

Polio Awareness Day: Medical Myths Die Hard

By Gary Krasner September 19, 2006
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INTRODUCTION: Manufacturing Epidemics

To appreciate how epidemics can be “created”, one has to understand the degree of control that public health officials have throughout the entire process.

Public health agencies have assumed wide discretion in announcing “public health alerts”. Such powers have been abused. The CDC loosely defines an “epidemic” as 5 or more confirmed cases clustered in a concentrated area. An “area” may be a few city blocks, or an entire country. An “outbreak” is defined as at least one case in one area. There’s also a loose standard by which if one person living in a household has a confirmed case of a “communicable” disease, then there’s no need to draw blood to test anyone else with similar symptoms living in that same household.

Also, there’s an over-reliance on incidence statistics rather than mortality, to demonstrate vaccination effectiveness. However, statisticians tell us that mortality statistics can be a better measure of incidence than the incidence figures themselves, for the simple reason that the quality of reporting and record-keeping is much higher on fatalities. [Darrell Huff, *How to Lie With Statistics*, p. 84] In 1982, Maryland state health officials blamed an epidemic on a television program, “DPT: Vaccine Roulette”, which warned of the risks from the DPT vaccine. However, when Dr. J. Anthony Morris, former chief virologist for the U.S. Division of Biological Standards, had analyzed the 41 cases, only 5 were confirmed cases of pertussis, and all 5 had been vaccinated against the disease. [Trevor Gunn, “Mass Immunization: A Point in Question”, p 15 (E.D. Hume, *Pasteur Exposed-The False Foundations of Modern Medicine*, Bookreal, Australia, 1989.)]

Historically, public health officials have routinely increased disease surveillance in areas of low vaccination acceptance as a retaliatory response (a) against people who reject Modern Medicine’s vaunted public health tool, and (b) to justify predictions that outbreaks will occur because of said rejection. Intensified surveillance for whooping cough in Britain, Japan, and Sweden, for example, had followed steep declines in pertussis vaccination rates in those countries.

Sometimes the increased disease surveillance is accompanied by a relaxation of the case definition of the disease, and lowered criteria required for its diagnosis. Subclinical and borderline cases are suddenly classified as “severe”. Suspected cases are permitted to be clinically diagnosed without laboratory confirmation. After 1955, for example, polio had “disappeared” following the Salk vaccine, only because thereafter clinicians hung new and different names on the same polio-like symptoms. In fact, it appears that it was the Salk vaccine itself that was the “great crippler”, and that paralysis would have disappeared sooner, had we done without the vaccine. This type of skewering of medical statistics has also occurred with common diseases such as flu, and with major pandemics like AIDS, a syndrome of 30 disparate diseases said to be infectious.

Finally, there are two primary means by which public health officials manufacture infectious or communicable diseases where there are none, or where the causes may be chemical or environmental toxins. First, because symptoms from chemical toxins or malnourishment (poor nutrition) closely mimic symptoms from infectious diseases (ie.: the catarrhal and zymotic diseases that allopaths deem to be caused by biological pathogens), the former can often be hidden under the latter. Many journal papers have been written supporting such theories for West Nile, Mad Cow, “Foot & Mouth” (U.K.), Legionnaires’, AIDS (self-induced drug toxemias), and dozens of others. Public health officials exacerbate this medical bias through their notorious inclination to shun investigations into possible non-infectious causes.

Secondly, the commonality of human symptoms across diseases of different names enables public health officials to artificially inflate one disease from a large available cache of disparate disease categories. Specifically, there's a limited number possible combinations and sequences of fever, cough, sinus mucous, diarrhea, and skin lesions and rashes. Yet there are thousands of different names for infectious diseases which include these symptoms. Thus, hundreds of different diseases are symptomatically interchangeable. This enables health officials, for examples, to claim that there's a West Nile virus epidemic despite the fact that the normal background incidence of encephalitic reactions for that given year, for that given locality, hadn't risen at all. (The increase in bird mortalities caused by environmental pollution is a key factor not considered or investigated by officials in this example.)

Similarly, health officials may alert us to a flu epidemic, despite the fact that the normal background incidence of fever, muscle stiffness, and sinus release may have remained level, or even have dropped. Since so many other diseases share these same symptoms, it merely requires a clinician to report a cluster of "flu". The deception (and self-deception) is facilitated and perpetuated through subsequent DoH bulletins ordering clinicians to increase disease surveillance for flu, and concomitantly, to relax the case-definition and requirements for lab confirmation.

The final result is an "epidemic" that was actually non-existent, or grossly inflated. Yet public health agencies are able to achieve what every publicly-funded entity requires to thrive: They remind the public of how much they are needed. The gullible media aids them in this endeavor by routinely dropping their usual objectivity and deferring to the medical experts. (What newspaper wants to be held responsible for risking lives by challenging the advice of medical authorities?)

Most people would be surprised to learn that there are more than one thousand outbreaks worldwide each year, including colds, seasonal flues, hepatitis, and numerous noninfectious syndromes, all running their course and disappearing, often despite remaining unexplained by scientists. Even the dreaded Ebola epidemic failed to materialize. The CDC claimed that 108 people may have been killed by the Ebola in Zaire in 1995. However, there had been no further deaths and not a single case has ever been reported in the U.S. or Europe. As historian Elizabeth Etheridge wrote, "the epidemic was virtually over before their work [CDC & WHO] began" (Sentinel for Health, 1992).

Considering the speed from exposure to death, the mortalities were more likely the result of a chemical toxicological agent. A couple of other indications point in that direction: Symptoms were rarely seen outside the localized area where it began. And 20 per cent of the 55 million Zairens are Ebola virus antibody-positive, having survived the virus without apparent disease (Dietrich J., 1995). One guess is that those who became sick had been exposed to the deadly cleaning solvents and oils that are often left at military base camps—possibly from groundwater contamination. Indeed, civil wars extending across 8 nations in central Africa killed about 2.5 million African civilians between 1998 and 2001 alone. If it were not for the gullible media and fanatical virus hunters seeking fame and fortune, this virus would have joined the ranks of the thousands of known harmless passenger viruses. According to renowned molecular biologist Peter Duesberg, "these many outbreaks provide the CDC with its inexhaustible source of epidemics" (Inventing The AIDS Virus, 1996).

In conclusion, such deceptions skew the correct picture of disease prevalence. Too often, an apparent rise in cases of a disease is an artifact of epidemiological methodology—and bias. State legislatures cannot properly ascertain which vaccines to mandate based upon information provided solely from health officials. Dissenters outside, and from within the medical community must also be heard. Thus, given the traditional abuse of this responsibility by health officials, it is imprudent to continue to vest public health officials sole authority during states of "public health alerts"—particularly when they're so poorly defined and entail such a low threshold to demonstrate.