March 13, 2019
Dr. Jovana Stojkovic
Belgrade, Serbia

Dear Dr. Stojkovic:

I am writing concerning the procedure to revoke your medical license which was raised by the Serbian Chamber of Medicine because of your advocacy against mandatory vaccinations.

There is a very *fitting term* indeed for what is currently practiced by the Serbian Government against parents who refuse to vaccinate their children according to official vaccination schedules (i.e., financial sanctions, threat of imprisonment or passing laws by which their children would be taken away): *medical fascism*. However, we ought not to be surprised that such measures are resorted to, for it ought to be evident to all who have not completely divorced themselves from the faculty of a sound mind, that if vaccines were indeed as safe as effective as the official medical science tells us, then such draconian measures would not at all be needed to ensure their universal uptake.

The current "one-size fits all" vaccination policies practiced in so many countries are in fact seriously flawed both scientifically and ethically for the following reasons:

First and foremost, because vaccines are "*the only medical intervention that we attempt to deliver to every living human on earth*"[1]. Second, vaccines are predominantly given to infants and children, the most vulnerable of all populations. Third, unlike conventional drugs, which are prescribed to people who are ill, vaccines are administered to healthy individuals, thus increasing the concern over adverse reactions.

Although most immediately apparent side effects attributed to vaccines seem to be mild, acute and transient, reactions such as hypersensitivity, anaphylaxis, neurological complications and induction of autoimmunity do occur, and can be severe and even fatal[2-13]. The occurrence of such serious adverse events has been clearly described in the scientific literature and in some cases a direct causal link was established between vaccination and the adverse event[2, 14]. Indeed, as recently noted by Peter Doshi in the February 2017 issue of the *British Medical Journal*[15], "*Contrary to the suggestion—generally implicit—that vaccines are risk free (and therefore why would anyone ever resist official recommendations), the reality is that officially sanctioned written medical information on vaccines is—just like drugs—filled with information about common, uncommon, and unconfirmed but possible harms.*" Doshi also correctly recognizes that labeling people concerned about the safety of vaccines as "anti-vaccine" is a derogatory form of attack as it stigmatizes the mere act of even asking an open question about what is known and unknown about the safety of vaccines. Moreover, such a position lumps all vaccines together as if the decision about the risks and benefits is the same irrespective of disease or mode of

transmission (i.e., accidental or lifestyle related such as hepatitis B, HIV or HPV), or vaccine type (whether live attenuated, inactivated whole cell, adjuvanted, monovalent, polyvalent, etc). Doshi concludes that such a an extreme position "*seems about as intelligent as categorizing people into "pro-drug" and "anti-drug" camps depending on whether they have ever voiced concern over the potential side effects of any drug.*"

Indeed, it should be noted that even those in the scientific community who are strong proponents of vaccinations have come to question the scientific legitimacy of "one-size fits all" vaccination practices. One such individual is Gregory Poland, a professor of Medicine at the Mayo Clinic, and the Editor in Chief of one of the most respectable journals in the field of vaccination, *Vaccine* and co-author of the article: "*The age-old struggle against the antivaccinationists*"[16]. Thus one can hardly label Poland as an "antivaxxer". In his article entitled *Vaccine Immunogenetics*[1], Poland and colleagues ask whether "*with the advances coming from the new biology of the 21st Century*", it is time to consider "*how might new genetic and molecular biology information inform vaccinology practices of the future?*". In light of this question Poland et al.[1] conclude that "one-size fits all" approach for all vaccines and all persons should be abandoned. According to Poland, this conclusion applies to both vaccine efficacy, as well as safety. Poland's current data may thus have far broader implications for understanding vaccines, not only in terms of efficacy and the desired immune response, but also in terms of safety. Indeed, vulnerable populations will neither have the same antibody response nor the same level of tolerance to serious adverse reactions as non-vulnerable populations. Moreover, given that vaccines are delivered to billions of people without preliminary screening for underlying susceptibilities is thus of concern.

