To Encourage the Others

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Abstract

This essay and the one that follows, 'The Urabe Farrago' were written with the intention of throwing light on the decision making process of the Joint Committee on Vaccination and Immunology (JCVI), the National Health Service (NHS) and the pharmaceutical industry. Since the beginning of vaccination with Mumps, Measles and Rubella (MMR), the government has denied the existence of vaccine damage. The two-year General Medical Council (GMC) 'trial' of Dr. Andrew Wakefield and two other doctors has been one consequence of the view that the vaccine was perfectly safe. In this essay, I looked the various areas of possible vaccine damage, their causes and how the official agencies have tried to argue them away. This essay became the subject of a threat of legal action for defamation from Dr. David Salisbury the Director of the department of Vaccination and Immunology inside the NHS.

Keywords: MMR, vaccination, vaccine damage denial, Joint Committee for Vaccination and Immunology (JVCI), Coroners.

Chance is a word void of sense;
Nothing can exist without a cause.
Voltaire

There are no accidents.
Master ShiFu in Kung Fu Panda.

When police and paramedics arrived at the house of the distraught Fisher family, on the morning of January 19th 2006, they found two-year-old George Fisher dead and were unable to resuscitate him. He was declared dead exactly 10 days after his MMR vaccination. His lungs and blood examined during the autopsy, showed measles virus, while his enlarged spleen showed he was fending off a virus.

Over three days, two and a half years later, in November 2008, Coroner Alan Crickmore presided over the Inquest into George Fisher's death. Apart from the bereaved parents, the amphitheatre court was full of pharmaceutical company representatives and vaccine and immunological department apparatchiks, including Dr. Liz Miller, formerly of the Public Health Laboratory Service and more recently head of the Immunisation Department of the Health Protection Agency.

Crickmore, a solicitor with a one-man-band practice in a small black fronted office resembling a funeral director's on the High Street in Cheltenham,[1] deals with everything from divorce to licensing and conveyancing and civil partnership to cohabitation. Qualifying as a solicitor in 1980 he became the Coroner for Gloucestershire a decade later. Making a formal complaint against him following the Inquest, the Fisher family described him as 'a man without any social skills'.[2] The Fishers maintain that he was brusque and rude to them throughout the hearing and acted with a condescending and authoritarian abruptness to their female counsel.

With twenty years of public argument about the safety of and the damage caused by MMR, the Fisher family and those gathered in their support, felt alarmed from the outset when Crickmore announced that he was 'a legal and not a medical man'. One might have thought that in a case where the parents were suggesting their child's death had been caused by a pharmaceutical product, the proceedings might at least have been overseen by a coroner who knew his medical arse from his elbow, especially as the only evidence of any consequence concerned a pre-vaccination febrile fit suffered by George Fisher.

Evidence of the fit was given by Mr. Alan Joseph Day, a local Consultant Paediatrician. His report written in March 2008 covered George's medical history relating to his first febrile convulsion in September 2005, four months before his death in January 2006. According to Day, the fit was a short but dramatic seizure; however, despite this seizure and the following vaccination, George was not monitored. In Day's opinion, George's febrile convulsion had not been serious enough to count as a contraindication to vaccination.

George's MMR vaccination left him with a runny nose, diarrhoea (he was also teething), sore ears, a temperature of 37.5 ºC, vomiting, a lack of appetite and sore red eyes, all of which had prompted his mother to make another doctor's appointment.

The Inquest's next most important witness was Practice Nurse Hannah Mitchell who administered the MMR shot to George on January 9th, 2006. Mitchell could not recall the specifics of George's case, but was sure she followed the regular pattern of checking notes and medical records and informing the parents to put them at ease. Chris and Sarah Fisher could not remember Mitchell having gone into the detail she suggested she had. In fact, they maintained they were not given the correct advice or even a leaflet. They had also been unaware of a need to monitor their son especially closely on account of his previous febrile convulsion. Had they been aware, they might

[1] Alan C. Crickmore, Solicitors, 49 High Street, Cheltenham, GL50 1DX.
[2] 'Grieving parents' anger at coroner.' Friday, December 12, 2008, ***Western Daily Press***: Mr. Fisher, 43, and Mrs. Fisher, 42, who believed the MMR jab was implicated in his death were 'disappointed' with a verdict of natural causes but are keen to stress that is not the reason they feel they must make a complaint against Mr. Crickmore. Mrs. Fisher said: 'We were shocked by the way he handled such a sensitive inquest.'

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have requested that he be admitted to hospital for the vaccination, or opted not to give him this 3-in-1 jab at all.

Dr. Elizabeth Miller, who has various interests in vaccine manufacturers,[3] giving evidence, as it were, for the State, was ready to admit that febrile convulsions can happen after MMR and that the vaccine was most active around the tenth day. However, Dr. Miller suffered no real cross-examination and Mr. Crickmore, being a legal chap rather than a medical one, hardly opened his mouth except to be platitudinously deferential.

Having given sufficient consideration to his predominantly medical verdict, Crickmore fell heavily on the side of the vaccine-damage denialists. In fact, he opened his verdict speech with a rounded appreciation of the MMR vaccination, which he had admitted to knowing nothing about at the start of the hearing. In giving a glowing reference to MMR, he broke one of the first rules of the coroner's task, which is to examine the details of each death without fear or favour and most certainly without general ideological considerations. In favour of MMR- and with the opinion that this could have had nothing to do with George Fishers death, Crickmore said:

> Those of us of a certain age remember well the dreadful illnesses and the consequences of them that the MMR–immunisation programme was designed to combat and the success of the vaccination programme,[4] involving millions of vaccinations worldwide has been evident by the decrease in the incidence of the disease although it is to be noted that some recent adverse comment has affected the uptake rate in certain parts of England and Wales and this has led to the alarming rise in reported cases of measles ... The function of the inquest is to seek out and record as many of the facts concerning the death as the public interest requires ... so that matters of concern are revealed while unjustified disquiet and suspicion are allayed.

For his verdict that George had died from 'natural causes', a victim of Sudden Infant Death Syndrome (SIDS). He seemed to rely upon selected parts of the evidence, suggesting that vaccine damage usually shows after a longer period than ten days and it was unlikely that the febrile convulsion from which George died was brought on by the vaccination. In relation to his first conclusion, he was wrong and in relation to the second, even acting on expert advice, few high street solicitors are equipped to arrive at such conclusions.

It was, however, what Crickmore did with these facts in making his judgement that was most bizarre. Without any prompting from experts or amateurs, Crickmore introduced a 'natural cause' verdict and the mysterious, SIDS.[5] This was surely a case where the clearest and most logical evidence was dismissed in favour of a non-evidenced conclusion.[6]

In front of the divorce lawyer's natural causes verdict, shone the slippery superficiality of the British press doing government business. Reassurance reached into every home:

> MMR jab 'played no part in boy's death', coroner rules. No link to MMR over baby's death. MMR jab 'didn't kill healthy tot'. MMR baby died of natural causes.

The Individual Dangers of Mass Vaccination

Over the last two or three decades, the government and its agencies has taken a specifically strategic approach to deaths and serious adverse reactions following vaccination. The metamessage is simply: herd immunity is the goal and anything that gets in the way of this is to be made secret and invisible. Adverse reactions, however serious, are to be trivialised and deaths are to be brought to the door of another cause or temporal coincidence. At the same time, everything is to be done to reassure the public about the absolute safety of all vaccination.

The central axis of this middle part of this essay deals with fits and convulsions and the way in which the JCVI has consistently changed its public approach to these, both as a contraindication and as a resultant adverse reaction. However, the approach of the committee to fits must be seen within the context of their approach to a series of other questions about herd immunity and individual susceptibility.

