April 4, 2023

The editorial board of BMC Infectious Diseases recently made a decision to retract the following article:

> Skidmore, M. The role of social circle COVID-19 illness and vaccination experiences in COVID-19 vaccination decisions: an online survey of the United States population. *BMC Infect Dis* **23**, 51 (2023). https://doi.org/10.1186/s12879-023-07998-3

The summary results from the article are provided below where the finding highlighted in **bold** sparked controversy:

> A total of 2840 participants completed the survey between December 18 and 23, 2021. 51% (1383 of 2840) of the participants were female and the mean age was 47 (95% CI 46.36–47.64) years. Those who knew someone who experienced a health problem from COVID-19 were more likely to be vaccinated (OR: 1.309, 95% CI 1.094–1.566), while those who knew someone who experienced a health problem following vaccination were less likely to be vaccinated (OR: 0.567, 95% CI 0.461–0.698). 34% (959 of 2840) reported that they knew at least one person who had experienced a significant health problem due to the COVID-19 illness. Similarly, 22% (612 of 2840) of respondents indicated that they knew at least one person who had experienced a severe health problem following COVID-19 vaccination. **With these survey data, the total number of fatalities due to COVID-19 inoculation may be as high as 278,000 (95% CI 217,330–332,608) when fatalities that may have occurred regardless of inoculation are removed.**

When the article was published on January 24, 2023, several notable scientists and medical professionals tweeted about it. News of the article went viral on social media, reaching up to 17 million Twitter followers. Of interest, news of the article had near zero exposure on Facebook. Altmetric ranks this article at #1 in the history of BMC Infectious Diseases, and #850 of 23,485,953 of all research articles ever tracked by Altmetric. The exposure is due to two factors. First, the finding resonated with many who have loved ones who they believe experienced harm from the COVID-19 vaccine. Second, for a variety of reasons many were angered by the study. Some of these people approached the Editor of BMC Infectious Diseases and my university with their criticisms. As a result, the Editorial Board conducted a re-review of the manuscript, which ended with the retraction decision. While BMC Infectious Diseases has a policy of making referee comments and author responses of published manuscripts available to the public, it does not provide any documents relating the re-review process. Thus, the only thing readers will see on the BMC Infectious Diseases website is the following retraction notice:

> The editors have retracted this article as concerns were raised regarding the validity of the conclusions drawn after publication. Post-publication peer review concluded that the methodology was inappropriate as it does not prove causal inference of mortality, and limitations of the study were not adequately described. Furthermore, there was no attempt to validate reported fatalities, and there are critical issues in the representativeness of the study population and the accuracy of data collection. Lastly, contrary to the statement in the article, the documentation provided by the author confirms that the study was exempt from ethics approval and therefore was not approved by the IRB of the Michigan State University Human Research Protection Program.
>
> The author disagrees with this retraction.

With the goal of greater transparency, I decided to make public my responses to the re-review questions as well as my reaction to the retraction notice. Interested readers can then decide for themselves

whether the retraction is warranted. I also note that this is not the first unfavorable "COVID-19 vaccine" article to be retracted or withdrawn. As examples, see below for two other cases:

Kostoff, R. N., Calina, D., Kanduc, D., Briggs, M. B., Vlachoyiannopoulos, P., Svistunov, A. A., & Tsatsakis, A. (2021). RETRACTED: Why are we vaccinating children against COVID-19? https://www.sciencedirect.com/science/article/pii/S221475002100161X

Rose J, McCullough PA. WITHDRAWN: A Report on Myocarditis Adverse Events in the U.S. Vaccine Adverse Events Reporting System (VAERS) in Association with COVID-19 Injectable Biological Products. Curr Probl Cardiol. 2021 Sep 30:101011. doi: 10.1016/j.cpcardiol.2021.101011. Epub ahead of print. PMID: 34601006; PMCID: PMC8483988. https://pubmed.ncbi.nlm.nih.gov/34601006/

Like the article in question, these articles document potential harms from the new gene therapeutic COVID-19 vaccine. Is it possible that the primary reason these three articles received a vote of no confidence is because they offer evidence that contradict the assertion by government officials that the COVID-19 vaccines are safe? I leave it to the reader to make his/her own assessment. The re-review questions/comments from BMC Infectious Diseases with my responses are provide in the following pages.

Dear Dr. Gonzalez-Lopez:

I am pleased to have an evidence-based scientific discussion, which we all believe can make the world a better place. Below, please find my detailed responses to each your questions and comments.

Comment 1:

One of the main points of discussion related to the second objective of your study, which is to "estimate the total number of COVID-19 vaccine-induced fatalities nationwide from the survey data". The mathematical equation used to calculate fatalities due to COVID-19 vaccination uses the survey responses from the 2840 participants as a factor. This seems to raise several concerns regarding the scientific soundness of your results.

