Comment on "June 25-27, 2025 ACIP Meeting Notice". Center for Disease Control and Prevention. Docket No. CDC-2025-0024. Federal Register. 2025 Jun 9; 90(109): 24278-24279. https://www.regulations.gov/document/CDC-2025-0024-0001. Submitted June 20 2025.

I worked as a federal (Food and Drug Administration) epidemiologist for most of my career. During that time I witnessed many instances when staff and managers wanted to advocate for decisions that "felt right"; I was one of many scientists that insisted on the primacy of the data, which sometimes was contrary to perceived experience and intuition. The importance of scientific data was helped by the requirement that all of the experts with input needed to document their reasoning for the archived record. Those experts were both internal and advisory. I appreciated being able to trust and learn from the input of experts in different disciplines who worked on the same regulatory decisions as I did. I also appreciated being able to trust the decisions of my fellow federal employees for products that I was not involved with. Now that I'm retired, I rely entirely on their expertise. My trust in those decisions has been shaken in the past several months because of mass federal firings, intimidation, overruling of scientists by the political appointees, and now, radical changes to the tried and tested advisory committee system [1-3].

I have not always agreed with the decisions made by federal staff and advisors. However, I believe most of the decisions produced by the system were valid and well-supported. The current direction is destroying the parts of the system responsible for good decisions.

I feel particularly vulnerable to federal public health decisions because I'm elderly and have acquired some disadvantageous conditions. I can still read and analyze the public research literature to see if I agree with the decisions, but I may lose that ability due to my own illness, or censorship of publications [4-5] and decisions [6]. I won't be able to act in my best interest if the federal government restricts my access to preventive measures and treatments. I'm very worried that the current direction of public health policies is going to shorten my active and overall life.

My concerns for myself apply to everyone else, as well. Most of them, including healthcare professionals, can't or won't read the scientific literature for themselves and rely on the guidance from FDA and CDC. This makes that guidance even more crucial. Even the rest of the world relies on FDA and CDC guidance [7].

I have comments on the Advisory Committee on Immunization Practices (ACIP) composition, practices, and policies, as well as the importance of universally-available COVID-19 vaccination.

ACIP Composition

Before 2025, nominees were vetted for capability in their fields and lack of conflict of interest, in a process that took 2 years [7]. A few were finally named to the committee within the past 6 months. The rationale for dismissing all 17 members was conflict of interest [1] and lack of trust [8-9]; I would like to see details, for each fired member, showing what the alleged conflict was and why prior decisions to put them on the ACIP were defective.

Rotating staggered membership provided efficiency as the members with longer tenure knew better what work and inputs were expected of them. Letting all 17 members go at once ruins the institutional knowledge that they had [7].

The appointment of the 8 new members didn't go through any lengthy vetting process. They have been announced in the press but the HHS press announcements and CDC website for ACIP membership don't list anyone. The new members [1] seem to largely not have been chosen for science expertise:

- Vicky Pebsworth, PhD, RN: "Her son — her only child — experienced serious, long-term health problems following receipt of seven live virus and killed bacterial vaccines administered during his 15-month well-baby visit which sparked her interest in vaccine safety research and policymaking and chronic illness and disability in children." She is a board member of National Vaccine Information Center [10], which aims to inform people about the "complications of infectious diseases and complications of vaccines" and advocates for the "right" to refuse vaccination [11]. A summary of her study of Gardasil vaccination adverse events was published by NVIC under her prior name (Debold) [12], but it was never published in a scientific journal. My searches for "Pebsworth" and "Debold" on the National Library of Medicine index of scientific publications [13] found a study and a letter:

    - The study claimed in its abstract to show that non-medical vaccination exemption laws weren't related to disease rates; the paper showed that the laws also weren't related to vaccination rates [14].

    - The letter [15] regarding an article [16], disputed the safety of the quadrivalent HPV recombinant vaccine compared to other vaccines. The letter claims the article misinterprets the data, even though the article correctly discloses that their method of comparing, for different vaccines, numbers of reported adverse events to doses distributed has faults.

    Her vaccines work relies heavily on reported adverse events, without the use of methods to understand whether the vaccines caused the adverse events, which is critical to assessing vaccine safety.

- Robert Malone, MD, has publicly stated that "getting vaccinated puts people who already have had COVID-19 at higher risk", which is false [17]. He exaggerated his role in the development of mRNA technology and has stated other falsehoods about the COVID-19 vaccines [18].

- Martin Kulldorff, PhD, is a biostatistician who violated CDC rules by serving "as an expert witness against Merck's Gardasil human papilloma virus (HPV) vaccine" [19]. The only study he authored related to vaccines I could find on PubMed was a study of the waning of influenza vaccine effectiveness [20], yet he "has been a leader at the Brownstone Institute, which opposes COVID-19 restricts and publishes literature on the dangers of the COVID-19 and other vaccines" and has been recently bypassing peer review by publishing in a journal he cofounded [19].

- H. Cody Meissner, MD, was previously a member of ACIP who "made 12 conflict of interest disclosures during his time on the committee from 2008 to 2012" [21], so it's unclear why those conflicts of interest (among the conflicts of interest that Secretary Kennedy declared were disqualifying for all past ACIP members [9]) are now fine. Dr. Meissner reportedly voiced support for not recommending COVID-19 vaccines for healthy children and pregnant women [19], a position not supported by the evidence [22-23].

