Open Letter to Parents Regarding COVID Vaccination

<u>Part III</u>: Questions to Ask Your Physician

One Pediatrician's Responses

By Robert Rennebohm, MD

Above: Diego Rivera's depiction of Vaccination, Detroit Museum of Arts, 1932. (See "Afterword" for discussion of this painting. The other paintings in this article are also by Diego Rivera.)

KEY TAKE-HOME MESSAGES:

This Open Letter—Part III (coupled with the original Open Letter and Open Letter—Part II) will explain in depth the following take-home messages:

1. The human immune system is ingeniously complex. Its complexity must be understood and appreciated. (See BACKGROUND---THE HUMAN IMMUNE ECOSYSTEM.)
2. It consists of a mucosal immune system and a systemic immune system, both of which have an innate immunity division and an adaptive (acquired) immunity division.
3. The importance of the innate immunity division (also called the innate immune system) has not been emphasized by proponents of the COVID vaccination campaign. This is unfortunate, because innate immunity is enormously important, throughout life, particularly during early childhood when innate immunity receives its foundational education: (See Question 4.)
    a. An important component of the innate immune system is "innate antibodies" ("natural antibodies"). Children are born with these innate antibodies, which are present in high concentration during early childhood and wane thereafter.
    b. Innate antibodies are nonspecific---meaning that they are capable of binding to and neutralizing many different viruses.
    c. By binding to viruses, innate antibodies play a major role in educating the innate immune system to recognize and appropriately attack viruses (and other foreign, "non-self" entities).
    d. Also, by binding to viruses, innate antibodies teach the innate immune system to distinguish between "non-self" (which it may attack) and "self" (which it should leave alone).
    e. Interference with the binding of innate antibodies to viruses interferes with the education and function of a person's innate immune system, leaving the person less able to fight off infection and more prone to autoimmune disease (disease due to immune attack waged against "self"---parts of one's own body).
    f. A person's greatest opportunity for excellent, foundational education of their innate immune system occurs during early childhood. If that greatest opportunity is missed or disrupted, it is irretrievably lost.
4. The human immune system employs a multi-faceted, multi-dimensional, collaborative, inclusive approach that uses the innate immune system as its first line of defense and employs the adaptive immune system for a more antigen-specific (e.g., virus-specific) response, the latter developing antigen-specific memory in the process.
5. It uses wise checks and balances, feedback mechanisms and back up mechanisms; it learns from experience; it has astonishing memory; it requires education and practice (particularly during early childhood); it is efficient and adjustable; its marvelous capacities have been perfected over thousands of years

6. It represents an elegant immune ecosystem. (See BACKGROUND.)
7. Just as ecosystems in Nature (forests, wetlands, prairies, lakes, and their living species) are complex, delicate, and must not be subjected to misguided tampering, the same is true with the human immune ecosystem.
8. In comparison, the COVID vaccines are relatively uni-dimensional, exclusionary, and interfere with the proper education, practice, experience, and function of the innate immune system, particularly in young children, but also throughout life. (See Question 4.)
    a. The COVID vaccines are focused primarily on production of antibodies to the spike protein of the **SARS-CoV-2 (SC-2, for short**) **virus**, and they primarily rely on these spike-specific "neutralizing antibodies" to fight the virus.
    b. Compared to innate antibodies, the neutralizing vaccinal antibodies bind much more strongly to the SC-2 virus (even after their neutralizing capacity has markedly diminished) and, thereby, outcompete the innate antibodies for attachment to binding sites on SC-2. That is, the vaccinal antibodies interfere with binding of innate antibodies to the virus. (Innate antibodies, by design, bind only loosely to viruses.)
    c. This vaccinal interference with the binding of innate antibodies to SC-2 results in impairment of normal education and function of the innate immune system, leaving the vaccinated person less able to fight off infection and more prone to autoimmune disease.
    d. Why and how does vaccinal interference with the interaction of innate antibodies with the specific SC-2 virus affect the overall education of the innate immune system, regarding response to other viruses and distinction between non-self and self? This is very complex but has to do with shared molecular patterns that many viruses have in common and that are also similar to molecular patterns ("self" patterns) on components of the human body. (See Question 4.)
    e. This harmful vaccinal interference with the binding of innate antibodies to SC-2 lasts for as long as the titers of spike-specific vaccinal antibodies are elevated, which inevitably occurs when vaccinated (primed) individuals are continuously (or frequently and repeatedly) exposed to highly infectious SC-2 variants (e.g., Omicron variants) or receive "booster doses" of COVID vaccine.
    f. When the COVID vaccines are given to children during early childhood, they disrupt the greatest opportunity for the child's innate immune system to become optimally educated. This disruption has irreversible long-term consequences: such children are rendered highly susceptible to severe disease from numerous glycosylated microbial pathogens (like coronaviruses and other acute respiratory viruses) and to immune-mediated diseases (autoimmune diseases and allergic diseases). There is also legitimate concern that such