Response 1:

Generating projections from a valid sample is a standard statistical technique, which is commonly used in survey research. The article provides confidence intervals for all variables so that the margins of error are disclosed, and therefore transparent. The evaluation in this article applies this technique to generate a projection of population-wide potential vaccine-related fatalities and adverse events. The large number of projected vaccine-related fatalities and adverse events merits further scientific exploration.

Comment 1a:

The fact that these data rely on people´s perception and experiences within undefined "social circles" seems to be an issue itself, as there seems to be no way to define to what extent these social circles expand or how social media input influence their responses. It is also unclear analytically how clustering effects were handled. Providing more information regarding clustering is also related to the need to provide inputs regarding the sampling approach.

Response 1a:

The notion of social circles utilized for the survey and analysis is well-defined in the literature. The references are extensive and available for review if requested. The notion of social circles has been used by Bruin, et al (2019) in the literature on vaccination decisions. Also, the study by Shupp et al (2020) uses the same social network style of question to increase understanding of stigma around prescription drug use disorders.

> Bruine de Bruin, W., Parker, A. M., Galesic, M., & Vardavas, R. (2019). Reports of social circles' and own vaccination behavior: A national longitudinal survey. *Health Psychology, 38(11),* 975–983. https://doi.org/10.1037/hea0000771

> Shupp R, Loveridge S, Skidmore M, Green B, Albrecht D. Recognition and stigma of prescription drug abuse disorder: personal and community determinants. BMC Public Health. 2020;20(1):1–9. Article Google Scholar

As with Shupp et al (2020), the survey provides a brief description of social circle as "family, friends, church, work colleagues, social networks".

Regarding social circle size, according to Stiller and Dunbar (2007), personal social networks form a set of "concentric circles of acquaintanceship containing, roughly, 5, 15, 50, 150, 500, 1,500 individuals with their circles reflecting successively declining emotional closeness and frequency of contact." On the scale of regular contact (in contact at least once a month), the authors indicate a network size is in the range of 12-15 people, and there are 150 people with whom one has a personal relationship.

Stiller, J. and Dunbar, R. I. M. (2007). Perspective-taking and memory capacity predict social network size. Social Networks, 29(1): 93-104. https://doi.org/10.1016/j.socnet.2006.04.001

In the context of health issues such as vaccination, social network size is important to the study. Consider the following:

1) Each person is likely to know health information such as vaccination status of a relatively small number of people. While some people appear willing to announce their vaccination status in the public sphere, most people remain private about health issues. In the context of an adverse event, one might observe that a person had a stroke or heart attack, yet without knowing vaccination status or the temporal relationship between the health event and vaccination, a person would not associate the health event with vaccination.

2) During a portion of 2021, many US citizens were on lockdown in parts of the US. Accordingly, in-person interactions were likely limited. Many did not attend community gatherings, and many worked from home, etc. Thus, people were less likely to have direct personal conversations about health and other personal topics.

Regarding measuring the size of social circles, the survey included a question about the size of respondent social circles:

Q32 Think about your social circles (family, friends, church, work colleagues, social networks, etc.). About how many people in your circles do you know well enough that you would typically learn about a significant emerging health condition? (numerical answer only please)

On average, respondents indicated that they know about 10 people well enough to learn about a significant emerging health condition. The mean size of social circles is then utilized to calculate the number of fatalities within respondents' social circles that would be expected to have occurred based on fatality rates from heart attacks, blood clots, and strokes.

Using a social circle size of 10 people in combination with CDC data on the incidence rates of heart attacks, strokes, and blood clots reduces the estimated vaccine fatalities by about 4%, or from approximately 290,000 to 278,000 (as described in the article). Using the Stiller and Dunbar (2007) size of the social network of people a person sees as least once a month (15), the fatality estimate drops by about 6%, in which case estimated fatalities are 273,000. If a broader social network size of 30 or 100 is utilized, the resulting estimated fatalities fall to 210,000 and 174,000, respectively.

Perhaps most importantly, the primary questions about Covid-19 illness and Covid-19 adverse events among family and friends asks people to report on the person they know best, and not the total number of people they know who reported problems. This approach was taken with the intent to reduce the concerns expressed above.

To show that results are robust with respect to the computational approach used, consider an alternate method for calculating social circle size and estimated vaccine fatalities. Estimated vaccine fatalities are calculated using the following equation:

1) Estimated Vaccine Deaths =

(Survey Vaccine Deaths/# People in Social Network) * Total Population

Estimated Covid Illness fatalities can be calculated in a similar way:

2) Estimated Covid Illness Deaths =

(Survey Covid Illness Deaths/# People in Social Network) * Total Population

Total official COVID-19 fatalities of 839,993 through the end of 2021 in combination with equation 2) can be used to examine the both social network size and fatalities under the assumption that a respondent knows just one person who they report died from COVID-19 illness. Note that it is likely that some people know more than one person who died from COVID-19. The following table provides projections of nationwide COVID-19 fatalities and COVID-10 vaccine fatalities under different social network size scenarios.

