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Pilots May Hold Key to Mobilizing Against Military COVID Vaccine Mandate

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When the military mandated the anthrax vaccine and military pilots showed they were willing to throw away careers and pensions in order to avoid the vaccine, it got the military's attention — maybe they can do the same with COVID vaccine mandates?

With the U.S. military announcing plans to mandate the COVID vaccine for all personnel, possibly by Sept. 1, many service members already enduring coercive restrictions for failing to take the "voluntary" vaccine, are concerned about their careers.

To date, 23% to 42% of military members, depending on the branch of service, have not taken the vaccine.

The clinical trials for the three COVID vaccines being administered in the U.S. — Pfizer, Moderna and Johnson & Johnson — are not scheduled to be completed until 2022 or 2023, when they would then be eligible for review and full licensing by the U.S. Food and Drug Administration (FDA).

However, President Biden could issue an executive order to impose a military mandate and waive FDA approval in the event of a health emergency.

Experimental anthrax vaccine precedent

The U.S. military has now, in an unprecedented move, decided to administer an experimental drug to the entire force. Even with the experimental anthrax vaccine scandal, there was never a completed mandate for the entire force.

The Anthrax Vaccine Immunization Program (AVIP) was disrupted by numerous legal challenges in Doe vs. Rumsfeld (2003, 2004, 2006, 2007) for an illegally mandated drug, without full FDA approval and licensure, which was never proven to be effective to protect against inhalation anthrax as required under the FDA's Emergency Use Authorization (EUA) guidelines.

During this legal battle, which lasted years, service members who declined the anthrax

vaccine were reduced in rank and pay, and disciplined under the Uniform Code of Military Justice which brought criminal charges resulting in jail and dishonorable discharges for declining a vaccine with serious long-term side effects. Others were forced into early retirement, and lost veteran benefits.

The U.S. Department of Defense (DOD) denied a readiness problem or a vaccine safety problem, but Congressional oversight revealed the experimental anthrax vaccine mandate in 2001 provoked a pilot retention crisis.

This, and the anthrax vaccine side effects experienced by military personnel, was summarized in a report issued by the Government Accounting Office (GAO).

As The Defender previously reported, in addition to the legal challenges, the GAO report found the military had a serious retention crisis due to the anthrax vaccine. The most experienced pilots left or planned to leave the military to avoid the anthrax vaccine — they were even willing to walk away from retirement benefits.

According to the GAO report:

> "According to our survey, between September 1998 and September 2000, when AVIP was mandatory, about 16 percent of the guard and reserve pilots and aircrew members had transferred to another unit (primarily to non-flying positions), moved to inactive status, or left the military altogether. In addition, 18 percent of those still participating in units indicated their intention to transfer, move, or leave in the near future. About one-fifth of those who had already left did so knowingly before qualifying for military retirement.'"

The pending loss of pilots was undeniable. According to the report, 69% of those pilots who changed their status ranked the anthrax vaccine as the main factor, and 72% of those pilots who planned to leave the military ranked the anthrax vaccine as the main factor.

More than half of the losses and potential future losses of aircrew members in the guard and reserve were pilots. These personnel losses included more experienced positions of flight evaluator, flight instructor and aircraft commander, in whom the military had invested years of training.

In retrospect, there were very few commanders willing to protect the service members from side effects of blindness, vertigo, tremors and blackouts. **Col. Felix M. Grieder**, commander of the 436th Airlift Wing at Dover Air Force Base, was an exception.

According to Stars and Stripes:

> "In 1999, dozens of C-5 pilots from the base reported side effects after taking the shot. One senior officer resigned and 40 percent of the pilots in the Reserve wing left rather than take a shot.
>
> "Concerns by the pilots prompted Col. Felix M. Grieder, commander of the 436th Airlift Wing at Dover, to suspend the inoculation program, making it the first base to do so."

Not incidentally, all vaccine manufacturers continue to be indemnified for their products leaving the public to assume all the risk of personal injury with little to no meaningful

redress.