It is indeed naive to believe that all humans are alike. Notably, autoimmune diseases have been increasingly recognized as having a genetic basis, thus, certain genes create a genetic predisposition towards development of autoimmune disease, typically requiring some environmental trigger to evolve into a full-blown disease state. The example of such environmental triggers which are commonly associated with development of autoimmunity are viral infections and also vaccinations[3, 17-21].

It is further important to note that an increased proportion of individuals, *regardless* of their genetic background, may react adversely to vaccines, particularly if exposures to compounds with immune adjuvant properties exceed a certain threshold. This concept has been demonstrated by a team of Japanese researchers led by Dr Ken Tsumiyama who in 2009 showed that repeated immunization caused systemic autoimmunity in mice otherwise not prone to spontaneous autoimmune diseases[22]. Specifically, the Japanese team showed that CD4+ T cells from mice repeatedly-immunized with staphylococcus enterotoxin B (SEB) acquire the ability to induce autoantibodies which produce autoimmune tissue injury akin to that seen in human autoimmune diseases. From these observations Tsumiyama et al.[22] concluded that systemic autoimmunity appears to be the inevitable consequence of over-stimulating the host's immune 'system' by repeated immunization with antigen. Yet in spite of these observations, current vaccination schedules for pre-school children in developed countries, often exceeding a total of 120 antigenic compounds administered in booster shots every 2-3 months[23], are assumed to be safe.

Now, although it is true that people are exposed continually to myriads of infectious agents in the environment, it should be recognized that there is a vast difference between natural exposure and that induced by vaccinations. Namely, the immune response induced by vaccination is greatly amplified owing to the addition of adjuvants with immune-stimulating properties.

Other than having immune adjuvant properties, some vaccine constituents are known neurotoxins (i.e., mercury, aluminum (Al))[23-27]. Thus a typical vaccine formulation contains all the necessary biochemical components to induce both autoimmune as well as neuroimmune disorders[23]. In addition, vaccines contain an array of other toxicants which may in their own right act as neuroimmune and endocrine disruptors (i.e., polysorbate 80, phenol red, phenoxyethanol, formaldehyde, monosodium glutamate, various antimicrobials, cell components of animal and aborted fetal tissues, residual nucleic acid contaminants, adventitious host-tissue infectious agents, etc)[28, 29]. Although the significance of all these potentially toxic vaccine constituents is frequently dismissed because they are only present in trace amounts[28, 30], experimental evidence shows that when individually administered in vaccine-relevant human exposures, both mercury and Al are capable of causing serious adverse persistent neuroimmune outcomes in animal models [31-39]. Moreover, Al vaccine adjuvants are now strongly linked to central nervous system disorders and a variety of autoimmune/inflammatory conditions in human adults[23, 40-49]. Since children receive much more aluminum (and other potentially toxic vaccine compounds) from vaccines per kg of body weight than adults, they are at greater risk of vaccine-related neuroimmunotoxic effects[23, 42]. Further, it is important to realize that the route of administration of most vaccines (*i.m* or *s.c*) may considerably lower the threshold amount of toxic constituent capable of causing harm, compared to oral administrations of the same compound in diet or water[50, 51].

That current ***assumptions*** on vaccine safety should be replaced by adequate scientific evidence has been urged in 2004 by the WHO Global Advisory Committee[52] which,

> "*considered the safety of adjuvants used in vaccines. **This hitherto neglected subject** is becoming increasingly important given modern advances in vaccine development and manufacture*."

In spite of WHO's recommendation, to date, little progress has been made in this specific area of vaccine safety. Given the scarcity of evidence of safety of the combined pediatric schedule and the fact that administration of only a few vaccines in human adults can lead to brain dysfunction and a variety of autoimmune conditions[6, 10-12, 14, 26, 53-55], concerns about the overall safety of current childhood vaccination programs appears to warrant further investigation.

