April 6, 2023

Re: Board certification of John Littell, MD

American Board of Family Medicine
1648 McGrathiana Pkwy Suite 550
Lexington, KY 40511

Attn: Warren Newton, MD, MPH, President
Rachel Shelton, Associate Counsel
Andrea Back, MHA, Credentialing Assistant

To Whom It May Concern:

As physicians and scientists we note with concern the disciplinary action by the American Board of Family Medicine, dated March 16, 2023, suspending the board certification of John Littell, MD, justifying this arbitrary and unwarranted action on the grounds that Dr. Littell allegedly disseminated "medical misinformation" via public channels. The ABFM's letter notifying Dr. Littell of the disciplinary action not only fails to demonstrate adequate grounds for such punishment, but is itself riddled with scientific errors and inaccuracies, which could be considered "medical misinformation" in their own right. In drawing your attention to these misstatements and false claims, we request an immediate reinstatement of Dr. Littell's board certification as well as a public apology to Dr. Littell, whose long service as a conscientious clinician is reflected in his sterling professional reputation.

This letter comprises three sections:

I) Analysis demonstrating that the comments by Littell incorrectly labeled "misinformation" by the ABFM are simple statements of fact supported by scientific evidence.
II) Presentation of evidence that the spike protein encoded in the mRNA vaccines is itself a pathogen.
III) Review of significant changes in medical guidance from countries which are our closest peers in terms of public health policy, drastically curtailing COVID-19 vaccination for healthy young people.

I. Dr. Littell's statements are based in scientific fact

The public statements by Dr. Littell which your organization deems "misinformation" are all supported by peer-reviewed research published in reputable scientific journals. We will address the examples cited in the ABFM's letter one by one.

1. The ABFM cites examples of Dr. Littell referring to the mRNA vaccines as "genetic engineering," arguing that the vaccines cannot be considered genetic engineering because the "mRNA does not enter the nucleus of cells where genes are present."

The ABFM is wrong. Common definitions of genetic engineering make no mention of nucleic acid-based material entering the nucleus. Merriam-Webster defines genetic engineering as "The group of applied techniques of genetics and biotechnology used to cut up and join together genetic material and especially DNA from one or more species of organism and to introduce the result into an organism in order to change one or more of its characteristics." By this definition, mRNA vaccines qualify as genetic engineering because they change the characteristics of vaccine recipients by inducing an immune reaction that results in long-lasting changes in B and T cells. Additionally, contrary to the ABFM's claim, research has shown that the mRNA contained in the vaccines can in fact penetrate the nucleus of animal cells and undergo reverse transcription into DNA.

- Alden, Markus, Francisko Olofsson Falla, et al. "Intracellular Reverse Transcription of Pfizer BioNTech COVID-19 mRNA Vaccine BNT162b2 In Vitro in Human Liver Cell Line." *Curr. Issues Mol. Biol.* 2022, 44(3), 1115-1126. Doi: 10.3390/cimb44030073
  Summary: "Our results indicate a fast up-take of BNT162b2 into human liver cell line Huh7, leading to changes in LINE-1 expression and distribution. We also show that BNT162b2 mRNA is reverse transcribed intracellularly into DNA in as fast as 6 h upon BNT162b2 exposure."

2. The ABFM claims that Dr. Littell's statement that COVID-19 vaccines have killed more young people than the disease itself is misinformation, citing flawed and incomplete CDC data.
   The ABFM is wrong. Reliable population-level data from the United Kingdom, which is more transparent and forthcoming than that provided by U.S. federal government agencies, shows that all-cause mortality has been consistently higher among vaccinated young people than their unvaccinated peers.
   - The U.S. government hasn't released all-cause mortality data broken down by vaccinated versus unvaccinated status or stratified by age, but the UK – perhaps our closest peer in terms of healthcare provision, pandemic response, and the socioeconomic factors underlying health – released this data regularly between April 2021 and December 2022, the height of the British mass vaccination campaign.
   - In the English NHS 18-39 age group, age-standardized mortality per 100,000 person-years was lower among unvaccinated than vaccine recipients who received the first dose "at least 21 days ago" for 18 out of 21 months over that time period. Over the entire period, the average age-standardized monthly mortality rate among unvaccinated individuals ages 18-39 was 47.7 per 100,000 person-years, compared to 65.4 per 100,000 person-years for vaccine recipients who received the first dose "at least 21 days ago."
   - U.S. data on mortality from COVID-19 disease versus mRNA vaccination among young people fails to account, on one hand, for wide prevalence of prior infection among young people according to the CDC's own estimates, and on the other, established underreporting of vaccine adverse events including deaths based on historic data.