Responsibility

Despite our suspicions, the vaccine industry spends days concerned about safety.[7] However, the safety of the vaccine in an absolute sense, is quite different from its relative safety. There are as well, inevitable differences in responsibility: while it is mainly the responsibility of the vaccine producers to make a vaccine as safe as possible, it is mainly the responsibility of politicians, government agencies and doctors to ensure that so-

[3] MMR. Interesting Conflicts http://www.private-eye.co.uk. http://ombudsman.co.uk/_wsn/page3.html (last accessed January 1990): One leading health official responsible for immunisation has been working as an expert for the three defendant drug companies in the UK MMR court case since July 2002. Yet as far as the Eye can ascertain, she has never declared that potential "conflict" on any of her research papers. Dr. Elizabeth Miller, head of immunisation at the government's Health Protection Agency (HPA), Nowhere on Dr. Miller's papers does she declare that she is also an expert witness for the drug companies GlaxoSmithKline, Aventis Pasteur and Merck. How can Sir Liam Donaldson, chief medical officer, and his deputy responsible for immunisation, Dr. David Salisbury, justify their attacks on Dr. Wakefield for non-disclosure of an interest when their own staff appears equally compromised?

In minutes of the Joint Committee on Vaccination and Immunisation Pneumococcal subgroup for it's meeting on Friday 7 September 2007. (last accessed January 2009 at http://www.advisorybodies.DH.gov.uk/JCVI/mins-pneumococcal-070907.htm. Dr. Miller declares non-personal interests in vaccine manufacturers Wyeth and/or Sanofi Pasteur.

[4] Crickmore's ignorance of vaccination is clearly evident in this first sentence of his 'verdict'. Measles and Mumps vaccination had been in existence for many years prior to the introduction of MMR- in 1988. The return to these single vaccines is all that many parents and doctors have called for.

[5] December 09, 2008: On Media: Why I Hate the British Press Boy Georgie By Anne Dachel, Media Editor of ***Age of Autism***.

[6] The whole of this account, draws on the article by Allison Edwards, The Inquest into the Death of George Fisher, first published on www.cryshame.com (last accessed January 2009)

[7] See chapter 7 of Janine Roberts, ***Fear of the Invisible***, Impact Investigative Media Productions, 2008, and Progress Towards Assuring the Safety of Vaccines. The Academy of Medical Sciences: Forum. 20th April 2004 held at the Health Protection Agency Colindale. Published by the AMS.

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ciety is protected from adverse reactions, not just from vaccines, but also from food and pharmaceuticals generally.

In recent years, these two sets of responsibilities, of producers and of regulators, of private and public interests have become entangled essentially because of the developing corporate nature of our society. The entanglement, however, is far from simple. Today, for example, the UK's Health Protection Agency (HPA), the central government agency designed to protect the health of the public, is most concerned to protect the profits of those companies that damage public health. In relation to vaccines, the government and the pharmaceutical companies are interlocked on many levels. [8]

In respect of liability, very complex matters have now surfaced. Superficially, the drug companies feel that they have partly covered themselves by listing all possible adverse reactions and contraindications in their data sheets. And government agencies, such as the HPA, because they have been involved in the manufacture of vaccines and because they believe that the collective public health takes precedence over personal health, work continuously on an ideological footing to enforce a regime aimed at herd immunity and the ultimate eradication of certain diseases. Both agencies claim, for different reasons, that there are no serious adverse reactions to vaccination.

It is an unfortunate fact of life in Britain that, unlike in the US, successive governments, scientific establishments, and apparently independent academics, have fought hard against any revelation of vested or conflicting interests. Drug companies like GlaxoSmithKline (GSK) have found it easy to colonise Britain because the politicians of all hues have been snugly in their pockets. The debate over vaccine damage has been plotted and designed in its entirety by interested parties, whilst the parents, one of the only groups capable of telling the truth, have been cut out of the equation.

Of course, most might suggest profit will always be trying to find ways to cut corners and save money on inconvenient truths. However, others might say, the pharmaceutical companies are heavily scrutinised and called to account, while the mechanism of government committees are completely secret. As the argument heats up, another bright spark might bring it to a sudden stop with these words: 'Look, if the government was doing absolutely everything it could to protect not only the public health but individual health, why would they indemnify a pharmaceutical company against claims? Surely, if governments felt that they protected the people, they would be happy to maintain an entirely separate position, exempt from liability and completely separate from the drug companies'.

This question might have a number of answers. However, one of the underlying premises to any answer entails looking at what the government does in order to make every vaccine accepter fully conversant with the possible risk of adverse reactions. Does the government, through its various agencies, explain, from the outset, the possible adverse reaction risk of vaccination to all parents? The personal experience, sociology and the history of vaccination informs us that, few, if any parents are put through the complex family questions that all parents were originally meant to be asked on behalf of their children. At the most, parents today are asked, if anything, whether their children have, at the time of attending the surgery, a cough or a cold or other infective illness.

The Joint Committee on Vaccination and Immunisation

The Joint Committee on Vaccination and Immunisation (JCVI) was set up in 1963 and might from the beginning have been called the Joint Committee *for the Defence of* Vaccination and Immunisation. The committee was a product of and answerable to the Department of Health Medicines Division, a department that worked incestuously close to the pharmaceutical companies.[9] The committee's original brief makes no mention of this:

> To advise the Secretaries of State for Health, Scotland, Wales and Northern Ireland on matters relating to communicable diseases, preventable and potentially preventable through immunisation. In addition to their work on the Committee, members may be called upon by the Secretariat to give advice when matters arise on which the members' particular expertise may be of assistance to the public service. Members may also from time to time be requested to attend and contribute to the deliberations of one or other of the Panels of the JCVI.

In 1968, mainly as a consequence of the Thalidomide scandal,[10] an extra-government agency, the Medicines Control Agency (MCA), was set up to handle all pharmaceutical regulatory affairs. Despite constant chatter in the media about individual members' of four committees originally managed by the agency, no one commented on how the agency was being funded, or said anything about it being funded by pharmaceutical company fees for medicines licensing. In 2005, the Medicines and Health Care Regulatory Agency (MHRA) took over from the MCA; again this was a part of the UK Department of Health (DH) but totally funded by the pharmaceutical industry. The MHRA is, in fact, a trading company within the DH, it has its own police, pays for its own legal cases, and controls all the pharmaceutical regulatory bodies.[11]

The core of this essay looks at the way in which the JCVI has handled contraindications over the years. Understanding that the committee has frequently downplayed education and information to parents about contraindications and risks in fa-

[8] See: ***J Med Ethics*** 2003;**29**:22-26, Misled and confused? Telling the public about MMR= vaccine safety. C J Clements[1], S Ratzan[2]. http://jme.bmj com/cgi/content/full/29/1/22 (last accessed December 30th 2008.)

[9] In a recent interview, a previously well-placed regulator expressed the opinion to me that thirty years ago, things were so much better. People working in the Medicines Division, had consistent contact with their counterparts in the industry with whom there was a revolving door employment policy. If we had an adverse reaction to a drug, the interviewee said, we just picked up the phone and chatted to a colleague in the drug company and came to a decision, for instance to leave the matter for a couple of months and see what happened before taking any action. Now, the man said, with the power of multinational corporations, it was not possible to do business in such a collegiate manner!

[10] Although the Thalidomide scandal dragged on until the end of the 1970s and is to some extent still going on, it originally pertained to pregnant women who had taken the drug between1958 - 1961.