Average Network Size	# Survey Respondents	Aggregate Network Size	# of Vaccinated in US Population	Total US Population	Survey Covid Deaths in Social Circles	Survey Vaccine Deaths in Social Circles	Projected Covid Fatalities	Projected Vaccine Fatalities
10	2,840	28,400	242,000,000	334,000,000	165	57	1,940,493	670,352
15	2,840	42,600	242,000,000	334,000,000	165	57	1,293,662	446,901
23	2,840	65,320	242,000,000	334,000,000	165	57	843,693	291,457

Assuming a respondent knows just one person who died from COVID-19, social network sizes of 10 or 15 generate too high a number for projected COVID-19 illness fatalities to match actual data on COVID-19 fatalities. The projected COVID-19 vaccine fatalities are therefore also too high. A social network size of 23 creates projected COVID-19 fatalities that match official statistics, as show in column 3 of the table. In this scenario, COVID-19 vaccine fatalities are projected to be 291,457, which is similar to the estimate reported in the article. Again, a limitation of this approach is the needed assumption that respondents only know one person who died from COVID illness. Instead, if a person who knows at least <u>one person</u> who died from COVID actually knows an average of 1.3 people who they report died from COVID-19 and 1.3 people who died from the vaccine, the adjusted calibrated social network size increases to 30, generating projected COVID-19 illness fatalities of 841,000 and vaccine fatalities of 290,000.

Returning to the method used in the article, a social network size of 30 yields a projection of 255,000 COVID-19 vaccine fatalities.

The above alternative calculations are provided to demonstrate that different approaches yield projected vaccine fatalities that are in a similar range.

Clustering and sampling approach:

In reviewing the literature on clustering within the medical field, clustering patients by physician is common, and clustering can result in a deflation of various statistical tests such as t-tests, chi-square, and F-values of predictor values. (Ferguson and Corey ,1990). With survey data, it may be useful to cluster geographically by region. The procedure is straightforward, requiring the use of a logistic mixed random effects model (Agresti, 2013) where observations are clustered by region. Due to time constraints in meeting the deadline for a response to the questions posed, I am not able to run an alternate regression, yet upon request and given additional time, I am able to estimate the model and share the result.

Ferguson JA, Corey PN. Adjusting for clustering in survey research. DICP. 1990 Mar;24(3):310-3. doi: 10.1177/106002809002400319. PMID: 2316238.

Agresti, A. (2013). *Categorical Data Analysis* (3rd Ed.), Hoboken, New Jersey: John Wiley & Sons.

The article contains a discussion of Dynata's sampling approach:

"The sample was obtained by Dynata, the world's largest first-party data platform, and is representative for the US American population. The sampling using Dynata is based on opt-in sampling, respondents deliver high quality data, they are diverse and have community norms of honesty and accuracy."

The Dynata website includes additional information about online survey validation and reliability: https://www.dynata.com/a-guide-to-online-survey-validation-and-reliability/. Here is a summary from their website:

> "There is much that panel companies can do to prevent frauds from entering questionnaires. Dynata uses the following controls, among others:
>
> - Recruiting from trusted partnerships with loyalty programs whose memberships are verified at source.
>
> - Feedback loop with action taken on any poor-quality respondent reported to Research Now SSI by a client.
>
> - Tracking of quality throughout a panelist's lifetime.
>
> - Two-factor claim authentication required for reward redemption.
>
> - 24 and 72-hour claim delays.
>
> We can also establish the truthfulness of the participant by asking them something they should know repeatedly. If they provide consistent answers on age, gender, etc., we can assume they are telling the truth there, and can have confidence they are telling the truth on other questions."

Upon request, I am happy incorporate the above additional information in the article.

Comment 1b:

The fact that the survey uses an opt-in sampling may result in significant selection biases among the responders—how was this addressed analytically?

Response 1b:

It is well known that opt-in sampling can generate selection bias. However, Dynata provided a sample that closely matches the US population in all demographic and political dimensions. Further, research documents that a survey title can help reduce potential selection bias (Sutton and Edlund, 2019). To limit bias, a neutral title was purposely utilized: "NATIONAL SURVEY OF COVID-19 HEALTH EXPERIENCES". Also, to further reduce potential bias, the survey began with a series of questions about experiences with COVID-19 illness before asking questions about the more highly debated issue of vaccination. In addition, the questions about COVID-19 illness and COVID-19 vaccine adverse events incorporated the very same wording. Finally, a survey weighting technique was used to make small adjustments for age and sex, though the resulting analysis was not meaningfully affected by the weighting.

> Sutton, TM, Edlund, JE. Assessing Self-Selection Bias as a Function of Experiment Title and Description: The Effect of Emotion and Personality. North American Research Journal of Psychology. 2019; 21(2).

Comment 1c:

What additional efforts were made by the survey company to validate fatalities reported by the responders?

