34 INFORMATIVE YEARS

THE informed PARENT

FINAL EDITION 2025/6 A NEWSLETTER ON VACCINATION ISSUES AND HEALTH

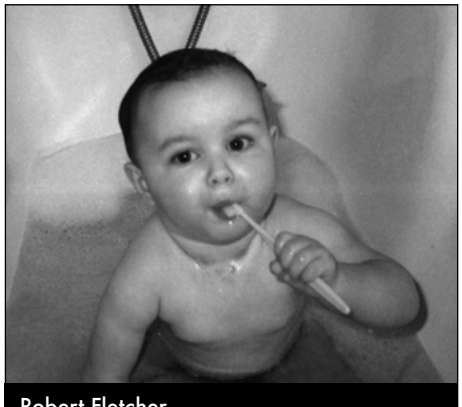
VACCINE INJURY – A REAL LIFE EXPERIENCE

IN LOVING MEMORY OF ROBERT FLETCHER: 18th OCTOBER 1991–15th SEPTEMBER 2025

JACKIE FLETCHER, ROBERT'S MOTHER, AND FOUNDER OF JABS WHICH WAS SET UP IN JANUARY 1994, HIGHLIGHTS THE REALITY OF VACCINE DAMAGE.

On the 23rd November 1992 my thirteen-month-old son's life and the lives of our whole family changed forever. It was the day when he was vaccinated with MMR and Hib meningitis vaccines. He suffered an extended seizure ten days later - the first seizure we had ever seen in our family - and this seizure set in motion a chain of events leading to uncontrolled epilepsy, severe learning difficulties, severe mobility issues, oesophagitis and leaving him with a mental age of about 14 months. From that point on he would need round the clock care for the rest of his life.

Every NHS doctor we spoke with at the time dismissed a link between Robert's health issues and his recent vaccines. Everything was a coincidence until a close friend downloaded the vaccine manufacturer's product information sheets from a newfangled thing called the internet. All the symptoms and long-term problems that were surfacing were listed as rarely reported events in these very same sheets. This was a major culture shock. I had not seen these sheets before and had based our decision to vaccinate Robert on answers to my questions from his health visitor. Her answers came from the Government's health education leaflets which stated how serious and deadly the illnesses could be and how the vaccines had been used for 25 years in the United States (which implied that there had been no problems of note).



Robert Fletcher

In my search for answers, information and 'fix-its' I contacted The Informed Parent and there began a life-long friendship with the indomitable Magda Taylor. Her sympathetic ear, her understanding of all things vaccine-related and her common sense approach to searching for help were invaluable.

"You can only claim for a child once he/she is two years old. If the child dies of a vaccine injury before they reach this age the family is entitled to nothing."

During the course of hospital appointments and emergencies my husband, John, and I met other parents who also complained that their children had been fine until they'd had an MMR vaccine. We talked to our local Community Health Council and our MP. Following a significant response to a small paragraph in our local free paper which asked if anyone believed that their child had had an adverse reaction to this vaccine a meeting was arranged at Wigan Town Hall and JABS (Justice, Awareness & Basic Support) was launched. One hundred and fifty people had attended this meeting making it very clear that Robert was not an isolated case. Families reported to us that their previously healthy children had reacted withing the incubation period of the vaccines with symptoms and long-term problems known to the manufacturers as listed in their product information. Some of these children died of their injuries.

Robert and Jackie Fletcher

All these children had families who loved them. The injuries would have an untold impact on all of their lives.

To give you an idea of this: Robert's epilepsy resulted in seizures every week and hospital admissions two or three times a year. The vaccine injuries had caused a left-sided weakness which robbed him of his ability to walk and had resulted in broken toes, sprained and twisted ankles and facial injuries from falls which resulted in further hospital admissions. He became wheelchair bound. His two older brothers coped admirably with all the sudden changes in family plans. John and I were and still are so proud of them for accepting the situation without resentments and always uncomplaining.

Over the years that followed we were contacted by many thousands of parents and JABS had representatives in the UK and in New Zealand offering basic support to families who believed their children had suffered vaccine injuries. The families might have wanted practical help in

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Magda Taylor

Editor's note

AS THIS IS the very last edition of TiP newsletter I felt it appropriate to touch briefly on my journey since reading the article: 'Vaccination The Hidden Facts' by Andrew Tyler, back in September 1991, which was featured in the London Evening Standard ES magazine.

What a journey of discovery! I have learned, and still continue to learn, a great deal over the years and not just from books, published medical/scientific papers and video presentations. Real people with their real-life experiences have taught me an immense amount also, whether they be health practitioners or just ordinary folk, like me.

When I initially started researching vaccination the year before TiP evolved it was rather daunting as I felt very isolated and did not know anyone who had declined the vaccines. However, the more I mentioned the subject I started to discover others, including doctors who had many concerns about the safety and the efficacy. The networking proved to be very fruitful and by September 1992 along with two other mothers, Kim Harrington and Melany Still we launched The Informed Parent. Shortly afterwards another mother, and former health journalist, Janet Smith came on board and between us we started to produce a quarterly newsletter.

There was a lot more freedom of speech in the early nineteen nineties, and after getting mentioned in a few publications our number of subscribers began to grow. As the amount of work increased it became difficult for the other founder members to be involved and within a couple of years or more I found myself in a challenging situation. Do I continue alone keeping The Informed Parent up and running or a call it a day? Obviously, I decided to continue with the newsletter and also set up a website to try and assist other parents who had concerns about all the vaccines being offered to their children.

Due to attending a variety of talks, presentations, 1-2 day seminars as well as organising many talks over the years I met with many doctors, health practitioners and health researchers from across the world. Viera Scheibner PhD, travelled from Australia twice a year for a 10-year period to do a spring and autumn UK lecture tour for those interested. Viera presented mostly the medical published papers she had discovered whilst scanning the medical literature on vaccination. This research resulted in her first book: Vaccination – 100 Years of Orthodox Research shows that Vaccines Represent a Medical Assault on the Immune System (1993). Behavioural Problems in Childhood – The Link to Vaccination, followed (2000). During the 1990s it was very straightforward booking a venue and holding a talk discussing vaccination. How times have changed! Even back in 2019 when I was invited to give a talk in a village hall near Totnes, Devon there was at least one disgruntled local parish councillor trying to prevent the talk happening. At least these days there is the option to attend a lecture online, although personally I much prefer hearing a speaker in person, if it is possible.

I have had the good fortune to hear and meet many other independent researchers over the years, including: Dr Jayne Donegan, Dr Patrick Quanten, Dr Andrew Kaufman, Dr Gerhard Buchwald, Dr Robert Blomfield, Trevor Gunn BSc, Dr Kris Gaublomme, Dr Anthony Morris, Dr Archie Kalokerinos, Sylvie Simon, Ian Sinclair, Jackie Fletcher,and Dr Andrew Wakefield. Apologies to anyone else I may have forgotten to mention!

Presentations by Natural Hygienists Dr Keki Sidwha and Dr Alec Burton, and Classical osteopaths John Wernham and Howard Beardmore have also been very enlightening, especially around the concept of what is health, and what do symptoms of disease represent.

Also, on my journey of discovery I was in contact with people who were part of the National Anti-Vaccine League, including Dr Gordon Latto and Ian and Monique Stirling. They provided me with many interesting archive pamphlets and literature which inspired me to take a deep dive into the history of vaccination to reveal the untold history. I am also full of gratitude to all those doctors, scientists and researchers from the past who gave much of their time, some who were ostracised from their profession, to write essays and books full of historical data which would never have seen the light of day otherwise.

In recent times, especially over the last five years, I have particularly found the following individuals very eye-opening and informative: Dr Tom Cowan, Drs Samantha and Mark Bailey, Daniel Roytas, Christine Massey, Mike Stone, Dr Stefan Lanka, and Roman Bystrianyk, and I highly recommend them and their work to people genuinely interested in the subject, also.

Although this edition is the final one of its kind, I will endeavour to keep the website available, and should any opportunities arise to be interviewed, give a presentation, or write an article I will do so if possible. We all need to keep this conversation going, raise our concerns, and demand answers and evidence from those who are part of, and adhere to without question, the present medical and scientific establishment.

Lastly, my gratitude goes out to all subscribers, past and present, who have made this publication possible!!

Magdalene Taylor, TiP Editor, February 2026

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"THE ONLY THING NECESSARY FOR THE TRIUMPH OF EVIL IS FOR GOOD MEN TO DO NOTHING."

~ EDWARD BURKE

managing their children's conditions to supplement whatever medical care they were getting and we would direct them to support groups dealing with that particular ailment in case it was of help.

We did many interviews in the media to raise awareness of the number of families coming forward to complain of vaccine damage and to highlight the flaws in the system that continue to this day:

The failure to inform anyone considering vaccination of the real potential of serious adverse reactions to any vaccine.

The failure to inform anyone of the likelihood of a problem with any given illness based on the person's age, sex and medical situation.

The failure to allow a full range of choice: everything seems to be done for the speed and efficiency of the clinic and for the maximum up-take of profit margins for the vaccine-makers.

The failure to report serious events and to monitor and follow-up on every reported adverse reaction to ensure the accuracy of safety data.

The failure to put in place a proper financial safety net to help any person seriously injured or who had died from that injury.

Our group has strived to seek justice for children and adults injured by vaccines.

The UK government has a Vaccine Damage Payment Unit (VDPU). It is a scheme that seems designed not to pay as the criteria are so strict.

You can only claim for a child once he/she is two years old. If the child dies of a vaccine injury before they reach this age the family is entitled to nothing.

Also, a person has to be at least 60% disabled and that degree of disablement has to be shown to have been caused by a vaccine. Anything less than 60% and the person is ineligible for a payment. Can you imagine the furore if a person had suffered the same 'less than 60%' injury in a car accident and the insurers stated that the person was not damaged enough to receive a payment?

A knock-on effect of this strict criteria is that it keeps the statistics artificially low. When health chiefs talk about how safe vaccines are it is based on skewed data.

As the VDPU was so unfair parents in our group launched an MMR multi-party action against the vaccine manufacturers in order to seek long-term care packages and damages for those who had been injured or had died. To pursue such a case it was necessary to obtain legal aid and in Robert's case he had had legal aid certificates for ten years as had many of the other children.

The funding for scientific work on the cases had been restricted by the Legal Services Commission to the bulk of the group action which comprised of autism and bowel cases. The other cases,

Robert Fletcher

neurological damage - like Robert - chronic arthritis etc., had to wait in the background while the lead group was investigated. By the autumn of 2003 the autism and bowel cases had not yet assembled sufficient evidence to have a reasonable prospect of success in court.

At the time, there were 1400 live legal aid certificates covering all types of injury when suddenly legal aid was stopped for all of the children. Let me repeat: 1400 children seriously injured or had died - the cases just stopped!

Some families fought on, as we did with Robert, and in January 2005 one hundred children, including Robert, had legal aid re-instated. One by one the families were whittled down again. In Robert's case it was found that there had been a clerical error in his GP records: a problem with the MMR batch number. We had apparently been pursuing the wrong manufacturer all this time and it was now too late to substitute one vaccine-maker for another. We were timed out on a technicality. You can surely imagine our family's frustration, anger and disappointment in this turn of events after all these years.

As this door closed we decided to open the next with an appeal to the VDPU. We had tried this route once before and the assessor had accepted that Robert was severely damaged and had been fine before his MMR. He accepted that all Robert's symptoms and long-term problems were known to be associated 'rarely' with the vaccine and that nothing else had happened to him that could have caused such catastrophic changes. However, he then asked John and me to explain the biological mechanisms that led to Robert's brain damage. Not being neurological experts we couldn't answer this and the case failed.

In 2010, however, we were in a better position. We now had two medical reports to support his case. Our solicitor had worked tirelessly to obtain legal aid again so that Robert had legal representation at the tribunal hearing and the presence of a neurologist via a video link to America who could answer any questions from the tribunal panel.

Two months later we got the news that Robert's case had been successful. It had taken 18 years for the cause of his disabilities to be officially recognised.

Now other vaccines have been added to an already congested childhood vaccination schedule. The fiasco of all things COVID has resulted in another large group of people fighting for justice following life-changing or life-ending injuries. It's now more important than ever to ask questions.