[11] See Martin J Walker. **The Fate of a Good Man: The investigation, prosecution and trial of Jim Wright by the MHRA**. Slingshot Publications. London 2007

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vour of obtaining the goal of herd immunity is vital to an understanding of the government's present position of vaccine-damage denial. Had government agencies, together with pharmaceutical companies, from the beginning steeped themselves in the science of sub-groups and vulnerable individuals, in an attempt to present a clear picture to the public of which children could be susceptible to vaccine damage and what the alternatives were for these small groups, there never would have been as many vaccine-damaged children as there are now nor would there have been a need for the shameful vaccine-damage denial.

The regressive, rather than progressive, defensive rather than transparent JCVI has determined that, over the years, many parents have had their children inoculated even though the full information regarding their child's vulnerability has not been disclosed to them. The exact responsibility for this lack of information clearly falls first upon the members of the JCVI and then on the civil servants who resolve policy in the DH. The heart of the vaccine policy resolved by 'experts' and civil servants has, for forty years, been the JCVI. This committee has been, for the majority of its life, intimately linked to the pharmaceutical companies. The committee has also been secretive and lacking in transparency to such a degree that its members clearly hoped to evade responsibility for their poor and sometimes criminal decision-making. This secrecy is shown by the fact that, even now, minutes of the meetings, some originally not made public for 'commercial' reasons, are still difficult to get hold of and even now have the names of participants blanked out.[12]

The Minutes of the JCVI during the 1970s and 1980s, show a constant state of vigilance and conflict between the Committee and the rights of the public and even, on occasions, a state of conflict between the Committee and the government. These conflicts have almost always been over the matter of how information to parents would affect the take-up or drop-off of vaccination.

Don't Mention Deaths from Vaccination

In one episode of the TV comedy series Fawlty Towers, Basil Fawlty played by John Cleese and his wife Sybil played by Prunella Scales, who run a boarding house in Torquay, on the English South Coast—sometimes referred to as the English Riviera—accept a party of German tourists.[13] At the start of their stay, Basil, possessed by a manic but hidden pathological chauvinism, warns everyone, 'don't mention the war'. He then proceeds to drastically undermine his own advice by making spooneristic references to the war while dealing with the German guests.

A similar comedy about the JCVI, might begin with a member reminding everyone not to mention deaths and adverse reactions to anyone, from which a committee meeting moves on to consider a whole host of deaths and adverse reactions which have in some manner to be 'talked away'. The comedy dialogue could be taken from numerous meetings of the JCVI that contain classic lines such as: 'Mr. _____ spoke of the risk to the MMR programme of adverse publicity and said that vigilance by all was essential'.[14]

On the 17th February 1986, at their first meeting, the JCVI subcommittee on adverse reactions discussed six deaths, reported through the 'yellow card' notification scheme,[15] that had occurred between 19th September 1985 and 15th January 1986 - a period of 4 months.

By 1986, the JCVI and the ARVI had a strategy for dealing with deaths. This strategy was, through 'expert' witnesses, to argue to coroners and other public officials that the deaths should be reported as natural or as SIDS. The six deaths associated with DTP discussed at the ARVI meeting were:

A three month old boy found dead 18 hours after vaccination. (PM result not known).
A three month old girl found dead three days after vaccination.
A six month old girl found dead the morning after vaccination. (Coroner's finding of SIDS).
A eleven month old girl with congenital heart disease and a missing spleen.
A four month old girl died two hours after her vaccination. (Coroner's finding of SIDS).
A healthy infant boy vaccinated during the day of 14 January, found dead 6am. 15th January. (Coroner's finding of SIDS).

It should be noted before any comment on these cases, that the severely immune impaired young girl, case 4, should never have been vaccinated.[16] The report of the discussion that ensued took up all of six lines in the minutes and one unnamed person summed it up by suggesting: 'it was agreed that timing in relation to death and time of vaccination was critical'. What this means is not clear, however, this vague concept has always been used to confuse observers - the child dies either 'too soon' or 'too late' after vaccination. The meeting decided to pass these cases back to the JCVI and thought that they would probably get them back again ... good committee practice! One of the members of the committee who discussed these six deaths, looking for a time-link loophole was Professor D. Hull. Sir David, as he was later to become, was a member of the JCVI almost from its inception.

The JCVI's involvement with SIDS has been more in the way of an embarrassed flirtation than a consummated relationship. Committee members appear to have been very wary about making public the word, vaccination, in conjunction with the word, death. Rarely, if ever, was there an offer to the JCVI to carry out research into vaccination and SIDS, clearly most people in the know, knew, this was not the way for the commit-

[12] Minutes of the JCVI can be obtained by Googling 'How to get minutes of the JCVI meetings?' and are currently available from URL: http://www.advisorybodies.DH.gov.uk/jcvi/minutes.htm

[13] The Germans: BBC, Fawlty Towers Series One, Episode Six — First shown 24 October 1975.

[14] JCVI Minutes of 3rd November 1989.

[15] Even the Committee for the Safety of Medicines, concluded that yellow card reports represented only one tenth of all actual adverse reactions.

[16] Whenever there is a death from wild measles, the DH and the science lobby groups maintain that the child would not have died had they been vaccinated. However, in a number of these cases the victim was seriously immune deficient and therefore more seriously affected by the virus. Exactly the same principle applies to vaccination. In fact, the logical course in this case would be to have informed the police and had the doctor who administered the vaccination charged with manslaughter.

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tee to go. But, in 1995, enterprising statisticians in the Department of Health and Social Security (DHSS) came across the idea of looking in a slightly more resolute manner at whether there was or was not a link between vaccines and SIDS. The DHSS memorandum suggested that it might be worthwhile to look at background levels of SIDS in the absence of vaccination.

A few months before he became chairman of the JVCI in 1996 and while he was Professor of Child Health at the University of Nottingham, Professor Hull was sent a DHSS memorandum, which having already been mentioned at a previous meeting of the JCVI was due to be tabled again for discussion at the next meeting. The short paper reflected on the incidence of SIDS and deaths following vaccination. It seems that the JCVI sent on the proposal to Hull at his department in Nottingham University. So that he might give his professional opinion outside the JCVI meetings, Hull showed the paper to another professor of Epidemiology and Public Health, at Nottingham, Richard Madeley, then a member of staff in the Community Medicine & Epidemiology Department of Child Health.

On the 13th December 1995, Hull wrote back to the Senior Medical Officer at the Department of Health and Social Security, including Madeley's report, with which he noted, he was in complete agreement. Both men concluded for a number of reasons, that epidemiological research into vaccination and SIDS would be a wasted exercise. The first half of Madeley's report, in answering the DHSS paper, looked at the hypothesis that vaccination might cause SIDS, while the second part referred to the statement from the DHSS Statistical Division that suggested further research on the basis of a breakdown of SIDS cases both in conjuncture with vaccination and the absence of vaccination.

At this distance in time and without a proper scrutiny of the proposition made by the DHSS Statistical Division, it is difficult to assess the profitability of the research suggested. It is clear, however, that some research, perhaps a large post-mortem clinical study looking at the association between SIDS and vaccination was needed, principally because concerned parents had raised the issue time and again and because the JCVI seemed to be using the catch-all diagnosis of SIDS, that apparently had nothing to do with vaccination, to cover all sudden infant deaths.

Madeley's report made the following concluding remarks:

> For those reasons, I think it would be extremely unwise for the DHSS to get involved in any type of epidemiological work on this hypothesis. The hypothesis seems most unlikely on grounds of basic scientific reasoning and such evidence as already exists points in the opposite direction (away from any link between vaccines and SIDS).
>
> To go ahead in these circumstances would endow upon the hypothesis a respectability which it does not deserve. It is impossible to disprove through numbers. To try to do so, using flawed assumptions, as in the memorandum of the DHSS Statistics Division, weakens the position.

