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ISSUES RAISED BY THE SUNDAY TIMES AND THE DISPATCHES PROGRAMME

A STATEMENT BY
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Issues Raised by the Sunday Times and the Channel 4 Dispatches Programme

The Sunday Times of the 14th November and the Dispatches programme of 18th November raise a number of issues in relation to MMR, autism and events at the Royal Free Hospital. Since many of the claims made by journalist Brian Deer have been demonstrably false and there in no objectivity in the manner of their intended portrayal, I declined to participate in any way in the making of the Dispatches programme. In addition, vulnerable parents have complained of being "tricked" into participating in the programme. I was not invited to comment on the Sunday Times article prior to its publication. It appears to be the claim that, whilst at the Royal Free Hospital, I was developing a new vaccine to compete with MMR and that I conspired to undermine confidence in MMR vaccine in order to promote this new vaccine. It is suggested that a conflict of interest arises. This is untrue. The facts are that:

- no vaccine or anything resembling a vaccine was ever designed, developed or tested by me or by any of my colleagues at the Royal Free Hospital;
- it has never been my aim or intention to design, produce or promote a vaccine to compete with MMR;
- my genuine concerns about the safety of MMR are wholly unrelated to any desire or opportunity to develop a competing vaccine;
- there was no conspiracy as insinuated by the Sunday Times article;
- there was no conflict of interest, actual or perceived.

In contrast, it was our intention, at one stage, to conduct a formal therapeutic clinical trial of a compound that might have the ability to promote the body's immune response to measles in order to assess the effects of this therapy upon the disease in children with regressive autism and bowel disease. This compound is known as Transfer Factor and whilst there is a large scientific literature on this subject, the nature and mechanism of action of Transfer Factors are largely unknown.

The Transfer Factor that was intended for use in the trial was to be against measles virus. I have urged and continue to urge parents to have their children vaccinated against measles using the current vaccines. This would be in direct conflict with the intentions that are part of the claim that I was developing a new vaccine to bring onto the market. Whether a Transfer Factor could ever protect children against measles is entirely speculative and is something that was never studied or pursued by me or by any of my colleagues.

RESEARCH FUNDING

The purpose of generating funding was for the research programme and for a proposed new Centre for Gastroenterology at the Royal Free Hospital, explicitly not for personal financial gain. All of this can be substantiated by contemporaneous documentation.

MOTIVATING FACTORS

The patent application was motivated by two main factors. First, it was felt that there may be difficulty in raising traditional grant funding for cutting edge, controversial work that was vulnerable by virtue of the fact that it might conflict with perceived wisdom and the commercial interests of others. Secondly, there was, and is, a government-led emphasis on commercial exploitation of discoveries within the medical school.

TRANSFER FACTOR (TF)

- A clinical trial of measles-virus specific Transfer Factor was planned in order to determine whether there was benefit to children with regressive autism and inflammatory bowel disease.
- It was not known at this stage whether this therapy would work. The purpose of the trial was to start to answer exactly this question as well as to monitor the safety of TF in these children.
- This was a treatment trial, not a vaccine trial.
- A trial of TF was based upon an extensive scientific literature, demonstrating safety and efficacy of TF in different diseases. I consulted widely with experts in the UK and US on the history and scientific background to TF both prior to and in the planning of the trial.
- The protocol was extensively peer-reviewed with written endorsement from experts in the UK and US. The trial protocol was submitted to, and subsequently approved by, the Ethical Practices Committee of the Royal Free Hampstead NHS Trust.
- The trial protocol was approved by the participating physicians.
- The trial was funded by charitable foundations after independent peer-review.
- The trial was cancelled due, in part, to my departure from the Royal Free Hospital.

THE PATENT

- A provisional patent filing was made in 1997 for the use of measles virus-specific TF in regressive autism and inflammatory bowel disease (Regressive Bowel Disease: RBD).
- The reference to the possible use of

A VERY HAPPY AND HEALTHY NEW YEAR TO ALL!!

TF to protect children against measles infection – the thrust of the Sunday Times' conspiracy theory – was put in as an afterthought in the patent. It was entirely speculative and never pursued in any shape, manner or form.

• The provisional patent filing was for a possible therapy; as such, it had no bearing on the 1998 Lancet paper.When the patent was later awarded, this fact was communicated directly to the Editor of the Lancet in order that it might accompany a letter, written in response to a paper by Taylor et al that claimed to find no evidence of a link between MMR vaccine and autism. The editor did not consider the patent disclosure of sufficient significance to publish it alongside my letter.

• Since it was awarded, the patent has been disclosed in relevant publications. The claims for TF have since been abandoned.

DRS NICK CHADWICK (NC) AND IAN BRUCE (IB): MEASLES VIRUS DETECTION IN INTESTINAL BIOPSIES.

NC was employed as a post-graduate researcher in my laboratory, studying for a PhD. He investigated various technologies for measles virus detection using gene amplification. Due to problems within the laboratory with contamination and the need for additional expertise, we collaborated with IB at the University of Greenwich. IB and NC developed a technique that increased the sensitivity of measles virus detection over standard methodology from approximately 1 million viral copies in a reaction to 10,000 copies. In other words, even with the enhanced technique, the technology could not detect this virus when present below 10,000 copies.

We published the fact that we could not detect measles virus in Crohn's disease using this technique. This publication went ahead on my recommendation, despite some resistance to publishing negative data. I considered that failure to publish negative data was inconsistent with good scientific practice and proceeded to publication.

By the time we applied the viral detection technology to the intestinal tissues of children with autism, new and more sensitive technology had come to my attention. In addition, the negative results obtained by NCs technique were inconsistent with other evidence of measles virus in the inflamed intestinal tissue obtained prior to publication of the Lancet study in 1998. This evidence, plus the availability of a new and more sensitive viral detection technology meant that more work was required to answer the question of whether measles virus was present in these children or not.

The new technique could potentially detect down to 2 viral copies, compared with NCs 10,000. The advantages were obvious and the possibility that NC's results were falsely negative (i.e. that the virus was present in the tissues but at very low levels that NC's technique could not detect) could now be addressed by the new technology.

Using this new technology measles virus was detected in controlled studies and these results were published. They confirmed that our previous results were falsely negative due to the limitation of the technique we were using. The more sensitive techniques used to detect measles virus in the autistic children is now the gold-standard and the previous technology has been abandoned. On entirely scientific grounds I was proven correct on this occasion. The facts stated above can be supported by contemporaneous documentation.

AJW

DIFFICULTIES FOR CHILDREN IN THE THIRD WORLD

An small extract from 'The Truth Behind The Vaccines Cover-Up' by Russell Blaylock, MD, Part 1, Nexus, Vol. 12 No. 1, Dec 2004.

This article takes an in-depth look at the Simpsonwood meeting that took place in June 2000. The official title of the meeting was the "Scientific Review of Vaccine Safety Datalink Information" assembling 51 scientists and physicians, including representatives from the vaccine industry, for this 2 day conference.

I have chosen this extract as sometimes it is remarked that maybe children in the so-called 'developed' world may not need vaccines but those in the poorer countries do. As I have often pointed out to parents - if they are concerned about how their reasonably healthy children will tolerate a vaccine, then imagine what kind of burden it places on those very malnourished children in the third world.

Dr Blaylock, referring to the Simpsonwood Report, states:

'Now this next statement should shock everyone, but especially the poor who may in any way think that these 'vaccinologist' experts have their best interests in mind.

Dr Johnson says on page 17: "We agree that it would be desirable to remove mercury from US-licensed vaccines, but we did not agree that this was a universal recommendation that we would make because of the issue concerning preservatives for delivering vaccines to other countries, particularly developing countries, in the absence of hard data that implied that there was in fact a problem."

So here you have it. The data are convincing enough tht the American Academy of Pediatrics and the American Academy of Family Practice as well as the regulatory agencies and the CDC all recommend mercury's removal as quickly as possible from US-licensed vaccines because of concerns about the adverse effects of mercury on brain development, but don't recommend the same for vaccines given to children in developing countries. I thought the whole idea of child health programs in the US directed toward the developing world was to give poor children a better chance in an increasingly competitive world. This policy being advocated would increase the neurodevelopmental problems seen in poor children of developing countries (as well as in the US), impairing their ability to learn and develop competitive minds. Remember, there was a representative of the World Health Organisation, Dr John Clements, serving on this panel of 'experts'. He never challenges this statement made by Dr Johnson.

It also needs to be appreciated that children in developing countries are at a much greater risk of complications from vaccinations and from mercury toxicity than are children in developed countries. This is because of poor nutrition, concomitant parasitic and bacterial infections and a high incidence of low birth weight in these children. We are now witnessing a disaster in African countries caused by the use of older, live-virus polio vaccines, which has now produced an epidemic of vaccine-related polio; that is, polio caused by the vaccine itself. In fact in some African countries, polio was not seen until the vaccine was introduced.' *Editor: I recently read in science journal 'Nature' that HIV kills around 1,300 children daily in Africa, many dying from routine childhood infections, which overwhelm an immune system that has been hobbled by the virus. Personally I think their systems have been hobbled by something else that begins with 'v'.*

MMR CAPITAL CATCH-UP CAMPAIGN

Pulse, 8/11/04 reported that 'officials have launched a catch-up campaign in a last ditch bid to avert a measles epidemic. But GPC negotiators warned the campaign could fail unless GPs are paid for the extra work. All primary school children in London will receive a leaflet this month or next telling their parents a measles outbreak is inevitable and urging them to get their children immunised if they haven't already.

Children whose parents consent will then receive the first dose of an accelerated schedule in school clinics and be told to visit their GP a month later for a booster. Health officials are also considering extending the catch-up programme across the UK over the next year, starting in major cities.....

Dr David Elliman, consultant community paediatrician at Great Ormond Street Hospital who has played a key role in the programme, was confident the leaflets would scare parents of primary school children into accepting the vaccine.....' *.Our emphasis.* My reaction to this is that if something is obviously good there would be no need to scare people into doing it. For those who have not seen the 'catch-up' leaflet, here are a few extracts.

