





MEDICAL GENOCIDE

PART SEVENTEEN

If history repeats
itself, mass immunization
against AIDS could
lead to a deadly epidemic.

VACCINE VICTIMS

BY GARY NULL

A glaring example of modern
medicine's questionable status as a
humane science is the
profession's predilection toward mass
vaccination programs. At one

PHOTOGRAPH BY
ANDREW UNANGST

time, few doctors were opposed to these programs. The medical community considered vaccines harmless, therefore the fact that many had never been proven effective didn't bother anyone. Over the years, however, evidence has been accumulating that suggests that some vaccines are not only of questionable efficacy, but that they can be extremely toxic as well, especially when administered to infants and young children, as they often are. This has led a growing number of physicians and medical researchers to speak out against mass immunization, particularly when the medical establishment insists that such programs are mandatory.

In his recent book, *DPT: A Shot in the Dark* (1985), researcher Harris L. Coulter does an in-depth analysis of the controversial DPT (diphtheria, pertussis [or whooping cough], and tetanus) vaccination. The controversy surrounding this vaccine stems from the pertussis component, which has been linked to illnesses that can result in mental retardation, convulsive seizures, and paralysis. While these severe reactions may affect only a small minority, others may be more subtle and far more pervasive. Children may develop chronic infections, or behavioral problems such as hyperactivity or retarded development, which often manifest themselves as learning disabilities in school.

Ironically, there was a dramatic decrease in the death rate from whooping cough before any program of mass vaccination was ever introduced. Vincent A. Fulginiti, M.D., a noted pediatrician and spokesman for the American Academy of Pediatrics, writes, "Prior to the widespread use of pertussis vaccine, both the incidence of pertussis and the case-fatality ratio declined. A 50-fold reduction in incidence and an 84 percent reduction in case fatality were recorded in Great Britain in the years between 1947 and 1972. . . . These data suggest that pertussis virulence was declining before the pertussis vaccine and that the incidence of the disease continued to fall, both before and after the introduction of the vaccine. To further complicate the analysis [of the efficacy of the vaccine], serial studies . . . have shown results varying from no effect through 20 percent protection to 80 percent protection."

Coulter points out that the decline in fatalities from pertussis parallels similar declines in other infectious diseases, such as scarlet fever, measles, influenza, tuberculosis, and typhoid. He suggests that this decline was attributable not to mass vaccination programs, but rather to better sanitation, nutrition, and housing, which resulted in an improvement in the general health of the population.

In addition, antibiotics—which were successful in controlling secondary infections such as pneumonia and bronchitis—improved a child's chances of surviving whooping cough and various

other serious childhood diseases.

In the late 1940s, doctors and government health officials were campaigning intensively for mass immunization against pertussis. Already at that time, the incidence and fatality rate from whooping cough was on the decline. Furthermore, there had been no studies, double-blind or not, on either the safety or efficacy of the vaccine. Consequently, it was by any definition an experimental remedy—and the test subjects were the children of America.

In the 1930s, there had been reports of the vaccine's toxicity. In 1933 a Swedish doctor reported two infants had died immediately after vaccination. A few years later American researchers reported that some children reacted with high fevers, convulsions, and collapse. Then, in 1948, two researchers at Harvard Medical School, Randolph Byers and Frederick Moll, conducted a study in which they followed 15 children who had reacted se-

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verely within 72 hours of receiving the vaccinations. One case they described was of an eight-month-old infant who had reacted with irritability and drowsiness to his first shot. The second shot, given three weeks later, caused a more severe reaction. Within 72 hours, he went into convulsions; eight months later, "he was blind, deaf, spastic, and helpless."

Of the 15 children studied, all of whom had been normal prior to vaccination, "one child recovered completely; three had had too short a period of observation to allow for final conclusions; two pursued a long downhill course, ending in death; and the remaining nine suffered from damage to their nervous system, which in most instances promised to interfere with competitive living."

This was the first of a long series of studies that pointed to the highly dangerous nature of the pertussis vaccine. Other studies have introduced the following findings:

- In 1953, a list of 82 cases of pertussis-vaccine damage was compiled. In 1958, the medical literature documented 107 such cases, 31 of which showed signs of permanent damage.

- Between 1946 and 1957, large-scale studies conducted in Britain showed that a significant number of children suffered from convulsions after receiving the vaccination. But doctors denied any connection. From this study, British and American medical communities both concluded that the vaccine was safe.