Response 1c:

The reported fatalities are not validated. Validation would require that each reported fatality would be verified by death certificates and a pathologist, which is not feasible. This is a weakness of the survey approach that was disclosed in the article. Further, one stated intent in the article is to spur additional

research and scientific discussion. The discrepancy between the results from the valid sample and reported fatalities available from government sources is worthy of further scientific exploration.

Comment 1d:

The calculation of fatalities due to COVID-19 vaccination appears to be estimated using data from the Vaccine Adverse Events Reporting System (VAERS). While VAERS can represent an important source of data, there are relevant limitations affecting the validity of estimations that emerge from the use of VAERS without validation. (https://vaers.hhs.gov/data/dataguide.html). These limitations were not discussed in the "limitations of the study" section. Could you clarify how this issue was addressed and why it was not discussed in the limitations of the study?

As stated by the managers of this database:

> A. "VAERS reports can be submitted voluntarily by anyone, including healthcare providers, patients, or family members. Reports vary in quality and completeness. They often lack details and sometimes can have information that contains errors"

> B. "A report to VAERS generally does not prove that the identified vaccine(s) caused the adverse event described. It only confirms that the reported event occurred sometime after vaccine was given. No proof that the event was caused by the vaccine is required in order for VAERS to accept the report. VAERS accepts all reports without judging whether the event was caused by the vaccine."

Response 1d:

Among professionals in the vaccine research arena, the limitations of the VAERS data are widely known. However, even though it is common knowledge this is a limitation can be discussed in the article, which I am willing to add for further clarity. Note, however, that if VAERS over counts actual fatalities and adverse events, the result would be an even wider gap between the government's figure and those suggested by the survey. At present, the government reports that there are nine fatalities from the COVID-19 vaccines and that there are 18,977 preliminary reported deaths in VAERS, noting that these reports do not mean the vaccine caused the fatality (https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/adverse-events.html). It may also be useful to cite Shimmabukuro et al (2003), which discusses the strengths and limitations of the VAERS system.

> Tom T. Shimabukuro, Michael Nguyen, David Martin, Frank DeStefano, Safety monitoring in the Vaccine Adverse Event Reporting System (VAERS). Vaccine. 2015. 33(36), 2015: 4398-4405, https://doi.org/10.1016/j.vaccine.2015.07.035.

Comment 2:

In the methods section, you mention that a medical doctor and a survey research specialist helped to validate the survey. We would like to request the identity of these individuals and the reason why they were not included as co-authors of the manuscript, as their participation in the study seems relevant.

Response 2:

The individuals are:

> Dr. Michael Palmer (MD, Ph.D)

> Ms. Sarena McLean (Director of Research, SNJ Associates)

Both colleagues are listed in the acknowledgements section of the article with an indication that they helped review the survey. They were not included as co-authors because they did not meet the co-author criteria outlined by the International Committee of Journal Editors

(https://www.icmje.org/recommendations/browse/roles-and-responsibilities/defining-the-role-of-authors-and-contributors.html).

Comment 3:

Additional methods are required to understand the sampling approach for Dynata. The reference provided (Shupp R, Loveridge S, Skidmore M, Green B, Albrecht D. Recognition and stigma of prescription drug abuse disorder: personal and community determinants. BMC Public Health. 2020;20(1):1–9.) appears disconnected from this—focused on stigma and prescription abuse. Additional details are also needed with a focus on how the sample size was calculated to reach data saturation specifically related to COVID-19 vaccines as not specified in the manuscript. One of the reviewers raised a comment on this issue but it seems it was missed during the revision. Could you provide more detail on this issue?

Response 3:

With 2840 respondents, the survey for this article has a larger single country sample size than all the peer reviewed publications on vaccinations cited in the article. Listed below are the references of the articles on vaccination cited in the manuscript coupled with sample size. Shupp, et al (2020) is also listed.

As discussed by Faulker and Trotter (2017), data saturation refers to "the point in the research process when no new information is discovered in the data analysis this redundancy signals to researchers that data collection may cease. Saturation means that a researcher can be reasonably assured that further data collection would yield similar results and serve to confirm emerging themes and conclusions." For the survey pre-test, there were 1098 completed surveys, which demonstrated that a significant portion of respondents offered sufficient positive responses to the primary questions on COVID-19 illness and COVID-19 vaccine adverse events within respondent social circles. The comments regarding the nature of the COVID-19 illness problems and the COVID-19 vaccine adverse events were then reviewed. Many of the descriptions of the COVID-19 illness impacts were repeated throughout the responses (died, respiratory problems, lung damage, blood clots, loss of sense of taste, etc.). The COVID-19 vaccine adverse event descriptions were also repeated (died, blood clot, stroke, heart attack, heart issues, etc.). In reviewing the pre-test data, data saturation was occurring with 1098 observations, which is consistent with the literature cited on vaccination uptake. To ensure data saturation, the final survey garnered 2840 completed responses, far more than other articles.