3. The ABFM letter states, "There is no evidence that pediatric myocarditis deaths, attributed to COVID vaccination, are more numerous than prevented deaths, serious illness, or hospitalizations from COVID. The myocarditis caused by COVID vaccination is mild and not associated with fatalities."
   The ABFM is wrong. Data from independent domestic studies and foreign public health agencies in peer nations indicates that both incidence and severity of post-vaccination myocarditis and other cardiovascular harms are higher than official U.S. estimates. There is evidence that myocarditis resulting from vaccination is more common than myocarditis resulting from COVID-19 disease.
   A. Multiple studies contradict a commonly cited estimate placing the incidence of post-vaccination myocarditis at a rate of one symptomatic case per 10,000 vaccinated individuals ages 12-15, falling to one per 12,500 individuals ages 16-17. By definition, symptomatic myocarditis requiring hospitalization is not mild, and therefore a major concern.
      - Li, Xue, et al. "Myocarditis Following COVID-19 BNT162b2 Vaccination Among Adolescents in Hong Kong." *JAMA Pediatr.* 2022;176(6):612-614. Doi: 10.1001/jamapediatrics.2022.0101
        Summary: In Hong Kong researchers estimated the incidence at one symptomatic case per 4,515 individuals ages 12-17 who received the Pfizer vaccine.
      - Karlstad, Øystein, et al. "SARS-CoV-2 Vaccination and Myocarditis in a Nordic Cohort Study of 23 Million Residents." *JAMA Cardiol.* 2022;7(6):600-612. Doi: 10.1001/jamacardio.2022.0583
        Summary: This Scandinavian study estimated the upper range of myocarditis incidence at 28 per 100,000 males ages 16-24 after the second dose of the Moderna vaccine, or around one in 3,570.
      - Chiu, Shuenn-Nan, et al. "Changes of ECG parameters after BNT162b2 vaccine in the senior high school students." *Eur J Pediatr.* (2023). Doi: 10.1007/s00431-022-04786-0
        Summary: This study of 4,928 Taiwanese high school students found 17.1% experienced cardiac symptoms after receiving the second dose of the Pfizer vaccine, including one case of myocarditis and four others with "significant arrhythmia."
      - Krug, Allison, et al. "BNT162b2 Vaccine-Associated Myo/Pericarditis in Adolescents: A Stratified Risk-Benefit Analysis." *Eur J Clin Invest.* 2022 May; 52(5): e13759. Doi: 10.1111/eci.13759
        Summary: Researchers using data from the Vaccine Adverse Events Reporting System (VAERS) calculated the rate of myocarditis and pericarditis among boys ages 12-15 after the second dose of Pfizer at 162.2 per million, or roughly one in 6,165.
   B. Smaller studies suggest asymptomatic post-vaccination myocarditis may be more common than generally understood.
      - "Temporary mild damage to heart muscle cells after Covid-19 booster vaccination." MyScience. November 9, 2022.
        Summary: In this Swiss study tracking 777 healthcare workers who received an mRNA booster, 2.8% showed elevated levels of troponin, a biomarker signaling cardiac damage.

- Mansanguan, Suyanee, et al. “Cardiovascular Manifestation of the BNT162b2 mRNA COVID-19 Vaccine in Adolescents.” *Trop. Med. Infect. Dis.* 2022, 7(8), 196. Doi: 10.3390/tropicalmed7080196
  Summary: This Thai study of 301 high school students who received the Pfizer vaccine found 29% experienced cardiac symptoms, including one student diagnosed with myopericarditis, as well as four with suspected subclinical myocarditis and two with suspected pericarditis, for a total incidence of 2.3% when suspected cases are included.

C. No U.S. public health authorities have addressed the potential for long-term damage from post-vaccination myocarditis, despite mounting evidence of lasting harms in young people.
   - Kracalik, Ian, et al. “Outcomes at least 90 days since onset of myocarditis after mRNA COVID-19 vaccination in adolescents and young adults in the USA: a follow-up surveillance study.” *Lancet Child Adolesc Health.* 2022; 6: 788–98. Doi: 10.1016/S2352-4642(22)00244-9
     Summary: Researchers at Vanderbilt University screened 151 patients who experienced myocarditis after mRNA vaccination with cardiac MRIs 90 days later, finding over half (54%) showed “late gadolinium enhancement,” a sign of myocardial fibrosis or scar tissue on the heart.
   - Ghanizada, Muzhda, et al. “Long-term prognosis following hospitalization for acute myocarditis – a matched nationwide cohort study.” *Scand. Cardiovasc. J.* 2021;55:5. Doi: 10.1080/14017431.2021.1900596
     Summary: This Danish study tracked 1,557 patients diagnosed with myocarditis from 1996-2016 and concluded, “Myocarditis in younger patients without prior cardiac disease was associated with a long-term excess risk of [heart failure] hospitalization, and death,” with an incidence of heart failure hospitalization over four times the control group, and a death rate double the control group.

