WRITTEN TESTIMONY

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Regarding HB 3063, State of Oregon

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My name is Dr. Brian Hooker and I hold a PhD in Biochemical Engineering from Washington State University. I have been a research scientist for the past 28 years in the field of biotechnology and have worked for a government contractor, a private corporation and several universities. I am currently an associate professor of biology and department chair at a small university in Northern California. I have published over 65 research papers in peer-reviewed scientific and medical journals and hold 5 U.S. patents. For the past ten years, my research has focused primarily on the epidemiology around vaccine injury. I am also the father of a 21 year old son who was injured by his infant vaccines which he received in Washington State.

There is a problem with measles in Oregon, but it's not low vaccination rates, it's actually high vaccination rates with a vaccine product unable to provide lifetime immunity or vigorous passive maternal protection to infants during the first year of life.

When the measles vaccine was first introduced, everyone over the age of 15 had lifetime immunity. In developed nations, like other communicable infections, measles was no longer dangerous because of adequate nutrition, sanitation, and access to healthcare. Because it was a routine part of childhood, teens, adults, parents, grandparents were immune. Because of maternal passive immunity, infants were protected. The death rate due to measles in Washington State in the four years prior to the introduction of the measles vaccine was 1.4 in 10,000 cases and approximately 2 in 1,000,000 in the general population.

Legislators are being told that use of personal and religious belief exemptions are putting the public's health in danger. They are told that two infants were recently exposed to measles. If the mothers of the children had wild measles when they were children, and they are nursing, the babies are protected. If the mothers were vaccinated, they may not be.

Non-responders, waning, modified, subclinical, transmission chain, etc. all mean that even 100% vaccine uptake would not eradicate measles. Pushing vaccination rates up even higher with a flawed vaccine product is not the answer. As the editor of the journal Vaccine Dr. Gregory Poland of the Mayo clinic stated in 1994, "…as measles immunization rates rise to high levels in a population, measles becomes a disease of immunized persons." Measles clusters historically in the United States have had vaccination rates as high as 75%. Dr. Poland is right and measles is a disease in those children and adults previously vaccinated using the MMR.

Patient zero in the Clark County, Washington cluster was a visitor from the Ukraine and was reportedly vaccinated. This spread to 6 cases of measles in the household where children possessed religious exemptions. The majority of the remaining cases are in the same Ukrainian religious community and although the Clark County Health Department now reports of total of 65 cases, most of these cases have resolved. The Disneyland "outbreak" of measles in 2015 resolved through adept public health intervention by April of that same year as have all the previous measles clusters. That experience demonstrates that when public health focuses on detection, notification, and isolation of cases, those vulnerable to poor infection outcomes can be protected.

As I have already remarked, vaccination does not guarantee immunization and infectious diseases routinely break out in highly vaccinated communities. Two examples of this are outbreaks of mumps on multiple college campuses, due to problems with the low seroconversion rate of the mumps portion of the MMR, and pertussis outbreaks, due to problems with the acellular pertussis portion of the DTaP and Tdap vaccine which create asymptomatic carriers.

The SB 277 experience in California, where personal belief exemptions were struck down in 2016, has not led to 100% vaccine compliance even within the school system. Removal of personal belief exemptions has served to alienate parents leading to an exodus from the school system (1.2%), as well as from the state, and placing the school districts in the untenable role of "vaccination enforcers." An additional 1.4% within the school district are still unvaccinated due to Federal Individualized Education Programs, medical and other exemptions. SB 277 did not "change the minds" of non-vaccinating parents. Instead, it pushed families out of school and created lost income to school districts. Regarding the Australian experience with vaccine mandates, one official stated that "Parents reported a greater commitment to their decision not to vaccinate and an increased desire to maintain control over health choices for their children including an unprecedented willingness to become involved in protest action." (J. Public Health Policy 2018 39:156, Helps et al.) Mandates do not encourage vaccination, they push exemption-using families out of schools.

Fully 47 states offer either a philosophical or religious exemption to vaccination for school attendance.

The Supreme Court in the Bruesewitz vs. Wyeth case called vaccinations "unavoidably unsafe" and the scientific literature shows an incidence of vaccine adverse events that is dangerous in light of the proposed mandate. Over the past ten years in the U.S., there has been one reported death from the measles and it is unclear based on the medical history of the patient whether and how measles played a role in their death. During the same time period (based on VAERS reports), there have been 105 reported deaths from the MMR or MMRV vaccinations. From 2006 to 2011, the CDC funded a project by Harvard Pilgrim Health Care, Inc. for the automation of the VAERS (Vaccine Adverse Event Reporting System) database. VAERS up to this point has been a passive surveillance system based on voluntary reporting of vaccine adverse events (AEs) and CDC officials were concerned about underreporting of such events. The team from Harvard Pilgrim set up a monitoring system of a large health care provider (with 35 clinics) and monitoring the outcomes of from 1.4 million vaccines received. Using chart abstraction, 35570 potential adverse events were reported within a window of 30 days post-vaccination. In other words, the rate of potential adverse events was 2.6%.

As legislators, you are feeling pressure to protect infants and others susceptible to poor infection outcome, but taking away the personal belief exemption for a flawed product is not the answer. You must not only protect those who are susceptible to poor infection outcome, but protect those who are susceptible to poor vaccination outcome, and to consider the unintended consequences of a fully vaccinated population that does not have lifetime immunity. Please consider my son and many others who trusted the vaccination schedule and now face a lifetime of debilitating disease.