- In 1960, a Swedish researcher stated "the incidence of neurological complications after pertussis does not appear to be as high as that after vaccination." Noting the decrease in the severity of the disease itself, he concluded, "It is questionable whether universal vaccination against it is justified."

- In 1961, an American physician recognized a reluctance on the part of parents to bring their children in for further DPT vaccination because of violent reactions to previous shots. He collected data from 52 cases, and found six had collapsed, 14 had persistent vomiting, and 13, uncontrollable screaming.

These reports went unheeded by the American medical establishment and government health authorities. By the mid-1950s, the vaccination program was in full swing. By the 1970s, however, the debate over the pertussis component of the DPT vaccine was renewed by new reports of its toxicity. In 1974 British physicians released a report on their study of 36 cases of neurological illness thought to be attributable to the vaccine. Of these cases, two died, four recovered completely, one was permanently paralyzed on one side, four were mentally retarded, three had epilepsy, and 22 were retarded and had epilepsy. The report was the basis of a television program and is believed to have triggered the dramatic decline in vaccination from 80 percent to 30 percent of British schoolchildren over the succeeding four years. That same year another British researcher estimated that an average of 80 cases of severe neurological damage resulted from the pertussis vaccine annually.

It was not until 1978 that the Food and Drug Administration, the agency responsible for monitoring the safety of drugs in this country, commissioned its first study of the effects of the DPT shot—some 30 years after it had been in wide use here and a good ten years after most states had passed legislation requiring pertussis vaccination for entry into school. The two-year study, conducted at U.C.L.A., was, according to Coulter, like so many other medical investigations in that it was riddled with statistical manipulations, misleading statements, and unwarranted conclusions.

The U.C.L.A.-F.D.A. study showed a significant number of adverse reactions to the DPT vaccine, but through the magic of statistical manipulation, downplayed the importance of these often severe reactions and concluded that "this study supports the conclusion of others that the benefits of pertussis immunization far outweigh the risks."

The flaws in this study were easily detectable. According to Coulter, the data was compiled in terms of numbers of vaccinations, not numbers of children who received them (DPT is a multiple injection). This resulted in a much larger denominator against which adverse reactions were measured. Children in the study were prescreened for any conditions that might predispose them to such responses. In doing so, the study failed to replicate normal distribution of the vaccine in the general population. The study did not recognize high-pitched screaming as an adverse reaction, even though many physicians consider it a symptom of central-nervous-system irritation. Follow-up on children who showed severe reaction was limited to just a few weeks, and the F.D.A. did not recognize reactions that occurred more than 48 hours after the actual injection.

In attempting to estimate the total number of children who have been damaged by the vaccine, Coulter says, "We concluded that a number of children die from the vaccine. There are about 8,000 or 9,000 cases of sudden infant death [S.I.D.] per year in the United States. The vaccine authorities admit that they can't tell the difference between the case of a child dying from vaccination and the case of a child dying from some other cause. So they are both classified as sudden infant death from unknown causes. So the question is how many of these cases of S.I.D.'s might be due to the vaccine. We estimated, and it is really difficult to tell how accurate the estimate is, that probably a quarter to a half were caused by a vaccine."

The same may be true for children with epilepsy. There are 25,000 children born every year in the United States who are diagnosed as being epileptic from birth. But those children are first diagnosed after each has had four DPT shots already. Since it has been reported that the DPT vaccine can cause seizures or epilepsy, how many cases of infant epilepsy are congenital, and how many really are caused by the vaccine? Nobody really knows.

Coulter believes that the DPT vaccine is just another example of the American public being used as guinea pigs for medical experimentation for the profit of vaccine manufacturers and the medical profession, both of which campaign diligently for mass vaccination programs. Their solution to the troublesome problem of adverse reactions has not been to proceed with caution in vaccinating American children, but rather to launch a full-scale lobbying effort to convince Congress to fund the National Childhood Vaccine Injury Act of 1986, which would assign the financial responsibility for injuries caused by the vaccine.

J. Anthony Morris, Ph.D., a research virologist who has spent more than 30 years studying vaccines at the National Institutes of Health (N.I.H.) and the F.D.A.,

is opposed to any such scheme. Testifying before a House subcommittee last March, Morris stated, "My urgent plea to the members of this subcommittee is, do not fund the compensation program of the National Childhood Vaccine Injury Act of 1986. This program, in my judgment, will be found to be a black hole for taxpayers' dollars, to be an escape from just responsibility by manufacturers and medical practitioners for their product and their practices, and to be an injustice to children who will be irreparably harmed by mandated vaccine injections.