On January 30th 1986, the Joint Working Party of the British Paediatric Association and the JCVI sat and, under item 7, was the heading: *Reservations of Professor Hull concerning publication of data on background rates for SIDS, convulsions and encephalopathy which occur in absence of vaccination.* The committee spent a short time, discussing this issue before it was agreed that the suggestion from the DHSS was not a sound one and that the suggestion was anyway coming up before the committee on adverse reactions and perhaps should be deferred meanwhile. All reference to research papers and hypotheses are obliterated in this short minute and so the item makes next to no sense. However, committee members show some considerable confidence in a hypothesis of their own which had not been researched. Off-the-cuff, it was noted, that high numbers of SIDS appear to coincide with high levels of whooping cough. *Ipso facto*, SIDS was probably caused by whooping cough and not vaccination.

Although Professor Hull was not quoted in any of the JCVI minutes as particularly concerned about the issue of SIDS in relation to vaccination, some twenty years after these issues were discussed in the JCVI, he was moved to write to Professor Zuckerman at the Royal Free Hospital to express concern about the work of Dr. Andrew Wakefield that intimated a link between MMR vaccination and serious adverse reactions including gastrointestinal conditions and regressive autism. Sir David Hull became, in fact, the person who threw the first stone at Dr. Wakefield.

A Bad Take-Up Day in Maidstone

There was considerable consternation when, in 1986, there was a failure to attain measles immunisation uptake-levels inside the Maidstone Health Authority area. To enquire into this, the JCVI sent in a team consisting of a Dr. Lakhani and others from the Department of Community Medicine, St Thomas's and Guy's Medical and Dental Schools.[17]

When their report came back to the meeting of the BPA, JCVI and ILG working party, the anonymous Chairman[18] was really fed up because the report described a position where local health workers were telling parents the truth about the vaccine and had consequently developed a long list of *'so-called reasons'* for withholding measles vaccine. The report, he said, 'was very disheartening', adding, 'A small minority of health professionals were [sic] causing disproportionate harm' (where have we heard that before). Parents *who wanted vaccination* were actually being dissuaded from having it by Health Service staff.

What might they do about this, the committee had pondered: It really wasn't good enough that parents were being told the truth about possible adverse reactions. At a previous meeting of the JCVI, it had been decided to select 'responsible people' in each health authority area and the Chairman suggested that these people would be the best ones to carry out training in how health service staff might interface with parents and what they should be told about contraindications and risks of adverse reactions.

[17] Minutes of the Joint Working Party of the British Paediatric Association and the Joint Committee on Vaccination and Immunisation Liaison Group Tuesday 30th September 1986.

[18] This seems to be the Chairman, but, as his position is obliterated for reasons of secrecy, we can't be sure.

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Convulsions: Now You See Them Now You Don't

Moving away from these broader issues and coming to the individual child, in many cases we see that convulsions and fits are at the centre of many of the diagnostic conundrums facing vaccinators. Febrile convulsions fit into the vaccine scenario in two different ways; while vaccine-damage-deniers are constantly telling us that vaccines do not *cause* convulsions or fits, they usually completely forget to bring up the matter of febrile convulsions as a *contraindication*. Up until the 1980s, it was generally accepted that one fit in a child prior to vaccination was sufficient reason for the parents to claim exemption from vaccination.

The JCVI has altered or messed about with nearly all the warnings of contraindications that have given parents an opportunity to 'opt out' since coming into existence. However, because relatively large numbers of children have febrile convulsions prior to age two and full disclosure of information about this might deter parents from vaccinating their children, denting the possibility of herd immunity, the JCVI has consistently been unwilling to make research data about convulsions available to parents.

Enforcement of this particular exemption could exclude somewhere in the region of 2,000 children per 100,000.[19] In a contemporary study by Tahir Saeed Siddiqui,[20] out of 100 children who suffered febrile convulsions, 55 male and 45 female, forty-four percent of sufferers had a first febrile convulsion before the age of 12 months and 56 percent of sufferers after 12 months of age. Febrile convulsions were complex in 35 percent and simple in 65 percent of the affected children. In this study, a positive family history of convulsions led to an earlier onset in children, around 15 months as against 21 months in those with no family history.

The Report on Whooping Cough Vaccine published by the Department of Health and Social Security, in 1981, lists one febrile convulsion prior to vaccination as a contraindication for a number of different vaccinations, for instance whooping cough vaccination itself and measles vaccine. Unfortunately, the JCVI in the 1970s spent enormous energy fighting off the view that if febrile convulsions occurred after vaccination, no causal relationship could be proved, when in fact the most important question about febrile convulsions was whether their occurrence prior to vaccination was a contraindication and whether they should be seen as constructing a wider picture that might act as a warning to parents not to allow their children to have the vaccination.

Further evidence from 1986, demonstrating that the JCVI seemed more concerned with uptake than child safety, can be seen by their response to a report from the US of a strong correlation between children who suffered seizures after whooping cough vaccine and family members with a history of fits. The committee more or less ignored the report. Again, they were apparently concerned that if they were to alter the recommendations for the vaccine it could result in fewer eligible children and a drop in uptake figures.

At a meeting of the JCVI in March 1980 and for some time before the meeting, members reviewed the information concerning cases between 1970 and 1975 handed to them by the Association of Parents of Vaccine Damaged Children (APVDC).[21] The Association had been campaigning mainly against the adverse reactions caused by pertussis (whooping cough) vaccine. The JCVI/CSN sub committee on adverse reactions had tendered a report to the meeting about these figures.

The first thing the committee stated before it began its run-through of the seven points made in that report was about the press. Cases had been classified as 'likely or unlikely to be due to the vaccine' and members of the sub-committee commented that any incidence figures, however guarded, would be 'seized upon by the news media'. This has been a common theme with both manufacturers and regulators that the media are responsible for amplifying non-scientific information about vaccination and other drug adverse reactions.[22]

The last item on the list of seven observations made by the subcommittee drew attention to the fact that a number of cases of children who had experienced adverse reactions to whooping cough vaccine exhibited contraindication prior to vaccination. This is a good point and one wonders why, in that case, they had been vaccinated!

Measles vaccination, in two brands, manufactured by Wellcome and Glaxo, was first introduced in Britain in 1968. In 1969 the Wellcome brand of measles vaccine Wellcovax was withdrawn following two (declared, but there must have been more) alleged cases of encephalitis. When these single measles vaccines were the order of the day, febrile convulsions were commonly recognised as a consequence. In order to protect certain children, who had either a personal or family history of convulsions or fits, such children were given immunoglobulin, at the same time as they received their vaccination. The immunoglobulin had a marked effect in reducing fits.[23]

In 1986, clearly on the edge of changing its mind about immunoglobulin, the JCVI recommended that this policy be discussed by the JCVI/ BPA Advisory Group. Looking at the Lingham paper,[24] that discussed the use of immunoglobulin, the committee 'were unconvinced by the arguments in the paper' of

[19] In a large American series, 18.8 per 1,000 children aged up to two years had at least one convulsion ... many children would have more than one convulsion. Van den Berg, B. J. and Yerushalmy, J. Studies on convulsive disorders in young children. Incidence of febrile and non-febrile convulsions by age and other factors. ***Pediatric Research***, 1969, **3**, 298-304

[20] Tahir Saeed Siddiqui, febrile convulsions in children: relationship of family history to type of convulsion and age at presentation. Department of Paediatrics, Ayub Medical College, Abbottabad. Pakistan http://www.ayubmed.edu.pk/JAMC/PAST/14-4/Tahir.htm (last accessed 22nd December 2008).