The fight goes on but sadly not for Robert. This year he had to deal with a number of serious health issues, especially his epilepsy, and he was admitted to hospital on numerous occasions. These problems took a serious toll on his health. It was all too much. He passed away on the 15th of September 2025. John and I were with him when he took his last breath.

Jackie Fletcher, JABS can be contacted at: jackie@jabs.org.uk

HERE WE GO AGAIN... !!

MAGDALENE TAYLOR, TiP editor: The measles propaganda is becoming rife yet again. I have lost count how many times the media machine has churned out scaremongering measles headlines over the last three decades. I am noticing more and more social media posts declaring measles is on the rise and how the UK has lost its 'elimination' status. The average person does not understand what they mean by elimination status* – they read it as if it means eradication and are led to believe that losing elimination status is due to the rise of 'anti-vaxxers' and their unvaccinated children spreading disease. Are they attempting to cause more divisions, by encouraging those who blindly believe in vaccination, without any research, to view those who actually study the subject, basing their views on their findings, as dangerous lepers of society?

'Elimination' is the official term used once a country has reduced the number of cases of a disease to, in the view of the establishment, a low enough level to stop it spreading through the general population for at least three years. It doesn't mean that measles has been wiped out or eradicated in the UK.

Obviously here in the UK there will be a push to get more children vaccinated with the updated MMR now that the chickenpox vaccine has been added – ie MMRV. It is highly likely, in my opinion, that the measles scaremongering descriptions will be used to entice those who are what the establishment label 'vaccine hesitant' into accepting this 4-in-one jab. Since most people do not worry too much about the childhood illnesses, such as, mumps, rubella and chickenpox, the measles is always turned to in order to create fear!

This time of the year it is acknowledged by officialdom that conditions such as measles typically peak in late winter and early spring. You will find the following if you 'google' it:

'In temperate climates, such as the United States and Europe, the peak season for measles is typically ***late winter and early spring.'***

This creates the perfect timing for using this fearmongering measles rhetoric as there is likely to be more measles cases peaking! This, in my opinion, happened also with the so-called 'covid'. Flu cases (a seasonal detox) peak at the spring and autumn equinox. The timing of the lockdown in March 2020 conveniently coincided with the spring equinox and flu cases were labelled 'covid' – how very fortunate for the establishment.

Interestingly, this mainstream observation regarding the peak time for measles actually falls very much in line with the naturopathic view that rash presentations particularly occur at this time of the year. Back in the 9th century Rhazes, a Persian physician and important figure in the history of medicine wrote many volumes on disease, one being the: 'Treatise on the Smallpox and Measles.' Rhazes noted that they were seasonal – usually around spring, predominantly in children and were the result of something innate in each child. Rhazes believed the nature of the symptoms suggested that something undesirable was being eliminated through the skin. This aligns very much with the naturopathic philosophy that measles, along with other childhood rashes are some kind of childhood detox. A clearing of cellular debris to enable maturation, both physically and mentally, in the child – a spring clean/growth spurt as they enter the new season.

> *"Anyone who cares to look at the epidemiological data can clearly see that measles deaths reduced greatly, long before any vaccine was introduced in the developed countries."*

Some may say – but children used to die from measles?!

And yes, sadly many used to perish from secondary complications due to the filth, squalor, bad living conditions, poor nutrition and so on. The child did not have the strength to detox, to allow elimination of their internal rubbish and this could lead to the 'rubbish' internalising instead of externalising depending on their level of health.

Anyone who cares to look at the epidemiological data can clearly see that measles deaths reduced greatly, long before any vaccine was introduced in the developed countries. The credit should go to all the social improvements that took place during the late 1800s and early 20th century in the UK, US, parts of Europe, and Australia. However, sadly there are still areas of the world where they have not experienced huge improvements to their living conditions and continue to live in extreme poverty. These are the present populations who are likely to develop secondary complications and fatalities to any disease, including measles. And often worldwide figures, rather than national figures on measles deaths and complications are used to further frighten the public living in parts of the world where complications are rare due to their much improved standard of living.

Yes, problems can arise in the richer parts of the world to a degree, and the most likely reason would be mismanagement of a case of measles. Suppression of fever, over-feeding, and 'just-in-case antibiotics' alone can prevent a child or adult from expressing the internal rubbish and instead push the debris inwards and preventing an eliminative rash.

This reminded me of a particularly good example regarding fever suppression which was cited by Dr Philip Incao at a vaccine risk conference in 2000. This was covered in an article entitled: Is Fear of Fever Hurting Our Children? By Edda West, editor of a Canadian newsletter (VRAN), similar to The Informed Parent. I featured the article in Issue 3, 2003 and also in the Special Edition compilation. Here is the relevant text relating to fever suppression in measles cases:

'High fevers in some diseases like measles and roseola are needed in order to discharge the virus. In a clinical study of 56 children during a measles epidemic in Ghana, Africa in 1967, it was standard practice to treat every case of measles with sedatives, antipyretics like aspirin and tylenol, cough suppressants, and also as needed with antibiotics. In the first half of the epidemic, 35% of the children died. But the treating doctors also observed that the children who survived were usually the ones who had higher fevers and more severe rashes than the ones who died. Although the

Photo by Jon Tyson on Unsplash

ones who died seemed less sick than the survivors at the beginning of the illness, they then later got pneumonia and died.

At a vaccine risk conference in 2000, Dr Philip Incao cited this study as an example of the vital role of fever. "The doctors began to think that the higher fevers and rash helped clear the measles virus from the body and enhanced survival. And so half way through this measles epidemic, the doctors revised their treatment and gave no sedatives, no aspirin or tylenol, nor cough suppressants, but still gave antibiotics, antimalarials and blood transfusions if needed. In this group, also of 56 children, only 7% died compared to 35% in the first group. This is a dramatic demonstration, and there are many others, of the vitally important basic principle that it is dangerous to suppress an inflammatory discharge."

By the end of the 1950s measles was generally viewed by many UK doctors as a run-of-the-mill childhood disease with rarely any complications. The demonization of measles began prior to the UK launch of the single measles vaccine in 1968 in order to justify to the public as to why this vaccine was being introduced. Even then the uptake during the early 1970s was relatively low, as at that time much of the general public had a much more realistic view of measles. Over the following two decades the fearmongering measles propaganda greatly increased leading to each new generation of parents becoming more and more frightened of measles. Many young people of today have a completely false idea of measles based on what they are taught at school and via social media. Most, if not all, do not study the subject they just accept what they have been told. It's simply an adopted belief (presented as fact) that they have been indoctrinated with throughout their school and college days.

The same can be said about medical professionals as they have been more thoroughly indoctrinated to a much higher degree as regards to childhood illness and vaccines, as well as other areas of health. Most will turn a blind eye to questioning the subject, especially once they have qualified and are hoping for a prosperous career. They will dismiss any concerns raised and just come out with the same response, ie, safe & effective etc.

Rather than address growing concerns regarding vaccines, increasingly, the establishment prefer to fund and publish medical papers on areas, such as looking at opportunities to intervene earlier with vaccine hesitant parents and improve the vaccine uptake. Exploring vaccine coverage and factors associated with timely and delayed childhood immunisation in the under-2s in an attempt to allay hesitancy and ensure children are on track.

In my opinion, if they really cared about our health their absolute priority should be addressing all the growing questions surrounding the safety and efficacy, and more importantly, the validity of the vaccination procedure itself given the foundational science was, and still is, highly questionable, and lacking in properly conducted scientific evidence?

It seems that their main priority is achieving vaccine compliance. A recent example of this is: **Delayed or Absent First Dose of Measles, Mumps, and Rubella Vaccination**, by Masters N B et al, published in the JAMA Network Open. (JAMA Network Open. 2026;9(1):e2551814. doi:10.1001/jamanetworkopen.2025.51814)

The article typically starts with the opening sentence: 'Vaccination is one of the greatest accomplishments of public health, resulting in dramatic decreases in childhood morbidity and mortality.'

Now if this were a true statement you might wonder why the second sentence follows: 'However, vaccine hesitancy has been increasing both globally and in the US.' Why would a great accomplishment in public health create more and more hesitancy?? No one would be hesitant if a

procedure was so clearly of benefit. If we cast our view back to Jenner's smallpox vaccination you will see that only a few years after the medical establishment embraced vaccination, around 1808, there was an increasing public distrust of vaccination, with numerous failures revealed, and mounting evidence that it was dangerous, ineffective and sometimes fatal. Indeed near to Jenner's death he admitted through his letter writing that *'I am harassed and oppressed beyond anything you can have a conception of.*' And wrote, 2 days before his death in January 1823, to his confidential friend, Gardner that he *'was never surrounded by so many perplexities.* Now that does not sound like the words from a man who had received international recognition as the pioneer of vaccination against smallpox, does it? Surely if vaccination was so safe and effective Jenner would have been strutting around the world full of confidence and pride?

Additionally, when something is very beneficial there would be no need to bring in a compulsory law. A US doctor back in 1900, Dr James M Peebles in part of his response to the compulsion of vaccination stated that: '…if the medical profession have anything specific of value to offer, the common sense of the people will come to know and adopt it.'

Even The Lancet medical journal expressed concern when the first compulsory vaccination bill was before Parliament, on 21st May 1853:

'In the public mind, extensively, and in the profession itself, doubts are known to exist as to the efficacy and eligibility of vaccination – the failures of the operation have been numerous and discouraging.'

And yet despite the mounting concerns the Vaccination Act was passed leading to forced vaccinations without choice, or fines or imprisonment.

Returning to the article the authors continue speculating that the hesitancy may have been a spillover effect from the covid-19 pandemic and vaccine. I would agree that the covid injection has led to more questioning of the subject, however the growing decline in vaccine uptake had been steadily increasing over the last few decades. I found almost every following sentence either laughable or full of unproven assumptions.

The opening line of the second paragraph the authors declare: 'Children receive several lifesaving vaccines in the first 2 years of life' followed by a reference. I was expecting to read evidence as to how the vaccines were lifesaving but the reference just leads to the US Immunisation schedule. Words such as lifesaving are often used to give the impression that this is a proven fact, this is misinformation in my view.

At present it is possible to download the full article free if you wish to read it in full. Alternatively please email me and I can forward you a copy.

The Conclusion of the article reads:

Conclusions

The US has entered an increased landscape of surveillance and data uncertainty, as well as proliferation of vaccine misinformation. This study of children with regular access to care shows that childhood vaccine coverage and timeliness have been decreasing since the COVID-19 pandemic and that staying on the vaccine schedule early is the factor most associated with receiving a timely MMR vaccine, the best protection against the measles outbreaks that are spreading rapidly across the US. This study also highlights the importance of using EHR (electronic health record) data for timely vaccine surveillance, to identify opportunities for intervention, and to provide better care to patients.

In my opinion, based on all my observations and reading over the last three decades, the masters of the proliferation of vaccine misinformation are the those within the presently established medical and science fields and with their uncertain data!

UK LOSES ITS MEASLES ELIMINATION STATUS

COMMENT BY MAGDALENE TAYLOR, TIP EDITOR:

A RECENT ARTICLE published in the BMJ in January 2026 entitled: **UK loses its measles elimination status** (BMJ 2026;392:s172) led to one Rapid Response by a doctor who, in my opinion, clearly and sadly believes his medical education without question. It reads: *'The UK continues to experience outbreaks of measles due to unvaccinated children. Vaccines have made the greatest contribution to global health since their invention. They have contributed significantly to the minimisation of mortality, morbidity and hospitalisations. Measles, a highly contagious acute viral respiratory disease, leads to serious repercussions ranging from fever, skin rash to pneumonia, encephalitis, otitis media, diarrhoea, conjunctivitis, blindness, seizures and potentially death [1]. Moreover, measles places intolerable burdens on families and communities physically, psychologically and emotionally. Children with fragile immune systems are more vulnerable to serious illness, slow recovery and death. More than 90 percent of susceptible individuals can contract the virus and develop measles. This highlights the infectivity and transmissibility of measles [2].*

Vaccine hesitancy has been declared by the WHO as one of the top ten threats to global health on a par with climate change, air pollution, antimicrobial resistance and non-communicable diseases[3]. Vaccine hesitancy is a state of indecision and uncertainty about vaccination before a decision is made to act. It represents a time of vulnerability and opportunity [4.]

