

FACTS ABOUT SMALLPOX

Smallpox is one of the most contagious diseases known to mankind. It attacks persons of all ages. In severe epidemics, 30 of 100 persons contracting the disease may die. In mild epidemics, the death rate may be less than 1 in 100. Significantly, in those areas where few people had been previously exposed for years to the disease, the death rate is higher when an epidemic strikes. In past centuries, large numbers have succumbed to this plague.

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Name—Smallpox (*variola major*) is caused by a filterable virus, called *variola*. It is a type of *orthopoxvirus*, or pox-producing virus.

Transmission—Smallpox is transmitted by tiny droplets of moisture transmitted during coughing, sneezing, and even talking. The disease can even be transmitted through clothing, bedclothes, and utensils.

The droplets enter the mucous lining of the nose and throat of another person. From there, they invade the entire body. The virus is also present in the “pox,” the skin eruptions.

Symptoms—The first signs and symptoms of smallpox usually appear 12 to 14 days after infection, although the incubation period can range from 7 to 17 days. During this time, an infected person may look and feel normal.

Following the incubation period, a sudden onset of flue-like signs and symptoms often occur. These may include fever, chills, malaise, severe fatigue, headache and severe back pain, nausea, and vomiting.

A few days later (usually 3-4 days after the disease begins), the characteristic smallpox rash appears as flat, red spots (lesions) on the skin. Within a day or two, these

spots have raised and become blisters filled with fluid (vesicles) and then with pus (pustules). On about the 14th day, they reach their largest size.

Physicians can clearly identify smallpox from similar diseases (such as chicken pox) from the fact that the spots usually appear first on the face, hands, and forearms, then on the trunk and legs. They may be especially prominent on the palms of the hands and soles of the feet. Lesions also develop in the mucous membranes of the nose, mouth, and vagina.

The skin distribution pattern of the pox (lesions, or spots) is quite different in chicken pox: In this disease, the lesions are more superficial than those associated with smallpox, and they occur primarily on the trunk. Chicken pox comes in waves—with spots, blisters, and crusted lesions all present at the same time.

Lab tests—Lab tests can, of course, also be used for diagnostic purposes. Fortunately, researchers at the Mayo Clinic, working with those at the Centers for Disease Control (CDC) and the U.S. Army, have recently (summer of 2002) developed a new rapid laboratory test for the smallpox virus. The test can deliver results within three hours.

Aftereffects—If the patient survives, the fever drops, the blisters dry up; and he begins improving. Scabs form and later drop off. Red or brown discolorations remain. In severe cases of skin eruptions, pockmarks always remain on the skin.

Prevention—Careful, temperate living and eating only good, nutritious food builds a strong immune system and helps prevent a wide variety of diseases. However, smallpox is so virulent, that exposure to a person who has it could likely lead to infection.

Vaccination—It is generally believed that the only way to successfully combat smallpox is by vaccination, which was developed in 1796 by Edward Jenner, an English physician. He used cowpox germs as a method of preventing smallpox. All clothing and eating utensils used by the patient should be sterilized.

The present writer does not recommend vaccinations. (See his book, *The Vaccination Crisis*; 116 pp., \$6.00 + \$2.50). But smallpox appears to be a special problem.

Smallpox can attack a person who has been vaccinated more than five years prior to exposure, but the previous vaccination may still limit the severity of infection.

Before 1971, vaccinations against smallpox were routinely available in the United States. They were given to children between the ages of 1 and 2 years old, and then every five years.

Smallpox was eradicated in the United States in 1949.

Simple math—The CDC estimates that, at the very least, each known case will infect 3.5 to 6 additional people. At that rate, the disease could sweep through the general population. It would be especially difficult to control a smallpox outbreak in any of our large cities.

A chilling possibility—William Bicknell of the Boston University School of Public Health wrote: “If I were a terrorist, I’d get 10 infected people to come to the country, go to a ball game, Penn Station, Union Station, the Times Square subway station . . . By then, a lot of people would be exposed. And there is no possible scenario I can conjure up where those [exposed] people can be identified.”—*Boston Globe*, Sept. 24, 2002.

The last case, worldwide, occurred in 1977. So one might think that should forever solve the problem. Unfortunately, as we will learn below, it only added to it.

Shared samples—Two high-security laboratories possess samples of the variola virus. One is in Russia and the other in the United States. It is considered very likely that quantities of the virus have fallen into the hands of countries who want to use them as weapons.

The U.S. government declares with certainty that Iraq now has supplies of smallpox. This is one of the reasons why the Bush Administration wants to invade Iraq—in order to get rid of those supplies.