[21] The APVDC was set up by Rosemary Fox and others in an attempt to fight vaccine damaged caused by DTP and single whooping cough vaccine. The campaign which found the support of Jack Ashley MP and considerable press coverage, was entirely successful leading to the setting up of the Vaccine Damage Payment Unit and the recognition, despite causality not being scientifically proven, of vaccine damage from whooping cough vaccine.

[22] See Martin Walker, Vaccine damage and the British Press. ***The Autism Files.*** January 2009.

[23] The immunoglobulin was given in one arm as the vaccination was given in the other. One research paper (Lingham *et a*l) that looked at the effectiveness of immunoglobulin, administered to children who had a family history of fits, contained the following quote; 'The conclusion was that the reactions were mild and the antibody response satisfactory when these vaccines were given with immunoglobulin but that the vaccines were not suitable for use alone'

[24] Antibody response and clinical reactions in children given measles vaccine with immunoglobulin. S Lingham, CL Miller, M Clarke and J Pateman ***British Medical Journal*** (Clin Res Ed) 1986 April 19th, **292** (6527): 1044-1045

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the good done by the use of immunoglobulin. 'The immunoglobulin had to be specially ordered', making 'The whole concept', they said, a 'disincentive to parents'. Obviously a real drag!

The approach of the JCVI to research coming from outside the committee and to published papers with which they disagreed ideologically, is quite frightening. A paper by Hirtz *et al* from 1983[25] discussed a group of 20 children who had seizures post vaccination. More than half had either suffered previous fits or had family members who had had fits; this paper got the familiar short-shrift treatment.

In 1985, another US study[26] pointed to the large number of fits in individuals who had been vaccinated with whooping cough vaccine, therefore arguing that more attention should be drawn to fits as a contraindication. Again committee members 'observed that changing this recommendation might decrease the number of children available for vaccination against Whooping Cough.'

In 1986, the JCVI reviewed a paper in the ***BMJ*** titled 'Antibody response and clinical reactions in children given measles vaccine with immunoglobulin.'[27] S. Lingham *et al.*, but was completely cynical about it.

In reviewing a paper published in the ***BMJ*** in 1986 on the long-term sequelae to whooping cough, the JCVI inadvertently blew the whistle on the breathtaking brainlessness of its members. In discussing the paper Mr. _____ makes a comparison with a study carried out by Mr. _____ and his colleagues, and also to those by Mr. _____.[28] How is it possible to censure the names of the research workers who have written a paper? Was the paper peer reviewed, was it published? Perhaps it was just a piece of the usual off-the-cuff speculation, in which case the authors did need protection. Here, in the record of one of the important committees of the British Government in the area of health, while discussing issues of immense public interest, the committee had the names of academic researchers censured from its minutes. You have to ask, is there any hope for these people?

The subcommittee of the CSM /JCVI, on adverse reactions to vaccines, held its second meeting on the 6th July 1987 at 10.30 in the Market Towers building. The meeting was noted as 'commercial' and 'in confidence'. David Salisbury was there representing the DHSS. In fact the DHSS had six participants in the meeting. It was decided, to considerable relief of most attendees, that measles specific immunoglobulin would be stopped with the advent of MMR, leaving vulnerable all those people who had previously been afforded protection by the administration of this valuable safeguard. Anyway, it was said by someone who didn't dare have their name mentioned, that, although it was necessary in conjunction with early measles vaccines, it *may not* be necessary with newer measles vaccines.

The truth was that members of the JCVI were always concerned that the use of immunoglobulin represented a disincentive to parents to vaccinate and so the committee took some pleasure in the arrival of MMR because they could immediately stop the prescription of immunoglobulin. Firstly, because they guessed that it might interfere with sero-conversion to the mumps and rubella components.[29] Secondly, though less publicly, as MMR covered an age range from 2 to 10, with booster shots, it meant that the cost of immunoglobulin would rise considerably.

When it came to medication that might control convulsions in vaccinated children, as well as the successful immunoglobulin, committee members were quick off the mark with new technology. If vaccination really did jeopardise the safety of some children, while they couldn't be bothered to identify subgroups, they would do their best to help children who had fits. In some European countries, children with a history of fits were given anti-convulsants. But the JCVI could go one better than this: parents of children likely to have fits, could be given valium - a major best selling tranquilizer, that hadn't been tested for children, but then what had! It could be administered anally while their children were having fits - nothing could be simpler. The meeting also agreed that perhaps studies in the control of febrile convulsion were needed.

Finally this committee meeting agreed that far from preparing further items for a list of contraindications, a list of conditions that were *'definitely stated not to be contra-indications to vaccination e.g., allergy'* should be created. Yes, this definitely appeared to be the most scientific way to go about this problem, a list should be prepared for parents and doctors of conditions that *were not* contraindications to vaccination. This list would look really impressive, and could have on it everything from wet feet to hair lip and gout, to show parents that they could approach vaccination fearlessly.

As for allergy, everyone knew now that no child could ever have an allergic reaction to any of the component parts of vaccines or any condition associated with vaccination. After all, hadn't the JCVI now written in its recommendations that only children at risk of anaphylactic shock from eggs and egg products should have their vaccinations in hospitals? Oh, but I was forgetting, as you will read later, the committee had taken egg intolerance off the list of contraindications because it was so rare.

Research in the year 2000 based in the USA, linked mitochondrial encephalomyopathies to epileptic disorders and fits of various kinds. Spasms are the most common seizure type and seizures of different kinds were one of the most common indicators of mitochondrial disease. The research showing children with mitochondrial disorders were susceptible to sequelae following vaccination led to evidence in the Hannah Polling case that gained her compensation for regressive autism developed as a consequence of vaccination.[30]

In December 2008, another case was resolved by the US courts. This involved a young boy named Benjamin Zeller, who was born in 2003 and given his MMR vaccination in November

[25] Hirtz D.G., Nelson K.B and Ellenburg J.H, Seizures following childhood immunisation. ***Journal of Paediatrics,*** 1983: Vol. 102, pages 14-18. Cited in the Minutes of the Joint Working Party of the British Paediatric Association, JCVI liaison group, 26th June 1986.

[26] History of convulsions and the use of pertussis vaccine. Harrison C. Stetler *et al*. ***Journal of Pediatrics*** 1985. Vol 107; pages 175-179.

[27] Antibody response and clinical reactions in children given measles vaccine with immunoglobulin.[27] S. Lingham, CL Miller, Marian Clarke and Jane Pateman. ***BMJ***

[28] JCVI 25 April 1986.

[29] It was suggested in committee meeting - Committee on safety of medicines/ JCVI/ Joint Sub-committee ARVI, 6th July 1987 that immunoglobulin might interfere with the sero-conversion of the Rubella and Mumps strains.

[30] David Kirby, New Study - 'Mitochondrial Autism' is Real; Vaccine Triggers Cannot Be Ruled Out. ***The Huffington Post*** November 28, 2008.

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2004. Benjamin had a febrile seizure within a week of being given MMR. Although doctors saved his life following the seizure, he was brain damaged. The judges in their ruling were quite clear that without the MMR vaccination Benjamin would not have had the febrile seizure that damaged him.