Under the heading 'Why is this campaign needed?' the explanation given is that due falling rates of MMR vaccine there will be increased outbreaks and that if your child is not protected they are at risk. An example then follows regarding an outbreak in Dublin in 1999. The leaflet states that this outbreak resulted in more than 1400 measles cases. 'Of these, 111 were admitted to hospital, 13 needed intensive care and three died. The MMR rate in Dublin at the time was under 70% similar to the rate in many parts of London.'

Looking at data I received from the Irish health department during the outbreak it was interesting to note that MMR uptake for, specifically, Dublin, Wicklow and Kildare was less than 80% for the years 1996 and 1997, with a slight increase to 80% in 1998. And yet during those years the measles notifications were 139, 131, and 152 respectively.

Looking at the table above you might wonder why there were not huge outbreaks in 2001 and 2002 considering there were lower levels of uptake?

Regarding the 3 deaths. There were 2 deaths originally, and a journalist from the Mail on Sunday, *(28/1/01)* after contacting the Irish Health Dept, reported that: 'One of the victims was a 12 month old baby girl from a very poor family living in grim conditions on a large Dublin housing estate and was, incredibly for a European capital in the year 2000, malnourished. The other was also exceptional and seiously ill before he contracted measles.He was a 2 year old with a severe malformation of the throat which linked his windpipe with his oesphagus and who had to be fed by a tube into his stomach.' The third death came later on, with no details apparently available.

YEAR	MEASLES NOTIFICATIONS	MMR UPTAKE
1988	936	*
1989	1248	*
1990	556	*
1991	135	*
1992	179	*
1993	4328	*
1994	1233	*
1995	235	*
1996	228	*
1997	185	*
1998	204	77%
1999	147	77%
2000	1603	79%
2001	241	73%
2002	243	72%
2003	572	79%

The table above shows MMR uptake figures for Ireland

* No accurate figures are available according to the Irish health department.

BLOW TO MMR UPTAKE

'Legal aid blow to MMR uptake drive' was the headline for an article *(Pulse 25/10/04)*, reporting on the fact that legal aid has been reinstated to fund the cases of 11 children whose parents claim they suffered serious damage from MMR, sparking fears that the debate over the vaccine's safety will be reignited.

There were no words of concern regarding the well-being of the children in question, the whole article focused on what effect this decision would have on the MMR uptake. 'GPs fear the decision will dent fragile parental confidence at a time when MMR uptake stands at a record low.' My reaction to this statement is if the parental confidence is low that means that more parents are looking into the issue and deciding that they are not confident about the safety and effectiveness of the MMR. If the evidence was so overwhelmingly good about the MMR then obviously parents would not hesitate, after all they simply want to see their children grow into healthy adults. Perhaps it would be more appropriate to refer to the positive evidence on MMR as very 'fragile'??

Another angle I have noticed creeping into the media is an attempt to create a divide amongst parents. For example: On the website: timesonline.co.uk, 8/12/04, Mother love - Nice mother, nasty mother. By Pink Mum.

Written in a diary format under the heading 'Monday evening', it states:

- 'A letter from the school about MMR jabs. Apparently 90,000 nursery and primary school children in London still haven't been vaccinated and the NHS is having one last go at persuading parents that MMR is safe, offering to vaccinate the children at school. We've already done the deed, taking some flak from some of the others in our NCT class in the process. Some of them were rushing off to private clinics for separate jabs and clearly thought we were Really Bad Parents for giving D the three in one. But did we buckle under the middle class pressure? For once, no.' -

The 'MMR jabs' in the first sentence was highlighted so readers could conveniently click straight on to the health department website. As regards to 'flak' it is much more likely that a parent who decides not to allow their child to be vaccinated will come under enormous pressure from friends and family. Also, not all concerned parents are 'rushing' to get separate jabs, a growing number are calmly walking away from all jabs.

It is not about being 'really bad parents' or 'really good parents', it's about being a really informed parent and making an educated decision based on knowledge.

Lastly, you do not have to be 'middle-class' to come to these decisions. I have no idea who 'pink mum' is but I should think she should be pink with embarrassment for writing such silly nonsense.

MUMPS - DO WE NEED TO WORRY?

By Dr Jayne Donegan.

'MUMPS HITS UNIVERSITIES', scream the headlines as universities set up mass vaccination programmes advising students to have the MMR jab as an epidemic of mumps threatens to sweep through campuses across the country. Figures from the Health Protection Agency show an increase in mumps from about 1,500 for all age groups in 2003 to almost 2,000 cases in only the first six months of this year.

We are told that most cases of mumps are among people in their very late teens and early 20s who have not been vaccinated with the MMR and are therefore vulnerable to infection (1). Mumps vaccine was added to the UK schedule in 1988 in the form of the MMR vaccine, but during 1988-1991, in a catch up campaign, MMR vaccine was also offered to all children up until the age of school entry. (2). This means that children with a birth date from 1983 would have been included in the campaign. These children will now be 21 years of age and younger, yet this is the very age group that we are told are getting mumps because they were too old to have been given the MMR vaccine in 1988.

Outbreaks of mumps in this older age group have not suddenly started happening this year, they have been occurring throughout the north of England and Northern Ireland since the late 1990's. By 2000, cases of mumps were steadily rising, increasing by 30 per cent per year compared to 1999. In some places, such as, Leeds and Bradford there were increases of nine times and 30 times the number of cases between the years 2000 and 2001 (3). One third of those affected were aged over 15, just the worst time for boys to get it. In Northern Ireland 95 per cent of confirmed cases were between the ages of nine and 19 (4).

In Stockport the mumps virus identified from several cases was of the G6 genotype. The mumps vaccine used in the UK MMR is of the A genotype. The Public Health Laboratory Service advises that cross protection from the different strains should be sufficient (I do not know what studies they base this advice on), but four of the confirmed cases in Stockport had received two doses of MMR. "It is possible that immunisation against mumps is causing a mutant strain to emerge with limited or no cross protection from the vaccine strain"(5), as has occurred with whooping cough (6).

In the USA where Mumps vaccination was introduced 11 years earlier than in the UK, outbreaks of mumps occurred in 'underimmunised' groups of people, again moving from the usual 5-9 year old children to older age range (10-19). Because of the concomitant failure of the MMR to control measles outbreaks, a further dose of MMR was added to the US schedule in 1989 and since then large outbreaks have occurred in populations vaccinated with two doses of MMR which American publications are open enough to call 'primary vaccine failure' (ie, the vaccine doesn't work). This does not, however, stop the United States from requiring it as a condition for school and university entry (7).
In the UK the official line is still that two doses of MMR will solve all our problems and how important it is that children are given good 'protection' against all three diseases.

'Protection'. This is the new word used to encourage us to vaccinate our children. Children no longer need to be immune from the disease but 'protected' from it. It sounds comforting, but what does it actually mean? The only thing that vaccines can do in terms of what is called 'protection' from disease is produce antibodies. No immunologist will ever truthfully say that the antibodies from artificial immunisation (vaccination) are of as good a quality or so long lasting as those from natural disease. And even naturally produced antibodies are only one part in a long chain of mechanisms by which the body protects itself from damage by outside agents. The most important point to be aware of, however, is that antibody levels, even if naturally acquired, do not necessarily equal immunity. This was emphasised with the mumps vaccine in Switzerland in the 1990s. Three mumps vaccines - Rubini, Jeryl-Lyn and Urabe (withdrawn in the UK in 1992 because it caused mumps meningitis) all produced excellent antibody levels but those vaccinated with the Rubini strain had a higher attack rate than those not vaccinated at all (8). Dr David Elliman, District Immunisation Coordinator for Merton, Sutton and Wandsworth Health Authority and Consultant in Community Child Health at St Georges Hospital London, says that it actually gave people mumps (9). The MMR vaccine used in the UK contains the Jeryl Lynn strain of mumps, a live attenuated virus grown on chick embryo.

Another hypothesis in the UK for the current outbreak of mumps is that as cases of mumps fell in the early 1990s, unvaccinated children had little opportunity to obtain natural immunity from contact with other children who had mumps. Well there seems to be plenty of mumps virus around - why else would people be getting mumps?
We are told that "before the MMR was introduced in 1988 there were 'tens of thousands of cases'. How would anyone know? Before 1988 mumps was not a notifiable disease and 30-40 per cent of people with mumps don't have any symptoms (10). In 1995 there were still 2,023 notifications of clinical disease (11), so there must still have been many more thousands of subclinical cases (no symptoms) and that was three years before Dr Andrew Wakefield's paper in the Lancet had even suggested a link between the MMR jab and autism. The Immunisation Against Infectious Diseases Handbook, a Department of Health publication, says that before the introduction of the MMR 1,200 children were admitted to hospital every year (11). It would be interesting to know why.

Mumps disease is caused by a virus. Humans are the only known natural host. Subclinical infections are common. The peak age of incidence is five to nine years. One attack of clinical or subclinical mumps confers lasting immunity and second attacks are most unusual (12). The incubation period is an average of 18 days. The disease starts with pain and swelling in the region of one parotid gland (salivary gland in front of the ear) and fever. Neck glands and those under the tongue may become involved. After four to five days the glands on the other side may be affected as the swelling on the first side goes down. In more severe cases the person will be more ill with a high fever, dirty tongue and able only to drink fluids. In

most cases the chief problems are difficulty in eating, swallowing and talking. The disease usually resolves in 10 to 14 days and there is complete recovery as a rule (10,12).