If attacked—But an invasion could result in serious problems: First, Saddam Hussein can rather easily hide his supplies of smallpox. Second, if attacked, he could easily spread it in Iraq, infecting both U.S. forces and his own people. Third, he could have previously arranged to send packets of the virus to America, Europe, Israel, and other nations—there to be released when he is nearing his own end. Fourth, if faced with arrest, imprisonment, or death, Saddam would be very willing to take extreme measures—even to killing of his own people and millions elsewhere. He is that kind of a person.

No one is prepared—The problem, of course, is that no one on the planet has contracted smallpox in over 25 years. Therefore, any outbreak of it would quickly decimate thousands of people. Regardless of whether it initially occurred in the Near East or the U.S., it is doubtful that it could be contained. Instead, it would quickly spread to other nations. There is an enormous amount of surface, sea, and air travel today. A vast number of merchant ships journey from continent to continent.

CDC action plan—The CDC has a response plan in case of a smallpox outbreak. The people in contact with those infected would be vaccinated first. This would be medical workers. Anyone with an active infection would be isolated to prevent infection of others. The CDC points to the fact that the vaccine can prevent or lessen the severity of smallpox, if given within 4 to 7 days of becoming infected.

Partial immunity—It is known that those who were vaccinated before 1972 (when those vaccinations ended in the United States), might still have partial immunity to smallpox. Yet the vaccine loses full effectiveness in 5 to 10 years. If infected, such people might have milder symptoms, a lower chance of dying, and be less contagious. Yet, in case of an outbreak, the CDC recommends that everyone be vaccinated again.

It would be nice if we could stop here. But there is more information.

The immune system problem—It is known that those with medical conditions such as severe eczema, immune-system suppressing conditions, or pregnancy could contract the full-blown disease, if given a smallpox shot.

On September 24, the *Boston Globe* reported that 20,000 health care workers will receive the smallpox vaccine. This is a serious matter; for some of those receiving it, if their immune system is in poor shape, could experience severe side effects—and either develop smallpox or spread it.

“Doctors, nurses, and others who receive the smallpox vaccine might need a three-week furlough because,

in rare cases, the vaccination could spread sickness, the [CDC] plan says. Under the draft plan, the vaccine would be given on a voluntary basis to health workers in emergency rooms or ambulances and specialists in skin disease. The main risk of the vaccination is that a small number of people who receive it could have severe side effects or, in some instances, die from the dosage.”—*Michael Kranish, Boston Globe, September 24, 2002.*

The HHV-6 factor—The number of medical workers who might suffer adverse side effects could be far worse because the CDC has not told the American public about a massive epidemic of immune dysfunction associated with a virus called *Human Herpes Virus 6* (HHV-6).

There are several different types of herpes infection: Herpes simplex (Type 1) is a mild form which causes cold sores on the lips.

Herpes zoster causes chicken pox and, as a secondary infection, shingles. Shingles is something you do not want.

Genital herpes (Type II) is also very serious, and is the most prevalent sexually transmitted disease in America.

Serious immune damage from HHV-6—This is the disease that is hardly ever mentioned. Like Type II, it has the same cause, but it more severely affects the immune system. The problem is that, because they show no symptoms, people usually do not realize that they have HHV-6. Yet all the while it is seriously weakening their body's immune factors. It is almost impossible to cure.

HHV-6 was first isolated in 1986 from people with AIDS. It has since been found to be relatively common in the population as a whole, although those with AIDS almost always have it. HHV-6 is frequently diagnosed as “chronic fatigue syndrome.” The scientific community agrees that HIV damages the immune system more than almost any other infection. Yet HHV-6 damages the immune system almost as much as HIV. The cause of HHV-6, and the lack of symptoms, are the reasons why this widespread disease is often diagnosed as something else.

Random sampling tests have consistently disclosed that a very large number of Americans have the HHV-6 virus. As mentioned earlier, it is well-known in the medical community that people with weakened immune systems should not be vaccinated for smallpox—because the vaccine would transmit the disease to them.

Forced immunization—A proposed federal act, widely discussed since fall 2001, would, if a crisis developed, require every U.S. citizen to receive smallpox vaccinations. Those forced vaccinations could be disastrous to many people. Because so many are living on fast food, junk food, tobacco, alcohol, and street drugs, many Americans are not physically ready for smallpox vaccination.

Many like the idea. A poll taken in the summer of 2002 by the Harvard School of Public Health found that 81% of the public would get vaccinated if the smallpox vaccine were available.

It is well-known among knowledgeable medical personnel that, at the present time, smallpox vaccine is not a safe thing to take into a person's body.

Dangers of mass vaccination—Here is how one news magazine described it:

“The pressing ‘post-9/11 question’ is how the public can best be protected—with the least risk—in the event of a bioterrorist attack involving smallpox . . .

“After the anthrax scare, the government ordered some 210 million [smallpox] doses, and by year’s end there will be enough for most Americans. But about 38 million Americans can’t be vaccinated because of health risks, including . . . compromised immune systems.”—*“How Small a Pox? U.S. News and World Report, June 17, 2002.*

The article also discusses how smallpox vaccines can cause encephalitis (brain inflammation) or outright death.