Back in England the death of a 17-month-old Scottish girl, Anna Duncan, raised similar questions to those raised by George Fisher: are regulatory bodies ignoring reports of serious illness and death following MMR vaccination. [31] Anna Duncan was exposed to chickenpox at a party just before receiving her MMR vaccination. She broke out with classic chickenpox days after she was vaccinated and died ten days later from an apparent febrile convulsion. Anna's mother, Veronica Duncan, told the healthcare worker at the time of the vaccination that Anna had been exposed to chickenpox but she was told there was nothing to worry about. In fact, 'other viruses' have always been recognised as a contraindication to vaccination. As in the case of George Fisher, the Duncan family has been living with the pain of Anna's uninvestigated death for two years. The Inquest is expected to be heard early in 2009.

While this legal and medical search for definition of contraindications and adverse events goes on in North America, in Britain researchers won't touch the subject for fear of being attacked mercilessly by the State and the pharmaceutical industry.

MMR

The mumps, measles and rubella (MMR) vaccination developed by Merck Sharp and DHme (MSD) in the United States of America, where it was licensed in 1971,[32] was given a license in Britain in 1972 but not marketed until 1988. The reason that it was licensed for 16 years prior to being implemented remains a mystery. Even before the introduction of MMR, as early as March 1988, the following passage appears in the Minutes of the Joint Sub Committee on Adverse Reactions to Vaccinations and Immunisations:

> Five cases of mumps encephalitis following MMR have been reported from Canada. Four of these cases definitely followed the use of vaccine containing Urabe Am 9 mumps virus and the fifth probably did.

The members of the JCVI Working Party on MMR also debated the Canadian situation, noting that a decision had not been made by the Canadian authorities to suspend the licenses of MMR vaccines containing the Urabe strain and conclude that 'the data on which the decision had been based was slender.'

As the introduction of MMR approached, the committee spent some time discussing what the contraindications and risks would be and what could be done about parents who refused the triple vaccine. The answer to this last matter was easy: 'for a limited period' they would be offered the single measles vaccine. But, after that limited period, MMR was to be almost compulsory and children starting nursery or primary school, who had not received the vaccination would have to show either: a documented record of MMR vaccination; ***a valid contraindication;*** parental refusal or laboratory evidenced immunity to measles, mumps and rubella.

If proof were required of how the immunisation up-take rates dominated all decisions made by the JCVI about susceptibility indicators, we need look no further than the way in which the contraindications of other contemporary viruses was quickly changed, without the slightest scientific information that it would no longer be a problem. Prior to MMR coming on the market in 1988, safety advice about all single vaccines contained the instruction that there should be a three-week period between live-virus vaccinations. After 1988, this instruction, which could not logically be maintained with a triple vaccine, was completely dropped.

The first acknowledged mishap with MMR occurred apparently in 1992, when it was announced that Urabe Mumps strain contained in two MMR products was associated with serious adverse reactions. However, the fact that both these vaccines had been found to produce very serious adverse reactions in other countries was not mentioned.

In March 1989, MMR (Urabe AM-9) was introduced in Japan and, by September 1989, the first post-vaccine cases of aseptic meningitis were reported to the Japanese Public Health Council.[33]A few months later, in 1990, when MMR has already been distributed for two years in Britain, the matter of data of serious adverse reactions in Japan was discussed at a May JCVI meeting, under item 9.1b. The records report:

> Of special concern to the ARVI were the reports from, Japan, of a high level of meningoencephalitis associated with the administration of MMR. However, ARVI concluded that the Japanese experience may be due to different reporting/investigating criteria or other local factors.

And these people call themselves scientists! *'ARVI concluded'* and *'may be due to'* and *'other local factors',* these are off-the-cuff remarks inside a secret meeting. There is no sense or logic or rationale to them, there is no evidence presented, there is only an evident and complete desire to dismiss the reports from Japan. No talk of setting up a small study in Britain amongst child encephalitis victims who have received MMR.

And minutes of a parallel meeting of the JCVI[34] headed by Professor Salisbury contained reference to some concerns but not relating to the vaccine's safety. The JCVI expressed concern *that details of the vaccine's dangers were to be published in the UK*, thereby exposing the problem and causing a scare. JCVI members were apparently less concerned about the fact they had licensed a vaccine that was now associated with meningitis, and more concerned about the Japanese data being published and the public being warned about this circumstance.[35]

In 1992, when the withdrawal of the vaccine was announced by Professor Calman, Chief Medical Officer at the Department

[31] Dan Olmsted, Anna's Last Days 2, ***The Age of Autism***, Friday, 14 July 2006,
[32] Strebel, P., et al., **Section 2: Licensed vaccines: Measles vaccine, in Vaccines**, S. Plotkin, W.A. Orenstein, and P. Offit, Editors. 2008, Saunders Elsevier. p. 363.
[33] see http://www.nih.go.jp/JJID/55/101.pdf.
[34] JCVI Minutes 4 May 1990 Article 9.2g.
[35] A C Golding, A Time to Revisit Decisions? August 2008. alangolding.blogspot.com (last accessed January 2009)

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of Health, he went to some lengths to claim that the withdrawal had nothing to do with previously received data from Japan and Canada, stating that a British team from Nottingham University, had tested the spinal fluid of all children admitted to Nottingham Health Authority hospitals after vaccination to check for meningitis and, after this study' had found a number of cases of aseptic meningitis, the DH had acted to withdraw the vaccine.[36] Calman, however, left out the part of the story where maligned forces fought the doctors who carried out this research when they tried to publish their results in the ***Lancet***. The researchers won and it was only after the publication of their paper that the government acted on the results.[37]

Persuading the manufacturers to move the goal posts

In 1986, at the Working Party of the British Paediatric Association and the JCVI liaison group[38] there were concerns over the uptake of whooping cough vaccines. The commonest reason for 'withholding' (from an eager public) whooping cough vaccine was a history of seizures in the child subject or a family history of seizures.

The committee, not content with the facts of this situation, tried to blame the medical reality on the wording of the 'contraindication' in respect of this vaccine and noted how it lacked clarity. There was a suggestion that the advice on contraindications should be altered to deal with the problem of withholding whooping cough vaccine when there is a history of seizures.

The JCVI was primarily concerned with the fact that if they altered the recommendations for the vaccine it might result in fewer eligible children and an equivalent drop in uptake figures. In a similar situation,[39] in1984, the JCVI decided that children under 15 months should be vaccinated against measles, despite the fact that the manufacturers data sheet said specifically that babies under 15 *months could not be vaccinated against measles.* It was not just the manufacturers data sheet that argued this point but also academic and clinical opinion in the USA.

In the meeting of 25 April 1986,[40] JCVI members found themselves in a pickle because they wanted to give the whooping cough vaccination to older children and spread the market. However, the data sheet stated very clearly that it was not to be used on children over six. After a brief discussion, during which the group admitted that they knew nothing about the short- or long- term effects of whooping cough vaccine on older children, the committee decided to approach the manufacturers and ask them to change the data sheet information so that they could vaccinate older children with the same vaccine.

It is, however, the grounds they articulate that shows them to be working to some hidden agenda—older children could be vaccinated with whooping cough vaccine, *as long as it was for the purpose of protecting younger siblings.* In other words, although the vaccine manufacturers data sheet suggests that children over six should not be vaccinated with whooping cough vaccine, the JCVI suggests that those children over six who either have younger brothers or sisters, or mix with younger children, should be vaccinated, to protect those younger children. Intellectually this proposition doesn't stand up. Scientifically it represents the promotional material worthy of a snake oil salesman.

In the case of MMR and seizures or fits, the JCVI was having none of it. Instead of complying with and endorsing the stance of the drug company's data sheet warning of a history of fits, they send a message to the Medicines Division asking them to approach the drug companies and ask if they would alter or modify the advice in their data sheet.