Appropriately managed, clinical mumps (ie mumps with symptoms so you know you've got it) is not a dangerous disease. It is the complications that are dangerous. How do you avoid complications? Common sense. If a child or young adult has an infectious disease they need rest, fresh air (window open), plenty of clean water and fresh juices (especially pineapple if their mouth is feeling unpleasant) which may be drunk through a straw if it hurts to move their jaw, (10) sympathetic nursing and more rest. They do not need to be dosed with paracetamol products (eg Calpol), non-steroidal anti-inflammatories (eg ibuprofen), unnecessary antibiotics, antihistamines, other proprietary medicines and being sent back to school just because their temperature has been suppressed to a normal value. This just pushes the disease inwards and makes complications more likely.

Complications are rare, the most common being swelling of the testicles but this is usually *after* the age of puberty. The swelling is generally only on one side, in the unlikelihood that it should occur on both sides a low sperm counts or sterility may follow. There may be swelling of the ovaries in girls but this does not result in sterility (12). In fact it is thought that having mumps with recognisable parotid swelling (hamster cheeks) has a protective value against getting ovarian cancer in later years (13). This is clearly a good thing as ovarian cancer generally has a very poor prognosis due to it being diagnosed late. Rarely, deafness can occur (12).

A retrospective survey by the Royal College of GPs (RCGP) published in 1974 looked at 2,482 cases of mumps treated in infectious disease units in England and Wales over the 11 years from 1958 to 1969(14). These were already severe cases as people with mumps are not usually admitted to hospital. Complications were recorded in 42 per cent of patients, the most common ones involving the central nervous system with 25 per cent of males and 18 per cent of females being diagnosed with meningitis or meningoencephalitis. All patients with complications recovered completely except for five people who became deaf, four of whom were adults.

Discussing mumps meningitis the authors say, "whether this is regarded as part of the mumps syndrome or as a complication, there seems to be a general consensus that it is a benign condition rarely giving rise to sequelae (long term effects)."

"Three patients died. In two of these there was serious underlying disease and mumps may have been unrelated to the cause of death." The remaining patient was described as a healthy 20 month old boy who was admitted with a provisional diagnosis of mumps and suspected sore throat for which he had been prescribed penicillin by his GP. On admission there were erythematous (red) and purpuric (purple and does not go white when pressed against a glass) rashes on his arms and legs which were considered to be probably due to penicillin allergy. He was febrile with a raised heart and respiratory rate which continued to rise until he died "suddenly, and unexpectedly, on the third day after admission". The changes found at post mortem examination lead the authors to comment: "In retrospect, the diagnosis of mumps must be doubted in this patient."

'The fact that, out of a total of 2 462 patients with mumps admitted to these hospitals over a period of years, there were only three deaths (in two of which there were other associated factors) and five cases with persistent sequelae amply confirm the essentially benign nature of the disease.'

They conclude: "It seems clear from this survey that there is little need for general vaccination against mumps, although there might be an indication for vaccinating certain groups of the male population. Such groups might include post pubertal boys before admission to residential institutions...it should be born in mind that serological studies have shown that 90% of boys aged 14 years and over have already been infected with mumps; consequently there may be a case for preliminary antibody screening and only those males in the above group who are seronegative need be vaccinated."

In the 1960s mumps meningitis occurred in less than 2.5 per cent of clinical cases of mumps under the age of 20 years (15). As the incidence of subclinical infection is 30-40 per cent, this means it happens in less than 1 per cent of cases of mumps and the prognosis is usually good (10). Mumps meningitis requires no specific treatment although lumbar puncture provides relief from intense headache and the outlook is usually excellent (10). Textbooks as late as 1987 comment on the generally benign nature and long lasting immunity conferred by wild mumps infection (12). However we are now told that the incidence of mumps meningitis can be as high as 10 per cent (7). Maybe modern medicine is not so clever nor advanced as we like to think, and perhaps children a quarter of a century ago with less school, less vaccinations, less processed food, less central heating, less TV; more outside, more walking, more mothers at home to look after their family - were more robust.

As with measles vaccination, mumps vaccination has been associated with disease occurring at an older age which is certainly more serious in terms of the side effects in boys - orchitis, swollen testicles, is much more likely to occur as a complication in boys over the age of puberty and bilateral orchitis can, in rare cases, lead to sterility. We now just need to wait for the other side of the vaccination pendulum to swing - cases of mumps in babies.

Vaccination with mumps vaccine is associated with plenty of side effects: Balraj and Miller in a study published in 1995 (16) claim that only aseptic meningitis and parotitis are 'causally' linked to it. The first well documented cases of meningitis linked with the Urabe containing MMR vaccine appeared in Canada in 1987, further cases were reported in 1988,1989 and 1990. Canada and the USA then withdrew this vaccine. The UK did not follow suit until September 1992, despite a clear causal connection having been shown. The excuse was that it was not 'proven'. The same paper states that insulin dependent diabetes mellitus and pancreatitis have been reported to occur after measles, measles-mumps and MMR vaccine at an incidence of 1 per 250 000 doses. Nerve deafness has also been noted, though the authors say that this is anecdotal and, "the temporal

association is inconclusive although suggestive of a possible connection in some instances. Controlled epidemiological studies are needed if further evidence of causality is sought" (these have not been done). Orchitis has been reported in Canada and after the MMR vaccine in the USA through the US vaccine adverse event reporting system (17).

The Balraj and Miller paper also considers thrombocytopenia, Guillain-Barre syndrome and allergic reactions but here they all followed the MMR vaccine so it was difficult to separate out what was due to the mumps component and what due to the measles or rubella part of the vaccine(16).

Regarding allergic reactions, "it is difficult to be precise about the incidence of these reactions in the absence of a common case definition." It is worrying that such case definitions are not established during initial safety trials and post marketing surveillance. "The highest reported incidence is from New York (18) where five out of 2789 children had potentially life threatening reactions within 2 hours post-vaccination." The authors note that they all responded to treatment with adrenaline and antihistamines and that the reactions were, " more likely to be due to the vaccine excipients such as neomycin or gelatin, or residual traces of egg related antigen, than any of the viral components." I suspect that this would have been of small comfort to the children in whom the reactions occurred.

After the MMR vaccine containing the Urabe strain of mumps virus was withdrawn in the UK because it caused mumps meningitis (11), the vaccine manufacturers then sold this same vaccine to South America for their MMR vaccination campaign causing a predictable epidemic of mumps meningitis. When challenged as to why vaccine manufacturers would do such a thing if they had the best interests of children at heart, Dr Mike Watson, speaker for the UK Vaccine Manufacturers Group said that the mumps meningitis was, "only a bad headache and they all recovered." (19) Yet the (small) risk of mumps meningitis associated with the disease is the main the reason that GPs pressure parents into having their children vaccinated against mumps.

Once again we are told that a disease we once believed to be fairly harmless is much more serious than had been realised, as soon as a vaccine becomes available. This is not new. It was commented on in the nineteenth century when the smallpox vaccination became compulsory. Wait for the medical journals and newspapers to start telling us all what a dangerous disease chicken pox can be. Of course, this will to some extent be true, because as we inject ever increasing numbers of vaccines containing mercury, aluminium, formaldehyde, antibiotics, animal and bird products as well as viral, and other contaminants into our children and adults they will become more susceptible to the complications of these diseases.

As the 1974 RCGP paper says, "Mumps is usually regarded as a relatively mild disease which does not often cause serious complications or permanent sequelae. For this reason little interest has hitherto been taken in its prevention, but the advent of an effective live attenuated mumps vaccine in the USA has prompted a review of the disease to assess the need for such a vaccine and its probable use in any future vaccination programme." (14) It seems that being vaccinated against mumps you expose yourself, or your child, to all the risks associated with the vaccine and those of getting the disease itself. I know what my choice would be.

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UK TO CONSIDER SINGLE DOSE SCHEDULE FOR MENINGITIS C

Pulse, 15/11/2004

Government advisers may consider one-off immunisation for meningitis C at 14 months after a Dutch study found it was far more cost-effective than the UK schedule.

Researchers calculated that a one-off vaccine would provide up to 95 per cent of the protection of the two-, three- and four-month schedule and would be twice as cost-effective. The three-part UK schedule costs £100,000 more per life year saved, according to the study, published in Vaccine (November).

The Joint Committee on Vaccination and Immunisation is currently reviewing the UK schedule, after concerns that immunity may drop off in older children and suggestions that a booster at 14 months might be required.

Dr Mary Ramsay, consultant epidemiologist at the Health Protection Agency, said babies had been given meningitis C at two, three and four months because of concerns that later vaccination could leave them unprotected.

But she said more recent UK evidence suggested herd immunity was sufficient to protect young children.

Dr Ramsay added: 'The Netherlands, which had the UK evidence when it introduced Men C in 2002, decided to vaccinate only children over 12 months. The UK schedule is under review.'

WARNING!

Southwark Primary Care Trust issued the following warning to local health professionals:

WARNING! ERRORS REPORTED WITH ADMINISTRATION OF NEW CHILDHOOD VACCINES

We have received several reports of errors in administration of Pediacel, Repevax and Revaxis. All the vaccines currently supplied are made by Aventis Pasteur MSD and will therefore have similar coloured packaging. You are advised to be extra vigilant when giving these vaccines to ensure you have the correct vaccine for the right schedule/age of child.

Please place the enclosed vaccine colour chart in a plastic folder and attached to the door of the vaccine fridge in your surgery/clinic, so that all staff immunising are aware of the vaccines to be used.

All staff involved in immunising children should be familiar with the content of the CMO letter (CMO 2004/3), New childhood vaccines information pack (including fact sheets / leaflets) and content of the revised chapters of the Green Book,.

As you will be aware, the advice in the new chapters of the Green Book, and patient information /product leaflet supplied with the vaccines are different. This can cause concern / anxiety for patients/parents. You may need to reassure and share the information on p.4 of the Green Book,, which makes it clear that the national programme is following the expert advice of the Joint Committee on Vaccination and Immunisation (JCVI). When presented with children of uncertain immunisation history, who may be receiving vaccination at a slightly older age, this will be particularly relevant. A copy of the current advice from the Health Protection Agency (HPA) is enclosed which covers this group. Please note, children up to the age of 10 years should now be protected from Hib disease.