Faulkner, S.L. and Trotter, S.P. (2017). Data Saturation. In The International Encyclopedia of Communication Research Methods (eds J. Matthes, C.S. Davis and R.F. Potter). https://doi.org/10.1002/9781118901731.iecrm0060

Shupp R, Loveridge S, Skidmore M, Green B, Albrecht D. Recognition and stigma of prescription drug abuse disorder: personal and community determinants. BMC Public Health. 2020;20(1):1–9. Article Google Scholar

   N= 631

Hyland P, Vallières F, Shevlin M, Bentall RP, McKay R, Hartman TK, et al. Resistance to COVID-19 vaccination has increased in Ireland and the United Kingdom during the pandemic. Public Health. 2021;195:54–6. Article CAS Google Scholar

   N=1041 (Ireland), N=2025 (United Kingdom)

Kreps SE, Goldfarb JL, Brownstein JS, Kriner DL. The relationship between us adults' misconceptions about covid-19 vaccines and vaccination preferences. Vaccines. 2021;9(8):1–8. Article Google Scholar

N=1027

Yoda T, Katsuyama H. Willingness to receive covid-19 vaccination in Japan. Vaccines. 2021;9(1):1–8. Article Google Scholar

N=1100

Bendau A, Plag J, Petzold MB, Str A. COVID-19 vaccine hesitancy and related fears and anxiety. Int Immunopharmacol. 2021;97:107724. Article CAS Google Scholar

N=1779

Guidry JPD, Laestadius LI, Vraga EK, Miller CA, Perrin PB, Burton CW, et al. Willingness to get the COVID-19 vaccine with and without emergency use authorization. Am J Infect Control. 2021;49(2):137–42. https://doi.org/10.1016/j.ajic.2020.11.018. Article CAS Google Scholar

N=788

Agley J, Xiao Y, Thompson EE, Golzarri-Arroyo L. Factors associated with reported likelihood to get vaccinated for COVID-19 in a nationally representative US survey. Public Health. 2021;196:91–4. https://doi.org/10.1016/j.puhe.2021.05.009. Article CAS Google Scholar

N=1017

Comment 4:

Based on these previous points we have concerns regarding the causal inference of mortality in your study and its level of consistency with suitable mortality estimation approaches. Could you provide an explanation on the lack of assessment of these limitations and additional specifications of the sampling approaches?

Response 4:

The statistical methods applied in this article are commonly used to conduct analysis of survey data. Making projections from a sample to a population is also a common and widely accepted practice. If the sample is representative of the population, the projection will be accurate.

The analysis demonstrates that the characteristics of survey respondents match very closely with the US population. More detail on sampling approaches is described by Dynata: https://www.dynata.com/content/The-New-Dynamics-of-Online-Sample-Quality.pdf. Upon request, I would be happy to provide more detail and a link to this resource on the Dynata website.

A key limitation with this evaluation is that we cannot be certain that reported fatalities are caused by either the COVID-19 illness or the COVID-19 vaccine. They are reports of what people think happened, which may or may not reflect what actually occurred. The stark difference between officially reported fatalities and fatalities reported in the survey is cause for refection and further scientific inquiry – which as stated previously, was one intent of the study. Many such limitations were reported in the article, yet I am willing to include further discussion of limitations.

Comment 5:

We would also like to request the following documentation:

a) Ethics proposal documentation sent to Michigan State University Human Research Protection Program for the approval of this study

b) Ethics approval from the Michigan State University Human Research Protection Program (file number: STUDY00006960, date of approval: November 17, 2021, name of IRB: Michigan State University Human Research Protection Program)

Response 5:

Please see the following attachments:

- HRP-512 – Skidmore Exemption Request (which also included the consent form and the survey instrument)
- HRP-5031 Skidmore IRB Protocol
- STUDY00006960 Exemption Determination

Comment 6:

According to our editorial policies (https://www.biomedcentral.com/getpublished/editorial-policies#competing+interests): "Competing interests may be financial or non-financial. A competing interest exists when the authors' interpretation of data or presentation of information may be influenced by, or may be perceived to be influenced by, their personal or financial relationship with other people or organizations. Authors should disclose any financial competing interests but also any non-financial competing interests that may cause them embarrassment if they were to become public after the publication of the manuscript.

Non-financial competing interests include (but are not limited to) political, personal, religious, ideological, academic, and intellectual competing interests."

The funder of this article (Catherine Austin Fitts) has made regular statements regarding COVID-19 vaccination and is a former politician. Considering the potential political implications of your publication we would like clarification on why this was not disclosed as a conflict of interest.

Response 6:

I have appropriately acknowledged Catherine Austin Fitts as the source of funding for the survey. Accordingly, I do not consider non-competing financial interests to exist.

Dr. Gonzalez-Lopez, I am grateful to engage in this scientific discussion. As I have made clear in the article, it has been my intent to engender further scientific inquiry.

For such an important topic, thoroughness of the review process is equally essential.