THE PROPOSED FORCED VACCINATION LAW

The Model State Emergency Health Powers Act (October 23, 2001) was prepared by the Center for Law and the Public’s Health at Georgetown and Johns Hopkins Universities, for the Centers for Disease Control and Prevention, in collaboration with the National Governors Association, the National Conference of State Legislatures, the Association of State and Territorial Health Officials, the National Association of City and County Health Officers, and the National Association of Attorneys General.

The present writer has a complete copy of the 38-page, 8½ x 11, *Model State Emergency Health Powers Act*. A national health crisis could quickly cause it to be enacted by Congress. Such a law would give far-reaching powers to the government. Many of the provisions are understandable; others appear to violate personal property, movement, and health rights. Forced vaccination and medical treatment are included.

Preamble: “. . . *The Model State Emergency Health Powers Act* (the ‘Act’) therefore grants specific emergency powers to State governors and public health authorities” (p. 6).

“The Act authorizes the collection of data and records, the control of property, the management of persons, and access to communications” (p. 6).

“Section 103. **Purposes.** The purposes of this Act are—(a) To authorize the collection of data and records, the control of property, the management of persons, and access to communications. (b) To facilitate the early detection of a health emergency and allow for immediate investigation of such an emergency by granting access to individuals’ health information under specified circumstances. (c) To grant State officials the authority to use and appropriate property as necessary for the care, treatment and housing of patients, and for the destruction of contaminated materials. (d) To grant State officials the authority to provide care and treatment to persons who are ill or who have been exposed to infection” (p. 9).

“Section 201. **Reporting illness or health condition.** A health care provider, coroner, or medical examiner shall report all cases of persons who harbor any illness or health condition that may be caused by bioterrorism, epidemic or pandemic disease, or novel and highly fatal infectious agents or biological toxins” (p. 12).

Pharmacists. A pharmacist shall report any unusual or increased prescription rates, unusual types of prescriptions, or unusual trends in pharmacy visits” (p. 12).

Manner of reporting. The report shall be made in writing within twenty-four hours to the public health authority” (p. 12).

“Section 303. **Emergency powers.** During a State of public health emergency, the governor may (1) Suspend the provisions of any regulatory statute prescribing procedures for conducting State business or the orders, rules, and regulations of any State agency . . . (2) Utilize all available resources of the State government and its political subdivisions, as reasonably necessary to respond to the public health emergency . . . (4) Mobilize all or any part of the organized militia [police, national guard, etc.] into service of the State” (p. 17).

Access to and control of facilities and property—generally. The public health authority may exercise, for such period as the state of public health emergency exists, the following powers concerning facilities, materials, roads, or public areas—

“(a) **Use of facilities.** To procure, by condemnation or otherwise, construct, lease, transport, store, maintain, renovate, or distribute materials and facilities as may be reasonable and necessary for emergency response, with the right to take immediate possession thereof. Such materials and facilities include, but are not limited to, communication devices, carriers, real estate, fuels, food, clothing, and health care facilities.

“Section 402. **Access to and control of facilities and property—generally.** (b) **Use of health care facilities.** To compel a health care facility to provide services or the use of its facility if such services or use are reasonable and necessary to emergency response. The use of the health care facility may include transferring the management and supervision of the health care facility to the public health authority for a limited or unlimited period of time” (p. 20).

“(c) **Control of materials.** To control, restrict, and regulate by rationing and using quotas, prohibitions on shipments, price fixing, allocation or other means, the use, sale, dispensing, distribution, or transportation of food, fuel, clothing and other commodities, alcoholic beverages, firearms, explosives, and combustibles, as may be reasonable and necessary for emergency response.

“(d) **Control of roads and public areas.** (1) To prescribe routes, modes of transportation, and destinations in connection with evacuation of persons or the provision of emergency services. (2) To control ingress and egress (entrance and exit) to and from any stricken or threatened public area, the movement of persons within the area, and the occupancy of premises therein” (p. 21).

Safe disposal of infectious waste . . . (b) Control of facilities. To compel any business or facility authorized to collect . . . infectious waste . . . to accept infectious waste, or provide services . . .

“(c) **Use of facilities.** To procure, by condemnation or otherwise, any business or facility authorized to collect . . . infectious waste . . . with the right to take immediate possession thereof” (pp. 21-22).

“Section 404. **Safe disposal of corpses . . . (b) Possession. To take possession or control of any corpse . . . (c) Control of facilities.** To compel any business or facility authorized to embalm, bury, cremate . . . to accept any corpse or provide the use of its business or facility” (p. 22).