Vaccine hesitancy is a complex, dynamic, multifaceted phenomenon with varying time, place, context, geographic location and vaccine specific [4].

Trust underlies the hesitancy to the MMR vaccine. Trust has been undermined by the debunked link between autism and the vaccine. Trust is influenced by myriad factors ranging from trust in the vaccine, healthcare provider, health system, policymakers and pharmaceutical companies to external factors related to the historical legacy of abuse and neglect by government and healthcare system. Past experiences of racism, discrimination and social ostracism decrease vaccination coverage rates and thwart efforts to reach the 5 percent threshold needed to achieve herd immunity. It is time to address the social determinants of vaccine hesitancy and espouse a whole of society approach that includes: family, friends, neighbours, politicians, celebrities, political and religious leaders, the

government; only then can we address this societal scourge.'

Competing interests: *No competing interests. 27 January 2026. Munjed Farid Al Qutob, Physician, Private Practice, London.* https://www.bmj.com/content/392/bmj.s172/rapid-responses

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This rhetoric is not only inaccurate throughout, it is also very dangerous. Referring to those who question, study and decline vaccination for themselves and their loved ones as a scourge on society is more than demeaning, and could be seen as a form of psychological abuse. According to an online search the primary motives of those who make such verbal accusations is to elevate their own status, or sense of self-worth, often stemming from their own deep insecurities. This doctor is calling for espousing a whole society approach! What is this doctor suggesting - it sounds very much like mandatory vaccines with no choice?

Regarding Rapid Responses to any BMJ articles. There used to be a time when you would have a good chance of having your comments published in response to published medical articles. I used to participate on occasions and most were published, but oh how times have changed! Responses that reinforce the mainstream mantra are very likely to be included whilst the rest usually go unpublished!

WHO QUALIFIES AS BEING QUALIFIED?

BY MAGDALENE TAYLOR, TIP EDITOR

I HAVE HAD people, especially mainstream media presenters, questioning my qualifications on vaccination. 'You are not a doctor' has been hurled at me on more than one occasion implying that without a medical degree one cannot possibly have a valid comment on the subject. My usual response is that it is my good fortune that I did not have any 'formal' training. My study was broad and independent, and I had nothing to gain, no incentive to come to any particular conclusions. Unlike the typical medically-trained view due to the limited, biased and 'unquestionable' information parroted to medical students and doctors throughout their training and career. They also have to stay in line, follow protocol without question, and meet targets to ensure they continue in their profession successfully in order to receive the very nice salary and potential bonuses attached.

In my opinion, it is far easier as a lay person to let go of the official narratives we have had fed to us since childhood. Although, due to the increased brainwashing of the young children of today, it is becoming much more difficult! The state is using narratives to encourage the younger generations to look to the state for support and information rather than their parents. Labelling the parents who question the 'orthodox' view as radical or extreme right, conspiracy theorists, and so on. You might consider the actual meaning of orthodox?

Definition: Derived from Greek orthos ("right") and doxa ("belief/opinion"), meaning holding the correct belief - "of the right opinion". The true doctrine and its adherents as opposed to heterodox or heretical doctrines and their adherents.

AI Overview online states:
Orthodox refers to the strict adherence to established, traditional, or "correct" beliefs and practices, commonly used in religious (Christianity, Judaism) or, less frequently, secular contexts to describe conventional approaches. It signifies holding onto traditional, authorized doctrines over modern innovations, often emphasizing continuity with historical, foundational creeds.

Just because something has become established – does that make it correct? Who established it? Who decides if it is "correct"? If it, as it states above, signifies holding onto traditional doctrines over modern innovations then why has the word 'orthodox' been misused? Modern pharmaceutical medicine has hijacked this term and used it to brainwash the public into viewing all other differing views on a subject, such as vaccination, as unorthodox. Now, the present-day establishment demand 'strict adherence' to their established doctrine. It is only since around the time of Pasteur's Germ theory and birth of the pharmacological industry that this present orthodoxy has been in existence. Where is their evidence that proves that previous traditional orthodox doctrines are all to be abandoned?

On more than one occasion, when reading historical literature I have noted how individuals, often with substantial and well-researched evidence to justify their concerns, were labelled unorthodox and unpopular by those within the establishment. Yes, naturally the establishment would consider these individuals as unorthodox, as in their prejudiced minds anything out of their belief system would be, but to attach the word unpopular into the description is very misleading, Unpopular with whom? Only for those who want to dictate to the public that their doctrine is correct and strictly adhered to.

Increasingly, and sadly, the parents these days, who are deemed as to holding unorthodox views and declining the vaccines for their children are sometimes seen as a barrier to vaccinating their children. I would encourage you to gently teach your children about health and disease so they remain confident in your parental decisions and have at least a basic understanding of the subject to carry with them into adulthood where they will then have to make their own decisions about their own health and the health of their children.

The Quanten Theory

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THE DOCTOR SAYS by Patrick Quanten MD

So many years of digging underneath the structure of medical explanations for diseases and health issues has shed a bright light on the unscientific approach of the industry. It has highlighted lies, untruths and half-truths. A job well done. However, as far as the world outside our 'research lab' is concerned, the power of medical explanations has strengthened, not weakened. The gross of the population is now even more convinced of the truth in medical explanations, is more militant than ever before to defend the healthcare system as a whole. What would we do without it? Save the NHS. No matter what, we must keep this ship afloat. In fact, even though people despise the profits the industry makes each year, we must keep paying them whatever their demands are as we will be unable to survive without them. In spite of obvious proof against it – medical intervention is the third highest placed cause of death - we continue to believe they are our saving grace. It seems we like to grasp at straws. If you are happy with that situation I suggest you stop reading, have a nice cup of tea and relax in the knowledge that it is all being taken care of for you.

But if you are still here, it might be worthwhile to point out how truly nothing in the medical stories of late has a real relationship to truth. I suggest you begin with plain common sense and, if you feel so inclined, you do your own research, outside of the industry sponsored 'studies', to unravel the enormous gaps in the foundations of what the medical profession calls 'their' science.

It all starts here. When your car mechanic tells you that he knows how to fix your car and that he is the only one who has the right idea about how to fix your car, and he tells you that there is a 60% chance it will work properly again after his treatment, would you be inclined to leave your car in his care? Someone who gives me a percentage of possible success to fix a problem either tells me the problem is not really fixable, or he doesn't really understand what the problem is. If it is the first, I will be inclined to ask several others for their opinions, and preferably people from a different background and different training, before I make a final decision. If it is the second, I would never ever set foot in his establishment again. You may benefit from realising that health is not a percentage game. In the natural world, animals are either completely healthy or they are seriously ill and will die. There is no 'muddling' along. But we choose to do just that. We cling to straws, the straw that says "hold on to me, because you may possibly, at some point later, get the feeling that you are falling". In doing so, we forget that we can walk perfectly well without holding on to anything. So we muddle through, mainly on the recommendation of the one who turns us into dependency addicts. We follow the recommendations of our drug dealers!

Let's take a look at what the fundamental stories are that our healthcare system relies on to guide us back to health.

Patrick Quanten MD

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INFECTIONS

Infections are not caused by the invasion of germs. Germs that enter the body from the outside, either by inhaling them or ingesting them, will be broken down immediately and have no further influence. This is not exceptional as everything that enters our digestive system is immediately broken down and sent to our largest internal detoxification organ, the liver. The anatomy of the hepatic circulation proves this. None of the food items you eat reaches any of the cells in your body. None of the germs that enter your body reaches any of the cells in your body either.

Germs found within infected tissues are generated in situ by the disintegrating tissue itself. The role of these germs is to clean up the area and return it to a healthy state. Killing these germs through the use of antibiotics is detrimental to our health and causes many chronic diseases as the debris of diseased tissues is left to rot within the body. Germs appear within the diseased tissue as the next phase of the healing process, following on from an inflammation whereby the higher temperature and the increased pressure ensure a burning of the accumulated debris.

Knowing that an infection is a healing process removes the need to oppose it. It also removes the need to be afraid of it. If, in order to remain healthy, we are in need of the infectious process then we do not need anything that tries to prevent this process from happening. The medical profession advocates the use of vaccines to prevent infectious diseases. Since, in nature, there is no need to prevent an infection, the endless discussion about whether or not vaccines are effective and safe is pointless. Even if it is true what the medical profession proclaims, vaccines have no place in the life of a healthy person or anybody who wants to become healthy again, simply because there is no need to fight an infection or 'to prevent' it. As nature tells us.

CHILDHOOD DISEASES

Common childhood diseases, that are now by the medical profession being portrayed as dangerous and deadly, are infections. But we now know that

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infections are healing crises, not diseases, which means that the infection itself cannot be deadly. In fact, when we research this, it turns out that the 'deadly' bit, in essence, is extremely rare, almost non-existent. However, it does appear more prominent on the radar since the introduction of treatments against infections, since the massive use of antibiotics in early childhood and a nationwide vaccination programme, fighting infections, thereby preventing the clean-up these infections provide. Outbreaks of childhood infections in adults only occur as a result of the suppression of the process and nature fighting back and breaking through the artificial barriers. However, to the health of this adult this is a big problem. It shows how long this debris has been lying inside the tissues, festering, all the time producing more and more toxins.

Common childhood diseases occur spontaneously at specific development stages of the child. Hence, there is a direct relationship to where the individual child is in its development and the inner balance of the individual child. Every growing organism will have to readjust its structures at specific junctions in life. There is a spontaneous breakdown happening of child-like tissue to create space for the construction of more adult replacement tissue. The debris that results from the breakdown needs to be cleaned up, which is done through the use of an infectious process. If one doesn't allow this natural process to take place, the accumulated debris will remain in situ and will become the feeding ground for problems that will show up later in life. As these infections are signs of stages of development, it would only be natural to allow the system to take care of this without interrupting the process. Makes sense, no?

MEASURING IMMUNITY

Various parameters are used by the medical profession to measure and evaluate the immune status of individuals. All of these are blood tests. *"Immunity is when antibodies are present that can help the body resist harmful microorganisms or toxins. Antibodies are disease-specific and there is no broad-based 'immunity' that protects the body."* It starts with a lie. Antibodies are not disease-specific. If they were that specific, you would have never heard of 'false negative' and 'false positive' test results. In other words, sometimes the result of the test is negative while everybody can see that the person has the specific infection and sometimes the test gives a positive result while we are very sure the person is not ill at all. Hence, even though the medical profession maintains and acts as if the immune tests are specific and always correct, their own literature reveals that this is not the case. But you can imagine what would happen to their story if all the evidence they can produce has to be considered as nothing more than a blip that can mean everything and nothing. Some studies have shown incidences of false positive results of over 50%!

Antibodies are proteins. The size of proteins varies greatly, ranging from a few hundred amino acids to over

34,000. Typical proteins are about 300–500 amino acids long. A simple rule of thumb for thinking about typical soluble proteins is that they are 3-6 nm in diameter. They say that antibodies can coat the microorganism, thereby playing a crucial role in our immunity. Bacteria sizes range widely, from about 0.2 micrometers for the smallest (like mycoplasmas) to up to 0.75 millimetres for the largest (like Thiomargarita namibiensis). A nanometre, which the antibodies are measured in, is 10-9m while a millimetre is 10-3m and a micrometre is 10-6m. This means that a substance of a few nanometres big is going to 'mark', to 'coat', a substance which is 100x to 100,000x bigger. And it is this crucial action that the system relies on to eliminate the invader and to protect us from becoming ill! Really? It's up to you what you want to believe.

But the medical profession also says that antibodies can attach to toxins. Of course, toxins are chemicals, just as proteins are, which makes the combining of what is called an antibody protein with a toxin a much more likely proposition. Now the format of the toxin has been changed, so it can't exert a similar effect. The medical profession specifically calls substances produced by bacteria toxins, even though all cells eliminate products from their interior, and these are basically all waste products, toxins, coming from their internal energy processes. There is no fundamental difference between them. Hence, an antibody protein that has an affinity to one of these products will attach to it without making a distinction between the various cells the substance could come from. This simply explains all our false test results, because in the absence of the 'specific' bacteria the toxin, said to have been produced by that bacteria, can still be present in abundance as any cell may have produced it, under 'specific' circumstances.