"Rather, money and efforts should be directed towards reduction or elimination of the need for funding of a seriously flawed compensation system. Money and efforts should be directed toward improving vaccines . . . not towards funding a seriously flawed compensation system to pay for damage that should and can be prevented."

Could the government be hoodwinked into footing the bill for such a preposterous program? It did precisely that in the swine-flu fiasco back in 1976. The Justice Department reported that six years after the end of the swine-flu program, 1,571 lawsuits had been filed against the federal government for compensation that it agreed to provide when the insurance industry considered it too bad a risk. At that time, 290 suits were settled for \$57 million and an additional 693 were still pending with total compensation of over \$1 billion being sought by plaintiffs.

Even with the limited compensation of \$250,000 per victim provided in the proposed National Childhood Vaccine Injury Act, in a letter to the editor of *The Washington Post*, the executive vice president of Dissatisfied Parents Together (a group organized by the parents of DPT victims), writes, "Five more years of American children dying and becoming brain damaged by the current 45-year-old [DPT] vaccine is not only an unnecessary human tragedy, it could well bankrupt the federal vaccine-injury compensation system recently approved by Congress." (The vaccine compensation system referred to will not become effective until Congress approves a funding system as contained in the 1986 Injury Act.)

Even before a funding mechanism is set up for a compensation program, its bankruptcy can be foreseen. One vaccination scheme after another has been proven to be either largely ineffective or highly toxic or both. Nevertheless, the proponents of these schemes are constantly proposing new vaccinations for what often turn out to be manufactured epidemics. At best, the target of an immunization program is usually a disease that is showing a natural decline in incidence and morbidity before the vaccine is even introduced.

Morris has long been a critic of influenza vaccines, for instance. He says that with the current state of medical knowledge and technology, we do not have the

means to develop a vaccine against the flu, because influenza viruses can and do in fact spontaneously mutate by changing their surface molecules. Each change represents a new strain of the virus that may or may not be resistant to the vaccine, depending upon the degree of mutation. Consequently, as soon as one vaccine is prepared, it may be necessary to prepare another and still another, ad infinitum.

Most flu shots are merely ineffectual—that is, while they may be a waste of money, at least they do not cause harm. This, however, was not the case of the swine-flu vaccine, which represented perhaps the most dramatic example of "political immunization." There is little doubt that swine flu was at one time responsible for one of the largest pandemics that the world has ever seen. In 1918 the swine-flu virus was responsible for 15 to 25 million fatalities.

The swine-influenza virus went into hiding until 1976, when Private David Lewis collapsed and died in a matter of hours at Fort Dix, New Jersey. His death was traced to a virus that was related to the swine flu. Some medical authorities feared that this was just the first case of what could turn out to be a new epidemic of the disease. Fortunately, this proved to be a false alarm. In the years after Lewis's death, no other similar fatalities were reported. A nationwide search turned up a few isolated cases, but researchers ruled out the possibility of human-to-human transmission and attributed the cases to contact with pigs. But the alarm was sounded nevertheless. Under the direction of the Centers for Disease Control (C.D.C.), the nation began to arm for battle against a deadly epidemic.

There were, of course, a handful of doctors, scientists, and government officials who were urging a more conservative approach. For example, consumer advocate Ralph Nader's Health Research Group stated that everyone was being overly alarmist and that the push for nationwide vaccination was just a waste of taxpayers' money. Congressman Henry A. Waxman (D-Calif.) and former congressman Andrew McGuire (D-N.J.) suggested that the whole scheme was a "rip-off" by the vaccine manufacturers. But these voices were ignored in favor of far more influential pro-vaccine advocates. One of these was Dr. David Sencer of the C.D.C., who drafted the initial memorandum that described the swine flu and recommended a course of action.