- Joseph Hibbeln, MD, is a psychiatrist and nutritional neuroscientist who hasn't published about vaccines [19].

- Retsef Levi, PhD, is a professor of operations management and has his doctorate in operations research. He has admitted little expertise in vaccines, but stated publicly that mRNA vaccines cause serious harm and death and should be stopped [19]. He clearly doesn't understand how to research the risks of vaccines compared to the risks of infections.

- James Pagano, MD, is a retired emergency physician [19]. I haven't found any expertise in vaccines or evaluating studies of medical treatments.

- Michael A. Ross, MD, has been a practicing Ob/Gyn, pediatrician, and health care entrepreneur. Without any apparent expertise, he (coauthored with 68 other authors) criticized the methods for studying the effectiveness of Ivermectin for COVID-19, that they couldn't get published in the journal that had published the study to which they objected [24].

On the contrary, they seem to have been chosen because of their criticism of vaccines, that don't have bases in facts [1]. Please note that an MD degree doesn't qualify one to evaluate or conduct scientific research. None of these new ACIP members have documented understanding of the methods of unbiased scientific medical research.

Moreover, the MD and other clinical and health degrees generally include instruction in clinical ethics, which is available to the public, as well [25]. People who conduct human research have generally been required to learn the applicable publicly-available ethics guidelines before gaining approval to begin their study [26]. Anyone who says they support comparing a vaccine that has already been approved, or is similar to one that has been approved, to an inert placebo is advocating for the violation of the basic ethic against withholding vaccines that are known to work. Such people have no business being on ACIP, in CDC, leading any HHS organization, or leading HHS.

As an epidemiologist, I object to my access to vaccines being advised by people who don't rely on science or ethics to make their recommendations.

ACIP Practices and Policies

One of the ACIP members (until a month ago), already a vaccines expert, said that he usually devoted 3 weeks before each meeting to study the materials and review other related materials [27]. The new members, announced on June 11, have less than 3 weeks to study any materials that may have been sent to them [1] and any background they need to catch up on, and will probably be unprepared.

As I have noted before in public comments, the public receives no prior access to meeting materials. Thus, our comments are less informed and more easily ignored by ACIP members. Now that there will be a new executive secretary, I urge the CDC to begin making meeting materials available to the public at the same time they are sent to the ACIP members, and allowing enough time (at least 2 weeks) for the public to digest the materials before the deadline for written public comments.

I have seen absolutely no evidence that oral or written public comments influence ACIP recommendations. Please enable our opportunities to make more informed comments, summarize written public comments during the meetings, and allow longer and more oral public comments during ACIP meetings.

COVID-19 Vaccines

For years now, FDA and CDC decisions on COVID-19 vaccines have ignored long term effects of COVID-19, popularly called "long Covid". Recent studies of the prevalence and devastation of long Covid among adults [28] and children [29] support the importance of doing everything one can to prevent initial and repeat COVID-19 infections. COVID-19 vaccines have been shown to reduce the risk of acute COVID-19, severe acute COVID-19, and long Covid [30-35]. Even if the vaccines aren't as effective against COVID-19 as other vaccines are against "their" respective diseases, their level of effectiveness is still very important because of the prevalence of SARS-CoV-2 circulating year round, with 2 major peaks per year [36].

Data regarding the length of time that the COVID-19 vaccines are effective show that immunity wanes significantly after about 4 months [35, 37]. Therefore, yearly and twice-yearly vaccinations are inadequate. They should be offered three times per year.

Waning of immunity from the vaccines should fairly be compared to the waning of immunity from infections, which is also fast [38-39].

Adverse events from the vaccines should be acknowledged, and properly compared to the adverse effects of getting COVID-19, in terms of severity and prevalence. For example, myocarditis among young men is much less frequent and severe in those who got the vaccine compared to those who got the infection [40]. The prevalence of COVID-19 is so high that the risks from the infection aren't theoretical or remote [7].

Vaccination is both an individual and group protection. I can get vaccinated to achieve a certain amount of protection. The more people around me who also get vaccinated raises the personal level of protection for every individual (vaccinated or not), including me, in the group. Therefore, I advocate vaccine availability and encouraging vaccination for everyone for whom the benefit/risk ratio makes sense.

In the case of COVID-19 vaccines, the evidence has been clear that it is beneficial for people of all ages, including pregnant women [22-23]. Restrictions that aren't based on science [7, 41] are unconscionable.

Universal access needs to be restored and maintained so that health insurance will cover the cost [7]. Access should be available for all vaccines approved by FDA.

Requests

1. Reinstate the 17 ACIP members that had been let go.

2. Bar ACIP membership to those who refuse to follow established principles of clinical and human research ethics.

3. Require ACIP members to show evidence of the ability to perform science-based assessments of reports and studies.

4. Provide ACIP meeting materials to the public at the same time as the ACIP members, and allow at least a week to file responsive written comments.

5. Provide summaries and discussion of public comments at the meetings.

6. Allow more and longer oral public comments at the meetings.

7. Consider long Covid incidence and severity when recommending COVID-19 vaccine schedules.

8. Recommend universal access to FDA-approved COVID-19 vaccines three times per year.

9. Call for development of more effective COVID-19 vaccines.

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