There is another peculiarity in the explanation provided by the medical profession. A high level of antibodies can indicate a recent infection, a chronic or long-term infection, an autoimmune disease, an allergic reaction, or certain cancers. However,

measuring the amount of 'specific' antibodies in the blood is also the type of blood test that shows if a person is immune to a specific disease. This test measures the level of specific antibodies in the blood. A high level indicates, so my doctor tells me, that the person is protected due to a past infection or vaccination. And yet, a moment ago the same high level of antibodies was, according to my doctor, an indication I was infected by that very disease. Now you tell me which is which! – A high level of antibodies in your blood indicates an infection, and a high level of the same antibodies in your blood indicates you are immune to the infection.

Luckily the doctor will tell me which is which, and what I need to believe.

BLOOD TESTS

Can you imagine medicine without blood tests? We would have no idea what is happening regarding our metabolism without blood tests. Everything shows up in blood tests.

To test the blood, a sample is taken, typically from a blood vessel in the elbow fold. A needle is inserted in a vein and blood is withdrawn from the vein. Veins are blood vessels that carry blood from the cells to the heart and from there the blood is directed to the lungs, where it is energised with oxygen. The blood inside the veins is filled with waste material, coming from the cells, that needs to be cleaned up and recycled by glands that are spread out over the circulation system. One could simply say that the sample that is taken for laboratory examination is 'dead' blood, devoid of life, full of waste products. In the laboratory, one is going to make measurements of the vitality of the blood such as how well protected the individual is (immune testing), how well-nourished the individual is (vitamins, sugars, fats, proteins) and how well the various organs function. I don't know how you would be able to evaluate how well your kitchen is functioning, and how much food has been eaten, by examining the waste bin, but that is essentially what the medical profession is doing.

The content of the venous blood is determined by what has not been used by the cells from what was on offer in the first place. It just stayed in the circulation, compounded by the waste all the cells excreted into the circulation. Cellular waste is the leftovers from the burning of energy and the internal processes that have taken place. For instance, finding an elevated level of glucose in the venous blood indicates a high level of energy burning in the cells. Finding a high level of adrenaline in the venous blood indicates a high work rate of the cells. Science already tells us that every cell in your body produces everything it requires by itself. So, bear in mind that what they examine in the lab is the waste bin of cellular activity.

But there is more. In this blood sample, they also test for the function of various organs such as kidney, liver, thyroid, pancreas and heart. Very clever. Remember that the sample is taken from a vein in the elbow. A vein carries

blood away from the cells, back to the heart, and via the lungs it is sent to the various organs. Hence, the venous blood at the level of the elbow contains material that originates from the fingers, hand, wrist and forearm on the side of the body the needle goes in. As far as I am aware there is no kidney, no liver, no thyroid, no pancreas and no heart present in that part of my body. And yet, they tell me that the level of certain chemicals in that blood sample is indicating how well these organs function in my body. Would your car mechanic be able to tell you how much fuel you have in the tank or how low your battery charge is by examining the exhaust fumes of the engine?

Wouldn't it make more sense to believe that levels of certain chemicals within that blood sample have a reference to the cellular activity of the cells in the forearm and hand? If I wanted to know how well my kidney is functioning, should I then not get two blood samples, one from the arterial blood entering the kidney and one from the venous blood leaving the kidney. Only by comparing those two test results can I get some idea as to what the cells of the kidney have achieved. The interpretation of the test results from our standard blood sample is far-fetched, to say the least. In fact, it is so far-fetched it doesn't register on the truth scale at all.

BLOOD PRESSURE

How blood pressure is measured and how these figures are being interpreted is wide open to a serious logical debate. However, let's sidestep this for a moment. What is blood pressure? It is the pressure of the fluid, the blood, inside the blood vessel. In particular, we are talking about arteries, the blood vessels that move the oxygen rich blood to the cells of the body. These arteries are in essence elastic tubes. They have a muscular wall, which contracts and expands, pushing the blood forward towards the capillaries, where the cells are able to extract the oxygen from the blood. Maintaining a decent pressure within the arteries ensures a good perfusion of blood through the organs. Measuring the pressure exerted onto the blood can only really be done by sticking a probe into the artery. An indirect measuring, as the medical profession is doing, increases the number of intervening factors one hasn't got any control over and very likely isn't even aware of.

Your blood pressure doesn't stay the same all the time. It changes based on what you're doing. When you're exercising or excited, your blood pressure goes up. When you're resting, your blood pressure is lower. However, when we consider the fight or flight response the picture becomes a little more complex. Activity levels in different parts of the body change in different direction at different times, and consequently the blood flow through those tissues changes too. Blood pressure and tissue flow are directly related.

Blood pressure provides the driving force for flow, but each tissue independently regulates its own flow by adjusting resistance. In the fight or flight response, we see that there is an increased activity in brain, breathing and skeletal muscles, and a diminished activity in the digestive system. Hence, the blood circulation increases in some parts of the body while at the same time diminishing in other parts, as a result of the achieved blood pressure at a local level. The blood pressure is different in different parts of the body. So, when a doctor measures your blood pressure on your arm, how can he be sure that this is also the exact pressure in the arteries of your brain, digestive system, or lungs? The truthful answer is: he doesn't know what your blood pressure is in those regions, as he is not measuring it. On your arm he is measuring the blood pressure (indirectly) within the skeletal muscles, and then only in that arm. If there is tissue pressure on the artery going down one of your arms – for instance, pressure in the lower neck or around the shoulder – then there will be a different blood pressure between the two arms. This then also means that it is irresponsible to draw any conclusions from a pressure measurement on just one arm, bearing in mind that any suggestion of a blood pressure within part of the skeletal muscular system doesn't allow one to draw conclusions about the blood pressure anywhere else in the body, not even in a different part of the skeletal muscular system. Hence, the medical method of measuring blood pressure doesn't provide any information that can be used to draw conclusions regarding the present state of health or to make predictions about a future state of health.

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On top of that, stating that the blood pressure has a direct relationship to the contractions of the heart is another painful mistake. The fact that the heart by itself is incapable of sustaining the circulation of the blood was known to physicians of antiquity. The heart, an organ weighing about three hundred grams, is supposed to 'pump' some eight thousand litres of blood per day at rest and much more during activity, without fatigue. In terms of mechanical work this represents the lifting of approximately 100 pounds one mile high! In terms of capillary flow, the heart is performing an even more prodigious task of 'forcing' the blood with a viscosity five times greater than that of water through millions of capillaries with diameters often smaller than the red blood cells themselves! Clearly, such claims go beyond reason and imagination.

THINNING THE BLOOD

Blood thinners is a name given by the medical profession to a number of chemical substances, used as medication, that are officially called anticoagulants, because that is what they do. They stop the blood from forming clots in areas where the wall of the blood vessel has been damaged. In effect, it stops the healing process of plugging leaks (coagulation), leading to ›

continual internal bleeding, both on a small but ongoing scale as well as massive ruptures. These have life threatening effects on the brain, the lungs, the intestines and the heart.

The blood is essentially a fluid, containing many different ingredients which thickens the blood, makes it more viscous. Blood viscosity is determined by red blood cells and protein components in plasma. More red blood cells and more proteins makes the blood 'thicker'. Less of these ingredients makes the blood 'thinner'. Compare it to a sauce you are making. The more flour and starch you put in, the thicker the sauce becomes. How can you make your sauce thinner if you find it has become too thick? There is only one way: to add more water. Adding more fluid to the mix will 'dilute' the other ingredients.

The medical profession claims that by stopping the blood from clotting, by stopping platelets to stick together so they can cover a hole in the wall of the blood vessel, the blood has been thinned. This can only mean that the medical profession has invented different laws of physics. To the rest of us, it is obvious that the only way 'to thin the blood' would be by adding more fluid to the circulation and that preventing the blood from carrying out necessary repairs such as plugging holes is not going to make the blood flow any easier or smoother. It will, however, ensure that every naturally occurring small leak will continue to bleed into the tissues, as one can easily observe in the fact that superficial small skin breakages are very difficult to stop bleeding in people who take 'blood thinners'.

PAEDIATRIC MEDICATIONS

Until the end of the last century children were precluded from entering clinical trials, a resolution intended to shield particularly vulnerable individuals from the unanticipated risks inherent to experimental drug exposure. Consequently, most of the drugs used every day in children have been studied only in adults, a situation that has prompted an extensive, virtually 'regular', use of drugs unlicensed in paediatrics. It has been acknowledged,

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by the medical profession, that children are exposed to a greater iatrogenic (= caused by medical treatment) risk compared to adults. In the years 2007–2012, a major result was achieved by an increased number of paediatric patients enrolling in clinical trials. Of approximately 600 Paediatric Investigation Plans submitted, about three quarters were related to not yet authorised medicines (new drugs) and the remainder to new indications for on-patent or off-patent medicines (existing drugs used for indications they are not licensed for). In other words, no clinical trials were done on existing treatment protocols. These treatments have been established by the medical profession simply by assuming that babies and toddlers are small versions of adults. As a result, extrapolating results from adult clinical trials to the treatment of children may be inappropriate and, possibly, harmful. So they confess!

If physicians rely primarily on data collected from adult clinical trials to guide their practice toward children, adverse outcomes are more likely to occur. Yet, doctors continue to prescribe various therapeutic drugs on an 'off-label', because there are not enough approved indications in the paediatric population. You don't test the drugs. You don't get a license for the use of this drug. You keep prescribing it, because you deem it necessary. Once you have illegally been using treatments for long enough, there is a general consensus amongst colleagues that it is a most useful thing to do. Combine this with the fact that your experts have created a belief amongst the general population that this is the right way to treat babies, toddlers and infants, and nobody is ever going to question your knowledge, or lack thereof. Getting used to how things are incorporated no longer demanding proof for how things are. We just assume it has all been done!

In spite of 'good intentions' as portrayed towards the public, the reality of the big change towards more paediatric double-blind studies shows a very different picture. The correlation between paediatric burden of disease and clinical trials, however, continues to be poor, with only 12% of trials focusing on the conditions with the highest burden. The small number of clinical trials involving paediatric patients is found across many fields of medicine. One study looking at randomised control trials (RCT) in speciality journals between 1985 and 2005 found that adult RCT papers had increased at four times the rate of paediatric studies. One of the most used excuses is that it is unethical 'to withhold' a known effective treatment to the placebo group, especially with regards to children. There are, apparently, moral and ethical implications of implementing placebo control groups in paediatric clinical trials. There are, apparently, no such concerns for implementing an untested treatment protocol in paediatric medicine. We consider it dangerous to test the validity of the treatment for an ill child!

CANCER METASTASES

Metastasis is the process whereby cancer cells spread from their original site to other parts of the body. The process involves the following phases:

- Detachment: Cancer cells break away from the primary tumour.
- Invasion: They invade nearby tissues or blood vessels.
- Travel: Cancer cells circulate through the bloodstream or lymphatic system.
- Extravasation: They settle in distant organs.
- Proliferation: Cancer cells grow and form new tumours (metastases).

Here is what the medical research is telling us about what is involved in the process of a cancer cell moving to somewhere else in the body.