Thank you and best regards,

Mark Skidmore

Responses to the Retraction Notice on March 24, 2023

Greetings Dr. Gonzalez-Lopez,

I acknowledge receipt of the retraction notice. As requested, I provide the response: THE AUTHOR DOES NOT AGREE TO THIS RETRACTION.

I offer my thanks and gratitude to the original editor who handled the paper for her courageous decision to publish the manuscript. I believe that she realized that the paper could bring controversy but saw the importance of the work and acted decisively despite the potential for push back. Thank you.

If members of the editorial board have not yet done so, I recommend that they review Additional File 3 of the article, which provides respondent comments regarding health problems in social circles following COVID-19 vaccination. A sampling of the eleven pages of comments is provided below.

-Heart attack when he had no heart problems at all before it. He <u>died</u> from the heart attack.

-Had a shingles like rash all over her face, on both sides not just one. This happened March 2021. The doctors said it was in fact from the vaccine, and to this day it hasn't been cured.

-Blood clotting causing loss of limb.

-Hospitalized for three days with breathing and heart issues. He was required to take the shot to participate in the college world series.

-My friend with no preexisting heart condition <u>died</u> of a heart failure after the second dose.

-Severe heart issues. 1 hour after injection my 22-year old friend had a massive heart attack and has been hospitalized for 7 months. Was very healthy and athletic before that shot.

-Migraines that never seem to go away when they almost never had one before.

-A member of my church <u>died</u> from blood clot surgery less than a week after having a covid vaccine in the hospital during recovery.

-Cousin 47-stroke Cousin- blood clots.

-<u>Death</u> from a heart attack after vaccination by a few weeks.

-Close friend began having cardiac issues after vaccination.

-Anaphylactic shock twice. Nearly killed my mother.

-Neurological damage and a spontaneous pneumothorax.

-Seizure, hospitalization, life has been altered. Partially paralyzed.

-Myocarditis.

-Paralyzed, waist down.

-<u>Death</u> with organ failure.

-Ended up <u>dying</u> from a reaction to the drug which caused a major heart attack.

-Individual experienced a mild stroke from excessive blood clotting.

-Blood clots and suffered a stroke.

-Heart condition. New conditions never had previous issues.

-Bell's palsy.

To date, the United States federal government has paid $0 in vaccine injury claims. This article presents evidence that those who have been injured, along with their families, are in need medical and financial assistance. In my opinion, the decision to retract the article dishonors those who have been harmed, the evidence of which has rapidly expanded since the survey was administered. At your request, I will provide references to more than a 1,000 peer reviewed articles reporting on COVID-19 vaccine adverse events such as those provided in the list above. Instead of retracting the article, the editorial board would do well to call for more research to prove/disprove the evidence presented in the article.

I also offer specific responses to the retraction notice for: https://doi.org/10.1186/s12879-023-07998-3

> The editors have retracted this article as concerns were raised regarding the validity of the conclusions drawn after publication. Post-publication peer review concluded that the methodology was inappropriate as it does not prove causal inference of mortality, and limitations of the study were not adequately described. Furthermore, there was no attempt to validate reported fatalities, and there are critical issues in the representativeness of the study population and the accuracy of data collection. The author did not describe in detail the potential conflict of interest of the funder of the study, Catherine Austin Fitts. Lastly, the ethics statement is incorrect since the ethics approval documentation provided by the author states that the study was exempt from ethics approval and was not approved by the IRB of the Michigan State University Human Research Protection Program, contrary to the statement provided in the article.

Below are the main points of the retraction notice with my brief CAPITALIZED responses. Please note that I include requests for changes in the retraction notice.

1) Post-publication peer review concluded that the methodology was inappropriate as it does not prove causal inference of mortality, and limitations of the study were not adequately described.

THE ARTICLE CLEARLY INDICATES THAT THE FINDINGS ARE BASED ON RESPONDENT REPORTS/PERCEPTIONS AND THUS WE CANNOT BE SURE OF CAUSAL INFERENCE.

2) There was no attempt to validate reported fatalities.

VALIDATING REPORTED FATALITIES IS NOT POSSIBLE WITH AN ANONYMOUS SURVEY, WHICH WAS KNOWN FROM THE TIME OF THE ORIGINAL REVIEW.

3) There are critical issues in the representativeness of the study population and the accuracy of data collection.

AS REPORTED IN THE ARTICLE, THE SAMPLE CLOSELY MATCHES THE US POPULATION IN DEMOGRAPHIC, ECONOMIC, AND POLITICAL MAKE-UP.

I HAVE NOT RECEIVED SPECIFIC COMMENTS FROM THE EDITORIAL BOARD REGARDING DATA COLLECTION ACCURACY, AND THUS IT IS NOT POSSIBLE FOR ME TO RESPOND WITH CLARIFYING REMARKS.

4) The author did not describe in detail the potential conflict of interest of the funder of the study, Catherine Austin Fitts.