disruption could adversely affect education of the immune system's cancer surveillance system.

9. An "optimal" immune response to a virus involves much more than simply producing virus-specific "neutralizing" antibodies. An "optimal" immune response involves utilization of all of the potential immune capacities that might be needed to contain the virus and prevent transmission---e.g. innate antibodies and NK (Natural Killer) cells of the innate immune system. There is much more to the story (of immune protection) than the levels of neutralizing antibodies. It is simplistic and misleading to think only in terms of "levels of virus-specific neutralizing antibodies." In fact, natural immunity consists of a well-orchestrated collaborative effort of both innate and adaptive immunity. That is why comprehensive natural immunity is much more protective than antibodies alone. (See Question 1.)
10. Naturally acquired immunity to SC-2 is far superior to the immunity provided by the COVID vaccines. Naturally acquired immunity can provide optimal, long-lasting, sterilizing immunity that prevents transmission and can contribute to herd immunity. The COVID vaccines are sub-optimal---they do not provide sterilizing immunity, do not prevent transmission, and, thereby, do not contribute to herd immunity. In fact, the COVID vaccines interfere with development of herd immunity. (See BACKGROUND and Questions 1, 2, 5, 12, and 13.)
11. A rapid mass vaccination campaign, using a sub-optimal vaccine (like the COVID vaccines) and vaccinating across all age groups, in the midst of an active pandemic of a highly mutable and highly infectious respiratory virus--- is a recipe for abnormally generating a prolonged series of dominating new variants that become increasingly infectious, increasingly vaccine-resistant (due to "immune escape"), and inevitably more virulent. In other words, the mass vaccination campaign that has been implemented during the COVID pandemic has been responsible for prolonging the COVID pandemic and making it more dangerous. (See Question 1.)
12. The vaccinal antibodies produced by the COVID vaccines:
    a. Have been increasingly failing to adequately neutralize the spike protein.
    b. Have been increasingly failing to prevent entry of SC-2 into human cells.
    c. Have not been preventing transmission of the virus from one person to another.
    d. Have been actually facilitating entry of the virus into cells---i.e., have been making the vaccinated individual more susceptible to SC-2 infection. This occurs when the neutralizing capacity of the "neutralizing" vaccinal antibodies has greatly diminished, as is the case with current Omicron subvariants. This represents a form of antibody dependent enhancement of infection (ADEI). (See Question 5.)
    e. Have been impairing the foundational education and the continuing education of the innate immune system. When given to young children, COVID vaccines prevent the child's innate antibodies from actively teaching its innate immune effector cells how to recognize (glycosylated) viruses and distinguish them from

"self" antigens (i.e., distinguish between "self" and "non-self."). This is critical for any immune system to learn at an early stage of life (once passive maternal immune protection is no longer available) in order to provide for a healthy and appropriate immune response. This interference with the initial foundational education of a child's developing innate immune system renders a COVID-vaccinated child less able to handle glycosylated viruses (and glycosylated pathogens in general) and predisposes such children to immune pathology (e.g., autoimmune disease). And these adverse effects are irreversible. (See Question 4.)

f. Have been "priming" the immune system to respond to SC-2 in a narrow, inflexible, uni-dimensional, exclusionary, increasingly outdated way---instead of the comprehensive, flexible, continually updating, collaborative way in which the immune system normally responds. (See Questions 6 and 7.)
g. Have been predisposing vaccinated people to increased risk of breakthrough infection/reinfection and, thereby, have been predisposing the vaccinated to "immune exhaustion"---which, in turn, predisposes the vaccinated to increased infections (of many types, not just COVID) and also impairs protection against autoimmunity and malignancy. (See Question 7.)
h. Have possibly been providing some brief and modest protection against severe COVID disease---but this protective effect will disappear when more virulent SC-2 variants appear (which is inevitable if the mass COVID vaccination campaign is continued). (See Question 5.)
i. Have been causing an unacceptable number of severe adverse events in vaccinated individuals---e.g., myocarditis, blood clots/strokes, neurologic damage, sudden death, and predisposition to autoimmunity, immunodeficiency, and malignancy. We are only beginning to see the regrettable long-term complications of the COVID vaccines. (See Question 15.)