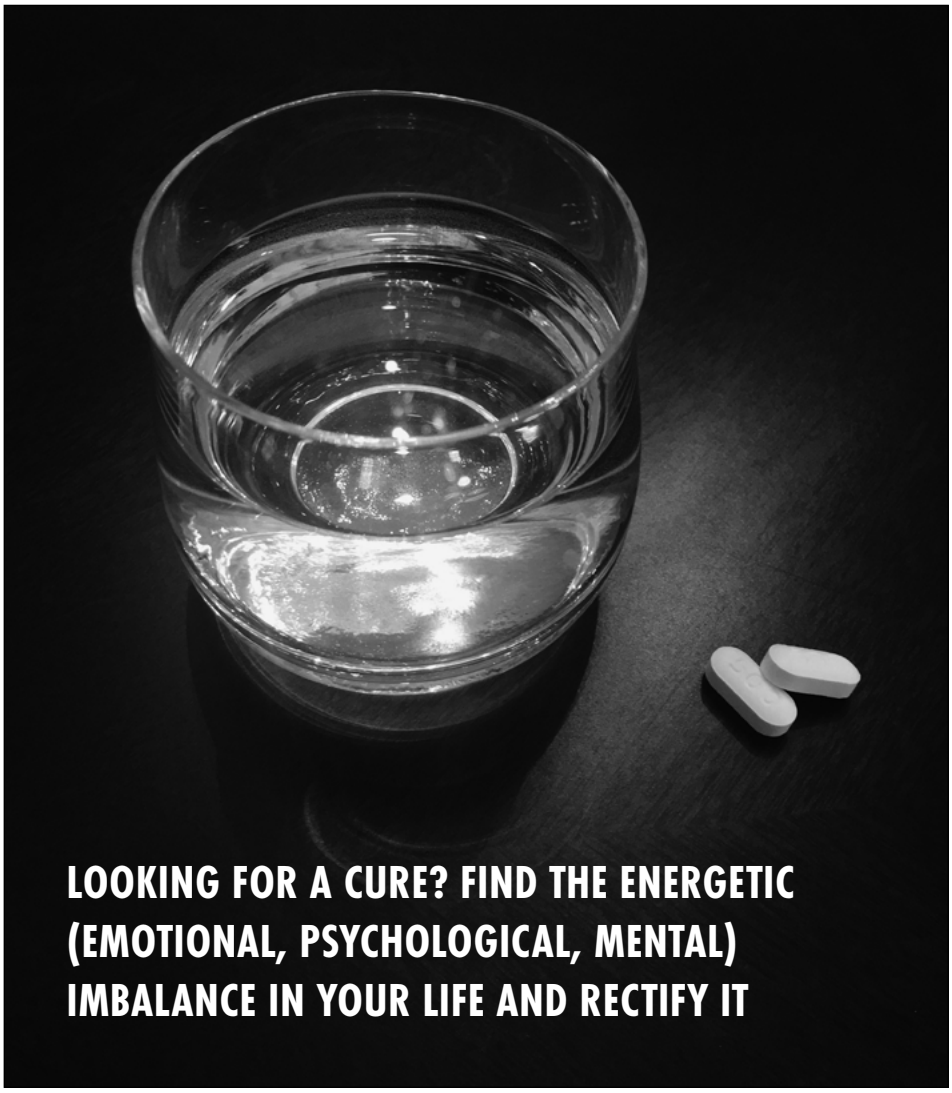
They change from stationary to

mobile, actively pushing their way out of their tumour home. They breach the walls of blood vessels or lymph nodes. They survive the strange new environment and physical forces of the circulatory system. And at their final destination, they do all these steps again in reverse, setting up shop anew and triggering the growth of a metastatic tumour.

Metastasis is very inefficient. Some large tumours may shed upward of a million cells into the bloodstream every day, but only a few of these cells actually form new metastatic tumours. If it weren't so deadly the feat of those few cells would be almost awe-inspiring — nearly all deaths from solid tumour cancers are due to metastatic disease, according to the American Cancer Society.

Tumours can shed up to a million cancer cells a day into the blood stream.

Here is a strange thing. After one hundred years of imaging and blood tests of all kinds, nobody has ever shown even one single cancer cell in transit! In one hundred years of research, not one cell of the millions released every day has been detected! The way they prove the process of metastases is not by showing cells in transit. Oh no, they do it differently. Proof of metastasis comes from a combination of imaging techniques (like MRI, CT, and PET scans), biopsies, and blood tests, which provide evidence of cancer cells spreading to new locations. Or to be more precise, dear doctor, evidence for the existence of cancer cells in new locations. How they got there is speculation! Imaging reveals physical evidence of tumours in secondary sites, while biopsies can confirm the cancer diagnosis and can analyse the tumour cells. Indeed, it confirms where the new tumours are located and what sort of tumour it is. It doesn't tell us anything about where that tumour comes from, even when it looks a bit like one we have seen somewhere else. Blood tests and other tumour marker tests can also help to detect markers associated with the spread of cancer. But, even though in the practice of medicine tumour markers are hailed as providing us with a definite yes or no answer as to the presence of cancer, the medical research tells a different story. Tumour markers have a limited reliability, primarily for monitoring and prognosis as well as for diagnosis or screening, because they often lack both sensitivity and specificity. High levels can be caused by non-cancerous conditions, and cancer can be present without elevated markers or even with a normal level. Not me telling you this, but the so-called science that underpins medical protocols.



LOOKING FOR A CURE? FIND THE ENERGETIC (EMOTIONAL, PSYCHOLOGICAL, MENTAL) IMBALANCE IN YOUR LIFE AND RECTIFY IT

But how does it work when we consider scientific knowledge? All matter is energy. All the tissues are expressions of a spectrum of energy. Hence, all the muscular fibres in the body, in all its variations, are expressions of the same energy frequency. All fat cells are, all collagen, all bone tissue, all nerve tissue, each of these belong to a separate frequency spectrum. Now suppose the frequency that produces collagen moves a little, away from its balanced position, then the corresponding matter, which is an expression of this frequency, becomes 'wonky'. It doesn't function as well. It may even change shape. This may initially become noticeable in one particular organ of the body, but when nothing is done to bring the energy back into balance, other places may also start to show signs of a malformation of the same tissue. Doctors call this metastases.

Looking for a cure? Find the energetic (emotional, psychological, mental) imbalance in your life and rectify it.

OESTROGEN

In addition to regulating the menstrual cycle, oestrogen affects the reproductive tract, the urinary tract, the heart and blood vessels, bones, breasts, skin, hair, mucous membranes, pelvic muscles, and the brain. Secondary sexual characteristics, such as pubic and armpit hair, also start to grow when oestrogen levels rise. Many organ systems, including the musculoskeletal and

cardiovascular systems, and the brain are affected by oestrogen. Oestrogens are used in medical treatments for conditions like menopausal symptoms (hot flushes, vaginal dryness), to prevent postmenopausal osteoporosis, and in hormonal birth control. They are also used to treat hormone-sensitive cancers and to provide feminising hormone therapy for transgender women, and are sometimes used for menstrual disorders or infertility.

The medical profession lists the following side-effects to the use of oestrogens for medical purposes: increased risk of breast cancer, increased risk of uterine (endometrial) cancer, heart attack, stroke, gallbladder disease, skin rash, and allergic reactions.

Birth control methods like the pill, patch, and intrauterine device (IUD) are generally considered safe and effective, yet they do have some risks you should know about. More oestrogen in your body increases the risk of blood clots. Signs of a blood clot are swelling, pain, or cramps in your legs. If a blood clot breaks free, it could travel to your lungs and cause pulmonary embolism. Birth control pills increase the risk for breast and cervical cancers. The longer you're on the pill, the greater your chance of getting these cancers becomes. The pill and other birth control methods that contain oestrogen can increase blood pressure, which could increase your risk for a heart attack or stroke. This type of birth control makes migraine headaches worse or more frequent in 'certain' women, but the medical profession fails to specify who these women are. Birth control pills may have a connection with liver disease and liver cancer. Women who use hormone-releasing IUDs are more likely to get ovarian cysts.

Hormone replacement therapy, for instance postmenopausal, is recommended as extremely beneficial to women, with hardly any risks attached to it. There is an increased risk of breast cancer. The risk increases the longer you take it, and the older you are. There is an increased risk for blood clots and strokes. Common side effects due to taking extra oestrogens at a time when the natural balance is to lower the

oestrogen level, are headaches, breast pain or tenderness, unexpected vaginal bleeding or spotting, feeling sick (nausea), mood changes, including low mood or depression, leg cramps, mild rash or itching, diarrhoea and hair loss. It seems that almost every system in the body is responding to this extra, unwanted, stimulation. And not in a nice way!

The medical profession sells their products while including on the label possible side effects. The main selling point, however, is the slogan that the benefits outweigh the risks. Benefits are highlighted at every turn, while the occurrence of known risks will have to be proven beyond reasonable doubt. It usually ends up as "the cause of the cancer, or the stroke, or the heart attack, is an underlying condition". Something else, be it smoking, alcohol consumption, diabetes, high blood pressure, will 'most definitely' have caused the major upset of cancer or a stroke. On the other hand, claims of less signs of the menopause – as if these are real diseases –, and less osteoporosis – lower bone density in old age is not a disease – are hailed as the result of the magic that is oestrogen replacement therapy, the magic to improve the life of older women. Take note, it doesn't say 'to improve the health of older women'!

In my opinion, when you know what is wrong then you either also know how to fix it or you can show me why it can't be fixed. That is one point. But the other one, and this is an important one as it forms the foundation of science, is that when someone else comes along who can show me how to fix it, then we have all learned something. The medical profession is not interested in this. When they say that the treatment they provide has, in their studies, shown to be successful in 70% of the cases, it is hailed as a fantastic breakthrough and we should all go for it, ignoring the fact that you might be one of the 30% failings. Bad luck! However, when another health approach, such as homeopathy or herbal medicine, says that their studies show a 70% improvement rate with their treatment, then nobody should take any notice of this. It is labelled an 'alternative' treatment, and they do have a lot to say on that specific subject.

Although alternative modalities are rooted in thousands of years of tradition, associated safety concerns remain. Implementing any alternative therapy can influence the efficacy and dosing of many pharmaceutical agents, and the medical profession, remaining true to their superior position on health matters, want you to understand that the pharmaceuticals are the most important elements to maintain and to restore health. So when there is a conflict between a natural treatment modality and the drugs an individual has been prescribed, it is always the

natural modality that has to make room for the pharmaceuticals, never the other way around. They remain convinced that they are the only ones who can be right. Evidence-based therapies – their evidence, not scientific evidence! - have shown remarkable success in treating diseases, so they say. So much so that it necessitates, in their opinion, the integration of modern complementary and alternative medical systems in terms of evidence-based information sharing. In other words, any other approach to health that is worth its salt must come under the supervision of the medical profession before it can play any useful role in medicine. An acupuncturist in Shanghai, trained in Traditional Chinese Medicine and with forty years of experience, can't be trusted as it is a not 'evidence-based' alternative treatment, but a medical doctor who followed a six months course in acupuncture at the School of Medicine is where you need to be for your acupuncture treatment. This is what the medical profession calls 'integrated medicine'. I am the boss, and you are only worth what I tell you, you are. You are only allowed to do what I tell you to do. It is a 'coup d'état', an overthrowing of an existing power.

Alternative medicine describes medical systems or practices that act as a replacement for conventional medicine. That's how the medical profession puts it. Conventional means 'following accepted customs and proprieties'. It is in accord with or being a tradition or practice accepted from the past. And in case you don't know, tradition means 'the transmission of customs or beliefs from generation to generation'. And here the waters get muddied. There is no specific time frame, but something becomes a tradition when it is repeated over time, passed down through generations, and imbued with meaning and significance by a group of people.

A specific group of people, investors in pharmaceutical products to establish a 'new' healthcare system, have managed to create a 'new' tradition, replacing old traditions of healing methods, pushing them into oblivion. They have managed to convince people of the dangers and the silliness of the old healing traditions and now they are able to call their new approach 'traditional', while traditional becomes the new 'alternative'. The roles have been reversed! The main difference is that old traditions are rooted in history and offer a sense of continuity, while new traditions are created more recently and often adapt to modern life or express personal values. Older traditions provide a connection to the past and a sense of familiarity, while new traditions are more likely to reflect a present-day lifestyle and future goals.

The beliefs behind allopathic medicine include the view that the body is a physical machine, diseases are specific entities to be fought with drugs and surgery, and the 'opposite cures' principle, which suggests using treatments to counteract disease symptoms. This approach was introduced in society and put into national laws via serious lobbying and huge private financial investments about two hundred years ago. Claiming it has roots in Roman and Greek medicine and traditions is misguiding us into believing that the new form of medicine is 'similar' to, and has evolved from, very old knowledge. Those old cultures had deep roots within nature, including the way they approached health and disease, which is lacking from our modern medical system.

"However, when another health approach, such as homeopathy or herbal medicine, says that their studies show a 70% improvement rate with their treatment, then nobody should take any notice of this. It is labelled an 'alternative' treatment, and they do have a lot to say on that specific subject."