YOU ARE ENCOURAGED TO REPORT ANY ERRORS OR NEAR MISSES IN ADMINISTRATION OF THE NEW VACCINES TO YOUR PCT 1MMUNISATION CO-ORDINATOR VIA THE IMMUNISATION HELPLINE 020 7771 5179 or COMMUNITY SERVICES PHARMACY TEAM 020 7771 3381.

Barbara Adie, Principal Pharmacist Manager, Community Services Pharmacy Team. October 2004

Editor: Over the years I have had numerous conversations with parents whose children were given wrong type/dosage of vaccination. The usual response from their health professionals has been a reassurance that it is unlikely there will be a problem. This of course is not based on long term studies subjecting babies and children to wrong dosages and observing long term outcomes. So if you do decide to go ahead with any of the recommended vaccines, please make absolutely sure that the person administering them has the correct vaccine, dosage and it is always advisable to take details of brand and batch number, in case of future reference.

PFIZER PLEADS GUILTY, BUT DRUG SALES CONTINUE TO SOAR

Although the headline above is in relation to a pharmaceutical drug - gabapentin (Neurontin) the related article (BMJ Vol. 328, 22/5/04) highlights once again how 'fraudulent scientific evidence' is used to promote off-label uses of particular drugs. Whistleblower, Dr Franklin's suit detailed how the company, Pfizer, suppressed study results, planted people in medical audiences to ask questions intended to put gabapentin in a good light, lavished perks on doctors, used ghostwriters, gave generous "consultation fees" to "thought leaders" and used psychological profiling of doctors in its successful bid to move gabapentin to so called blockbuster status (annual status in excess of $1bn). Another example of the kind of activities that go on within the industry!

DETECTING MISLEADING CLAIMS IN CLINICAL RESEARCH REPORTS

An article in the BMJ 2004; 329:1093-1096 (6 Nov), entitled 'Users' guide to detecting misleading claims in clinical research reports'. It starts with:

'Plenty of advice is available to help readers identify studies with weak methods, but would you be able to identify misleading claims in a report of a well conducted study?

Science is often not objective. Emotional investment in particular ideas and personal interest in academic success may lead investigators to overemphasise the importance of their findings and the quality of their work. Even more serious conflicts arise when for-profit organisations, including pharmaceutical companies, provide funds for research and consulting, conduct data management and analyses, and write reports on behalf of the investigators.

Although guides to help recognise methodological weaknesses that may introduce bias are now widely available, these criteria do not protect readers against misleading interpretations of methodologically sound studies.....

....The discussion section of research reports often offers inferences that differ from those a dispassionate reader would draw from the methods and results.

An example is then given with 'details of two systematic reviews summarising a similar set of randomised trials assessing the effect of albumin for fluid resuscitation. The trials included in both reviews were small and methodologically weak, and their results are heterogeneous. Both the reviews provide point estimates suggesting that albumin may increase mortality and confidence intervals that include the possibility of a considerable increase in mortality. Nevertheless, one set of authors took a strong position that albumin is dangerous, the other that it is not. Their positions were consistent with the interests of funders of their reviews.'

Editor: Another reminder for those who turn to scientific data to further their research to be vigilant. There may be a conflict of interest, as well as the conclusions not reflecting the raw data.

BREAKING THE ANTIBIOTIC HABIT

'Breaking the antibiotic habit; A parents guide to coughs, colds, ear infections and sore throats', by Dr Paul Offit, Fass-Offit and Bell is the title of an excellent book I came across, which gives a lot of detailed insight into why you should not accept antibiotic treatment from your GP for coughs, colds, ear infections and sore throats. The authors believe that, while it may seem these drugs are working, your child would get better anyway without them.

Their argument is two pronged; firstly most upper respiratory tract infections are caused by viruses NOT bacteria. Virus causes colds, sore throats, and bronchitis - so antibiotics should not be prescribed for bronchitis.

The authors say that for every 100 children with a viral infection, only one will have a bacterial infection. Viruses are much more common and many more times infectious than bacterial infections. One of the statistics they give is that bacterial meningitis affects only 3 out of every 1000 people who come into close contact with the disease. Whereas 900 children in close contact with chicken pox would develop it.

Their second point is that taking an antibiotic is not only useless but dangerous. "As many as 50% of children who receive several courses of antibiotics will then harbour bacteria that resist the killing effects of many antibiotics." Among them might be antibiotic resistant bacteria, salmonella or tuberculosis or streptococcus pneumoniae. After just one dose of a particular antibiotic, strains of drug resistant strep bacteria increased from 2% to 55%.

Almost all young children harbour this bacteria without them causing any infection. However with each course of antibiotics more and more drug resistant bacteria proliferate, increasing the chances that one of these might infect the person - and prove unresponsive to antibiotic treatment.

I'm sure you'd all agree that you'd rather reserve the use of antibiotics for your child if they develop pneumonia, feeling confident that the medication will work, rather than giving them useless courses for common childhood infections, that could easily be treated by natural means, increasing the risk that a more serious illness will not respond to medication.

One of the most alarming facts they give in their book is that your child's risk of developing a drug resistant streptococcal infection (which can cause pneumonia) is highest if they have had an antibiotic in the preceding 3 months.

One of the reasons why more and more resources are spent on developing vaccines is because of the drug resistance created by the over prescribing of antibiotics. For instance Hib infections always used to respond to the drug ampicillin, and now there are cases that do not. Pneumonia and meningitis can be caused by a range of viruses and bacteria. Incidents of resistance are now found with streptococcal pneumonia, which apparently always used to respond to penicillin. Bacterial meningitis always used to respond to vancomycin.

This are some of the compelling reasons why the authors are very much against the common practice of taking an antibiotic 'just in case' or because of "a secondary bacterial infection", whose existence cannot be proved without doing any lab tests.

Serious infections are always obvious; your child appears worryingly ill; listless, lethargic and not responsive even when their temperature has come down.

The apparent success of antibiotics has obscured the need to consider the whole ecological framework within which a disease flourishes. While antibiotics can interfere with the way bacterial cells multiply in the body, they don't deal with the problem of why some of us 'catch' infections in the first place. Now that antibiotic resistant bacteria have developed as a result of overuse, and the incidence of cancers is still rising despite advances in research and treatment, medical science is again asking why the immune systems of some individuals leave them more susceptible to certain kinds of disease.

The vast majority of childhood illnesses will be dealt with by your child's innate defence mechanisms, supported by your own common sense, tender loving care and nutritious food. In working out whether your child is really in need of medical attention, the most important aspects to diagnose illness are changes in your child's behaviour, appearance and the medical history - that is, how the symptoms developed. As their parent, you are the person who knows whether your child is really ailing; because you're the only one who knows them intimately when they're healthy. If they have a raised temperature or slight pains, but are otherwise bright and cheerful - there's rarely any need to worry. In other words, "If your child doesn't feel sick, look sick and act sick then he probably isn't sick." If they are lethargic, irritable or generally poorly, they may need a hand to fight off infection or illness. But the good news is that all these signs can be taken together to provide a picture of the appropriate homeopathic remedy to give their immune system a boost in it's efforts to fight off infection.

HOMEOPATHIC APPROACH

Homeopathic remedies are very good for treating infections and catarrhal problems, clearing up fevers, colds, coughs, sore throats, runny noses and earaches quickly. They work by stimulating the defence mechanism, enabling it to deal with disease more effectively.

Instead of trying to get rid of symptoms, the homeopathic approach is to work with them in order to support the body's own efforts to overcome illness. When mild, symptoms can be seen as signs that the body is working efficiently, and when severe they indicate the areas where the body needs some support.

Symptoms thus become the key to choosing an appropriate homeopathic remedy, showing exactly how the body is trying to restore balance. Clues are found in assessing what kind of inflammatory process the body is generating and where it is localising, what kinds of discharges are being produced, and what conditions are required to help the body's efforts to restore some kind of balance. The conditions that trigger off a particular infection are also relevant because they show in what circumstances the individual becomes susceptible to illness.

This is why it's important to observe your child's preferences when ill - what they want to drink, at what temperature they feel comfortable, and whether they need fresh air etc.

The art of using homeopathic remedies successfully depends on the ability to recognise the sometimes subtle ways your child changes when coping with illness.

By Cassandra Marks.

Homeopath, Cassandra Marks, RSHom, runs one-day courses on Homeopathy and child health in North London. For details please call 0208 444 0594, or check on the events page of The Informed Parent website.

HEPATITIS B VACCINE 'MAY TRIPLE RISK OF MULTIPLE SCLEROSIS'

Pulse, 20/09/04

Hepatitis B vaccination could triple the risk of developing multiple sclerosis within the three years following immunisation, suggests a controversial analysis of UK general practice records.

The study found 6.7% of patients with newly diagnosed MS had received the hepatitis B vaccine in the previous three years, compared with 2.4% of controls.

The findings, published in Neurology (Sept.), were based on 163 MS patients and 1,604 controls and implied an odds ratio of 3.1 for developing MS. The results did not change after adjustment for smoking, sex, age, clinical course of disease and type of first symptoms.

Other vaccines were not found to be associated with any increased risk, according to the data, which conflicts with previous conclusions from the WHO.

Lead auther Dr Miguel Hernin, of the Harvard School of Public Health in Boston, said it was unclear how the vaccine could trigger the process leading to MS but that he was planning to look into the adjuvant and yeast components of the vaccine in more detail.

'It is clear we do not fully understand the relationship between hepatitis B vaccine and MS,' he said.

Dr Hernin claimed previous research finding there was no link between the vaccine and MS had been based on small sample sizes.

But an accompanying editorial claimed the benefits of vaccination were indisputable and pointed out that the vast majority of MS patients in the study had not received the vaccine.

In 1998 France suspended its universal hepatitis B vaccination programme after evidence from surveillance reports of a link with MS. The UK has so far shied away from universal vaccination, but the Joint Committee on Vaccination and Immunisation has set up a hepatitis B working group to consider whether to introduce the vaccine into the UK's routine immunisation schedule.