D. Claims that myocarditis associated with COVID-19 infection is more common and more severe than myocarditis resulting from vaccination are contradicted by scientific evidence.
   - Tuvali, O, Sagi Tshori, et al. “The Incidence of Myocarditis and Pericarditis in Post COVID-19 Unvaccinated Patients-A Large Population-Based Study.” *J Clin Med.* 2022 Apr 15;11(8):2219. Doi: 10.3390/jcm11082219
     Summary: This study compared 196,992 individuals who experienced acute COVID-19 infection with a control group of 590,976 individuals representing the baseline rate in the population. 0.0102% of individuals with COVID-19 infection were diagnosed with myocarditis or pericarditis, comparable to the control group rate of 0.013%. The authors concluded: “Post COVID-19 infection was not associated with either myocarditis… or pericarditis... We did not observe an increased incidence of either pericarditis or myocarditis in adult patients recovering from COVID-19 infection.”
     Discussion: The very low rate of symptomatic myocarditis and pericarditis associated with COVID-19 infection (0.0102% = 1/9,804) must be weighed against the findings, cited above, suggesting symptomatic myocarditis rates ranging from 1/3,570 to 1/6,165 in healthy young people post-vaccination.

4. The ABFM denies that mass vaccination can give rise to viral variants that evade vaccine-conferred protection.
   The ABFM is wrong. It is generally acknowledged that mass vaccination with a "leaky" (non-sterilizing) vaccine can give rise to viral variants that evade the vaccine. The fact that viruses evolve on their own, in the absence of vaccines, does not preclude the possibility of evolution in response to vaccines when they are present.
   - William, TC, and Wendy A Burgers. "SARS-CoV-2 evolution and vaccines: cause for concern?" *Lancet Res Med.* Apr 2021 9;4: 333-335. Doi: 10.1016/S2213-2600(21)00075-8
     Summary: "When a virus is grown under the selective pressure of a single monoclonal antibody that targets a single epitope on a viral protein, mutations in that protein sequence will lead to the loss of neutralisation, and the generation of escape mutants. This sequence of events has been shown in the laboratory for polio, measles, and respiratory syncytial virus, and in 2020 for SARS-CoV-2."
     Discussion: "In principle, these findings suggest that variants of SARS-CoV-2 could evolve with resistance to immunity induced by recombinant spike protein vaccines (which are based on the original sequence, Wuhan-Hu-1) in some people…"
   - The Delta variant arose in Maharashtra state, India, following the beginning of phase III clinical trials for the AstraZeneca/Oxford/Serum Institute of India COVID-19 vaccine (AZD1222) at eight locations in that state, meaning that a causal link between vaccination and the evolution of the variant cannot be ruled out.

5. The ABFM claims it is "incorrect to suggest that people who have had prior infection with COVID-19 receive no benefit from vaccination post-infection."
   The ABFM is wrong. The benefit from vaccination for healthy young people with natural immunity from prior infection is negligible, short-lived, and must be weighed against the real risks of vaccines themselves (see item 2 above, and II below).
   - Lin, DY, Yu Gu, et al. "Effects of Vaccination and Previous Infection on Omicron Infections in Children." *N Engl J Med* 2022; 387:1141-1143. Doi: 10.1056/NEJMc2209371
     Summary: This study compared the effect of the Pfizer vaccine to natural immunity alone and natural immunity plus vaccination in a cohort of almost 900,000 individuals ages 12-17. The results showed not only that natural immunity on its own was far superior to vaccination without natural immunity, but that the additional protection from vaccination on top of natural immunity was barely measurable (less than 10%) and short-lived. In light of possible confounding factors acknowledged by the authors, the alleged benefit must be considered small to nonexistent.
     Discussion: A letter commenting on the study noted, "After approximately 5 months, the effectiveness of previous infection in preventing hospitalization was 97.9% (95% CI, 53.1 to 99.9), as compared with 76.1% (95% CI, 27.8 to 92.1) after two doses of BNT162b2 vaccine, and the effectiveness of previous infection remained high (86.9%; 95% CI, −0.4 to 98.3) at 10 months… Contrary to the authors' conclusions, the findings do not support a role for boosters in either

uninfected or previously infected healthy children 5 to 11 years of age." In fact, in view of the vaccine risks outlined above (2) and below (II), it is plausible that vaccination on top of natural immunity is not only not beneficial, but harmful.