13. When the risks of COVID vaccination (at both the population level and the individual level) are compared to the benefits, the risks far outweigh the benefits.
14. Compared to children who have been vaccinated against COVID, children who remain unvaccinated against COVID will be better able to handle SC-2 infection (and other infections)---both now and when a more virulent variant appears. (See Questions 6, 7, and 11.)
15. Regarding Pfizer's request for FDA approval of emergency use of its COVID vaccine in children between 6 months and 5 years of age (See Question 14.):
    a. The data provided by Pfizer are scant, inadequate, and do not provide compelling evidence that the COVID vaccine was effective in preventing infection, hospitalization, or severe disease.
    b. Although the study concluded that the data "do not suggest any new safety concerns compared with the safety profile described in older age groups," the median follow-up time was only 2.1 months after the 3rd dose of vaccine. This

provides an inadequate length of time to determine safety, particularly long-term safety.

c. The Pfizer study was too small, too short, and was of insufficient scientific quality to warrant FDA approval.
d. Furthermore, given Pfizer's history of proven, convicted health care fraud and their proven inclination to hide data (see AFTERWORD), their safety and efficacy data should be investigated and scrutinized not just by the FDA, but also by an independent objective panel of representative experts who have no conflicts of interest.

16. When a more virulent variant appears, there are several proactive, protective actions we can and must take---starting with prompt and accurate diagnosis, with attention to the Ct values of positive PCR tests and appropriate use of genomic sequencing (to confirm SC-2 and determine the involved variant/subvariant). (See Questions 16 and 26.)
17. According to the CDC, about 75% of children and adolescents now have evidence of a previous SC-2 infection, and, therefore, already have some degree of naturally acquired immunity. COVID vaccination of these children will not provide additional protection. In fact, COVID vaccination of such children will have deleterious effects on their immune function (as mentioned above). (See Questions 9, 10, and 11.)
18. Parents desperately want to do the right thing for their children. It is best for children to not receive any of the current COVID vaccines. That is best for each child and it is best for the population as a whole. The responsible act is to resist the misguided pressure to "get vaccinated." The responsible act is to call for an immediate moratorium on COVID vaccination---until a proper scientific evaluation of the COVID vaccination campaign has been conducted. **Statements that "*the COVID vaccines are very effective; exceedingly safe; get vaccinated; it is your social responsibility to do so; our patience is growing thin*" are scientifically inaccurate and irresponsible.**
19. Respectful, healthy, scientific dialogue about the above issues is critically important but has not sufficiently occurred among physicians, scientists, health policy makers, or the citizenry (often not even within families). Thoughtful challenge of prevailing understandings and careful exchange of ideas is healthy, essential, and should be welcomed---particularly during the current pandemic.
20. Please understand that I would much prefer that the questions posed in this article be answered by a representative panel of physicians and scientists with exemplary expertise in immunology, virology, vaccinology, evolutionary biology, and epidemiology who would engage in thorough, respectful, scientific, video-archived dialogue about these questions. Parents and physicians could then view and listen to that dialogue and decide whose explanations make the most sense and whose recommendations seem wisest. Parents and physicians (including me) deserve that opportunity.
21. Education of physicians and the public---about the COVID vaccination campaign and the COVID situation in general---must be honest and sufficiently deep. Education leads to

demystification and healthy unification; Mystery and confusion lead to polarization, extremism, and ugly intolerance.

22. Please, parents, grandparents, and physicians, consider all of the above before making your decision about vaccination of children against COVID.
23. Parents and grandparents can play a pivotal and powerful role in challenging and reversing the ill-advised campaign to vaccinate children against COVID. In fact, protection of children from the harmful effects (both at the population level and at the individual level) of the COVID vaccination campaign will likely depend on the homework and thoughtful advocacy of parents and grandparents, since the CDC, FDA, pharmaceutical companies, NIH, WHO, AAP (American Academy of Pediatrics), conventional media (CNN, e.g.) and silent acquiescing physicians have failed to provide that protection.