Dr George Kassianos, the RCGP's spokesperson on immunisation and a member of the working group, said he did not think the data provided proof of an association 'sufficient to implement policy changes with regard to immunisation programmes'.

ALSO....In Pulse, 25/10/04, it reports that 'the Government has been accused of 'penny pinching' by ignoring the World Health Organisation pleas to introduce universal hepatitis B vaccination.'

The current policy is to restrict this vaccination to high-risk groups, including drug users, health care workers and babies born to mothers with chronic hepatitis B.

The article then reports that Professor Williams, professor of hepatology at University College, London said that the JCVI had been sitting for 2 years on a decision to introduce hepatitis B immunisation into the childhood schedule. Also Prof Williams is director of the Liver Research Foundation, which apparently had published a report demanding mass vaccination.

Leicester-based GP, Dr Nigel Hewett, who vaccinates many drug misusers at his PMS project for the homeless, said he suspected public reticence to accept another vaccine was behind the procrastination.

ALSO.....Article in BMJ, 6/11/04, 'Hepatitis b infections - universal immunisation should be preferred in Britain'. The following was one of the Rapid Responses sent in.

Hepatitis B: how to manipulate the media machine 30/11/04

Marc Girard, Consultant. 1 bd de la Republique - 78000 Versailles (France)

As a medical expert witness involved in a number of judiciary cases on hepatitis B vaccine (HBV), I spent thousands of hours with a unique opportunity to make a thorough inventory of the evidence supporting universal immunisation in low-endemic countries, which proved to be nonexistent. Quite often in my reports, I opposed the BMJ's invigorating irony on how pharmaceutical communication may "manipulate the media machine" (1996; 313: 825) to the depressing naivety of French doctors, and ascribed this contrast to a traditional superiority of British training in clinical research, statistics and epidemiology. But even in France and within less than two months, the champions of universal vaccination have been shattered by a accumulation of catastrophic news including: the confirmation that the figures of viral contaminations had been grossly exaggerated (by more than a 1000-fold factor), a case/control study showing a 3-fold increase in the risk of post-vaccinal multiple sclerosis (MS) [1], the statistics of health insurance showing a burst in neuro- muscular diseases [2], and the first official admission of a sharp increase in paediatric MS of very early onset (even in neonatal age). For deprived they are of their longstanding argument that any controversy on the benefit/risk ratio of this vaccination would be a new French paradox (Hernans et al study being performed upon British data), French "experts" have now an opportunity to claim that even British "experts" came over to the necessity of universal immunisation. This admirable timing may be related to the fact that on both sides of the Channel, "experts" have the same links with manufacturers, the same contempt of EBM requirements regarding the validation of their sources and the same propensity to ignore all of those likely to ruin their claims, as exemplified by Beeching's editorial (6 Nov, 2004: 1059-60) which remains completely silent on:

1) the strong evidence showing that HBV is remarkable by the frequency, the severity and the variety of its complications [2],

2) increasing evidence supporting doubts on the duration of immunity given [3],

3) examples like the French one demonstrating that universal scheme failed to reduce HB incidence risk populations

(see http://www.rolandsimion.org for additional relevant references).

Moreover, it maintains the nonsense of recommending vaccination of autochthonous population to avoid a disease in immigrants. Finally, it bypasses the democratic debate on imposing the unusual toxicity of this vaccine to a large population to protect a narrow subpopulation of people who deliberately adopt risky behaviours.

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COMPETING INTERESTS: Dr Girard works as an independent consultant for pharmaceutical industry, including vaccine manufacturers and a number of their competitors.

PROVIDING BETTER STIMULATION OF THE IMMUNE SYSTEM??

Just an example of what is going on in the field of vaccine development.
http://www.technologyreview.com/
VAXINNATE'S VACCINES MAY PROVIDE BETTER STIMULATION OF THE IMMUNE SYSTEM.
By Corie Lok, Launch Pad, Dec 2004.

Vaccines are unarguably one of the greatest success stories in medical history, eliminating or largely curtailing numerous age-old scourges such as smallpox and polio. *(Editor: Actually there are a growing number who would disagree!!)* But researchers' track record in coming up with effective vaccines for today's major and emerging diseases is, by and large, dismal. A Yale University spinoff, Vaxinnate, hopes to use recent breakthroughs in basic immunology to re-invigorate vaccine development and create new vaccines for cancer, West Nile virus, and influenza.

In the last decade, immunologists have uncovered the biological mechanisms of a very different kind of immune reaction than the 'adaptive' response they've long studied. This 'innate' immune response kicks in within mere minutes of an infection. In contrast, the adaptive response, with its familiar antibodies, takes days to get up to fighting speed. An effective vaccine should elicit both types of responses, and researchers now understand that the vaccines of old - made with weakened live viruses - did just that. But to avoid the risks inherent in using live viruses, vaccine developers have turned to individual proteins as immune-system stimulators.

Although they're safer *(Editor: They were all supposed to be safe, weren't they?)* and can generally boost antibody production, these vaccines often fail to prod the innate immune system to action.

Armed with new knowledge of innate immunity, Vaxinnate is working on vaccines aimed at kick-starting both types of responses. The company's approach is to fuse a protein that cranks up adaptive immunity with another that stimulates innate immunity. The result is a single entity that 'would provide both signals that are necessary and sufficient to get an immune response to anything you want,' says Yale immunologist Ruslan Medzhitov, Vaxinnate's scientific cofounder and one of the key discoverers of some of the biological underpinnings of innate immunity.

Fusing the two protein molecules 'is a good idea,' says Alan Aderem, director of the Seattle, WA-based Institute for Systems Biology. Injecting the two together without fusing them runs the risk of turning on too many immune cells, says Bruce Beutler, a professor of immunology at the Scripps Research Institute in La Jolla, CA. This in turn could cause excessive inflammation and lead to side effects like fever, rash, and in the worst case, shock. The fused proteins, on the other hand, would activate only a subset of cells, those bearing receptors for both proteins, which in turn would call to action both the innate and adaptive immune branches.

Founded in 2001, Vaxinnate has raised almost $25 million in venture capital and is now in early-stage animal testing of vaccine candidates for West Nile virus and influenza, with a leukemia candidate soon to follow. The company faces stiff competition on all three fronts from other research groups and companies, several of which are using conventional single-protein approaches. A number of cancer vaccines, for instance - including ones for leukemia - are already in mid-to late-stage human trials. Vaxinnate's goal is to begin human tests of whatever emerges as its leading candidate by 2006.

Technical hurdles also stand in the way. Even coupling the two proteins may not be enough to avoid side effects, says Beutler. That's because the subset of cells that the fused proteins interact with might not be narrow enough to exclude all of the culprits in inflammation reactions. Vaxinnate likely 'would have to use some other trick,' says Beutler, to further restrict the vaccine to just the right cells.

Even with such challenges, Vaxinnate is one of only a few companies striving to inject some of the new science of innate immunity into vaccine and drug development. Medzhitov hopes that at the very least, Vaxinnate will turn vaccine development - traditionally a trial-and-error process - into more of a science. *Editor: Interesting that they use the term 'trial-and-error process', and that they may have to use 'some other trick' - hardly sounds very scientific!*

VACCINES ARE NOT MERCURY FREE

www.emediawire.com/ Press R. 2/12/04

If our Government is to be believed then we are not going to see Thimerosal in vaccines from now on. However in the last few months we have discovered that thimerosal-free does not mean 'mercury free' in USA vaccines and, in all probability, UK vaccines. A charity in the USA has bought thimerosal free-vaccines and had them analysed. Guess what? ... They contain mercury. One of the world's top mercury specialists, Prof. B Haley, investigated, after being consulted, and discovered that in order to save money the vaccines companies still make their vaccines with thimerosal and then try to filter it out afterwards. This results in mercury being left behind because it sticks to the proteins in the vaccine. So if you think stopping the use of thimerosal will stop autism...think again! Our children are still being poisoned by the back door by greedy corporations. Some people would say they are trying to prove that taking thimerosal out of vaccines doesn't affect autism rates. This would mean they are not sued and in time could go back to using thimerosal – and to maximising profits.

This is an extract from the formal press release: After much public controversy surrounding the mercury content of childhood vaccinations, Health Advocacy in the Public Interest (HAPI) raised $500 to have 4 vaccines tested for heavy metal content. The vials were sent to Doctor's Data, an independent lab which specialises in heavy metal testing.

Many manufacturers voluntarily began producing supposed "mercury free" vaccines in 1999. Some product inserts currently claim that a "trace" amount of mercury still exists in the final product but that the amount has been greatly reduced. Others claim to be producing completely mercury free products.

During an investigation into the mercury issue, HAPI learned that Thimerosal, a 50% mercury compound, is still being used to produce most vaccines and that the manufacturers are simply "filtering it out" of the final product. However, according to Boyd Haley, PhD, Chemistry Department Chair, University of Kentucky , mercury binds to the antigenic protein in the vaccine and cannot be completely, 100% filtered out. All 4 vaccine vials tested contained mercury despite manufacturer claims that two of the vials were completely mercury free. All 4 vials also contained aluminium, one 9 times more than the other three, which tremendously enhances the toxicity of mercury causing neuronal death in the brain.

CONSENT URGED ON VACCINES

Pulse,15/11/2004

GPs have been urged to ensure they keep a record of consent for all childhood immunisations after new figures showed around a third of practices were at medicolegal risk.

One in eight GPs did not routinely ask parents for consent and a further one in four did not always take a written record, according to a Medical Protection Society survey.
Guidance from the Chief Medical Officer states consent must be obtained before the administration of all vaccines, and the MPS warned that practices that did not take a written record were open to legal action.

Dr Gerard Panting, MPS communications and policy director, said vaccination was an emotive decision for parents and when complaints were made they were often pushed hard. 'By the time a complaint is made and there is a dispute about what happened, a doctor may have immunised several hundred other children and if there is no record it's difficult for the doctor to put his case,' he said.