This report started with a statement of "facts": "(1) In February 1976 a new strain of virus . . . was isolated from an outbreak of disease among recruits in training at Fort Dix, New Jersey. (2) The virus is antigenically related to the influenza virus, which has been implicated in the cause of the 1918-1919 pandemic which killed 450,000 people—more than 400 of every 100,000 Americans. (3) The entire

U.S. population under the age of 50 is probably susceptible to this strain. (4) Since 1930, the virus has been limited to transmission among swine . . . with no secondary person-to-person transmission. (5) In an average year, influenza causes about 17,000 deaths (nine per 100,000 population) and costs the nation approximately \$500 million. (6) Severe epidemics, or pandemics, of influenza occur at approximately ten-year intervals. In 1968-69, influenza struck 20 percent of our population, causing 33,000 deaths (14 per 100,000), and cost an estimated \$3.2 billion. (7) A vaccine to protect against swine flu can be developed before next flu season."

Most of Senser's "facts" are biased or distorted. Fact No. 3, for instance, is not even a fact, but a statement of a "probability," which in turn is more a possibility than a probability. Fact No. 5 fails to mention what proportion of the 17,000 annual deaths "caused" by influenza were of people suffering from debilitating primary diseases or who were in a weakened condition to begin with, such as following surgery. And while it was true, as stated in Senser's memorandum, that a vaccine could probably be developed before the next flu season, Senser fails to note that such a rapid development of the vaccine would necessarily preclude adequate testing for its safety and efficacy.

With "facts" and recommendations put in these terms, it should come as no surprise that very few politicians would adopt any other stand on the issue than that recommended by Senser. Says David Mathews, former secretary of the Department of Health, Education, and Welfare (now the Department of Health and Human Services), "As soon as I heard about the swine flu and its implications for a pandemic, I realized that the political system would have to respond. There was no way out, as long as the scientists supported it. . . . You can't face the electorate later, if the pandemic arrives, and say that the probability was so low that the costs outweighed the benefits. The people would never forgive us." Little over a week after Senser first circulated his memorandum, Mathews wrote a note to the head of the Office of Management and Budget warning that a request for funding the swine-flu program was on its way. In this note Mathews substantially upped the political stakes by stating that "there is evidence that there *will* be a major flu epidemic coming this fall. The indication is that we will see a return of the 1918 flu virus that is the most virulent form of flu . . ."

The ball was off and rolling. By March 1976, President Ford, who had long been criticized for being indecisive, came out firmly in support of a national immunization program. The Senate passed the swine-flu appropriations bill in April 19, 1976, by a vote of 61 to seven; it was approved by the House on April 12 and signed into law by President Ford on April

15. Rarely in the history of this country has our federal government moved with such speed and with this degree of cooperation, especially in an election year. (It should come as no surprise that attached to this bill were amendments for additional funding for the C.D.C. and the F.D.A., the government agencies most intimately involved in the immunization program.)

By April 1976, the program was under way, but it was soon announced that Parke-Davis, one of the vaccine manufacturers, had prepared several million doses using the wrong virus, thus delaying the delivery schedule by four to six weeks. The manufacturers also discovered that they could produce the vaccine at only half the rate they had initially estimated. This rendered the plan of massive immunization prior to the next flu season highly unlikely.

While tests of the vaccine indicated that it was about 85 percent effective in adults over the age of 24 and appeared relatively safe in children from ages three to ten, it also caused excessive adverse reactions. In addition, the recommended dosage for young adults between the ages of 18 and 24 was only 50 percent effective, while larger doses also caused adverse reactions.

Perhaps the most formidable obstacle to the swine-flu immunization program was presented by the insurance companies, which by April 1976 were sending out relatively clear messages that they did not intend to cover indemnity and defense costs for damages resulting from this program. Just two years earlier, the Supreme Court had upheld a decision awarding \$200,000 in damages to the family of an eight-month-old child who had developed polio after inoculation with the Sabin live-virus polio vaccine. Understandably, the insurance company was not enthusiastic at the prospect of being left holding the bag for an immunization program as vast and as hastily coordinated as that of the swine flu.

With the insurance companies out of the picture, the only alternative, other than letting the program die, was for the federal government itself to insure the program. This course was adopted because the prestige of the presidency had been put on the line in Ford's initial announcement of the program. Had the program originally been announced at some lower level instead of going to the "heroic" effort of trying to save the program by legislating the government into the insurance business, the administration would have let the program die in those last days of July.

Like the rest of the swine-flu program, the federal government's assumption of liability was not without controversy. Congressman John Dingell (D-Mich.) said that the bill was "an absolute unbridled, total, unlimited assumption of responsibility and liability," rather than simple insurance. The late congressman Walter

Flowers (D-Ala.) warned that the bill would open the floodgates to a myriad of lawsuits against the federal government, while former congressman John Moss (D-Calif.) pointed out that Congress was reacting to a national emergency that no longer existed. In fact, it had by that time been four months since the swine flu had appeared anywhere in the world.