Moreover, extensive research data have underscored the tight connection between development of the immune system and that of the central nervous system (CNS), and thus the plausibility that disruption of critical events in immune development may play a role in neurobehavioral disorders including those of the autism spectrum[56-58]. Indeed, early-life immune challenges in critical windows of developmental vulnerability have been shown to produce long-lasting, highly abnormal cognitive and behavioral responses, including increased fear and anxiety, impaired social interactions, deficits in object recognition memory and sensorimotor gating deficits[35, 36, 59-62]. These symptoms are highly characteristic of autism spectrum disorders (ASD). Although

ASD are partly determined by genetic susceptibility factors, reported dramatic increases in the prevalence of ASD in developed countries (particularly the U.S., U.K., Canada & Australia) have intensified scientific focus on environmental exposures. Both pre- and perinatal immunotoxic insults are now strongly suspected as contributors to this increase[57].

In summary, pediatric vaccines contain numerous constituents potentially toxic to the developing brain, some of which have been associated with adverse neurological and immune outcomes in animal models (i.e. aluminum[32, 42, 45, 63]; ethyl mercury[38]; formalin[64]). yet, the entire pediatric schedule has never been tested for toxicity outcomes because vaccines have not been viewed as inherently toxic by the U.S. Food and Drug Administration (FDA)[65]. This gap in our knowledge on vaccine safety has thus been replaced with an *assumption* that vaccines are safe, as illustrated by the 2002 U.S. Food and Drug Administration (FDA) statement at the Workshop on Non-clinical Safety Evaluation of Preventative Vaccines [65]:

> "*Historically, the non-clinical safety assessment for preventive vaccines has often not included toxicity studies in animal models. This is because vaccines have* ***not been viewed*** *as inherently toxic, and vaccines are generally administered in limited dosages over months or even years.*"

In lay language what the FDA is really saying here is that the regulatory procedures for the approval of vaccinations did not require toxicity studies in animal models which are required for all other drugs because vaccines are ***not considered*** toxic! Talking about ***blind*** belief!!

Furthermore, with regard to the studies which allegedly *demonstrably* show no link between autism and vaccines, it has to be emphasized that once such studies undergo proper expert scrutiny, the "evidence" against the link becomes rather flimsy. In reviewing the published literature on measles-mumps-rubella (MMR) vaccine (139 studies), the respected Cochrane Collaboration review panel concluded that, "*The design and reporting of safety outcomes in MMR vaccine studies, both pre- and post-marketing, are largely inadequate"*[66]. Moreover, none of the 31 studies that were included in the review met the Cochrane Collaboration's methodological criteria. More specifically, referring to the 2001 Fombonne and Chakrabarti study[67] which was widely regarded by medical health authorities as most *persuasive* in disproving the link between the MMR vaccine and autism, the Cochrane Collaboration commented the following: *"The number and possible impact of biases in this study was so high that interpretation of the results is impossible"*[66].
Although the Cochrane Review on the safety of MMR concluded that there was no credible link between MMR vaccination and autism and Crohn's disease, as pointed out earlier, the majority of the studies included in the evaluation were methodologically inadequate. The question thus is what "*credible*" evidence can be derived from methodologically *flawed* studies?

Finally, in a review of cases compensated by the U.S. Vaccine Injury Compensation Program (VICP) for vaccine-induced brain injury, Holland et al. found 83 cases of acknowledged vaccine-induced brain damage that include autism since the inception of that program, all the while the U.S. government spokespeople (much like those in Serbia) have been adamantly asserting that there was no link between vaccines and autism,

"*Using publicly available information, the investigation shows that the VICP has been compensating cases of vaccine-induced brain damage associated with autism for more than twenty years. This investigation suggests that officials at HHS, the Department of Justice and the Court of Federal Claims may have been aware of this association but failed to publicly disclose it*."[68]

So much for public transparency and honesty.

Other than debunking the myth that vaccines including MMR have no relation whatsoever to the autism epidemic, there is yet one more crucial myth related to global vaccination practices that desperately needs to be debunked – the giant myth of herd immunity. So let us then ask the question, whether infectious diseases can and indeed have been effectively prevented by high-vaccination coverage?