6. The ABFM claims that Dr. Littell compared the U.S. public health system's response to COVID-19 to Nazi Germany.
   The ABFM is wrong. In the quote cited, Dr. Littell warned against a public health response which suppresses dissenting views and coerces clinicians into betraying their own ideals and independent judgment, and urged health authorities to stop threatening healthcare providers for questioning official positions in a period when the state of scientific knowledge is changing from day to day. Dr. Littell invoked the experience of doctors in Nazi Germany as a cautionary tale, showing what can happen if political considerations are allowed to take precedence over science and medical ethics.

7. The ABFM claims that Dr. Littell stated that he would give medical exemptions from vaccination to "anyone" in the absence of a doctor-patient relationship.
   The ABFM is wrong. Nowhere in the quote cited does Dr. Littell state that he would give medical exemptions without first establishing a doctor-patient relationship.

8. The ABFM takes issues with statements made by individuals at a conference organized by Dr. Littell in October 2022. While it is inappropriate for the ABFM to punish Dr. Littell for the opinions of others, we will also show that these statements were grounded in scientific evidence.
   - The ABFM notes that Dr. Ryan Cole displayed a slide from the CDC's Morbidity and Mortality Weekly Report showing a dramatic increase in cancer deaths in 2021 following the rollout of the mRNA vaccines, but your letter does not appear to take issue with this statement of fact. Dr. Cole has hypothesized that the mRNA vaccines are causing an increase in cancer incidence due to the downregulation of toll-like receptors by the substitution of pseudouridine for uridine in the synthetic mRNA, which allows it to evade normal immune response in order to penetrate cells. The ABFM offers no argument or evidence to show that this is not the case.
   - The ABFM cites Dr. Angela Farella's advice to parents not to get their children vaccinated against COVID-19. In light of the risks discussed above (2) and below (II), this must be considered a plausible cost-benefit assessment.
   - The ABFM cites Dr. Farella's statement that masks induce hypoxia in children. Unfortunately there are virtually no high-quality studies addressing masking in children. However, a number of previous studies of masking in adult healthcare workers have shown decreases in oxygen saturation and oxygen consumption. More important are the results of this recent Cochrane meta-analysis of randomized controlled trials of both surgical and N95 masks, showing that masking mandates targeting untrained individuals likely have no impact on transmission.
   - The ABFM cites statements by Dr. James Thorp that the mRNA vaccines are causing intrauterine demise and killing pregnant women and newborn children. Dr. Thorp has presented evidence supporting these assertions here. Of note, after two years of obfuscation, in December 2022 it was revealed that Moderna's

laboratory trials found an adverse impact of the vaccine on fetal development in rats, resulting in congenital ribcage malformations, confirming that adverse effects on pregnancy are possible.

II. The spike protein encoded for by the mRNA vaccines is itself a pathogen

As part of the organization's mission aiding members in caring for the health of children and young people, ABFM should be aware of a large and growing body of scientific evidence that the spike protein encoded for by the mRNA vaccines is itself pathogenic independent of the rest of the COVID-19 virus, inflicting a range of harms in tissues and organ systems throughout the body. In this letter we will focus on cardiac damage and thrombosis, but we emphasize that these are only two out of a number of pathologies where the spike protein shows potential for harm, including neurologic, metabolic, oncogenic, and immune injuries.

1. Research has demonstrated that the spike protein is harmful to cardiac endothelial cells, myocytes, and pericytes – the likely causal mechanisms behind myocarditis.
    - Lei, Yuyang, et al. "SARS-CoV-2 Spike Protein Impairs Endothelial Function via Downregulation of ACE 2." *Circ. Res.* 2021;128:1323–1326. Doi: 10.1161/CIRCRESAHA.121.318902
      Summary: This study, published by the Salk Institute in March 2021, showed that the spike protein can damage endothelial tissue by lowering levels of ACE2, an enzyme that helps control the activity of mitochondria, fragmenting the mitochondria and causing inflammation.
    - Avolio, Elisa, et al. "The SARS-CoV-2 Spike protein disrupts human cardiac pericytes function through CD147 receptor-mediated signalling: a potential non-infective mechanism of COVID-19 microvascular disease." *Clin Sci (Lond).* 2021 Dec 22;135(24):2667-2689. Doi: 10.1042/CS20210735
      Summary: This study showed that the spike protein disrupted the activity of pericytes, resulting in inflammation of the heart tissue and damage to blood vessels.
    - "Coronavirus Spike Protein Activated Natural Immune Response, Damaged Heart Muscle Cells." *DAIC*. July 27, 2022.
      Summary: This research, first presented in July 2022 showed that the spike protein is also toxic to myocytes.
    - Yonker, Lael M, et al. "Circulating Spike Protein Detected in Post–COVID-19 mRNA Vaccine Myocarditis." *Circulation*. 2023;0. Doi: 10.1161/CIRCULATIONAHA.122.061025
      Summary: This study, published in January 2023, showed that myocarditis is strongly linked to the level of "free" spike protein, not attached to antibodies, in blood plasma.