By 1987, especially in relation to whooping cough vaccination, the JCVI and the Joint Sub-Committee on ARVI, had taken the bull by the horns and were rewriting the data on contraindications. What's more, they were going back to the drug companies and the BNF, asking them to get into line with the JCVI on changed data sheets and other information resources. The final sign of collusion between the JCVI, the government and the vaccine producers, is that the JCVI were actually calling on the producers to change the data on contraindications.

For the JCVI, the resolution to an impossible problem they encounter, is amazingly simple - just ask the manufacturers to change their data sheet. A review of the minutes of the JCVI between 1972 and 1986 reveals that the JCVI asks the manufacturers to liberalise their data sheets on at least eleven occasions. This conniving between the JCVI and vaccine manufacturers raises a considerable question of responsibility. If the vaccine manufacturers are independent of any government agency, they would be very skeptical about changing the details of their data sheet in relation to contraindication simply because they would be left wide open to law suits and claims for compensation of all kinds.

Pregnancy

It would be good to think that pregnancy has always been the irremovable contraindication that applies to all vaccines and for that matter the majority of allopathic drugs, but, in 1973, one of the most concerning alterations to contraindications took place to the data for Smallpox vaccine.[41] The JCVI agreed with their own Smallpox sub-committee that pregnancy should be removed from the list of contraindications and replaced with advice suggesting merely that pregnancy at the time of vaccination *should be avoided if possible*! By 2004 wiser council had prevailed again and pregnancy was returned as a contraindication.[42]

Egg Allergy

Egg sensitivity has been downplayed in modern times compared with the situation in the original MMR Product Licence.[43]

[36] Using lumbar puncture as a diagnostic aid is one of the charges levelled against Dr. Wakefield and others in their ongoing trial at the General Medical Council.

[37] Jeremy Laurence. Research team's work led to withdrawal of children's vaccines. ***The Times***, September 16 1992.

[38] meeting of 26th June 1986

[39] JCVI on the 19th October 1984

[40] JCVI 25April 1986.

[41] Report of Meeting of the Smallpox vaccination sub-committee. 8th October 1973.

[42] Pregnancy or planning pregnancy in the next month, or breastfeeding. http://www.scotland.gov.uk/Publications/2004/12/20464/49160 (accessed December 2008)

[43] Product License No. 0025/ 0078, for MMR. II vaccination 1972.

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In 1972, the contraindication with respect to egg allergy included not only eggs, but also the birds and their feathers. Clearly, the inclusion of feathers broadened the contraindicated group to those who suffered asthmatic type reactions to such things as feather stuffed pillows. Those who reacted to eating duck and chicken were also contraindicated in 1972.

In order to bring people back into the MMR vaccine fold, egg allergy has undergone consistent change. In its mid stage, light allergy to egg was not a problem, however if anyone had previously suffered anaphylactic shock from egg or products containing egg, then they should consider deferring the vaccination.[44] What deferring means is not clear, because anaphylaxis is rarely a temporary or short-term condition.

By 2007 egg sensitivity was no deterrent at all and even those who have previously experienced anaphylactic shock from eggs were not excluded. Although, if any note is taken of the condition, the vaccination is supposed to be given in safe surroundings with a Medipen available.[45] While the DH say that this transition has occurred following two studies of egg intolerance and MMR, this scientific approach would be more believable if allergy to eggs in any form was not still a seriously pursued contraindication for administration of the flu vaccine, for instance.

An Attitude Problem

In the 1970s, the JCVI and the APVC discussed 'the complex question of warnings about the risks of adverse reactions from vaccination and immunisation'. The APVC had raised this issue during the early 1970s, because they felt that there was little information available from the department.

> It would be generally agreed that it was the responsibility of doctors to identify patients with contraindications to vaccination: what was more doubtful was the extent to which parents generally should be warned of risks that were normally so remote.

In a meeting held in the second part of 1977, the committee discussed the fact that, while their advice on contraindications had been issued to doctors and nurses, there was still no advice issued on this matter to parents. This was because the committee was still awaiting information from the medical defence organisations that represented doctors.

The doctors were considered the primary individuals whose interests should be considered in liability and responsibility for vaccine damage. Both the industry and the government were keenly aware of this. It was after all no good giving the industry and the government protection while providing no protection for those on the front line. As for parents, they weren't professionals and could be offered no protection against making serious errors of judgment!

Conclusions

Forty years ago, in 1967, Sir Graham S. Wilson MD,[46] a former Director of the Public Health Laboratory Service in England and Wales published the ultimate book on adverse reactions to vaccines. **The Hazards of Immunization** comes as a breath of fresh air to anyone in the crowded carriages entrained in the present claustrophobic arguments around vaccine damage. In his book, Sir Graham lists and then writes chapters on 25 circumstances in which a variety of vaccines might be damaged in production, might be damaging, or might damage certain individuals.

Looking at the book now, any objective reader might weep at the signposts on the road, walked past blindly by the medical establishment. Wilson comes to the most sensible of conclusions that, forty years later, in today's climate, sound like the most serious heresy. Wilson's advice coincides with the contemporary idea of a precautionary principle, which, as a model, absolutely fits the history and the practice of MMR. Wilson says:

> The inherent dangers of all vaccination procedures should be a deterrent to their unnecessary or unjustifiable use. Vaccination is far too often employed, especially in the developing countries, to avoid the tedious, troublesome and sometimes expensive process of improving personal and environmental hygiene.

Having gone through everything that can be wrong with a vaccine to create an adverse reaction, Wilson moves on to contraindications - factors known or not known to the individual subject that might lead to adverse reactions - arguing, what any good scientist would argue, that we are dealing with idiosyncratic presentations and with subgroups.

> Most important is to realise the potential dangers of mass immunization. *In such an operation time does not permit an inquiry into the suitability of each individual subject for vaccination*. An allergic history, such as that of sensitivity to egg protein, horse dander, horse serum, or penicillin; a history of eczema either in the subject to be vaccinated or in a member of the family; a history of asthma from whatever cause; any stage of pregnancy; the presence of certain blood dyscrasias;[47] current treatment with corticosteroids, irradiation or alkylating agents; recent administration of other vaccines and sera; as well as the age, general health and state of nutrition - should all be taken into consideration before a person is inoculated . . . but this is not possible under the conditions of mass immunization. The ideal in any country is for the routine immunization of children to be so well organised that mass immunization should, seldom, if ever, be called for. This is perhaps a counsel of perfection, but it is the only

[44] September 2007 information from Medical Information department UK in which it is clearly stated there is no problem with egg sensitivity etc.

[45] http://library.nhsgg.org.uk/mediaAssets/hepcmcn/Immunisation%20Against%20Infectious%20Disease%202006.pdf. This page from "Immunisation Against Infectious disease" (2006) by the DH also alters the position on egg sensitivity.

[46] Sir Graham S. Wilson MD, LL.D., F.R.C.P., D.P.H.

[47] Dyscrasias is a nonspecific term that refers to any disease or disorder. However, it usually refers to blood diseases.

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way in which the dangers unavoidable in mass immunization can be circumvented.[48]

More recently, in 2008, in a desperate but still dissenting plea for the identification of subgroups and for testing of individual children to ensure that they would not be adversely effected, Dr. Bernadine Healy, a former Director of the US National Institutes of Health, called for a scientific approach to the problem. In a powerful video interview,[49] Healy called for more research into a possible vaccine autism link. Perhaps more importantly, she endorsed the idea of subgroups that should be studied because members of these groups might have increased risk of certain specific adverse reactions.

