October 25, 2021

Re: UUCB Oct. 25: Board of Trustees Special Meeting Re: Vaccinations

Dear UUA, UUCB Board (Beth Pollard, Helen Tinsley-Jones, Bill Brown, Randall Hudson, Elaine Miller, David Roberts, Kerry Simpson, Cordell Sloan, Ariel Smith-Iyer, Jessica Rider, Ann Harlow), Executive Advisory Team (Tess O'Riva, Michelle Collins, Alice Lemieux), Opening Task Force (Patrick Cullinane, Sheldon Jones, Greg Lemieux, Lisa Maynard, Catherine Boyle), Susan Lankford, and any other interested parties:

Thank you for holding a meeting to hear concerns about the contentious issue of vaccine mandates. Below is my take; in brief (one long sentence): since the current vaccines provide limited efficacy and durability, particularly against new strains, and since they convey risks that can be serious and unpredictable and are not well-characterized, and since the issue is controversial as well as complicated (the devil is in the details), and since the actions of our health authorities have not been fully transparent or defensible, mandates at this time are inappropriate.

In reviewing the online material provided for this meeting, two major observations emerge: 1) the church and the denomination have gone to great efforts to produce a sound foundation from which to guide policies in general; and 2) the current UUA policy encouraging vaccination ("We know vaccination is how we end this pandemic and care for each other," demonstrates an inappropriate certainty and a naive deference to mainstream authorities, as well as a failure to recognize the legitimate scientific debate raging under the radar. In addition, one submission by a congregant appears to advocate mandates with provision for medical exemptions — a policy that is unrealistic, as described below. Finally, the materials may beg the question of how to address future recommendations for additional doses of this and other new vaccines.

Below are, first, some stipulations of fact, followed by contextual considerations, then a policy critique, and finally my personal situation. I apologize for the length; much is simply context that helps explain the controversy to those who have not followed the "alternative" critiques of mainstream coverage.

Stipulations

The points below can likely be stipulated (i.e., acknowledged by all parties as true).

- **Vaccine safety/risks**

  Vaccines are biological pharmaceutical products that inherently convey risks of injury and death, and these risks can be greater for some people than for others. The policy debate is over the number of people who incur these risks and the severity of the risks.

  According to the Vaccine Adverse Events Reporting System (VAERS, a voluntary tool considered cumbersome and unreliable but better than nothing), US deaths related to COVID vaccines total over 17,000 as of October 2021.[1]

  According to a government data analyst who examined the Centers for Medicare & Medicaid Service database in July 2021, over 45,000 seniors died within 3 days of receiving a COVID vaccine, or about 5 times more than were reported to VAERS for that time period.[2]

  Vaccines are regulated as "biologic" products that are necessary for public health and national security, rather than as pharmaceuticals; therefore, transparent safety testing (comparing a treated group to an untreated group) is not required. Instead, new vaccines are safety-tested against already-licensed vaccines, such that some baseline level of adverse events is considered

[1] OpenVAERS.com

[2] Redshaw M. Federal lawsuit seeks immediate halt of COVID vaccines, cites whistleblower testimony claiming CDC is under-counting vaccine deaths, Children's Health Defense, July 20, 2021, citing original sources including an affidavit by Jane Doe, filed under penalty of perjury pursuant to a lawsuit by America's Front Line Doctors seeking to ban the vaccine.

acceptable. (While this may or may not be appropriate, what is inappropriate is the lack of transparency around this type of "safety testing.")

The tainted history of vaccine policy includes widespread contaminants such as SV-40 (a carcinogenic virus), and bad lots such as the DTP lot associated with eleven SIDS deaths in 1978-79, which began the industry coping tactic of dispersing the lot distribution to disguise any such future clusters. Thimerosal (mercury) remains a controversial ingredient in overseas children's vaccines and some US vaccines including multi-dose influenza (but not the COVID vaccines to date).

In a 2011 Supreme Court ruling, the dictum (the explanatory text accompanying the decision) stated that vaccines are "unavoidably unsafe." To date, under the existing vaccine injury compensation program, which covers fully-licensed vaccines, over $4 billion has been paid to claimants, yet the vast majority of claims are denied. Nearly all of the awards are for "categorical" injuries (those stipulated in an official table of recognized injuries), leaving the majority of claimants for idiosyncratic injuries out of luck.

Under current law, manufacturers of products authorized for Emergency Use are indemnified from liability for injuries arising from these products.