The belief behind natural medicine is rooted in the idea that the body has an innate ability to heal itself, a concept known as the 'healing power of nature'. This holistic approach seeks to identify and treat the underlying causes of illness rather than just suppressing symptoms, viewing health and disease as resulting from a combination of physical, mental, emotional, genetic, and environmental factors. Key principles include promoting the body's self-healing (principle of cures by similar), treating the whole person, and educating patients to take responsibility for their own health.

Matter arises out of energy, and very specific combinations of matter create living matter. Nature creates living matter, living organisms. The view of nature as a machine, popular during the scientific revolution but since referred to the rubbish bin, sees life as a collection of parts that can be analysed and controlled, but this overlooks its evolutionary and self-organising properties. This mechanistic model still exerts a powerful influence over our thinking about nature and the things in it, as proven by the principles of our medical model, where human life is considered to function like a machine and can be fixed by direct interventions, be it chemical or physical.

However, for roughly four billion years, the defining quality of life has been its purposive self-organisation. There is no programmer writing a programme, no architect drawing up a blueprint. The organism is the weaver of its own fabric. It sculpts itself according to its own inner sense of purpose. Hence, it shapes itself, it forms itself, it repairs itself.

Nature knows how to cure me. And I have been given the opportunity to either listen to nature or to listen to other human beings, who are car mechanics that are advertising and promoting their own skills and knowledge. And therein lies the problem. Nature is soft-spoken, whispers, gently touches and leaves me free. The body mechanics are loud, in my face, shouting, intimidating, threatening me, cursing me, hounding me down and locking me into dependency.

I understand. You are tired.

But I hope you understand that this is not going away because you ignore it.

Who you listen to is a choice you make, whether consciously or unconsciously. Become a conscious human being. Take responsibility for the choices you make in life.

October 2025.

INVENTING THE NATURE OF "VIRUSES"

BY MIKE STONE

viroliegy.com

https://viroliegy.com/2023/11/10/inventing-the-nature-of-viruses

EXTRACT:

For the greater part of the first 50 years of the 20th century, there was no agreed upon definition for what the invisible entities labelled as a "virus" actually were nor how these agents looked, formed and functioned. Some researchers believed that these entities were endogenous processes produced within the host while others envisioned them as exogenous invaders that came from outside and attacked from within. There were arguments over whether "viruses" were corpuscular in nature or whether they were a soluble liquid. Debates centered around whether these agents were alive or if they were simply inanimate and non-living. While there were researchers who believed "viruses" were a ferment or a chemical molecule of some kind, the majority believed that these invisible entities were just smaller unseen bacterium. According to biochemist and historian of science Ton van Helvoort's 1996 paper When Did Virology Start?, the "virus" concept lacked clarity and certainty over the first half of the 20th century. However, the link between bacteriology and "viruses" was so strong at this time that these unseen entities were not considered conceptually distinct from bacteria:

"I have come to believe that, despite its widespread appearance in textbooks and journals of that era, the early concept of the "filterable virus" lacked clarity and certainty. More importantly, I also believe that during the 1930s and 194Os, the links between the study of filterable viruses and bacteriology were so strong that viruses were still considered merely another form of bacteria-not conceptually distinct, as they now are."

The reason for these many contradictory ideas about the nature of the "virus" was a direct result of the fact that the researchers never had a physical entity on hand in order to study. The "virus" was nothing more than a fluid concept that was open to the interpretation of those who claimed to be working with them. Most of these researchers came from a bacteriological or chemistry background, and thus, they viewed the "virus" concept through their own lens and paradigms. Regardless, there was no way to actually determine the true nature of something that could not be seen or studied in reality and that only existed within the realm of the imagination.

Thus, it shouldn't be hard to understand why virologists often have a difficult time answering simple questions such as "What is a virus?" or "Is it alive or dead?" This is exactly the argument made in the appropriately titled 2014 article Inventing Viruses by William Summers, a retired Professor of Therapeutic Radiology, Molecular Biophysics & Biochemistry, and History of Medicine. While being able to define what a "virus" is should be an easy task for any virologist, simple questions about the nature of a "virus" are not ones that are simple for them to answer. In the opening of his paper, Summers asked a more subtle question about the invention of the "virus" category:

"The concept and the nature of the "virus" was invented, and continually reinvented, by virologists as part of the normal progress of their (pseudo) science."

"…how generations of microbiologists arrived at the idea that some of the entities they dealt with fell into a category that differed in fundamental ways from others. In other words, how did they invent the category of "virus" as we now know it?"

Summers looked to investigate how the idea that "viruses" are a separate entity that requires its own category away from bacteriology came to be. In doing so, he admitted that our beliefs, understandings, and conceptions of what a "virus" is changes over time. This is because "viruses" are whatever a virologist tells us that they are. The concept and the nature of the "virus" was invented, and continually reinvented, by virologists as part of the normal progress of their (pseudo) science. In other words, the idea of the "virus" is able to change at any time based upon whatever a virologist wants a "virus" to be at any given moment:

"Even so, how did the category "virus" come to be recognized, and what are its essential, defining qualities? Viruses are natural objects, but our beliefs, understanding, and conceptions of them change over time on the basis of new information, new points of view, and new scientific values and standards. In a very real way, a virus is what virologists say it is. It is a product of the way virologists talk about viruses—that is, the way facts about viruses are organized in their discourse. It can be said that virologists invent (and continually reinvent) the concept of a virus as part of the normal progress of their science."

The deliberate ever-changing concept of the "virus" shifted away from its original invention as an agent of disease transmission to its modern day concept as a genetic assembly that sometimes causes disease when it integrates into its host in order to survive. This reinvention of the concept happened in 1957 when French microbiologist Andre Lwoff took many competing and contradictory ideas and mashed them together into the modern definition of a "virus" based upon work done with bacteriophages. Prior to his reinvention of the concept, in 1953, Lwoff actually questioned whether a bacteriophage was a "virus" and wanted to know exactly what a "virus" was. He even noted that "viruses" are defined to be exogenous (coming from outside of the body) while bacteriophages are "always formed inside its host" and "could therefore be described as endogenous," i.e. originating from within the host. In fact, Lwoff stated that "if prophage is phylogenetically endogenous, the temperate phage produced by a lysogenic bacterium must be described as endogenous," meaning that the phage is from within the host, thus negating it as an exogenous entity in line with the definition of a "virus." Ironically, after redefining the "virus" as a genetic code in 1957, Lwoff would ultimately warn in 1991 that virology was "in danger of losing its soul, since viruses now show a strong tendency to become sequences."

He also argued that the abundance of discoveries was causing "the very concept of virus" to waver "on its foundations," noting that the "problem today and in future is to keep abreast of its whereabouts."

Regardless, Summers stated that his paper was not about the "triumphant accumulation of knowledge by the heroic scientists" of the past. Rather, it was an examination of the "continual struggle to understand and organize observations." This struggle was showcased by Lwoff's own attempts to rationalize and combine contradictory evidence in order to create the modern genetic concept of the "virus" from an entity that did not meet the necessary requirements:

"Nobelist Andre Lwoff, perhaps in a Gertrude Stein frame of mind, famously answered "viruses are viruses" (9), but the question "What is virus?" has been notoriously fraught since the role of virus in late nineteenth-century germ theories became central to medicine, and later, in the midtwentieth-century, to biology in general. The evolution, or perhaps deliberate and continuous reformulation, of the meaning of "virus" from an agent of disease transmission in the nineteenth century to a molecular assembly with remarkable properties by the end of the twentieth century is the subject of this article. This is not a story of the triumphant accumulation of knowledge by the heroic scientists of the past so much as it is an examination of the continual struggle to understand and organize observations that challenged and made obsolete the comfortable certainties of the often recent past. This examination requires consideration of past science on its own terms, without judgment in light of present-day understanding, and it requires consideration of the context and extent of background knowledge of the particular period considered."

This struggle to answer the question "What is a virus?" was ongoing, even in the so-called "modern age" of virology. There was no consensus as to the true nature of a "virus." Summers shared a quote by Joseph Beard that stated that the "virus" was a fabric of concepts that had been "woven of a plethora of woof and a paucity of warp." In weaving terms, this makes for an unstable foundation upon which to weave. Another example was of plant virologist N.W. Pirie who

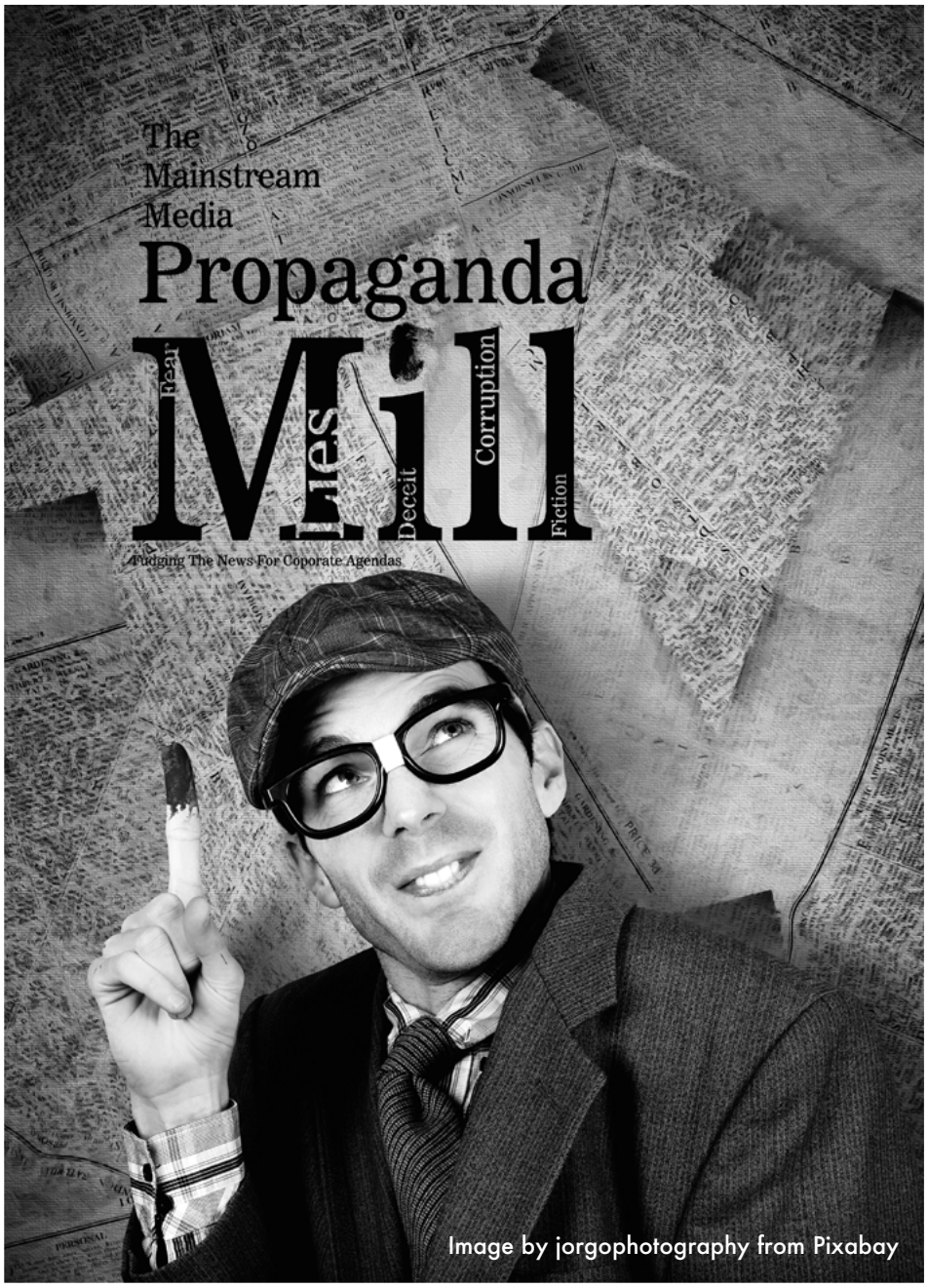


Image by jorgophotography from Pixabay

was considered "agnostic" (impossible to know one way or the other) on whether a "virus" was a molecule or a microbe. However, he seemed to argue that the variability in the chemical composition of the same "virus" went against the modern molecular hypothesis. Thus, we can see that there was no agreement on the nature of the "virus:"

"The construction of the virus as a living molecule in the middle decades of the twentieth century generated wide debate as to the correct answer to the question, "What is a virus?" Having rejected filterability, negative growth properties, and size as defining characteristics, microbiologists searched for new ways to think about viruses. Even at the beginning of what might be called the modern era, there was remarkably little consensus on this subject. Joseph Beard, in 1945, famously remarked, "Viruses are said to be living molecules and autocatalytic enzymes and are likened to genes and mitochondria—in short, a fabric of concepts has been woven of a plethora of woof with a paucity of warp" (quoted in 47, p. 332). N.W. Pirie, one of the pioneers in the study of plant viruses, even in 1949 was agnostic as to whether viruses were microbes or molecules. In a long review of the problem in the British Medical Bulletin (47), he argued that the variation in chemical composition reported for the same virus suggested a level of heterogeneity not compatible with the molecular hypothesis. He noted that "all the viruses purified so far have contained nucleoprotein, but this generalization may lack significance because the viruses that

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have been studied are a group selected to some extent on a chemical basis."