Actually, the frequent assertion that high levels of vaccination prevent disease outbreaks is not accurate as infectious diseases do in fact occur even in **fully** vaccinated populations[69] as well as individuals[70] (see Table 1 below). The likely reason for this is that vaccines primarily stimulate humoral immunity (antibody-based or Th2 responses) while they have little or no effect on cellular immunity (cytotoxic T-cells, Th1 responses), which is absolutely crucial for protection against viral as well as some bacterial pathogens[71]. This may be the reason why vaccine-induced immunities are transient, requiring booster shots, while naturally acquired immunity conferred by the cellular immune system in the absence of vaccination tends to be permanent.
Taken together, these observations may explain why outbreaks of allegedly vaccine-preventable diseases do occur in fully vaccinated populations and why, immunity (or its absence) cannot be reliably determined on the basis of serologic determination (measure of antibody levels)[72], which is the most common measure of vaccine efficacy in clinical trials[73-75].
Moreover, although, as was already noted above, in some instances vaccinations can and do induce T-cell (Th1) responses, yet the induction of such immune responses is quite deleterious as demonstrated by Tsumiyama et al.[22] who showed that repeated overstimulation of CD4+ T cells with SEB antigen led to the development of autoantibody-inducing CD4+ T cell which was capable of inducing autoantibodies and produce autoimmune tissue injury similar to that observed in humans.

Table 1. Reports of infectious disease outbreaks despite high vaccination coverage.

Report	**Journal**	**Reference #**
From December 9, 1983, to January 13, 1984, 21 cases of measles occurred in Sangamon County, Illinois... The outbreak involved 16 high school students, all of whom had histories of measles vaccination after 15 months of age… The affected high school had 276 students and was in the same building as a junior high school with 135 students. A review of health records in the high school showed that all 411 students had documentation of measles vaccination on or after the first birthday, in accordance with Illinois law. **This outbreak demonstrates that transmission of measles can occur within a school population with a documented immunization level of 100%.**	MMWR Morb Mortal Wkly Rep. 1984; 33(24):349-51	[76]
During 2006, a total of 6584 confirmed and probable cases of mumps were reported to the Centers for Disease Control and Prevention...College campuses with mumps outbreaks included ones with 77% to 97% of students having had 2 doses of a mumps vaccine.	Pediatr Infect Dis J. 2008; 27(10 Suppl):S75-9	[77]

The Czech republic has had a two dose MMR vaccination programme since 1987. The last outbreak of mumps was reported in 2002, but an increase in the number of mumps cases was observed in 2005, starting in October that year. In an 18 month period examined, 5,998 cases of mumps were notified, with a peak incidence in May of 2006. The highest incidence rate was observed in those in the age group of 15 to 19 years, in which 87% of the cases had received two doses of mumps vaccine.	Euro Surveill. 2008;13(16)	[78]
Despite high levels of vaccination coverage against diphtheria, an ongoing outbreak of diphtheria has affected parts of the Russian Federation since 1990… **an estimated 90% of children were fully vaccinated with four or more doses of diphtheria toxoid by the time they entered school**…**The outbreak described in this report illustrates that, despite a high vaccination coverage rate among school-aged children, diphtheria can cause epidemic disease in developed countries.**	MMWR Morb Mortal Wkly Rep. 1993; 42(43):840-841, 847	[69]
From January, 1988, to March, 1989, a widespread outbreak (118 cases) of poliomyelitis type 1 occurred in Oman. Incidence of paralytic disease was highest in children younger than 2 years (87/100,000) **despite an immunisation programme that recently had raised coverage with 3 doses of oral poliovirus vaccine (OPV) among 12-month-old children from 67% to 87%.**	Lancet 1991; 338 (8769): 715-720)	[79]
Subclinical measles infection in vaccinated seropositive individuals in arctic Greenland. **More than 90% of the total population was vaccinated and a 94-100% seroconversion was obtained.**	Vaccine 1998; 7(4):345-8	[80]
"The rates of secondary immune response (SIR) and secondary vaccine failure (SVF) during a measles epidemic were evaluated…**In conclusion, neither prior vaccination nor detectable SIR ensures protective immunity.**	J Clin Microbiol. 1992; 30(7): 1778-1782	[81]
Results from two independent studies that both showed children faced a substantially increased rate of pertussis infection 4 or more years out from their fifth and final childhood vaccination... **Recent surges in U.S. pertussis cases, which began in 2005, and then spiked even higher in 2010, implicated the acellular vaccine as the cause. "It certainly caused the 2010 California epidemic, and it happened in Minnesota and Oregon, too. Waning immunity with acellular pertussis led to greater vulnerability in 7- to 10-year-olds,"** commented Dr. Kathryn M. Edwards, Sarah H. Sell professor of pediatrics and director of the Vaccine Research Program at Vanderbilt University in Nashville, Tenn.	MDedge Pediatrics. 22 Nov 2011	[82]