In the same issue of Pulse there was also an article entitled 'Make removing a patient painless (for you at least).'
It starts by saying:

'If removal is inevitable it is essential to do it sensitively and properly - Dr Nicholas Norwell of the MDU shows how

It is unusual for a doctor/ patient relationship to break down to such an extent that a practice considers removing the patient from its list, but it does happen. What should GPs bear in mind when dealing with this difficult issue?

In the light of the recent updated guidance from the RCGP1 on removing patients from their lists, some GPs may be rethinking their policy. Not all relationship breakdowns with patients can or should be salvaged, and removing a patient sometimes has to be the last resort.

We at the MDU know the act of removal can itself lead to a complaint, so it's vital to handle the removal sensitively and properly.....
Further on in the article it includes:

'The RCGP says cases that do not normally justify removal include refusing to take part in a locally or nationally agreed screening programme, refusing to allow children to participate in immunisation campaigns, or failure to comply with health advice.

Remember that patients have a right to give or withhold consent to treatment and should not be penalised for exercising that right'.....

Regarding consent, another problem is occurring as a result of vaccination campaigns being carried out in schools and colleges. Over the years I have heard from various parents whose children have been wrongly vaccinated due to error or sometimes intimidation. For example very recently a mother contacted the Informed Parent about her 16 year old son, who was hauled out of class at his college and told to have a MMR booster. He did protest, saying that he did not have vaccinations, but was told that everyone had to have it - in a very strong and intimidating fashion. His mother was furious because she had no idea that the jabs were to take place, there had been no letter, or consent forms, only a poster had been placed in the college. The difficulty with the consent aspect is that once over 16 years old there appears to be no guidelines.

In the Dept. of Health Green book, on the page entitled 'Consent', here a few statement listed that may be useful to parents:

•Similarly, the attendance of a child at school on the day that the parent/ guardian has been advised that the child will be immunised may also be viewed as acceptance that the child may be immunised, in the absence of any reservation expressed to the contrary. However, because of the parent/guardian's legal responsibilities in respect of the child's attendance at school, the possibility that immunisation will be offered should be made clear to the parent/guardian.

• A child under 16 years of age may give consent for immunisation provided he or she understands fully the benefits and risks involved. However, the child should be encouraged to involve a parent/guardian, if possible, in the decision.

• A child under 16 who fully understands the benefits and risks of the proposed immunisation wishes to refuse the immunisation, that wish should be respected.

So please make sure that your child's school tutors/doctors are fully aware of your vaccination decision to avoid mistakes. Personally I feel very strongly that schools and colleges should not be used for medical procedures. It is an invasion of privacy regarding our medical choices. Some children, whose parents have refused a particular vaccine, experience taunting and peer pressure from their fellow pupils.

DOUBTS ON FLU VACCINATION

Influenza vaccination does not reduce the risk of hospitalisation in elderly patients with acute respiratory disease, concludes controversial new research, the Pulse reported (20/9/04).

Patients who received the flu vaccine had exactly the same risk of entering hospital over winter as those who had not, according to data presented at last week's Society for Social Medicine conference.

LOSS OF MONEY

An article in Pulse, 11/10/04 'GPs seek payout over flu chaos' reported on how some GPs were forced to cancel hundreds of thousands of appointments and turn away high risk patients due to a supply crisis. This was due to the suspension of the UK manufacturing of the vaccine (Chiron) leading to a shortfall of 2.4million doses.

The line that particularly caught my attention was:

'GPs, who are set to miss out on thousands in quality pay and vaccine fees, reacted with fury after Chiron failed to offer compentsation. '

So the GPC is now demanding the Government steps in to compensate those GPs affected.

TRENDS IN HIB INFECTIONS IN ADULTS IN ENGLAND AND WALES

BMJ 2004;329:655-658 (18 Sept)

Trends in Haemophilus influenzae type b infections in adults in England and Wales: surveillance study.

McVernon et al

Correspondence to: M Ramsay
mary.ramsay@hpa.org.uk

Here follows the main points of the study:

OBJECTIVE To describe invasive Haemophilus influenzae type b (Hib) infections in individuals aged 15 years or older in England and Wales between 1991 and 2003.

Setting England and Wales.

RESULTS After routine infant immunisation was introduced in October 1992, adult Hib infections decreased initially but then rose from a low in 1998 to reach prevaccine levels in 2003. An associated fall in median Hib antibody concentrations occurred, from 1.29 µg/ml (95% confidence interval 0.90 to 1.64) in 1991 to 0.70 µg/ml (0.57 to 0.89) in 1994 (P = 0.006), with no significant change observed thereafter.

CONCLUSIONS Although immunisation of infants resulted in an initial decline in Hib infections in adults, a resurgence in reported cases occurred in 2002-3. This rise was associated with an increase in cases in children and evidence of reduced immunity in older unimmunised cohorts. Childhood immunisation programmes may have unanticipated effects on the epidemiology of disease in older age groups, and surveillance strategies must be targeted at entire populations.

Dr Jayne LM Donegan sent a Rapid Response to the BMJ regarding the above article entitled 'Dogs chasing tails' she wrote:

Haemophilus influenza has six encapsulated forms that can cause human disease, type B does so most commonly. The incidence of invasive disease caused by these encapsulated forms has been rising since the 1950s, which is, coincidentally, the time that mass vaccination was introduced and antibiotics started to be prescibed so liberally.

Before vaccination against Hib was introduced, 90% of individuals carried Haemophilus influenza in their noses, approximately 5% being type B. Antibodies form against the encapsulated forms either as a result of such symptomless nasal carriage or of disease.(1)

As the vaccine is only targeted at type B, it is possible that a drift will occur towards more disease being caused by other types. For example, meningitis caused by Haemophilus influenza A when there has been vaccination against Hib. A similar drift has been seen in pertussis infection, and possibly mumps.

When the Hib vaccine was introduced in 1992, it was not given to children over the age of four years or adults because they were regarded as already immune. However, once the vaccine was introduced children were less likely to carry it in their nose and gain natural immunity. This would be expected to increase the likelihood of their contracting severe forms of the disease at a later age as has, in fact, been the case. After the introduction of the vaccine in 1992, cases of Hib disease were dramatically reduced, although some of this was thought to be due to significant underreporting of cases after introduction of the vaccine combined with more rigorous case definition with "consequent overestimation of the effectiveness of the immunisation programme"(2). However, after this initial decline, cases in children aged five to eleven months rose in England and Wales from 0.15 per 100,000 in 1998 to 0.76 in 2000 and in 2001, a similar rise was seen in one to two year olds; 0.45 in 1998 to 3.97 per 100,000 in 2001 (figures presented by Dr J McVernon at the International Network of Paediatric Surveillance Units in York April 2002). It was thought to be due to possible problems with vaccine efficacy but was difficult to test because of lack of information on antibody levels in these children after their primary course (3) due to lack of long term studies.

In 1992 before the vaccine was introduced, carriage of Hib was found in 4% of 1,500 children tested, this had dropped to 0.7% by 1994 and in 1997 none of 500 children were carrying it (unpublished results of Public Health Laboratory Service study) (4). Such reduced carriage rates left children without natural immunity to Hib and invasive disease is occurring in older children who would previously have been expected to be immune. Rather than giving serious thought to removing this vaccine from the schedule, a campaign to give a 'catch up' dose to all under four year olds took place in 2003 and the decision has now been made to add Hib to the preschool booster. A booster dose given to four to five year olds is likely to push invasive disease into adulthood as is already being shown by McVernon et al in this study.

No doubt we shall soon start offering Hib vaccination to school leavers, along with diphtheria and the soon-to-be-added pertussis vaccines, plus perhaps a bit of influenza vaccine for good measure and mumps and measles and rubella (the rubella antibodies from MMR given to preschoolers will definitely have worn off by the time these children are of an age to reproduce) - as we add booster after booster rather like a dog trying to catch its tail. Perhaps it is time to stop injecting the population with these toxins and return to real ways of promoting health:- good food, clean water and air, well ventilated housing, exercise and emotional harmony. The only people that benefit by such imprudent public 'health' measures are the vaccine manufacturers and their share holders. JLM Donegan, 23/9/04

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Competing interests: None declared

MY DAUGHTER'S WHOOPING COUGH

Following on from an article in the previous issue regarding a case of whooping cough. Another parent has written in about her very successful experience of dealing with whooping cough. She writes:

Two of my daughters, on separate occasions, when they were between one and 2 years of age, developed whooping cough. In both cases I gave them one dose of homeopathic Pertussis 30, then Drosera 30 at 4 hourly intervals. The older child was well in a fortnight, right down to behaviour being absolutely normal again. She only whooped one day and was not ill beyond going red in the face with the coughing.

My second child was well in 4 weeks and did not actually get as far as whooping.

STUDY FINDS FLU VACCINE BENEFITS HEALTHY ELDERLY MORE THAN THE ILL

Pulse, 15/11/2004. *By Emma Wilkinson*

A new study has turned expectations on their head by finding healthy elderly people benefit more than those with comorbidities from influenza vaccination. *(Editor: But the healthy people are the ones that won't be susceptible to developing flu in the first place, whilst the compromised will!)*

But further research suggests the healthy elderly remain unconvinced they need the vaccine amid warnings that many may be slipping through the net. *(Editor: Although I say this in jest, it would not surprise me if they started literally trying to catch them with nets, another reason to try and keep agile in our old age!!!!!)*

The vaccine can cut mortality by up to 34 per cent in healthy elderly people compared with 25 per cent in those with respiratory illness or other comorbidity, Dutch researchers found.

Mortality fell with each successive year that people were vaccinated, but a year's gap sent the risk of dying soaring - to even higher levels than in unvaccinated patients. *(Editor: So there were more deaths in the vaccinated??)*

Lead author Professor Bruno Stricker, professor of pharmaco- epidemiology at the Erasmus Medical Centre in Rotterdam, stressed the importance of vaccinating patients every single year, saying a year's interruption caused a 'strong and significant increase' in mortality. 'Fortunately if you restart vaccination, protection comes back again,' he added.