> This is the time when we do have the opportunity to understand whether or not there are susceptible children perhaps genetically, perhaps they have a metabolic issue, an immunological issue that makes them more susceptible to vaccines in the plural, to one particular vaccine or to one component in a vaccine, say mercury. So we now know in these times, to take another look at this hypothesis, not deny it. We have the tools today that we didn't have ten years, twenty years ago, to try and tease that out and find whether there is a susceptible group. A susceptible group does not mean that vaccines are not good. What the susceptible group will tell us is that there are individual children, or a group of children who should not have that particular vaccine or that combination of vaccines. If we did identify a particular risk factor for vaccines, I do not believe that the people would lose faith in vaccination.

Healy did more than identify a scientific pathway to dealing with susceptible children. She is quite clear when she suggested the reason why the medical-scientific community shied away from making public the reasons for susceptibility.

> I think that governments have been too quick to dismiss the concerns of these families that there is a link between vaccines and autism. Doctors and physicians should be out there studying populations of children who got sick a few weeks after the vaccine. A report from the Institute of Medicine in 2004 said, don't look for susceptibility groups. I really take issue with that conclusion. The reason they didn't want to look for those susceptibility groups was that if they found them, however big or small they were, that this would steer the public away. I don't think that you should ever turn your back on any scientific hypothesis because you are afraid of what it might show.
>
> If you read the 2004 report, there is a completely expressed concern that they don't want to pursue a hypothesis because that hypothesis might be damaging to the public health community at large by scaring people. One should never shy away from science. One should never shy away from getting causality information. The fact that we don't want to know those susceptible groups is a real disappointment to me, if you know who they are, then you can save those children. If you turn your back on the knowledge that there is a susceptible group, it means that you are ... (words fail Healy at this point but she intimates something like 'dooming those children') ... The question has not been answered

Forty years separates these statements from Wilson and Healy, about the dangers of mass vaccination. Unfortunately, during those forty years, the pharmaceutical industry has gained a massive ascendancy in the field of public health. Even when someone as well qualified and as brave as Bernadine Healey speaks out, contemporary observers can feel only a terrible despondency: How you make multinationals accountable to the people and ensure that their executives are honest? How you create a sense of moral regeneration in a quickly deteriorating developed society? These are questions that will probably overshadow the rest of this century.

The statements of Wilson and Healey suggest two solutions to the problems of both contraindication and a high standard of vaccine health care for the whole population, not just those that can keep up with the herd. At first sight, it might appear that the two novel approaches are at odds with each other: Wilson argues for a quieter community involving a healthcare system that has continual and updated contact with both children and their families, with proper record keeping and continuous surveillance. Wilson believes that when children reach the age for vaccination, their community medical personnel should be completely up to date with any possible susceptibilities.

Healey, on the other hand, doesn't address the issue of medical surveillance and care in the community but suggests that now, when science and technology are ready to conduct complex tests, such tests should be used to look at idiosyncratic susceptibilities prior to vaccination. The two solutions are not the same. While one looks towards a far better more integrated public health care system, the other describes a tool which such a healthcare system might use.

So in relation to contraindications and adverse reactions to vaccines and to identifying subgroups, it is not just a matter of making the vaccine safe, or in the paraphrased words of the American campaign 'Greening Our Vaccines', we have to ensure that the individual is safe for the vaccine as well. To do this, we can opt for the contemporary approach—tests can be carried out, on the run, by a stranger, outside any concept of community—or we can consider 'going back' to a period when there was time and energy to spend on the individual in society, when there was consideration of a community in which the doctor knew the child and knew the family. This, inevitably, is a massive undertaking for a society that has invested all its finances and strategies in the 'Wham bam, thank you ma'am' approach to health care.

* * *

[48] Sir Graham S. Wilson. **The Hazards of Immunization**. Based on University of London, Heath Clark Lectures 1966, delivered at the London School of H&TM. University of London, The Athlone Press, 1967.

[49] www.cbsnews.com/stories/2008/05/12/cbsnews_investigates/main4086809.shtml. (accessed 29 December 2008). Also at: www.cryshame.com (accessed 29 December 2008).

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If we want to look to a system of socialised medical care, that takes into account the long-term and continuous health care interests of the individual, the family and the community, we could do worse than look back at the Peckham experiment – a pioneer health centre begun in 1926, in South London. By 1939, the project had become known as the 'Peckham Experiment'. The large modern building of the health centre, designed to accommodate around 7,500 people, included a school, a swimming pool, a ballroom, a library, self-service cafes, mother-and-baby groups, pre-school and toddlers groups, together with classes and lectures in everything from sewing to economics.

As well as all this, there were doctors and surgeries for the whole family. All families who signed up had a full range of tests carried out, and a health profile was formulated before any preventive or remedial treatments were begun. The Peckham Experiment was built on money raised by a small committee of lay people to deal with the health needs of their community. The medical practice of the centre was based on a number of ideas: the service of science to humankind, the fostering and development of self-help, and the idea that wellness was a positive state quite different from the mere absence of disease.

The approach of the biologists and physicians who worked at the centre was that good health was a continuous fact, and that healthy babies, for example, were not simply produced by good early feeding, but also by assuring the pre-conceptual good health of both the mother and father. There were classes in Peckham in pre-conceptual care, and the organisation of the activities in the centre tried to ensure the everyday happiness and health of the whole family.

The ideas of the Peckham Experiment survive today only in the most rudimentary manner in the idea of the community health centre within British socialised medicine. The failings of the original project in post-modern eyes are easily imagined: it was, although privately funded, a 'public' project by design, and despite its insistence on self-help and education, it might today be seen as 'communistic'. Certainly, the project was dominated by the idea, very prevalent in the 1920s and 1930s under both capitalism and communism, that it was possible to organise both individual and social health scientifically. The emphasis at Peckham was not on the study of long-established traditions of health care, but on the brave new world of deep research into biology.

* * *

Vaccine-damage denial has presently reached epidemic proportions in Britain. The most exceptional thing about this movement is that it has, as members, many doctors sworn to protect individual human health. It might be said that the Government, the pharmaceutical companies and the science lobby groups have attempted to manage herd immunity with an argument that says vaccines cause no damage at all, ever, under any circumstances.

The test for herd immunity amongst vaccine-damage deniers is that, for individuals new to the conflict, no information is needed and no discussion is tolerated. The argument that vaccines cannot cause damage appears like magic with fully-fledged dogmatism. While such received opinions might be plausible amongst the general population, its plausibility amongst legal, regulatory and political office holders is startling, manifesting, at best, as an 'agreement in ignorance' and, at worst, a criminal conspiracy that causes death and disability to a subset of babies and young children, in the name of herd immunity.

The British vaccine programme and those who guide it, run it and oversee it, presents one of the clearest examples of unaccountable, misguided and possibly criminal decisions made by a group of self-interested medical apparatchiks, in the history of British medical politics. The programme began initially to fall apart under the pressure of adverse damage reports in the 1970s. But, instead of opening the doors to accountability and a minimal democracy, the DH and the government shut the gates of Whitehall and like unhappy totalitarians went on buying shoes and having architects build monuments to their greatness while the nation's children suffered.

But none of this reasoning is likely to affect the mandarins of Richmond House who have already signed a pledge to serve a Lucky Dip, low-cost public healthcare system. The Government will undoubtedly continue to chase herd immunity and measles eradication, apparently for reasons of public health, The pharmaceutical companies will chase it for reasons of vaccine profit and to gain added profit from treating those who are harmed. But, like Chaplin's character in Modern Times, who is unable to keep up with the conveyor belt, those unable to keep up with the herd, in this system, will become sick and fall by the wayside.

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