Congressman Waxman stated that the drug manufacturers and the insurance industry were being let off the hook by the bill. "We are being used," he said. "I think we are making a big mistake." But in the end, the Senate also capitulated. On August 12, 1976, the National Swine Flu Program of 1976 was signed into law by the President, amid the fanfare of the press and the medical establishment.

The program started on October 1, 1976. On October 11, it was reported that three elderly people had dropped dead shortly after receiving the swine-flu vaccine at a clinic in Pittsburgh. The C.D.C. later investigated claims of over 2,000 serious reactions to the vaccine, 181 of which resulted in death. Of these, 142 deaths occurred within 48 hours of immunization. When the statisticians made appropriate adjustments for age, sex, and other medical factors and compared these numbers with what would be expected in the general population, they concluded that the number of supposed vaccine-related deaths was actually *below* the number of deaths that would have been expected to occur by chance during any given 48-hour period, had vaccination not been given. Thus, by the magic of statistics, the C.D.C. was able to "prove" that the swine-flu vaccine really was safe and represented no threat to the health of Americans.

But all the magic in the world could not have saved the reputation of the swine-flu vaccine when the development of a rare and serious disease called Guillain-Barré Syndrome (GBS), which produces polioliike symptoms, was connected with the vaccine.

In the third week in November, the first case of GBS was reported to have developed in a patient shortly following his swine-flu vaccination. During the following week, three more cases were reported, one of which was fatal. By March 1977, there were 843 cases, over half of which occurred in persons who had recently received the vaccine. When these cases were analyzed, researchers estimated that the "relative risk" of developing GBS was 12 times greater in vaccinees than in nonvaccinees.

By February 1978, when Congress submitted its final report on the program, 1,241 claims (including 103 for wrongful death) had been filed.

It appears that our government, prodded by the medical establishment, health officials, and pharmaceutical manufacturers, is only too ready to disregard the lessons of the not-so-distant past. Testifying in March 1987 before a House sub-

committee in connection with the National Childhood Vaccine Injury Act of 1986, Dr. Morris stated, "In 1977, in testimony before the House Subcommittee on Health and Environment, at a hearing on review and evaluation of the swine-flu program, I testified that when I left the Food and Drug Administration in 1976, there was no available technique to measure reliably and consistently neurotoxicity or potency of most of the vaccines then in use, including DPT vaccine. Today, 11 years later, the situation remains essentially the same. And today this subcommittee is considering a funding mechanism for a vaccine-injury compensation program."

Will Morris's warnings against the pitfalls of the currently proposed indemnification program receive any more attention than they did ten years ago when he spoke out against the swine-flu program? If history repeats itself, probably not. In the early 1970s, Morris was advising the government on the questionable safety and efficacy of the Hong Kong flu vaccine. He was ignored then, as he and many others were ignored when they counseled caution with the swine-flu vaccine later in that decade.

The swine-flu affair is not an isolated event in this country's medical history; nor is it by any means an exception to the rule of how medicine operates, especially when the government gets involved. We are seeing the very same scenario, with the same actors, using the same script in the push for a federal indemnification program for DPT vaccines.

This scenario is also being played out on the AIDS front. The state of the public panic around AIDS is not unlike that promoted around swine flu in 1976. And it is precisely this kind of panic that leads the American public to believe that their only salvation lies in a miracle drug or a vaccination. Again, Morris warns us to proceed with caution. "I see the same thing developing with AIDS. There are political pressures to do something about AIDS. There are congressmen who are tremendously interested in being in the forefront of the AIDS program. There are scientists who want to be the first to develop an AIDS vaccine. It's written up already in the newspapers. There have been headlines: 'AIDS Vaccine Ready for Human Trials.' This is sheer and utter nonsense. If the scientist *believes* there is a vaccine ready for human trial, then he hasn't thought about it thoroughly. But it makes a nice headline.

"With the techniques now available, it is not possible to make a vaccine that will work against AIDS. There are a number of reasons why. First of all, AIDS differs from most viral diseases in that, with measles, for instance, the objective of the vaccine is to induce in the recipient antibodies that will be protective against measles. The same applies with mumps and with polio; the purpose of the vaccine is the formation of antibodies that

will protect the recipient against the infecting agent. That's not true with AIDS. The antibody in this disease is not a protective antibody.