THE ARTICLE ACKNOWLEDGED THAT MS. FITTS COVERED THE COSTS OF THE SURVEY. I REQUEST THAT THE LANGUAGE "FUNDER OF THE STUDY" BE CHANGED TO "FUNDER OF THE SURVEY EXPENSE". MS. FITTS DONATED TO $11,000 TO MICHIGAN STATE UNIVERSITY TO COVER THE COSTS OF THE SURVEY SEVEN WEEKS AFTER THE SURVEY HAD BEEN ADMINISTERED.

5) Lastly, the ethics statement is incorrect since the ethics approval documentation provided by the author states that the study was exempt from ethics approval and was not approved by the IRB of the

Michigan State University Human Research Protection Program, contrary to the statement provided in the article.

THIS POINT TOOK ME SOME TIME TO UNDERSTAND. BELOW, I PROVIDE THE ETHICS STATEMENT FROM THE ARTICLE:

"The survey instrument and recruitment protocol of the National Survey of COVID-19 Health Experiences were approved by the Institutional Review Board (IRB) of the Michigan State University Human Research Protection Program (file number: STUDY00006960, date of approval: November 17, 2021, name of IRB: Michigan State University Human Research Protection Program). All participants gave written informed consent via reading a written consent statement and clicking "I Agree" before being allowed to take the online survey. All methods were carried out in accordance with relevant guidelines and regulations."

IT SEEMS THAT THE EDITORIAL BOARD IS SUGGESTING THAT THE STATEMENT IS INACCURATE/DISINGENUOUS IN THAT IT FAILED TO INDICATE THAT THE STUDY WAS DETERMINED AS "EXEMPT" AND INSTEAD REPORTED THAT IT WAS "APPROVED". GIVEN THE STUDY IS BASED ON AN ANONYMOUS SURVEY, IT SEEMS CLEAR THAT THE STUDY WAS IRB APPROVED BY IT BEING GIVEN AN EXEMPT STATUS. MY INTERPRETATION IS THAT THE SURVEY AND CONSENT FORM WERE APPROVED IN THAT THE IRB DETERMINED THAT THE STUDY WAS EXEMPT. FOR COMPARISON, BELOW I OFFER LANGUAGE USED IN A 2020 ARTICLE I COAUTHORED, WHICH WAS PUBLISHED IN THE SISTER JOURNAL BMC PUBLIC HEALTH:

https://jgresearch.org/wp-content/uploads/2020/09/s12889-020-09063-z.pdf

"This study received ethics and consent approval on October 1, 2014 by Michigan State University Human Research Protection Program IRB board. All participants gave written informed consent via reading a written consent statement and clicking "I Agree" before being allowed to take the online survey."

THE LANGUAGE OF "APPROVAL" IS SIMILAR IN BOTH STATEMENTS IN THAT THERE WAS AN ANONYMOUS SURVEY THAT RECEIVED AN EXEMPT DETERMINATION BY THE IRB. THERE WERE NO PROBLEMS WITH THE LANGUAGE OF "APPROVAL" IN THE EARLIER ARTICLE. THIS IS A MINOR SEMANTICS ISSUE THAT COULD EASILY BE CLARIFIED. I REQUEST THAT THIS POINT BE REMOVED FROM THE RETRACTION NOTICE.

Finally, I ask that the editorial board reconsider the decision to retract the article, and instead request revisions that would make the manuscript suitable for publication in the editorial board's assessment. In my opinion, the issues outlined in the retraction notice could be addressed with minor revisions.

Mark Skidmore

Additional Follow-up Regarding the Language of IRB "Approval" vs "Exemption" on March 29, 2023

As a follow-up to the message I sent on March 24, 2023, I would like to acknowledge indicating that the study received an exempt determination is more accurate. However, I also wanted to share the ethics statements of all the survey-based articles cited in the paper. All of them use the language "approved". It could be that these articles did not receive an exemption determination, but I think it is very likely they did because they are all based on anonymous surveys. See the reference with the associated ethics statements below.

Thanks again,

Skidmore, M. The role of social circle COVID-19 illness and vaccination experiences in COVID-19 vaccination decisions: an online survey of the United States population. *BMC Infect Dis* **23**, 51 (2023). https://doi.org/10.1186/s12879-023-07998-3

Ethics Statement:

The survey instrument and recruitment protocol of the National Survey of COVID-19 Health Experiences were approved by the Institutional Review Board (IRB) of the Michigan State University Human Research Protection Program (file number: STUDY00006960, date of approval: November 17, 2021, name of IRB: Michigan State University Human Research Protection Program). All participants gave written informed consent via reading a written consent statement and clicking "I Agree" before being allowed to take the online survey. All methods were carried out in accordance with relevant guidelines and regulations.

Shupp R, Loveridge S, Skidmore M, Green B, Albrecht D. Recognition and stigma of prescription drug abuse disorder: personal and community determinants. BMC Public Health. 2020;20(1):1–9. Article Google Scholar

Ethics Statement:

This study received ethics and consent approval on October 1, 2014 by Michigan State University Human Research Protection Program IRB board. All participants gave written informed consent via reading a written consent statement and clicking "I Agree" before being allowed to take the online survey.