Summers ultimately concluded that each generation of virologists will look at "viruses" in their own way and will alter the concept of the "virus" based upon the "science" of the time. Thus, the "virus" is left to be a concept that is allowed to be continually reinvented at the whims of the researchers:

"Although "viruses are viruses," each generation of scientists looks anew at these fascinating entities in its own way, endowing them with properties, relationships, and capacities that reflect the science of the time. Truly, they are microbes being continually reinvented by their most ardent admirers."

In his summary, Summers laid out 5 very revealing points to end his paper on. Sharing similar sentiments as van Helvoort, he stated that the "virus" concept is an unstable one that "evolved," not due to an accumulation of facts, but rather due to an ongoing reformulation of the "virus" concept on the basis of "scientific" focus at a given time. This reinvention was determined by technological advances rather than scientific understanding. Thus, the answer as to what a "virus" is will depend upon the discourse at the time more so than the "known" characteristics of "viruses:"

1. The concept of a virus has not been stable and has evolved since its introduction in the latter half of the nineteenth century.
2. This evolution has been not a linear accumulation of facts but rather an ongoing reformulation of the virus concept on the basis of scientific focus at a given time, e.g., growth, metabolism, chemical composition, genetics, or physical structure.
3. The concept of a virus has particularly been determined by technological advances rather than scientific understanding.
4. The answer to the question "What is a virus?" is one that depends on the particular scientific discourse at a given time.
5. The discourse with respect to the physical object "virus" is based on the particular concerns and problems of interest at a given time more than on any one set of intrinsic characteristics known about viruses.

LIVING OR NON-LIVING???

Why is it so difficult for virologists to simply explain basic questions about a "virus" such as whether the "virus" is living or dead? Why must the concept of what a "virus" is change depending upon the researchers and technology of the time? What physical organism changes in concept after over a century of supposed study? The answer to all of these questions is actually fairly easy to grasp.

As the researchers have never actually had any physical entities on hand in order to study, the concept of what the assumed invisible entities are was allowed to constantly change in order to suit the needs and evidence of the researchers of the time. There was no solid foundation for virology to stand upon from the very beginning in order to definitively state what the nature of a "virus" truly is.

"There was no solid foundation for virology to stand upon from the very beginning in order to definitively state what the nature of a "virus" truly is."

While Summers paper on the invention of the "virus" offers some great modern insight into the problems related to defining the nature of the invisible beast, there is a much earlier paper by prominent virologist Thomas Rivers from 1932 that details the many issues with trying to give life to the imaginary shortly after its conception. You may know Rivers due to his 1937 proclamation that "It is obvious that Koch's postulates have not been satisfied in viral diseases." This shockingly honest admittance that the essential logical criteria considered necessary in order to prove a microbe causes disease remains unfulfilled for "viruses" and continues to haunt virology to this day. As it is a rather long 18 pages that I have reproduced here, I will try to keep my commentary throughout brief. However, what Rivers highlighted as key problems in 1932 during the formative years of virology compliments Summers 2014 paper on why virologists needed to invent, and then continually reinvent, the concept of the "virus" that was dreamt up in the late 1800s.

Thomas Rivers immediately began his 1932 paper on the nature of "viruses" by admitting that, up to 1932, "viruses" were defined solely based upon their absence as well as for what they were not. "Viruses" were defined in negative terms as they were:

1. Invisible to ordinary microscopic methods.
2. Unable to be obtained via filtration.
3. Unable to propagate in the absence of susceptible cells.

Interestingly, things did not progress away from defining "viruses" in negative terms even with Andre Lwoff's 1957 modern reinvention of the concept as noted by Professor Milton W. Taylor, teacher of virology and world-renowned historian from Indiana University. In a 2014 paper examining what a "virus" is, Taylor explained that Lwoff's reinvention of the "virus" concept was also a "negative definition" that "stresses the non-cellular nature of viruses." By Lwoff's own words from his 1971 paper From Protozoa to Bacteria and Viruses. Fifty Years with Microbes, he defined "viruses" by the "inability to grow and to divide, absence of metabolism, absence of the information for the enzymes of energy metabolism…the absence of transfer RNA and of ribosomes and also of the corresponding information." In other words, even by the modern definition, "viruses" were still defined by what they were not.

While Rivers attempted to define "viruses" in what he felt were positive terms of what was "definitely known" about these invisible agents, he admitted that the biological nature was still a moot question, i.e. one open to debate and challenges with no foreseeable solution or answer. Perhaps this was due to his feelings that, while there was plenty of data concerning the nature of "viruses," the accumulated data was "distinctly lacking in quality," and that "enough reliable data have not been acquired to establish the nature of the viruses."…

To read the full article please go to: https://viroliegy.com/2023/11/10/inventing-the-nature-of-viruses

FEAR

REPRODUCED from The Informed Parent, Issue 2 2008 p22.

TiP Editor: Fear plays such a huge role in the decisions we make in life so I thought it would be appropriate to reproduce the following article written by Dr Jayne LM Donegan back in 2008.

IN MY OPINION, the biggest barrier to intelligent management of childhood illnesses is fear which comes in many forms:

- Fear of trusting our own judgement and intuition because we have been led to believe that only the 'professionals' are qualified to make decisions about our children.
- Fear that diseases that were once regarded as part of growing up are now 'killers';
- Fear that without high tech interventions our children will suffer disability or death;
- Fear of symptoms such as fever, cough or rash;
- Fear that without paracetamol or ibuprofen, our children will all have febrile convulsions;
- Fear of every rash, that it might be meningitis;
- Fear of allowing cough and mucus to run its natural course (out of the body);
- Fear that the world outside is full of random bacteria and viruses that are just waiting to strike our children down;
- Fear that without antibiotics, no child will come through an illness;
- Fear that without 99% bactericidal soap our children will be infected by dangerous germs in their environment;
- Fear that without vaccination, no child will reach adulthood.

We even seem to be afraid nowadays that our children cannot cope with fresh air, so we keep them cooped up in over heated houses instead of putting them out to play in all weathers as our grandparents and great grandparents were. It is not surprising that there is so much fear in the realm of healthcare, or more accurately, disease care. If you feel this way, it is because that is how your doctor, health visitor and practice nurse feel too. Unless they have studied an alternative health philosophy, all they know about infectious disease is 'The Germ Theory of Disease' - all those bugs are out there waiting to get you, and if you don't have the latest antibiotic/ vaccine/ antiseptic/ bleach your child's toys three times a week, you will contract a hideous disease that may be mild in some cases, but could, without doubt, attack and harm your child, leaving them disabled or dead. No wonder so many of us reach for the bottle of paracetamol, sterilise our houses, don't allow our children to pick up food they have dropped on the floor, and vaccinate with 25 different vaccines by the time they are 13 months, according to the latest schedule (29, if your child gets the BCG and Hepatitis B vaccine).

We are also encouraged to fear by the sensationalist handling of disease in the media. We hear horror stories about an increase in cases of measles as if it were the black death. If a child can be found who has died, the story is paraded four times an hour on news bulletins and splashed across all the newspapers with the savage delight of a pack of hounds pulling apart a fox at a hunt. Any attempts at finding out the circumstances of the case, the prior state of health of the child, details about their treatment before or after reaching hospital are met with absolute silence – the idea seems to be to promote fear, not understanding. Even a visit to a farm is clouded with dire warnings of 'Deadly E.coli risk'!

Does this fear matter? Yes it certainly does, because a frightened parent is a stressed parent. The immune system is a delicate, sensitive and wonderfully intelligent apparatus. A child, and even more so, an infant, sees the outside world through the lens of their parents feelings and understanding. It is only later that they take their first independent steps along the path of self knowledge.

Common sense tells us that stressed mothers cause stress in their babies, and this has been confirmed in studies. Stress causes outpourings of steroid hormones which, after an initial boost, cause a lowering of the effectiveness of the immune system. So you enter a vicious cycle; you fear that the worst will happen to your child, this lowers you child's ability to cope with their day to day life, and when they get ill, lowers their ability to cope with the illness, then they go on to get complications and there you have it: a self fulfilling prophecy.

SO WHAT CAN WE DO?

We can put our feet back firmly on the ground, take a nice calm deep breath in, and an even longer one out and look at the facts. If it were really that difficult to reach adulthood, none of the human race would have reached the twenty first century. And if you look back at recorded history, the real killers throughout the ages have always been: war leading to famine causing pestilence and then death – the three horsemen of the apocalypse.

Worldwide, clean water has saved more lives than any other single intervention.

I believe that every parent inherits the ability to care for their child, in much the same way as we inherit the colour of our eyes, hair or skin. All the tools we need are inside us already, all we need is practice in their practical application.

The great American naturopath Herbert Shelton was fond of saying: "happiness, contentment and cheer should be cultivated with as much care and persistency as the gardener exercises in the cultivation of his plants."

So cultivate self-confidence, optimism and faith. Faith in yourself that you have been endowed with everything necessary for your present task, and faith that you and you children have been born into a supportive world where there are many more good people than bad, and abundance of what we need rather than lack.

VACCINE CHRONICLES

DR JAYNE LM DONEGAN MBBS DRCOG DCH DFFP MRCGP
Naturopath & Homeopath,
Retired NHS GP

THE WORLD HEALTH ORGANISATION states, *"Global immunization efforts have saved at least 154 million lives over the past 50 years,"* quoting a study published in the Lancet in May 2024. Such figures are widely and uncritically disseminated in the media. They are used to drive government economic, health and foreign policy.

How robust are these figures?

COMPUTER MODELS

Remember the Professor Neil Ferguson of Imperial College, London. His computer modelling validated the 2001 slaughter of up to 11 million UK farm animals with a total cost of £8 billion and from which British farming has yet to recover, but it earned him an OBE. In 2002 he overestimated by magnitudes human deaths from Bovine Spongiform Encephalopathy, similarly in 2005 regarding human bird 'flu deaths and in 2009, swine 'flu deaths. But none of this abysmal track record dented the eagerness of the government to enthusiastically embrace his 2020 COVID death projections – 2 million deaths in the USA and 500,000 in the UK – though based on the same flawed computer modelling. These figures were used to shut down the country, destroy businesses, deprive children of their education, force sick and elderly people to die on their own, in the company of strangers or no-one at all and wreck the economy for years to come.

It comes as no surprise, then, that two of the authors of the Lancet paper above are also from Imperial College London, and other institutions funded by Bill & Melinda Gates Foundation; Gavi, the Vaccine Alliance; and the Wellcome Trust.

Over 80 per cent of the funding of WHO's funding relies on "voluntary contributions", 88% of which are provided by the Gates Foundation.

Does this matter? Of course - because


DR Jayne L.M.Donegan

these investors are focussed on one single intervention which is not: providing clean water; installing sewage systems; correct farming practices, nor providing material to build ventilated housings and latrines - only vaccination.

Is it any surprise the information we are given is so skewed? *Qui dat, imperat* – He who gives, commands.