- **Vaccine efficacy**

  Vaccines do increase antibody levels to a particular antigen (a protein fragment that generates an immune response), as purported. The debate is over whether the targeted antigen (strain) is relevant, and whether by shifting immunity toward a particular antigen, immunity is increased or decreased toward other, perhaps more relevant antigens. Furthermore, one tenet of evolutionary biology is that mass vaccination during a pandemic is likely to promote resistant strains.

  As COVID variants emerge and data accumulate, vaccine efficacy appears to be trending downward, from its original ~95% to perhaps 39%.[3] Israel, once lauded for high vaccination rates, has seen a surge that appears unrelated to vaccination status but may reflect waning immunity toward new strains. Indeed, a recent analysis across 68 countries suggests that, on a population basis, the current vaccines may offer no discernable benefit.[4] Of course, population-level studies are crude, and firm conclusions cannot be drawn, but this surprising finding highlights the notion that the issue is complicated and that other risk factors aside from vaccination status may be key.

Context

The following context may have contributed to public confusion and polarization. In summary, many months ago, the vaccine was sold to a traumatized public as the best means to prevent infection, transmission, illness, hospitalization, and death, and thereby to return to normalcy. (In fact, these goals were never actually promised but were merely implied.) But with time and variant strains, these hopes have largely evaporated, leaving only the goal of reducing symptoms, as well as the question of whether regular boosters will be required in perpetuity. A portion of the public remains grateful for the vaccine despite its declining efficacy, while others feel betrayed by the moving goalposts as well as the lack of clean, transparent, science-based communication from our health authorities.

- **A media campaign to manufacture a false enemy and sell a false solution to a traumatized public**

  While the facts of the pandemic are indeed horrible, our health authorities and the media have exacerbated the trauma by presenting a one-sided view that emphasizes the most frightening

[3] Zimmer C. Israeli data suggests possible waning in effectiveness of Pfizer vaccine. NYTimes Aug 18, 2021.
[4] Subramanian, S.V., Kumar, A. Increases in COVID-19 are unrelated to levels of vaccination across 68 countries and 2947 counties in the United States. Eur J Epidemiol (2021).

statistics while offering a simple (albeit flawed) solution that many are desperate to embrace, and by identifying a clear villain, thereby polarizing the public. In addition, the lengthy shut-down, with its associated isolation and loss of opportunities to exchange views outside one's silo, has created frustration, impatience, and entrenchment, on top of the original fear. Incidentally, one tenet in psychology is that fear causes humans to lose rationality and to seek safety by reverting to a primitive deference to tribal authorities, in opposition to "other" tribes, thereby exacerbating the polarization and entrenchment. The President and others have actually blamed the pandemic on the unvaccinated — without citing evidence aside from cherry-picked associations between localized surges and localized vaccination rates (which may also correlate with comorbidities), thereby insulating a causal connection.

The media campaign appears centrally orchestrated — for example, identical sound bites, such as the labeling of one type of early treatment as "horse medicine," often appear across multiple media outlets. Our leaders have not chosen to convey, as FDR did, that we have nothing to fear but fear itself, nor have many of our church authorities attempted to balance the fear campaign by invoking the numerous Bible verses to "fear not."

- **Non-transparent data collection and biased reporting**
  - **The "case-demic"**

    COVID-19 "case" statistics have been reported based on positive PCR tests despite the acknowledged unreliability of this test. The large number of such "cases" produced what critics call a "case-demic," in which the high numbers include many people who were virtually unaffected. Furthermore, PCR cycle threshold is acknowledged as a key variable affecting the number of false positives; yet this opaque input varied across testing venues and by population. For example, cycle thresholds for unvaccinated persons were set much higher than for vaccinated persons, perhaps innocently, in order to minimize the number of false positives; yet in the context of the push for vaccine mandates, this manipulation is disquieting.

  - **Deaths *from* COVID versus deaths *with* COVID**

    While over 700,000 Americans have died in the pandemic;[5] this number includes everyone who died with a positive COVID test, including persons with severe preexisting conditions. Only 6% had no other reported causes of death; the rest had an average of 3.8 contributing comorbidities.[6]

    The death-certificate reporting guidelines for coroners were changed abruptly, without the traditional public notice, comment, and hearing, in order to allow COVID to be included as a primary cause of death whenever it was merely believed to be present, even when comorbidities were the likely primary cause. Government payments to hospitals for events which included a COVID diagnosis, ventilation, and death, may have incentivized such events, or their labeling as such.