Hyland P, Vallières F, Shevlin M, Bentall RP, McKay R, Hartman TK, et al. Resistance to COVID-19 vaccination has increased in Ireland and the United Kingdom during the pandemic. Public Health. 2021;195:54–6. Article CAS Google Scholar

Ethics Statement:

Collection of the data presented in this study was approved by the Research Ethics Committees at The University of Sheffield and Ulster University.

Kreps SE, Goldfarb JL, Brownstein JS, Kriner DL. The relationship between us adults' misconceptions about covid-19 vaccines and vaccination preferences. Vaccines. 2021;9(8):1–8. Article Google Scholar

Ethics Statement:

The study was conducted according to the guidelines of the Declaration of Helsinki, and approved by the Institutional Review Board of Cornell University (protocol # 2004009569, approved 29 January 2021).

Yoda T, Katsuyama H. Willingness to receive covid-19 vaccination in Japan. Vaccines. 2021;9(1):1–8. Article Google Scholar

Ethics Statement:

The study was conducted according to the guidelines of the Declaration of Helsinki, and approved by the Ethics Committee of KAWASAKI MEDICAL SCHOOL (Approval number: 5016-00 and date of approval: 4 September 2020)

Bendau A, Plag J, Petzold MB, Str A. COVID-19 vaccine hesitancy and related fears and anxiety. Int Immunopharmacol. 2021;97:107724. Article CAS Google Scholar

The authors assert that all procedures contributing to this work have been <u>approved</u> by the appropriate ethics committee (ethics committee of Charité Universitätsmedizin Berlin: EA1/071/20) and have therefore been performed in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki and its later amendments.

Guidry JPD, Laestadius LI, Vraga EK, Miller CA, Perrin PB, Burton CW, et al. Willingness to get the COVID-19 vaccine with and without emergency use authorization. Am J Infect Control. 2021;49(2):137–42. https://doi.org/10.1016/j.ajic.2020.11.018. Article CAS Google Scholar

Ethics Statement:

The study was <u>approved</u> by the Institutional Review Board at Virginia Commonwealth University, a large public research university in the Mid-Atlantic U.S.

Agley J, Xiao Y, Thompson EE, Golzarri-Arroyo L. Factors associated with reported likelihood to get vaccinated for COVID-19 in a nationally representative US survey. Public Health. 2021;196:91–4. https://doi.org/10.1016/j.puhe.2021.05.009. Article CAS Google Scholar

Ethics Statement:

This study was <u>approved</u> by the Indiana University IRB, #2008571490. All participants provided digital informed consent.

Further Correspondence on March 31, 2023

Greetings Dr. Gonzalez-Lopez:

Thank you for sharing the reports. I do not find the comments to be compelling enough to support the retraction decision. IMO the last two points of the retraction notice make it look like editorial board is desperate to include reasons to retract. I also again ask that you change the phrase "funder of the study" to "funder of the survey expense".

I retain the position "the author does not agree to this retraction".

FYI, the findings of a new survey by the reputable polling firm, Rasmussen, were released today. According to the new poll, nearly as many Americans believe someone close to them died from side effects of the COVID-19 vaccine as died from the disease itself. The latest Rasmussen Reports national telephone and online survey finds that 11% of American Adults say a member of their household died from COVID-19, while 86% answer no. Ten percent (10%) say a member of their household has died whose death they think may have been caused by side effects of COVID-19 vaccines, while 85% say there were no such deaths in their household. To read the full report, click on the link below.

https://www.rasmussenreports.com/public_content/politics/public_surveys/covid_19_virus_deaths_vs_vaccine_deaths

This 9-minute summary video by Rasmussen is well worth the time IMO.

https://rumble.com/v2fmz2o-rasmussen-polls-covid-vs.-vaccine.-americans-tell-us-which-is-the-biggest-k.html

For your information, since the journal does not publish the re-review questions with my responses nor the reasons for my dissent, I plan to make this information publicly available. I will only post my materials in which I incorporated questions from the editorial board along with my responses. I will not include any e-mail correspondence or materials. Interested readers will be able to make their own assessment regarding the decision to retract the article.

Regards,

Mark Skidmore

After this correspondence, the retraction notice was changed to its final form:

> The editors have retracted this article as concerns were raised regarding the validity of the conclusions drawn after publication. Post-publication peer review concluded that the methodology was inappropriate as it does not prove causal inference of mortality, and limitations of the study were not adequately described. Furthermore, there was no attempt to validate reported fatalities, and there are critical issues in the representativeness of the study population and the accuracy of data collection. Lastly, contrary to the statement in the article, the documentation provided by the author confirms that the study was exempt from ethics approval and therefore was not approved by the IRB of the Michigan State University Human Research Protection Program.

> The author disagrees with this retraction.