2. Research has shown that the spike protein, independent of the rest of the virus, is also causally linked to thrombosis, raising the risk of heart attack and stroke, among other potential harms.

- Li, Tianyang, et al. "Platelets mediate inflammatory monocyte activation by SARS-CoV-2 spike protein." *J Clin Invest.* 2022 Feb 15; 132(4): e150101. Doi: 10.1172/JCI150101
  Summary: The spike protein appears to bind angiotensin-converting enzyme 2 (ACE2), directly to platelets and endothelial cells, setting off a "coagulation cascade" and forming blood clots.
- Zheng, Yi, et al. "SARS-CoV-2 spike protein causes blood coagulation and thrombosis by competitive binding to heparan sulfate." *Int J Biol Macromol.* 2021 Dec 15; 193: 1124–1129. Doi: 10.1016/j.ijbiomac.2021.10.112
  Summary: The spike protein binds and disables heparan sulfate, which usually regulates heparin, another clotting factor.
- Grobbelaar, Lize M, et al. "SARS-CoV-2 spike protein S1 induces fibrin(ogen) resistant to fibrinolysis: implications for microclot formation in COVID-19." *Biosci Rep.* 2021 Aug 27; 41(8): BSR20210611. Doi: 10.1042/BSR20210611
  Summary: The spike protein interacts with fibrinogen, a protein that plays a key role in coagulation, to form blood clots that are especially resistant to anti-clotting factors.
- DeMichele, Manuela, et al. "Evidence of SARS-CoV-2 spike protein on retrieved thrombi from COVID-19 patients." *J Hematol Oncol* 15, 108 (2022). Doi: 10.1186/s13045-022-01329-w
  Summary: Spike proteins have been found in blood clots from patients who suffered heart attacks or strokes during COVID infection, without the rest of the virus, again confirming that the spike protein is a pathogen on its own.

III. U.S. peer countries are dramatically scaling back COVID-19 vaccination

The scientific evidence discussed above is sufficient to cast serious doubt on the claim that the mRNA vaccines are "100% safe and effective." In short, vaccines which decrease the individual's chances of dying from COVID-19, but increase their chances of dying from other causes, cannot be said to be beneficial. If these vaccines also fail to stop transmission, as has now been amply demonstrated with COVID-19, there can be no conceivable reason to administer them to healthy young people who are at very low risk of severe disease.

On that note, a number of developed countries with healthcare systems of comparable sophistication have diverged sharply from the U.S. on the necessity and advisability of mass vaccination against COVID-19. This sudden parting of ways with America's closest peer nations should give us pause, raising the question of whether our country needs to rethink its policies in this important area. The list of countries scaling back vaccination includes:

- United Kingdom: After recommending COVID-19 vaccination for most individuals, in July 2021 the UK stopped recommending vaccination for individuals under 18, and in February 2023 drastically reduced the scale of the vaccine program, limiting new vaccinations and boosters to high-risk individuals, such that, "for a large portion of people, there will be no more COVID vaccines."
- Nordic countries have moved to limit vaccination to older adults, with the Danish, Norwegian, and Swedish governments no longer offering vaccination for

individuals under 18 and limiting boosters to individuals ages 50+, 45+, and 65+, respectively.
- In April 2022 Japan limited second boosters to individuals ages 60+ and individuals 18+ with serious health conditions.
- Switzerland recommends against vaccinating children under age 16.
- In February 2023 the Netherlands limited vaccination under age 12 to children with serious health conditions.

Conclusion: Urgent Calls for Reinstatement and Reconsideration

We, the undersigned physicians and scientists, consider it our ethical duty to urgently bring these matters to the attention of the ABFM. We hereby call on your organization not only to immediately reinstate Dr. John Littell and issue a public apology to him, but to rethink your official position and cease recommending mass administration of the experimental COVID-19 vaccines and boosters to people who are at low risk of severe COVID-19 disease. While we are only beginning to understand the negative impacts of these vaccines, the evidence presented in this letter we also remind you that the ABFM, like other professional medical societies, will be held responsible by the public for the consequences of its guidance to healthcare providers.

Sincerely,

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