In 1999, these Anthrax vaccine side effects were correlated with the ingredient of non-FDA-approved squalene in certain lots of vaccines and linked to Gulf War Syndrome.

It took years for DOD, Walter Reed Army Institute of Research (WRAIR), and the FDA to verify that independent lab testing at Tulane University confirmed the presence of squalene, and then blame contamination and not intentional use of the vaccine adjuvant used in animal research.

The GAO pilot survey in 2000 indicated 86% of respondents had experienced a local or systemic reaction to the anthrax vaccine.

Tom Heemstra, a squadron commander forced into retirement for refusing the anthrax vaccine, testified to Congress that the Pentagon acted in abuse of power similar to what is being reported currently with SARS-CoV2 vaccines: "They coerced, intimidated, threatened and punished in order to enforce this program," Heemstra said.

There was a double standard with anthrax punishments policy which said Reserve and the National Guard personnel could not be court-martialed like active-duty personnel.

Those in the Reserve and Guard units who declined the anthrax vaccine tended to be officers and pilots who flew the majority of refueling and cargo aircraft in the Air Force, and nearly all of these pilots also flew for commercial airlines in their civilian careers.

There are many takeaways from the anthrax program. The DOD's inability to monitor vaccine reactions in an active surveillance system and reverse an unsound mandate policy in a timely response demonstrated a vulnerability that has not yet been corrected.

Likely, the DOD financial contract commitments for the vaccine in the planning phase outweighed changing course of action with surveillance in the operational phase.

The DOD implemented a policy that harmed health and retention, and the department has even continued a limited anthrax program years after overwhelming evidence of harm and lack of benefit.

Wargaming: Likely Scenarios, Worst-Case Scenarios, & Red Team Assessment

The use of wargaming as a tool to prepare for numerous scenarios is critical for the DOD. Traditional pandemic planning exercises must move beyond strictly how to synchronize response efforts against a pandemic to considering a catastrophic loss to the Armed Forces.

The DOD must expand its thinking on force readiness to include pharmaceutical reaction risks, losses of key skilled personnel and potential wide-scale catastrophic harms from experimental medical countermeasures.

Agency heads, including the Assistant Secretary for Health Affairs, the U.S. Army Medical Research and Materiel Command (USAMRMC), the Biomedical Advanced Research and Development Authority (BARDA), and the Assistant Secretary for Defense for Manpower and Reserve Affairs, plus outside independent scientists and researchers must be brought to this effort.

Wargaming scenarios for the implementation of a potential COVID vaccine mandate should include the likely scenario that the drug does not confer individual immunity or herd immunity, per the clinical trial endpoints that indicated symptom reduction was the primary measured outcome.

Evidence of vaccine failure is already demonstrated by high numbers of breakthrough cases before influenza season begins in October 2021.

The development of this scenario must include data showing that young, healthy people in the military have a 99.9% survival rate. It should also include data on how a failure to meet the recently changed definition of herd immunity would not be met.

Incorporate that AR40-562 allows military personnel to show proof of immunity in lieu of vaccination, and include estimates of naturally acquired immunity. A drug that does not confer immunity for a disease with a high survival rate in the military population does not demand a mandate that could result in a retention crisis.

This scenario should also include therapeutics as alternatives to the vaccine, as a protective measure against detrimental groupthink that exclusively perpetuates a single strategy to accomplish the mission of health for a diverse population.

The DOD, when conducting its wargame exercise, must also include the worst-case scenario of acute and chronic adverse reactions disrupting the health of the entire force in service members who have been vaccinated for COVID.

Antibody Dependent Enhancement (ADE) is well documented in the published mRNA research literature. ADE could become epidemic in the winter of 2021, with the pathogenic priming effect established in previous animal studies of mRNA vaccines.