The study, published in JAMA earlier this month, used a large primary care data- base of over 26,000 patients to assess the effect of successive annual flu vaccinations.

But GPs may have their work cut out convincing healthy elderly people of the merits of flu vaccination, according to research presented at the Five Nations Health Protection Conference in Manchester this month.

Many healthy elderly didn't believe they needed the vaccine and didn't regard age as a risk factor for flu, researchers at the University of Wales College of Medicine found.

Dr Douglas Fleming, director of the RCGP Birmingham research unit, said there was a hard core of healthy patients who refused to be vaccinated at any cost. *(Editor: Perhaps that is why they remain healthy!!)*

But he disputed the results of the Dutch study, saying GPs should continue to focus on patients with comorbidity. 'I've always believed we should be focusing on people with comorbidities whatever their age,' he said.

Editor: Over the years I have spoken to a number of people who work caring for elderly people and the typical feedback, is that the healthiest residents are the ones that refuse medications and vaccines. Also, that after flu jab campaigns a few deaths follow - but of course the cause of death would be classed as 'old age'.

INFANTS DIE; REACTION TO POLIO DROPS FEARED

Tuesday Nov. 23 2004 00:36 IST
www.newindpress.com/

KHAMMAM: In a shocking incident, three infants died, after allegedly developing reaction to polio drops administered on Sunday in Penuballi mandal of this district.

According to information reaching here, all the three infants, aged under two months, suffered from shivering after being given polio drops. One kid died on Sunday and two others succumbed on Monday. Unconfirmed reports said that another infant died in the mandal due to a similar reaction.

The victims were identified as R Venkat Narsaiah of Bramhalakunta, Pramila (Karaigudem) and another baby girl who is daughter of one K Narasimham Kumar in Upplachalaka village. The parents alleged that the deaths were a result of complications arising out of polio drops and that the children were normal and healthy before.

Dr Gopala Krishna and Dr Ranga Prasad from Hyderabad, who are a part of the rapid response team of WHO, visited the district to obtain a report on the deaths. When contacted, district medical and health officer Dr R Krisha Bramham maintained that the deaths were unrelated to polio drops. ``It is a coincidence that the deaths happened just a day after polio drops were given,'' he said.

PROMOTING OPENNESS AND FULL DISCLOSURE

A newly released report by the Center for Disease Control, Health US 2004--reveals how effective the pharmaceutical industry is in marketing its drugs - whether or not they are beneficial; whether or not they cause severe harm--they sell. Antidepressants showed the largest increase in use - prescriptions for children of both antidepressants and psychostimulants soared.

Confessions by insiders and an examination of the evidence leave little doubt that the that the promoters of these drugs claims are unsubstantiated, that integrity of medicine and the biomedical literature have been systematically corrupted thanks to collaborative efforts of the pharmaceutical industry and their paid prominent academic consultants.

Dr. William Pelham, a leading ADHD researcher for 30 years, is the latest insider to come forward: "In recent years, I have come to believe that the individuals who advocate most strongly in favor of medication - both those from the professional community, including the National Institutes of Mental Health, and those from advocacy groups, including CHADD - have major and undisclosed conflicts of interest with the pharmaceutical companies that deal with ADHD products."..... Dr. Pelham notes: "It's really misleading and I'm surprised the FDA is letting them use the studies to advertise no side effects. They had no side effects because they took only people with only a positive history of medication. This is really pushing meds without telling the full picture."

Pressure was also brought to bear to shape Dr. Pelham's written report: When his paper was in the galley proof stage at the medical journal Pediatrics, Pelham says he joined a conference call with a number of senior people from the corporation who lobbied him to change what he had written in the paper.

"The people at Alza clearly pushed me to delete a paragraph in the article where I was saying it was important to do combined treatments (medication and behavioral)." They also pushed him to water down or eliminate other sentences and words that did not dovetail into their interests. "It was intimidating to be one researcher and have all these people pushing me to change the text." In the end, Dr. Pelham says, they published a report with his name penned to it without his authorization....The Alliance for Human Research Protection calls upon medical journal editors to disinfect the scientific literature by putting these authors, other published reports through rigorous re-assessment, not by the authors' collegial peers--but by independent scientists. Otherwise journals such as JAMA may be accused of publishing 'junk science.'

www.ahrp.org

THE UNITY OF ACUTE DISEASES

Nature Cure Philosophy & Practice
Based on the Unity of Disease & Cure
Henry Lindlahr, M.D.
20th edition,Published by The Nature Cure Publishing Company,525 South Ashland Boulevard, Chicago.
1922
http://www.soilandhealth.org/

CHAPTER V

THE UNITY OF ACUTE DISEASES

On first impression, it might be thought that heredity is a primary cause of disease; but on further consideration it becomes apparent that it is an effect and not a primary cause. If the parents possess good vitality and pure, normal blood and tissues, and if they apply in the prenatal and postnatal treatment of the child the necessary insight and foresight, there cannot be disease heredity. In order to create abnormal hereditary tendencies, the parents, or earlier ancestors, must have ignorantly or wantonly violated Nature's Laws, such violation resulting in lowered vitality and in deterioration of blood and tissues.

The female and male germinal cells unite and form the primitive reproductive cell--the prototype of marriage. The human body with its millions of cells and cell colonies is developed by the multiplication, with gradual differentiation, of the reproductive cell. Its abnormalities of structure, of cell materials and of functional tendencies are reproduced just as surely as its normal constituents. Herein lies the simple explanation of heredity which is proved to be an actual fact, not only by common experience and scientific observation but also in a more definite way by Nature's records in the iris of the eye.

The iris of the newborn child reveals in its diagnostic details not only, in a general way, hereditary taints, lowered resistance, and deterioration of vital fluids, but frequently special weakness and deterioration in those organs which were weak or diseased in the parents. Under the conventional (unnatural) management of the infant, these hereditary tendencies to weakness and disease and their corresponding signs in the iris become more and more pronounced, proceeding through the various stages of incumbrance from acute, infantile diseases through chronic catarrhal conditions to the final destructive stages.

In the face of the well-established facts of disease heredity we have, however, this consolation: If the child be treated in accordance with the teachings of Nature Cure philosophy, the abnormal hereditary encumbrances and tendencies can be overcome and eliminated within a few years. If we place the infant organism under the right conditions of living and of treatment, in harmony with the laws of its being, the Life Principle within will approach ever nearer to the establishment of the perfect type.

Hundreds of "Nature Cure" babies all over this country are living proofs of this gladsome message to all those who have assumed or intend to assume the responsibilities of parenthood.

NATURAL IMMUNITY

Under Division II of "Secondary Causes or Manifestations of Disease" we find mentioned germs, bacteria, parasites, inflammations, fevers, skin eruptions, chronic sinus discharges, ulcers, etc.

Modern medical science is built up upon the germ theory of disease and treatment. Since the microscope has revealed the presence and seemingly entirely pernicious activity of certain microorganisms in connection with certain diseases, it has been assumed that bacteria are the direct, primary causes of most diseases. Therefore, the slogan now is: "Kill the bacteria (by poisonous antiseptics, serums and antitoxins) and you will cure the disease."

The Nature Cure philosophy takes a different view of the problem. Germs cannot be the cause of disease, because disease germs are also found in healthy bodies. The real cause must be something else. We claim that it is the waste and morbid matter in the system which afford the micro-organisms of disease the opportunity to breed and multiply.

We regard microorganisms as secondary manifestations of disease, and maintain that bacteria and parasites live, thrive and multiply to the danger point in a weakened and diseased organism only. If it were not so, the human family would be extinct within a few months' time.

The fear instilled by the bacterial theory of disease is frequently more destructive than the microorganisms themselves. We have had under observation and treatment a number of insane patients whose peculiar delusion or monomania was an exaggerated fear of germs, a genuine bacteriophobia.

Keep yourself clean and vigorous from within, and you cannot be affected by disease taints and germs from without.

Bacteria are practically omnipresent. We absorb them in food and drink, we inhale them in the air we breathe. Our bodies are literally alive with them. The last stages of the digestive processes depend upon the activity of millions of bacteria in the intestinal tract.

The proper thing to do, therefore, is not to try and kill the germs, but to remove the morbid matter and disease taints in which they live. Instead of concentrating its energies upon killing the germs, whose presence we cannot escape, Nature Cure endeavors to in-vigorate the system, to build up blood and lymph on a normal basis and to purify the tissues of their morbid encumbrances in such a way as to establish natural immunity to destructive germ activity. Everything that tends to accomplish this without injuring the system by poisonous drugs or surgical operations is good Nature Cure treatment.

To adopt the germ-killing process without purifying and invigorating the organism would be like trying to keep a house free from fungi and vermin by sprinkling it daily with carbolic acid and other germ killers, instead of keeping it pure and sweet by flooding it with fresh air and sunshine and applying freely and vigorously broom, brush and plenty of soap and water. Instead of purifying it, the antiseptics and germ killers would only add to the filth in the house. (1)

All bacteriologists are unanimous in declaring that the various disease germs are found not only in the bodies of the sick, but also in seemingly healthy persons. A celebrated French bacteriologist reports that in the mouth of a healthy infant, two months old, he found almost all the disease germs known to medical science. Only lately, a celebrated physician, appointed by the French government to investigate the causesof tuberculosis, declared before a meeting of the International Tuberculosis Congress in Rome that he found the bacilli of tuberculosis in ninety-five percent of all the school children he had examined.