INTRODUCTION---TRUE INFORMED CONSENT:

Since the COVID vaccines first became available (in December 2020), they have been strongly encouraged for all who have been "eligible." For many, COVID vaccination became mandatory. The goal has been to vaccinate the vast majority of the entire global population, including children as young as 6 months of age.

The COVID vaccines, especially the Pfizer and Moderna mRNA vaccines, represent experimental vaccines. Because they are experimental and have been incompletely studied, no adult should receive the vaccine without being fully informed of the risks and benefits (as best known at the time of vaccination) and without signing an "Informed Consent" Form.

Before a child may be vaccinated, the child's parents must sign an Informed Consent form. Before parents grant their informed consent, the physician is obligated to make certain that the parents are fully informed about the risks and benefits of the proposed vaccination (as best known at the time). In order to fully inform parents, the physician must be fully informed in the first place. To help physicians become fully informed, the organizations that inform them and encourage them to vaccinate (CDC, NIH, WHO, etc.) are obligated to provide physicians with accurate, honest, scientifically sound information.

The most important elements of the informed consent process are an opportunity for parents to: ask questions about the risks and benefits of the vaccine; receive accurate answers to those questions; and receive additional information that will increase the likelihood of their consent being truly informed.

This Open Letter—Part III is intended to facilitate a properly conducted informed consent process. It lists questions that parents might want to ask their physicians. It also provides physicians with questions they might want to ponder, research, and consider discussing thoroughly with patients/parents (and, perhaps, with their trusted infectious disease specialists

beforehand). Those physicians who have been too busy to do as much homework as they would like are referred to the websites, articles, references, and video presentations mentioned at the end of Part III.

In Part III (this document) I do my best to provide answers to the posed questions. Other physicians or scientists may have different answers to these questions. Please understand that I would much prefer to have these questions answered by a representative panel of physicians and scientists with exemplary expertise in immunology, virology, vaccinology, evolutionary biology, and epidemiology who would engage in thorough, respectful, scientific, video-archived dialogue about these questions. Parents and physicians could then view and listen to that dialogue and decide whose explanations make the most sense and whose recommendations seem wisest.

Unfortunately, healthy scientific dialogue between the scientists/physicians who promote the prevailing COVID narrative/mass vaccination campaign and scientists/physicians who question that narrative/mass vaccination campaign has not occurred, despite the efforts of people like Dr. Geert Vanden Bossche to arrange such dialogue.

You will note that I frequently mention Dr. Vanden Bossche in my answers. That is because I think his understanding of the COVID situation represents the deepest, broadest, most thoughtful, best informed, and most scientifically sound of any understanding I have come across. In my opinion, his voice has been the most important voice to consider during the course of the COVID pandemic

Note: The questions listed below are asked in the context of the COVID situation as of late June/early July 2022. However, it should be understood that the COVID situation is dynamic, ever-changing. Accordingly, answers to these question may be different in a few weeks or a few months from early July 2022. The questions, therefore, should be answered not only in the context of immediate COVID conditions but also with the thought in mind that a more virulent variant could emerge in the weeks or months ahead. Accordingly, the questions need to be answered both for the current COVID situation and for future COVID scenarios (such as the appearance of a more virulent variant)

For references, links, and more information, please see the **REFERENCES** and **LINKS** listed at the end of this document, as well as the **1078 references listed in the initial Open Letter**. For medical illustrations (of the SARS-CoV-2 virus, its spike protein, the attachment of the spike protein to the ACE2 receptor on human cells, etc.) see **APPENDIX OF MEDICAL ILLUSTRATIONS** at the end of this document (between the **AFTERWORD** and the REFERENCES).

BACKGROUND---THE HUMAN IMMUNE ECOSYSYEM:

The Genius and Delicacy of the Normal Human Immune System---A Marvelous Immune Ecosystem:

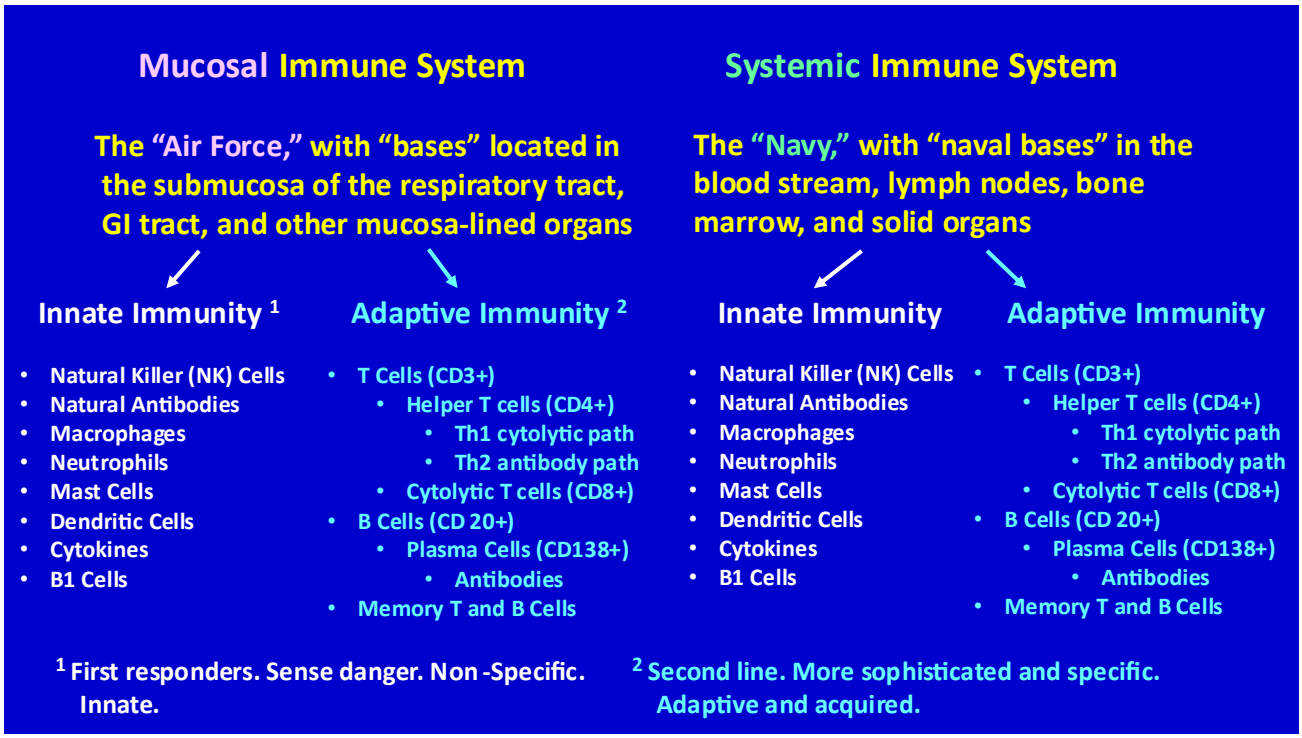
Before presenting the questions and responses to them, I would like to emphasize perhaps the most important concept for parents, citizens, physicians, and health officials to appreciate, regarding the human immune system---namely, the elegant, complex, multi-dimensional, collaborative approach of the immune ecosystem and how that compares to and is potentially disturbed by much narrower, less-collaborative, and less flexible COVID vaccine-induced immunity.

The Figure below provides an overview of the immune system, which can be divided into two major compartments, which work collaboratively---the mucosal immune system and the systemic immune system, each of which has an innate immunity division and an adaptive (acquired) immunity division. When a virus, like the SARS-CoV-2 virus, invades a person, the immune system potentially uses all of its dimensions---both its mucosal immune system and its systemic immune system---to quickly subdue the virus (initially by the innate immunity division in the mucosal compartment) and to create robust, trained innate immunity and as well as durable, virus-specific adaptive immunity (with memory) to protect the person from future invasion by that virus (and future variants of it).

The immune system is an ingeniously performing system that has developed and perfected its extraordinary, coordinated capacities over thousands of years. It is an extremely complex, efficient, collaborative system, with many checks and balances, finely tuned and orchestrated. I like to think of the immune system as an elegant immune ecosystem, just like the precious ecosystems in Nature. Just as ecosystems in Nature (forests, wetlands, prairies, lakes, and their living species) are complex, delicate, need to be respected, and must not be subjected to mis-guided tampering, the same is true with the human immune ecosystem.

Environmentalists and ecologists know, too well, how easily and disastrously Nature's ecosystems can be damaged and disrupted by mis-guided tampering by those who erroneously think their interventions will only benefit and not cause harm. We (including pharmaceutical companies) need to treat the human immune ecosystem with the same respect and care that we need to treat environmental ecosystems.