In the established likelihood of a zero-exemption policy under a vaccine mandate for active duty personnel, a policy that would reinforce readiness would allow those who decline the option to transfer to a reserve unit, without UCMJ punishment. If the entire vaccinated force is now susceptible to ADE, then the unvaccinated members in the reserves could backfill critical readiness missions.

Every wargame exercise should always consider the enemy or red team. Coronavirus is not the enemy, despite a media campaign trying to promote it as such. Coronaviruses are endemic, and have been known to affect humans for a long time.

Part of the red team assessment should include the history of the manufactured crisis of anthrax (the vaccine developer was blamed for mailing Anthrax letters and creating the threat to secure a $29 million no-bid vaccine contract with DOD), and the subsequent knee-jerk reaction of DOD to mandate an experimental drug for the entire force.

Policymakers should assess if this is a copycat operation. Both the alleged threat of a virus with a 99.9% survival rate, and the alleged cure of a fast-tracked vaccine using new mRNA technology demand a focused red team assessment.

This should include a scenario whereby a country such as China could co-opt a small number of influential scientists, pharmaceutical companies and news media outlets to ensure that U.S. Government advisors prevent and limit critical reporting on likely injuries across the DOD workforce.

Simulate degradation of the available pilot strength across critical combatant commands where airpower is a key military strength, attrite the numbers and assess the outcomes. This red team assessment should include the possibility that a biowarfare product or synthetically altered viruscould decimate airpower.

VAERS-derived data should be used as a key indicator of potential deaths and injuries that would ground pilots and crews.

The defense manpower assessment should include a detailed identification of the shortfalls and gaps that currently exist in order to prepare and defend against any of these possible scenarios.

Legal response strategy for service members

A legal challenge by individuals or class action suit should include the precedent of Doe v. Rumsfeld.

The COVID vaccine has not been approved by the FDA, which means at this time, a mandate is a direct violation of federal statute and service members have the right to decline.

The vaccine has not demonstrated, in clinical trials or in the real world, the ability to prevent infection or transmission, thus a mandate is a discrimination policy with preference for vaccinated with infection and rejection of unvaccinated with infection. New territory in a legal challenge would include the lack of evidence of a health emergency, a prerequisite for the military to mandate an EUA drug.

America's Frontline Doctors v. Secretary of US HHS, filed on July 19, provides the language and legal basis for all these challenges and more.

How to protect your rights and engage with stakeholders

First, service members should be aware of their vaccine exemption rights in AR40-562 (a joint regulation applying to all branches of the military).

Exemptions include proof of immunity, medical contraindication, administrative exceptions by the commander, and by religious accommodation approval.

Second, if pilots can obtain a Congressional oversight hearing with data on adverse reactions, degradation of readiness status,and retention losses, they can be influential in shaping a more sensible response to the COVID-19 medical countermeasure vaccine for all service members.

With the anthrax vaccine, 16% declination from pilots was the trigger to limit the vaccine mandate to "at risk" units.

Third, commanders have power under AR40-562 to halt the vaccine program in their units if they assess a risk to mission readiness. This requires service members to educate commanders who are currently in lockstep with a climate of coercion, where unvaccinated service members are already reporting alarming work segregation and public access restrictions during the voluntary phase of an EUA drug.

Fourth, the Office of the Assistant Secretary of Defense for Health Affairs (ASDHA) comprises

the chief medical adviser to the U.S. Secretary of Defense. She is assisted by a principal deputy assistant, and three deputy assistant secretaries. It is prudent for citizens to demand evidence from these unelected civilians at the office of ASDHA that they have conducted critical wargames and red team assessment for all aforementioned scenarios regarding the COVID vaccine.

The public should demand this information via the Freedom of Information Act (FOIA) and expect U.S. Congress members to expedite these actions.

Last, service members can contact members of the U.S. House Committee on Armed Forces and ask them to support HR3860, a bill to prohibit any requirement that a member of the U.S. Armed Forces take a COVID vaccine.

The stakes could be too high, the risks too grave, and with the inability to defend our nation during a time of multi-faceted global crisis, incalculable.

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