  - **Infection fatality rate**

    The COVID infection fatality rate is estimated at less than 1%, i.e., the survival rate is greater than 99%.[7] In addition, when the infection fatality rate is analyzed by subgroup, the role of comorbidities and the relative invulnerability of the young is apparent. Furthermore, many of the deaths have occurred in nursing

[5] Johns Hopkins Coronavirus Resource Center
[6] US CDC webpage, Comorbidities and other conditions
[7] Physicians for Informed Consent, citing Ioannidis et al. 2021 (Stanford) and others.

homes — a venue in which the average life expectancy absent a pandemic is only about 6 months.

- **COVID hospitalization rates for the unvaccinated**

  Anecdotes suggest that hospitalized persons identified as unvaccinated may actually be vaccinated but lack documentation within a particular hospital system.

- **Scientific censorship by media and health authorities**

  Science is rarely "settled." It is a process, not a result dictated by authorities, and it can only unfold in an open society. Most alarming in the ongoing sales campaign is the growing level of censorship of the well-credentialed, outspoken COVID-policy critics such as Peter McCullough, Pierre Kory, Michael Yeadon, and Robert Malone, who have risked their careers to speak out and who have been shunned by the media, de-platformed on the Internet, and "debunked" for presenting science-based views that differ from the orthodox narrative.

  - **Suppression of early treatment options, resulting in preventable deaths**

    Critics claim that many of the COVID deaths were related to lack of treatment due to the austere position taken by authorities and institutions who claimed that no treatments were available; meanwhile well-credentialed, independent physicians were using a variety of longstanding generic treatments for general respiratory infections, both in-patient and out-patient, and obtaining good results.[8] A cynical controversy has festered over the possible suppression of these early treatment options; the recognition of such treatments would have jeopardized the Emergency Use Authorization of the COVID vaccines, which depended on the lack of any available treatment.

- **Demonization and coercion**

  Across jurisdictions, an unusual mix of carrots and sticks have been deployed to pressure the "vaccine hesitant;" these tactics would be unnecessary if clean, transparent data on safety and efficacy supported the widespread use of vaccines. Incidentally, the "vaccine hesitant" group disproportionately includes not only people with little education but also people with a high level of education.

  - **Inappropriate coercion targeting youths and the COVID-recovered**

    The COVID-recovered have robust, long-lasting immunity and are clearly entitled to exemptions from mandates; they incur no benefit from vaccination, although health authorities claim such benefits despite a lack of clean evidence (evidence that controls for false-positive cases).

    Children, teens, and young adults may incur more risks from the vaccine than from the virus. In particular, teenage boys may incur a greater risk of heart damage from the vaccine than of any serious effects from the virus.[9]

  - **Institutional pressure on medical providers**

    Physicians are required to report serious vaccine injuries but are untrained in recognizing or reporting such cases. On the Internet, alarming anecdotes abound of injured patients seeking help from physicians who actually deny the possibility that new symptoms, such as weakness, seizures, or collapse, may be related to a recent vaccine. Also anecdotally, institutional physicians who do report vaccine injuries experience harassment by

[8] Front Line COVID Critical Care Alliance prevention and early outpatient treatment for COVID-19, https://covid19criticalcare.com/covid-19-protocols/i-mask-plus-protocol/

[9] Sample I. Boys more at risk from Pfizer jab side-effect than Covid, suggests study. The Guardian, 10 Sep 2021.

administrators who don't want their staff to appear "anti-vax." Medical exemptions, although available in theory, are virtually unavailable in practice, because physicians, who are under increasing scrutiny from medical licensing boards, have become reluctant to grant them.

- **The pharma lobby and its capture of agencies, academia, and the media**

  Pharma lobbyists outnumber members of Congress. Congress has granted pharma indemnity from legal liability for vaccine injuries. Criminal penalties against pharma have totaled tens of billions of dollars.[10] Three Moderna executives made the Forbes list of the 400 richest Americans — after their company received $2.5 billion in federal funding for COVID vaccine research and development.

  Agency capture is a phenomenon recognized within political science, in which regulators become unduly influenced by industry, due more to a shared culture rather than to overt corruption. Regulatory anomalies suggestive of agency capture appeared within the August 2021 full licensure process for the BioNTech vaccine (biochemically identical to the Pfizer vaccine but with differences in legal liability). Anomalies included use of the original clinical-trial data, which had already been reported during the Emergency Use Authorization process but which had meanwhile become stale. An additional 6-months of new data had obviously accrued but was not reported nor required (perhaps because it showed declining efficacy?). In addition, the usual documentation, reports, and advisory board hearings were absent.[11] (Possible motivations for this seemingly premature regulatory action include a desire to obtain licensure before any undesirable trends become apparent, or a desire to provide a quick legal basis for mandates, which would not be supportable absent full licensure.)