Dr. Osler, one of the greatest living medical authorities, mentions repeatedly in his works that the bacilli of diphtheria, pneumonia and of many

other virulent diseases are found in the bodies of healthy persons. The inability of bacteria, by themselves, to create diseases is further confirmed by the well-known facts of natural immunity to specific infection or contagion. All mankind is more or less affected by hereditary and acquired disease taints, morbid encumbrances and drug poisoning, resulting from age-long violation of Nature's Laws and from the suppression of acute diseases; but even under the almost universal present conditions of lowered vitality, morbid heredity and physical and mental degeneration it is found that under identical conditions of exposure to drafts or infection, a certain percentage of individuals only will take the cold or catch the disease. The fact of natural immunity is constantly confirmed by common experience as well as in the clinics and laboratories of our medical schools and research institutes. Of a specific number of mice or rabbits inoculated with particles of cancer, only a small percentage develops the malignant growth and succumbs to its ravages.

The development of infectious and contagious diseases necessitates a certain predisposition, or, as medical science calls it, "disease diathesis." This predisposition to infection and contagion consists in the primary causes of disease, which we have designated as lowered vitality, abnormal composition of blood and lymph, and the accumulation of waste, morbid matter and poisons in the system.

Bacteria: Secondary, Not Primary, Manifestations of Disease

In a previous chapter we learned how lowered vitality weakens the resistance of the system to the attacks and inroads of disease germs and poisons. The growth and multiplication of microorganisms depend furthermore upon a congenial, morbid soil. Just as the ordinary yeast germ multiplies in a sugar solution only, so the various microorganisms of disease thrive and multiply to the danger point only in their own peculiar and congenial kind of morbid matter. Thus, the typhoid fever bacillus thrives in a certain kind of effete matter which accumulates in the intestines; the pneumonia bacilli flourish best in the catarrhal secretions of the lungs, and meningitis bacilli in the diseased meninges of the brain and spinal cord. Dr. Pettenkofer, a celebrated physician and professor of the University of Vienna, also arrived at the conclusion that bacteria, by themselves, cannot create disease, and for years he defended his opinion from the lecture platform and in his writings against the practically solid phalanx of the medical profession. One day he backed his theory by a practical test. While instructing his class in the bacteriological laboratory of the university, he picked up a glass which contained millions of live cholera germs and swallowed its contents before the eyes of the students. The seemingly dangerous experiment was followed only by a slight nausea. Lately I have heard repeatedly of persons in this country who subjected themselves in similar manner to infection, inoculation and contagion with the most virulent kinds of bacteria and disease taints without developing the corresponding diseases.

A few years ago Dr. Rodermund, a physician in the State of Wisconsin, created a sensation all over this country when he smeared his body with the exudate of smallpox sores in order to demonstrate to his medical colleagues that a healthy body could not be infected with the disease. He was arrested and quarantined in jail, but not before he had come in contact with many people. Neither he nor anyone else exposed by him developed smallpox.

During the ten years that I have been connected with sanitarium work, my workers and myself, in giving the various forms of manipulative treatment, have handled intimately thousands of cases of infectious and contagious diseases, and I do not remember a single instance where any one of us was in the least affected by such contact. Ordinary cleanliness, good vitality, clean blood and tissues, the organs of elimination in good, active condition and, last but not least, a positive, fearless attitude of mind will practically establish natural immunity to the inroads and ravages of bacteria and disease taints. If infection takes place, the organism reacts to it through inflammatory processes, and by means of these endeavors to overcome and eliminate microorganisms and poisons from the system.

In this connection it is of interest to learn that the danger to life from bites and stings of poisonous reptiles and insects has been greatly exaggerated. According to popular opinion, anyone bitten by a rattlesnake, gila monster or tarantula is doomed to die, while as a matter of fact the statistics show that only from 2 to 7% succumb to the effects of the wounds inflicted by the bites of poisonous reptiles.2

In this, as in many other instances, popular opinion should rather be called "popular superstition." In the open discussions following my public lectures, I am often asked: "What is the right thing to do in case of snakebite? Would you not give plenty of whiskey to save the victim's life?" It is my belief that of the 7% who die after being bitten by rattlesnakes or other poisonous snakes, a goodly proportion give up the ghost because of the effects of the enormous doses of strong whiskey that are poured into them under the mistaken idea that the whiskey is an efficient antidote to the snake poison. People do not know that the death rate from snakebite is so very low, and therefore they attribute the recoveries to the whiskey, just as recoveries from other diseases under medical or metaphysical treatment are attributed to the virtues of the particular medicine or method of treatment instead of to the real healer, the vis medicatrix naturæ, the healing power of Nature, which in 93 cases in a hundred eliminates the rattlesnake venom without injury to the organism.

To recapitulate: Just as yeast cells are not only the cause but also the product of sugar fermentation, so disease germs are not only a cause (secondary) but also a product of morbid fermentation in the system. Furthermore, just as yeast germs live on and decompose sugar, so disease germs live on and decompose morbid matter and systemic poisons.

In a way, therefore, microorganisms are just as much the product as the cause of disease and act as scavengers or eliminators of morbid matter. In order to hold in check the destructive activity of bacteria and to prevent their multiplication beyond the danger point, Nature resorts to inflammation and manufactures her own antitoxins. On the other hand, whatever tends to build up the blood on a natural basis, to promote elimination of morbid matter and thereby to limit the activity of destructive microorganisms without injuring the body or depressing its vital functions, is good Nature Cure practice. The first consideration, therefore, in the treatment of inflammation must be to not interfere with its natural course. By the various statements and claims made in this chapter, I do not wish *(contd. overleaf)*

to convey the idea that I am opposed to scrupulous cleanliness or surgical asepsis. Far from it! These are dictates of common sense. But I do affirm that the danger from germ and other infectious diseases lies just as much or more so in internal filth as in external uncleanliness. Cleanliness and asepsis must go hand in hand with the purification of the inner man in order to insure natural immunity. *Henry Lindlahr, 1922.*

FOOTNOTES

1. All this was written before the introduction of antibiotics. The modern theory is still the same, however: 'kill the bug' and the disease goes away. This only happens if the body's vitality is strong enough to finish off the germs that are left after the antibiotic has done its work. If it is not, the condition will return again and again. The most common example of this is the reoccurring upper respiratory and ear infections in children raised on antibiotic therapy.

2. There are poisonous critters whose bite or sting can be nearly universally fatal so it is a good idea to take measures to avoid such exposure whenever possible. The better the vitality as defined by Dr. Lindlahr, however, the better chance you have of surviving such an attack, even with the use of antitoxins.

DR SCHEIBNER'S TALKS

A very BIG thank you to all those involved in the recent lectures given by Dr Scheibner. From those who organised the evenings, found venues, and promoted the talk locally, to all those who were able to attend!!! Don't forget to keep a check on the 'events' page on the website for talks for 2005.

STUDY FIRST, JUDGE LATER

Letters, Australian Doctor, 2/5/03

By Dr Viera Scheibner. *This letter was sent in response to an article attacking homeopathy.*

Editor in his article 'The unhealthy claims of pseudo-medicine' (4 April, Peter Bowditch of Australian Skeptics appears directly at odds with the original sceptic, Voltaire, who said: "I disagree with your ideas but I will fight to death for your right to express them."

Moreover, Bowditch, a computer man, not a medical researcher, expounds on subjects he has obviously not studied.

The American Chiropractic profession was granted a permanent injunction against the American Medical Association because, when asked by the judge what chiropractic was, the association's representative did not know.

If all those who rubbish homeopathy studied it and were "willing to discard ideas when they are shown to be false" they would learn that homeopathic remedies are an electromagnetic imprint of the structure of the substance on the solvent, a truly scientific principle. An honest American orthodox doctor, Dr Constantine Herring, wanted to debunk homeopathy; he studied it and became a famous homeopath.

In contrast to alternative medicine, orthodox medicine kills 18,000 Australians every year. Is that science or iatrogenesis? Directly injecting highly poisonous substances bypassing the body's natural defence mechanisms - as in vaccination- is evidently useless and dangerous. Good, orthodox immunology revealed that vaccines derange the immune system by reversing the T4/T8 ratio, a common denominator in many modern ills, from chronic fatigue syndrome, immunoreactive and autoimmune diseases, to AIDS.

Is Bowditch's article perhaps an extreme case of projection? Or just trying to silence the truth while showing gaping ignorance?

COMPARING NATURAL IMMUNITY WITH VACCINES

***with* TREVOR GUNN**, *BSc. LCH RSHom, graduate in biochemistry and author of 'Mass immunisation - A Point in Question'*

Would you like to know whether vaccines work? Would you like to know how to avoid serious illness? Would you like to live feeling safe, knowing what treatments work?

Topics covered:

Short and long term effects of childhood and travel vaccines - evidence from orthodox & complementary sources - information that the authorities don't tell you - making sense of statistics - childhood illnesses - dealing with fear- avoiding future problems- increasing health now

BRIGHTON

19th Jan 2005 • 16 Mar 2005

8 Jun 2005

Contact Karel on: 01273 277309

A new guide for parents: 'The No Nonsense Vaccine Handbook' by Liz Bevan-Jones, is now available. Includes info on latest 5 in 1 jab. For details phone Liz on: 020 8540 0486

PLEASE HELP PROMOTE THE INFORMED PARENT

You can send off for leaflets to pass on to friends, relatives or patients. Just send a large sae and state quantity needed.

THANK YOU FOR YOUR SUPPORT!

AIMS AND OBJECTIVES OF THE GROUP

1. To promote awareness and understanding about vaccination in order to preserve the freedom of an informed choice.

2. To offer support to parents regardless of the decisions they make.

3. To inform parents of the alternatives to vaccinations.

4. To accumulate historical and current information about vaccination and to make it available to members and interested parties.

5. To arrange and facilitate local talks, discussions and seminars on vaccination and preventative medicine for childhood illnesses.

6. To establish a nationwide support network and register (subject to members permission).

7. To publish a newsletter for members.

8. To obtain, collect and receive money and funds by way of contributions, donations, subscriptions, legacies, grants or any other lawful methods; to accept and receive any gift of property and to devote the income, assets or property of the group in or towards fulfilment of the objectives of the group.

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