Could it be possible then that vaccines have received the praise altogether *undue* to them in disease eradication? Although the medical community by large considers even posing such a question akin to committing a damnable heresy, yet, the notion that some other factor played a crucial role in the disappearance of infectious diseases is grounded in solid scientific evidence rather than in *unwarrantable* assumptions drawn out of thin air!

Indeed, for it has been clearly demonstrated that factors such as clean water and improved sanitation, as well as better nutrition, availability of antibiotics, greater access to health care, and technological advances in maternal and neonatal medicine) have played a major impact on infectious disease incidence [83]. In fact, according to the U.S. Centers for Disease Control and Prevention (CDC), these measures accounted for 90% reduction in infant mortality and 99% reduction in maternal mortality since 1900 [84]. So clearly then, vaccines could not have played such a major role in health as often claimed. This fact (of major reduction in mortality rates due to better sanitation measures prior introduction of vaccines) is also illustrated by a 2002 review in *Lancet Infectious Diseases*[83] which clearly shows that the crude death rate from infectious

diseases in the U.S. in the 20th century has decreased to baseline levels *prior* wide-spread introduction of vaccination practices.

Now to conclude, it ought to be evident from all of the afore-documented that vaccines are neither as safe nor as effective as often presented by the vast majority of medical authorities. Moreover, it has been recognized even by those who are most zealous propagators of mass-vaccinations that not all vaccines are safe for all people. In spite of this, current vaccination policies operate on a "one size-fits all" principle. That serious adverse events following vaccination do occur is evident in light of the published evidence to anyone who practices at least *some* intellectual honesty. Thus concerns about vaccine safety have a valid scientific foundation. Although it is popular to label those who express concerns over vaccine safety as "anti-vaccine", "anti-science", "baby killers" and similar, such labels should not have a place in any civilized society as they are irrational, bigoted and unscientific. We agree with Peter Doshi that such like labeling of people concerned about the safety of vaccines is derogatory. In truth, it would seem that those who employ these labels suffer themselves from cognitive dissonance, which is a psychological discomfort that most people experience when their deeply held beliefs are contradicted by new information that disproves their old beliefs. The hostile reaction against the bearer of the new information often takes the form of "ad hominem attacks". Attacking the messenger of a new unwelcome truth, rather than rationally dealing with the truth, is a commonly used tactic when the new information can't be refuted using sound logic.

Furthermore, medical bioethics has rejected the notion that we can treat another individual(s) as a means to an end, regardless of how honourable that end may appear to be. The Nuremberg Code and subsequent Helsinki Declarations clearly reject the moral argument that the creation of alleged benefits for the many ("herd immunity") justifies the sacrifice of the few.

Finally, history has taught us that when science becomes politicized, a paradigm shift occurs that threatens those who are wedded to the current state of belief. Semelweiss and Tesla paid a high price for challenging preconceived and dogmatic notions in their respective fields of sciences. Indeed, nothing in science research should be beyond scrutiny of questioning, since *inerrancy* is *demonstrably not* a human prerogative. The medical inquisition type propaganda and policies currently carried out in Serbia are thus truly deplorable and ought to be opposed. Their emperor – "All Vaccines For All People" is truly without any solid clothes of sound evidence and none are so blind but those who refuse to see that fact.

Very best wishes,

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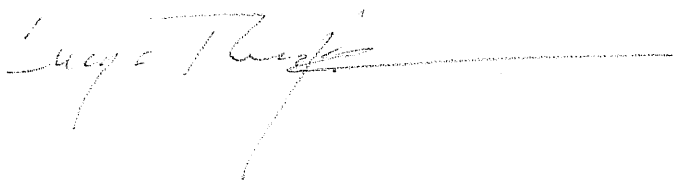

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