  Pharma funds most news outlets, including so-called public media, either via direct advertising or indirectly via strategic philanthropic foundations. Consequently, difficult questions, like whether the pandemic was caused by a lab leak from US-funded bioweapons research, are unlikely to be investigated by the media.

  Since the inception of standardized medical education in the early 1900s, strategic philanthropy by pharma has played an influential role in all aspects of the medical system. Medical boards and committees, which direct research and develop guidelines, curricula, and standards of care, have long been intertwined with pharma.

A reasoned, transparent, multi-pronged pandemic policy

The highly-credentialed COVID policy critic, Peter McCullough, MD, has advocated a four-pronged approach (and I add a fifth):

1. Reduce the spread, via outdoor venues, distancing, and improved indoor ventilation. An over-emphasis on masking has been a distraction from more effective policies. (Incidentally, my understanding is that the science on masking is equivocal; masks may limit droplet-based viral transmission, but inhalation of expired air is not health-promoting.)
2. Early outpatient treatment with a sequential, multi-drug protocol.
3. A similar in-patient treatment.
4. Vaccination.
5. Optimization of internal terrain via health practices to optimize nutrition,[12] the microbiome,[13] sunlight, sleep, and de-stressing, including socialization. (The church could play a role in discussing and facilitating these self-efficacious approaches.)

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[10] GoodJobsFirst.org
[11] Tanveer et al. BMJ Oct 2021
[12] Linus Pauling Institute at Oregon State University, Nutrition and the Immune System, 2018

In closing, as I articulated to my chalice circle recently, I'm an "anti-vaxxer" on three grounds: personal, professional, and political. Personally, I have autoimmunities, for which I work hard to maintain my many health practices to avoid provoking flares. In addition, my sister died of an idiopathic blood clot at age 24. Was her death related to the slew of overseas vaccines she'd received? Or perhaps birth control medication? We had no answers, nor were (are?) such deaths investigated adequately. Professionally, I write about toxicities such as mercury, and in my investigations, I've come to realize that toxicology (e.g., vaccine risks) is the ugly stepchild of science — nobody studies it, nobody funds it, and nobody recognizes it. Incidentally, my understanding is that vaccine science is not taught in medical schools (aside from its role as the "safe and effective" standard of care); nor was it taught in my public health program. Politically, I'm actually not a "freedom fighter" like many of my strange, new bed-fellows; rather, I'm simply called to fight corruption, especially when the issues are technical. Incidentally, last month, after posting a science-based summary of Peter McCullough's COVID policy critique onto Facebook (a post that had taken me hours to write), I received a sudden pop-up warning that I was in violation of "community standards." Such censorship, I believe, poses an even larger threat to our society than does the virus itself.

If this is your first time contemplating the notion that our health authorities and the media may not deserve our trust, I understand how disorienting and traumatic this notion can be. It may take some time to even begin to consider this possibility.

By the way, my father was a military virologist, and although he passed away in 2004, I suspect that his position is still relevant today — vaccines are great in theory, but in practice there's a lot we don't know. Anecdotally, my brother, who is on his church council in Minnesota, said that in retrospect he's glad that the "Republicans" on the council bullied the rest of them into re-opening before they felt comfortable, after only a few months of closure. He said that no serious cases of COVID have occurred and that as of early this year, things have relaxed back to normal. It seems that our church and denomination are on the extreme end of the continuum of deference to the virus, and I'm not sure how this fits within the larger goals of optimizing community health and well-being, including physical, mental, and spiritual aspects.

If you have any questions, I'm reachable by phone. I'm willing to do technical writing or assistance for board or committee members (and I'm aware that this document lacks full referencing due to today's deadline), but I cannot commit to attend any meetings. Incidentally, I have not yet felt drawn to return for the upcoming, cautious reopening. Before I consider returning, I'd be interested in seeing a statement by the church governance recognizing that extended closures are not without cost to the community and will not be implemented again without some sort of due process. Thank you for your efforts in shepherding the church through these uncharted waters.

Sincerely,

Kris Homme

Kristin G. Homme, PE(ret.), MPP, MPH; contributing author of several scientific, peer-reviewed papers on the vaccine adjuvant, Thimerosal (mercury), available on PubMed and ResearchGate

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[13] Thaiss et al. The microbiome and innate immunity. Nature, July 2016