"One of the reasons that there is no effective vaccine against influenza is that the influenza virus mutates rapidly. It has the capability of creating many flu strains against which the vaccine will not be effective. The same applies to AIDS—the AIDS virus mutates. So even if it was possible to create a vaccine against one strain, that vaccine would not be effective against another strain. To create an effective vaccine, it would have to protect against a multiplicity of strains.

"Furthermore, even if it was possible to develop a vaccine against AIDS, how would you test whether it worked or not? If the incubation period for the disease ranges from many months to many years, it is impossible to determine the efficacy of a vaccine."

Even a cursory examination of the direction in which AIDS is being pushed indicates that it will not be long before a vaccine is announced and a mass inoc-

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ulation program initiated. When this occurs, there is a strong likelihood that in the current state of AIDS hysteria, the mass vaccination program will commence prior to any adequate testing. This is, in fact, precisely what has occurred with the experimental drug AZT, the testing of which was stopped almost as soon as it began, because the medical establishment considered it "unethical" to withhold this drug from anyone suffering from AIDS. Now, not only is AZT out of its experimental stages, but the pharmaceutical company manufacturing it and the medical profession allied with federal agencies like the N.I.H. and the F.D.A. are pushing Congress to pass a bill to fund the use of this drug, which has never been proven to be an effective cure.

Morris discusses the current politics surrounding AZT: "There was a hearing held before one of the congressional committees on the tenth of March [1987]. The subject under discussion was the

funding for the use of the new drug AZT and who will pay for this drug. Supposedly, it will cost anywhere from \$7,000 to \$10,000 per year per patient to supply this drug. I read from the opening remarks of the chairman of that committee: 'We cannot permit the health-care system to keep this drug away from people any more ethically than we could permit the health-research system to do so. Giving patients nothing because they have no money and no insurance can be rationalized only if [it's] part of a system that provides health miracles to the wealthy and health neglect to the poor.'

"Now, he's talking about 'a miracle,' a 'health miracle,' AZT. He wants to get money appropriated so that the poor can get this drug costing \$7,000 to \$10,000 per year. Nowhere in his statement does he talk about the shortcomings of this drug. First of all, the manufacturer says it's not a cure, but a treatment, and that is certainly the case. This drug came about because when it was tested by the pharmaceutical companies and cooperating doctors, it was found that AIDS patients on AZT at the end of 24 weeks had a significantly lower death rate than the control group. So they broke the code and said we cannot deny people the use of this drug. . . . And indeed there were striking results. There was, I believe, only a single death in the AZT-treated group. The number of deaths in the control group was much greater. They went to Congress and to the F.D.A. and asked permission to test this drug in larger numbers. What they didn't say was that at the end of 48 weeks, that difference was no longer detectable—that is, the number of deaths were comparable. That means that at best this drug prolongs the life of an AIDS patient for several months, possibly a year. But there is no evidence that a long-term benefit will be derived from the use of this drug. It's like taking an aspirin tablet for a tumor. Instead of using this fantastic amount of money for the purchase of this drug, we should be looking for a better drug."

AZT is also not without its side effects, which can be serious. If a patient survives on the drug for any period of time, there is a good chance that serious anemia will develop, necessitating blood transfusions. The drug is also responsible for kidney damage. Additionally, AZT, according to Morris, has no effect on secondary diseases such as pneumocystis pneumonia or Kaposi's sarcoma, which are the most common causes of death in AIDS patients.

So what about the safety of an AIDS vaccine? Given the little we know about the virus and the rush to get a vaccine on the market as soon as possible, based on past history, one thing is clear: The potential for disaster abounds. If history repeats itself with an AIDS vaccine, the results could be a real epidemic, especially if the vaccine is rushed into a massive nationwide program. We saw with

the polio vaccine that the rush to get the vaccine on the market resulted in batches that contained live polio virus. The polio vaccine was also subsequently shown to contain a substance, SD40, that caused cancer in animals. Every indication points to the conclusion that we are moving in the same direction with an AIDS vaccine, unless the American public finally decides that it has had enough of medical experimentation and profiteering at the expense of human health.

Medicine is now the No. 2 industry in this nation, second only to defense. The question is, how much larger does it have to get and how many more people have to die at its hands before we finally get fed up?

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