ubi loqui debuit ac potuit*”, that is, “when he ought to have spoken and was able to”. [http://en.wikipedia.org/wiki/List\\_of\\_Latin\\_phrases\\_%28Q%29](http://en.wikipedia.org/wiki/List_of_Latin_phrases_%28Q%29)  
[12] <http://www.who.int/mediacentre/news/statements/2014/ebola-ethical-review-summary/en/>  
[13] [http://en.wikipedia.org/wiki/Hippocratic\\_Oath](http://en.wikipedia.org/wiki/Hippocratic_Oath)  
[14] The **Geneva Conventions** comprise four treaties, and three additional protocols, that establish the standards of international law for the humanitarian treatment of war. The singular term *Geneva Convention* usually denotes the agreements of 1949, negotiated in the aftermath of the Second World War (1939–45), which updated the terms of the first three treaties (1864, 1906, 1929), and added a fourth. [http://en.wikipedia.org/wiki/Geneva\\_Conventions](http://en.wikipedia.org/wiki/Geneva_Conventions)  
[15] <http://www.un.org/en/documents/udhr/>  
[16] <http://www.wma.net/en/30publications/10policies/g1/index.html>  
[17] <http://www.hhs.gov/ohrp/archive/nurcode.html>  
[18] [http://portal.unesco.org/en/ev.php-URL\\_ID=31058&URL\\_DO=DO\\_TOPIC&URL\\_SECTION=201.html](http://portal.unesco.org/en/ev.php-URL_ID=31058&URL_DO=DO_TOPIC&URL_SECTION=201.html) which provides:

Article 6 – Consent – 1. Any preventive, diagnostic and therapeutic medical intervention is only to be carried out with the prior, free and informed consent of the person concerned, based on adequate information.

The consent should, where appropriate, be express and may be withdrawn by the person concerned at any time and for any reason without disadvantage or prejudice. 2. Scientific research should only be carried out with the prior, free, express and informed consent of the person concerned. The information should be adequate, provided in a comprehensible form and should include modalities for withdrawal of consent. Consent may be withdrawn by the person concerned at any time and for any reason without any disadvantage or prejudice. Exceptions to this principle should be made only in accordance with ethical and legal standards adopted by States, consistent with the principles and provisions set out in this Declaration, in particular in Article 27, and international human rights law. Article 28 – Nothing in this Declaration may be interpreted as implying for any State, group or person any claim to engage in any activity or to perform any act contrary to human rights, fundamental freedoms and human dignity...

- [19] <http://jme.bmj.com/content/31/3/173.full>  
[20] [http://en.wikipedia.org/wiki/Informed\\_consent](http://en.wikipedia.org/wiki/Informed_consent)  
[21] *Missouri vs McNeely*, 569 US \_ (2013) [http://www.supremecourt.gov/opinions/12pdf/11-1425\\_cb8e.pdf](http://www.supremecourt.gov/opinions/12pdf/11-1425_cb8e.pdf) – [https://en.wikipedia.org/wiki/Missouri\\_v.\\_McNeely](https://en.wikipedia.org/wiki/Missouri_v._McNeely)  
[22] See Justice Sotomayor’s 2011 dissent in *Bruesewitz vs Wyeth*, where she discusses the history of “unavoidably unsafe.” <https://www.law.cornell.edu/supct/html/09-152.ZD.html>  
[23] *Jacobson v. Commonwealth of Massachusetts*, 197 U.S. 11 (1905)  
[24] <http://www.successwallpapers.com/wallpapers/0068-liberty.php>