Written testimony in support of LD867
Richard Atlee, Southwest Harbor — 11 January 2021
[brackets refer to source footnotes at end]

Senator Claxon, Representative Meyer, and esteemed members of the Health and Human Services Committee, my name is Dick Atlee and I'm a resident of Southwest Harbor. I'm here to testify in support of LD867.

There is widespread acknowledgment of significant stress on the state's healthcare infrastructure. According to yesterday's federal HHS hospital utilization figures [1], about 77% of inpatient beds were occupied, a quarter of these by COVID patients, with the same proportion of ICU beds, of which 3/8ths were COVID, not out of line with most of the country, though federal officials recently acknowledged [2] COVID hospitalization counts may be overcounted.

However, the other principal source of stress is Governor Mills's emergency declaration [3] of a COVID vaccine mandate for healthcare workers — one of the most stringent in the nation, which has destabilized the system by driving out the many healthcare professionals who have refused the vaccines.

What would induce nurses with many years of experience, often a career at stake — who have accepted previous traditional vaccines — to refuse these vaccines? It isn't that the vaccines have failed to prevent infection or transmission, and thus cannot protect either staff or patients, rendering the mandate substantively useless, though this is certainly the case. It's because of valid safety concerns.

Not only do they and their colleagues report seeing an increasing number of hospital admissions and deaths due to adverse effects of these vaccines, but they are all increasingly aware of the stark government statistics.

Although the FDA had the authority, in granting Emergency Use Authorization to the vaccine manufacturers, to require them to mount robust safety monitoring mechanisms, the FDA chose not to make that requirement, and the manufacturers followed suit, leaving the detailed monitoring up to the federal government. The systems available for doing this are

- the CDC's Vaccine Adverse Events Reporting System (VAERS) [4]
- the CDC's Vaccine Safety DataLink (VSD) [5]
- the CC's v-Safe app specifically designed for the COVID vaccines [6], and
- the FDA's Biologics Effectivenes and Safety System (BEST) [7]

The CDC has withheld permission from most independent researchers for accessing the VSD raw data, and because it is based on only diagnostic codes, it has been shown to miss many instances of injuries [8] described in the text of reports. The CDC is now refusing access to the vSafe data [9]. The BEST system has not yet been fully implemented [10].

This leaves the VAERS system, which has a long and well-deserved reputation for undercounting. A variety of factors play into this, particularly

- its "passive" nature — it requires a time-consuming submission by a human being
- a lack of awareness among medical professionals of the system itself and of the legal requirement for reporting,
- a lack of medical training on the existence of, and how to identify, vaccine adverse events,
- active discouragement of reporting by healthcare administrators, and
- the sheer time-consuming difficulty of filing the reports and dealing with the follow-ups, documented in my written testimony, which discourages both legitimate filers and (along with fines and imprisonment) any pranksters.

This underreporting reputation dates back to the now well-known HHS-funded 2007-2010 Harvard study[11] that found not only an under-reporting factor (URF) of over 99% of adverse events being missed, but also a refusal by CDC to fix the system. There have been other attempts over the years to quantify this, URF two of the more recent related to the COVID vaccines being 31% (deaths) [12] and 95% (anaphylaxis) [13].

But taking the VAERS data a face value (and it is reflected in the data produced by the analogous systems in the U.K., Europe, and Israel), the numbers are concerning. While VAERS offers a clumsy tool for accessing data (WONDER) [14], the most accessible access to COVID-related data is offered by the OPEN-VAERS [15] tool.

Some of the data (system totals rather than strictly U.S.), as of December 31, for some particularly serious events, were — and keep in mind the significant undercounting:

21,382	Deaths
113,303	Hospitalizations
36,758	Permanent disabilities
24,344	Life threatening events
23,713	Myocarditis/pericarditis cases, and
3,511	Miscarriages

These may be small as a proportion of total vaccinations, but the point is, we don't know why certain people suffer these reactions, and no research is being done to identify why that happens. So these numbers can justifiably loom large for an individual making a safety choice between a job and a possible future inability to work at all.

Some assert that it is easy to file fake reports, so the data is unreliable in that respect. However, this is belied by the following facts:

- The submission forms (online [16] or PDF [17]) are quite extensive and detailed.
- Completion time is estimated at about 30 minutes if all the data is available, and any greater-than-20-minute lapse in filling out the online form causes it to be lost.
- Submission creates a temporary VAERS record, but before it is permanent, the CDC follows up [18] on each of these, requiring more time (and overloading the CDC).

In summary, these vaccines protect neither healthcare workers nor their patients, and pose

serious risks for as-yet-unidentified population subgroups. One-size-fits-all mandates for such vaccines uselessly force people out of the healthcare industry.

Every time we enter a hospital or medical office, it is required that we be offered consent for whatever treatment we are to receive. A vaccine mandate is the sole exception to this — a direct violation of the long-held requirement for informed consent to medical procedures.

Sources:

[1] https://protect-public.hhs.gov/pages/hospital-utilization
[2] https://www.youtube.com/watch?v=Aktzp4jSXY8
[3] https://www.maine.gov/governor/mills/news/mills-administration-requires-health-care-workers-be-fully-vaccinated-against-covid-19-october
[4] https://vaers.hhs.gov/
[5] https://www.cdc.gov/vaccinesafety/ensuringsafety/monitoring/vsd/index.html
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