Control of health care supplies . . . (b) Rationing . . . In making rationing or other supply and distribution decisions, the public health authority may give preference

to health care providers, disaster response personnel, and mortuary staff” (p. 23).

“Section 406. **Compensation.** The State shall pay just compensation to the owner of any facilities or materials that are lawfully taken or appropriated . . . Compensation shall not be provided for facilities or materials that are closed, evacuated, decontaminated, or destroyed when there is reasonable cause to believe that they may endanger the public health” (p. 24).

“Section 501. **Control of individuals.** During a state of public health emergency, the public health authority shall use every available means to prevent the transmission of infectious disease and to ensure that all cases of infectious disease are subject to proper control and treatment.

“In Section 501, the text immediately following the heading ‘Control of individuals’ was adapted from California Health & Safety Code § 120575 (West 1996).

“Section 502. **Mandatory medical examinations.** The public health authority may exercise, for such period as the state of public health emergency exists, the following emergency powers over persons—

“(1) **Individual examination or testing.** To compel a person to submit to a physical examination and/or testing as necessary to diagnose or reat the person [underlining mine] . . .

“(3) The medical examination and/or testing shall be performed immediately upon the order of the public health authority without resort to judicial or quasi-judicial authority.

“(4) Any person refusing to submit to the medical examination and/or testing is liable for a misdemeanor . . . The public health authority may subject the individual to isolation or quarantine as provided in this Article” (p. 26).

“Section 503. **Isolation and quarantine . . . (c) Due process . . .** (2) The public health authority may isolate or

quarantine a person without first obtaining a written *ex parte* order from the court if any delay in the isolation or quarantine of the person would pose an immediate threat to the public health” (p. 27).

“Section 504. **Vaccination and treatment.** The public health authority may exercise, for such period as the state of public health emergency exists, the following emergency powers over persons—

“(1) **In general.** To compel a person to be vaccinated and/or treated for an infectious disease [underlining mine]” (p. 28).

“Section 702. **Public Health Emergency Plan.** (a) **Content.** The Commission shall, within six months of its appointment, deliver to the governor a plan for responding to a public health emergency, that includes provisions for the following . . .

“(17) Other measures necessary to carry out the purposes of this Act” (p. 35).

“Section 802. **Rules and regulations.** The public health authority is authorized to promulgate and implement such rules and regulations as are reasonable and necessary to implement and effectuate the provisions of this Act. The public health authority shall have the power to enforce the provisions of this Act through the imposition of fines and penalties, the issuance of orders, and such or remedies as are provided by law” (p. 36).

“Section 804. **Liability . . .** Neither the State, its political subdivisions, nor, except in cases of gross negligence or willful misconduct, the governor, the health authority, or any other State official referenced in this Act, is liable for the death of or any injury to persons, or damage to property, as the result of complying with or attempting to comply with this Act, or any rule or regulations promulgated pursuant to this Act. (b) **Private liability . . .** [refers to protection from liability for any individual, firm, etc., who obeys State orders in such matters]” (pp. 37-38).
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“The new guidelines for states on mass smallpox vaccinations are most notable for what was omitted: Unanswered and often unaddressed are critical questions like timing, costs, feasibility and the multiple problems of preparing health care workers to conduct vaccinations and communicating the plans to the public . . .

Dr. Mohammed Akhter, executive director of the American Public Health Association, called the plan good but questioned its feasibility. ‘This is a huge and massive undertaking, the likes of which we’ve never seen in our history,’ Dr. Akhter said. If a smallpox attack came tonight, he added, ‘there’s no way the state and local health departments would be able to implement the plan . . .

‘Jonathan B. Tucker, a germ-weapons expert in Washington . . . said, ‘A real potential problem is how you ensure that a vaccination process is orderly and people don’t panic.’ Mr. Tucker said, ‘What we saw last fall with the anthrax attacks, which were much less threatening than a smallpox outbreak would be, was public hysteria. In the context of a vaccination campaign, that would be very problematic.’ . . .

“In theory, during a deadly outbreak, mass smallpox vaccinations can protect many people: The vaccine is one of the few immunizations that can work even if a person is already infected. The vaccine can fully protect people if given within four days of exposure to the virus.

“The new plan addresses only the most comprehensive response to an outbreak of the contagious disease, which kills about one in three victims. It does not address giving vaccinations to anyone before an attack or an outbreak, only afterward . . .

“Dr. Tucker added . . . ‘It’s very unclear whether CDC or the states are developing the necessary communication strategy to prevent panic in the event of an outbreak.’ . . . The general goal is to be ready to vaccinate every American by the end of this year. Acambis, a company in Cambridge, England, is making 209 million doses of the vaccine for the [U.S.] federal government . . . Dr. Akhter, of the public health group, said an even bigger unknown was who in Washington would make the decision to begin mass vaccinations and how that decision would be communicated.”—*New York Times*, September 24, 2002.