For further details about how the immune system orchestrates protection against infection, please see ***An Open Letter to Parents and Pediatricians Regarding COVID Vaccination.*** This is the original Open Letter. It provides **1078 references**:
https://notesfromthesocialclinic.org/an-open-letter-to-parents-and-pediatricians-2/



Naturally Acquired Immunity versus Vaccine-Created Immunity: Because of the elegant and ingenious complexity of the human immune system---its multi-faceted, multidisciplinary, multi-dimensional, comprehensive, collaborative approach; its diversity, division of labor, respect for and use of all aptitudes; its flexibility, adjustability, efficiency, wise checks and balances, feedback mechanisms and back up mechanisms; its ability to learn from experience; its on-going education; its practiced training and astonishing memory; and the fact that its capacities have been perfected over thousands of years---most immunologists, virologists, and vaccinologists agree that naturally acquired immunity is superior to vaccine-induced immunity, particularly when compared to COVID vaccine-induced immunity. There is a great amount of evidence that naturally acquired immunity to SARS-CoV-2 (SC-2, for short) is far superior to the immunity provided by the current COVID vaccines. [See references 18—163 in the original Open Letter] This, in great part, is because the human immune system approaches the virus in a comprehensive multi-dimensional way, starting with a rapid and effective response by the innate immunity division (also called the innate immune system) of the mucosal immune system in the respiratory tract.

In comparison, the COVID vaccines are uni-dimensional, exclusionary, and interfere with proper education and practice of the innate immunity division, particularly in young children. (See Question 4). The COVID vaccines are focused almost exclusively on production of antibodies and, even then, only on antibodies to the spike protein of the SARS-CoV-2 virus, not on other components of the virus. They exclusively train the systemic compartment of the immune system, not the mucosal compartment. They focus on training the adaptive immune division, not the innate immune division. They focus on training only part of the adaptive immunity

division of the systemic compartment---the part that produces antibody against the spike protein of the SARS-CoV-2 virus.

As we will discuss later (Question 4), the COVID vaccines, by blocking and sidelining normal activities of the innate immune system, actually interfere with the necessary education, practice, and experience of the innate immune system---and this renders COVID-vaccinated people less able to handle virus infections in general and predisposes such people to autoimmunity. Furthermore, the COVID vaccines prime/program our immune system to repeatedly react in a narrow, inflexible, exclusionary way that becomes outdated when new variants appear.

It is a shame that the COVID vaccines do not focus on training and giving practice to the mucosal immune system (particularly the innate immunity division of the mucosal immune system), because the SARS-CoV-2 virus enters the body through the respiratory tract (and possibly through the GI tract) and often never penetrates into the systemic compartment---thanks to the mucosal immune system's ability to usually contain the virus within the respiratory tract. If the COVID vaccines were capable of fully training and mobilizing the mucosal immune system, they would be much more effective than they are. The main offering of the COVID vaccines is partial training of the systemic immune system, so that it (the systemic immune system) can respond if the mucosal immune system fails to contain the virus within the respiratory tract and the virus invades the systemic compartment. Even when that penetration does occur, the multi-dimensional approach of the natural systemic immune system is much more effective than the uni-dimensional (anti-spike protein antibody-based) response that the COVID vaccine teaches.

Furthermore, as will be discussed in the response to Question 1, the COVID vaccines are sub-optimal (non-sterilizing) vaccines---meaning that they do not fully prevent virus from infecting our cells, and they do not prevent transmission of the virus from one person to another. Optimal (sterilizing) vaccines adequately contain infection and prevent transmission.

Bottom line: The COVID vaccines are harmfully disturbing and disrupting the normal immune ecosystem and are particularly harmful when given to young children. **That is why it is so important to appreciate the complexity and delicate balances within the natural immune ecosystem and avoid mis-guided tampering with it.** For more information about disturbance of innate immunity and natural antibodies by COVID vaccination, see Dr. Vanden Bossche's video interviews, either by clicking on the Vanden Bossche LINKS at the end of the initial Open Letter (LINKS A-I and O), or by clicking on the following website:
https://www.voiceforscienceandsolidarity.org/

Also, "An Interview with the Human Immune System" may be found at this link:
https://notesfromthesocialclinic.org/interview-with-the-human-immune-system/