IMMUNITY OR 'PROTECTION'?

Vaccine manufacturers, package inserts, health authorities and doctors used to say that vaccines 'immunised' people against disease. This was imperceptibly dropped and the word 'protect' replaced it, after real world data showed that people were still getting the disease they were being vaccinated against. Measles vaccines were described as 'one shot for life' when introduced in the 1960's (USA 1963, UK 1968)- by the time we reached the 2000's they are described as 'highly effective protection' or 'help to protect' – which doesn't mean anything very much at all and therefore cannot be held against a manufacturer when vaccinated people get the disease. Far from it – the worse a vaccine performs, the more doses of it are added to the schedule so the more money they make.

It is a win/win situation for the vaccine makers. In addition, the public are now introduced to the idea that vaccines are still effective even if your child goes on to contract the disease, the narrative being that being vaccinated 'reduces the severity' of the disease. This was masterfully exemplified with the covid shots – the fact that they neither prevented infection nor transmission was highly successfully dressed up in the 'reduce the severity' spin to the extent that when multiple injected people developed symptoms of covid they declared, *"At least the shots meant I didn't end up in hospital."* If they had to be admitted to hospital, they said, *"At least I didn't have to go to ITU."* If they were so ill they had to go to ITU, they said, *"Well at least I'm not dead."* And of course, if they died ….. they didn't say anything. RIP.

PERTUSSIS

Pertussis vaccine used only to be given in the first year of life at 3, 5, 10m but babies kept getting whooping cough, so the start of the schedule was accelerated to 2, 3, and 4 months (1990). This was also ineffective, so a preschool dose was added in 1999.

It still failed to control the problem. Despite the dogma that pertussis was 'eliminated' in vaccinated adults, the landmark 1996 study from Kaiser Permanente (a California HMO) showed that 12% of vaccinated adults with a cough lasting longer than two weeks actually had undiagnosed whooping cough. Did that prompt any reflection that vaccine was perhaps not working and should be scrapped? *"No,"* they said, *"Let's add more doses."* It is a great business model for pharmaceutical companies: the worse your vaccine performs the more health departments and governments buy it. It certainly does not incentivise making a more effective product. Whooping cough without the classic 'whoop' is a cause of long-term cough in children and adults such that there is now talk of adding a school-leavers' vaccine. This is already done in the USA where children get a dose at 2, 4, 6, 15 months; 4-6 years, 11-12 year, during every pregnancy or every ten years.

DIPHTHERIA

Diphtheria vaccine was originally only given in the first year of life and preschool, but since the outbreak of diphtheria accompanying the break-up of the former Soviet Union in the 1990s, in multiple vaccinated as well as unvaccinated populations, diphtheria vaccination has been added to the school leavers' vaccination and also to the tetanus vaccination such that it is now no longer possible, should you want to, to get a tetanus shot at your local A&E department without having it combined with diphtheria and polio, although you may have to be quite firm in your

questioning to elicit this fact – so much for informed consent. Similarly the 'Whooping Cough' vaccine in pregnant women – the majority consenting have no idea that the vaccine they are receiving also includes diphtheria and tetanus vaccines, and in some cases polio vaccine as well.

HIB

Vaccination against Haemophilus influenza b (Hib) was introduced into the routine immunisation programme for babies in 1992 with a catch-up campaign for children up to the age of four years. It was not considered necessary in those over the age of four as they were regarded as already immune. It was hailed as a great success. But ten years later with rising cases of invasive Hib disease another 'catch-up' campaign was mounted in 2003 for all children aged six months to four years . Did it work? It doesn't seem to have, as waning effectiveness lead to another Hib booster combined with Men C vaccine being given at 12 months of age in 2006.

Parents are told that every vaccine in the schedule is crucial and that their child may die of an avoidable disease if they do not bring them to get every dose exactly on time. However, when GlaxoSmithKline (GSK), the manufacturers of the Hib/Men C vaccine Menitorix, discontinued it with stocks running out mid 2025, it suddenly became 'not crucial'. The Joint Committee on Vaccination and Immunisation (JCVI) gave the opinion that there would be cross coverage from the MenC containing 'quad' vaccine given to secondary school children, based on no evidence other than our friends the computer models.

They have however added another dose, at 18 months, of the 6 in 1 vaccine – another dose of diphtheria, tetanus, pertussis, polio, Hib and hepatitis B vaccine containing very high levels of aluminium compound adjuvant. So, we will soon be seeing invasive Hib disease in teenagers and adults, but that's alright, another dose can just be added to the school leavers' vaccinations as well.

HEPATITIS B

Regarding Hepatitis B vaccination, for years the JCVI refused to bow to the World Health Organization's insistence that everybody on the planet be vaccinated against Hepatitis B, stating that universal Hepatitis B vaccination was not cost effective in the UK as hepatitis B is not endemic there and those at higher risk are well catered for by selective vaccination of at-risk groups and screening of mothers in antenatal clinics. However, in 2015 the manufacturers of the 6 in 1 hexa vaccines lowered their prices making the universal programme cost-neutral vs selective high-risk vaccination. Hence, in 2017 the JCVI advised that three doses of Hepatitis B containing vaccines be added to the infant schedule at 2, 3, and 4 months of age, plus a new 18 month booster in 2026.

If your mother is not hepatitis B positive, you are only at risk from hepatitis B disease from sex, dirty needles, intravenous drug use, tattoos and infected blood transfusions. If your infant is at risk of any of these eventualities, there will be far more serious safeguarding concerns than the hypothetical risk of hepatitis B. Worse, when your child reaches the age of 15 years when they may just be at risk of sex, drugs and rock 'n' roll – the antibodies from the infant vaccination will have worn off.

I submit that 'the price being right' is not a good reason to give an infant four doses of a hepatitis B containing vaccine for a disease from which they are not at risk, and worse, a vaccine that has a such very high level of aluminium adjuvant. If there is no risk of contracting the disease under normal circumstances then there is not even hypothetical benefit of taking the vaccine to balance the risk of adverse drug reactions.

ANTIGENS AND ANTIBODY PRODUCTION

Antigens are 'antibody generators'. They are put in vaccines to stimulate an antibody reaction. Vaccines are not licenced based on their ability to stop disease but on the level of antibodies they produce with certain hypothetical levels being deemed 'protective' – that word again. Unfortunately antibody levels – all that vaccines give – are not the same as 'immunity' - health and correct management of fever are the only immunity. This is why you can have high levels of immunity and still get disease symptoms and have no antibodies. Just look at how many doctors and nurses care for patients in epidemics and do not succumb themselves.

This sole focus on antibodies has led vaccine manufacturers to spend billions of dollars making sure that their vaccines make massive levels of antibodies. This is the reason why aluminium salts are put in so many vaccines as *adjuvants* from the Latin *adjuvare* – to help. Just injecting disease antigens into the body does not guarantee antibody production. The body is very economic, an immune response uses energy which then requires more food, more metabolism - more building up, breaking down – excretion - respiration. Hence in many cases the body will just get rid of these antigens by innate mechanisms. However, as aluminium has no place in the body and is always toxic, the body will always make an antibody response to it.

The idea is that by adding the aluminium salts to the vaccine, while the body is making antibodies to the aluminium salts, it will also make antibodies to the disease antigens in the same syringe. This is the aim of the process. However, in nature what you want is not always what you get. Once stimulated by the aluminium component, the body will make antibodies to *everything* in the vaccines. If you want to know what that is – put *emc* drug into your search engine, This will bring you to the UK Electronic Medicines Compendium. Put, for example, tetanus into the search box. This will bring up all the *tetanus* containing vaccines currently licenced in the UK. Click INFANRIX Hexa and select *Summary of product characteristics (SmPC)*. Choose section 2. *Qualitative and quantitative composition*. You will see that the Polio component is propagated on *VERO* cells. Vero from Esperanto *"verda reno"* (green kidney). Vero cells are an immortalised cell line derived from the kidney epithelial cells of an African green monkey in 1962 by Japanese researchers. The Hepatitis B component is "produced in yeast cells *(Saccharomyces cerevisiae)* by recombinant DNA technology."

Are the monkey and yeast DNA and other contaminants of these 'live' biologics removed in the manufacturing

process? GSK claims purification "virtually eliminates" cell substrates though unverified by regulators. And what does 'virtually' eliminates mean? 'Virtually' is neither a specific nor scientific term. How much is required to cause problems when you are injecting such compounds into 2, 3, 4- month old babies to cause immune havoc in the body as well as sensitisation and overstimulation?

Is it any wonder that we are in the midst of an avalanche of allergies, not to mention neuro-immune dysmodulation and an epidemic of special needs in schools. GSK candidly state, *"The vaccine may contain traces of formaldehyde, neomycin and polymyxin which are used during the manufacturing process."* It is all there in plain sight, just nobody looks, especially not the doctor, nurse or health visitor who is frightening you about what terrible things will happen if you decide not to comply with the vaccine regimen they are pushing. Then go to section 6.1 of the SmPC, *List of excipients* and see what else is there - Medium 199 (as stabiliser containing amino acids (including phenylalanine), para-aminobenzoic acid – a folic acid (vitamin) precursor - and *other substances* - what might they be? All with Aluminium salts to stimulate antibodies to them.

ANTIGEN LEVELS

What about the levels of antigens? It is notable that the diphtheria toxin content in vaccines for tiny babies at two, three and four months of age is much higher than is permitted to be given to children over 10 years of age. Even though their kidneys and liver are not yet functioning properly, their gut and blood brain barriers are far more porous and they have very immature immune systems and detoxification mechanisms, the 6 in 1 vaccines (Infanrix hexa, Vaxeli) given to infants and 18m toddlers, contain 30-international units and 20iu respectively of diphtheria toxin. But this level is precipitously dropped to only 2iu for preschoolers and older. This means that a 70kg or 100kg man would get a dose of diphtheria toxin 10-15 times *smaller* than a tiny baby.

Why? Because the massive adverse reactions that older children and adults produce in response to the diphtheria toxin is so obviously linked to the vaccine that even the medical authorities have to acknowledge their seriousness. Conversely small babies with their immature immune and detoxification mechanisms do not produce such a competent response and are therefore flooded by the foreign constituents, including the material from other species and other vaccine components as described above. Injection bypasses natural protective barriers—skin, gut, and respiratory system—where exposure can sensitise more than immunise or even 'protect'. For infants, neurological or developmental problems can easily be dismissed as pre-existing. In older children and adults, prior health status is clearer and more observable.

"Why? Because the massive adverse reactions that older children and adults produce in response to the diphtheria toxin is so obviously linked to the vaccine that even the medical authorities have to acknowledge their seriousness."

Medical authorities justify reducing the diphtheria antigen dose by 10-15 times in those over 10 years of age by claiming immune priming from initial vaccines. This rationale fails, however, as unvaccinated children over 10 or adults still receive only the low-dose formulation. UK Green Book Chapter 15 Diphtheria (May 30, 2025 update), page 2:

"Vaccines containing the higher dose of diphtheria toxoid (D) are used to achieve satisfactory primary immunisation of children under ten years of age. Vaccines containing the lower dose of diphtheria toxoid (d) should be used for primary immunisation in individuals aged ten years or over, where they provide a satisfactory immune response, and the risk of reactions is minimised."

Official UK/US/WHO guidance thus prioritises reactogenicity over potency for older age groups—but not for infants—despite babies showing no overwhelming reactions, this does not preclude unrecognised vaccine-related problems.

JCVI FAILURE TO PROTECT BRITISH CHILDREN: URABE MMR

In 1988, the JCVI made the now infamous decision to licence MMR vaccines containing the Urabe mumps strain—Pluserix® (SmithKline Beecham [SKB]) and Immravax® (Pasteur-Mérieux)—for the UK MMR campaign because they were cheaper. Across the Atlantic in Canada, the same formulation under the name Trivirix® (Pasteur-Mérieux) had already been distributed and discontinued. Licensed in Canada in 1986, it was suspended by 1987 due to reports of more than 85 meningitis cases linked to the Urabe strain. Japan experienced a similar outcome, with 125 cases.

Nonetheless, the UK JCVI deemed this an acceptable risk—especially since Urabe-containing MMR cost half as much as the Jeryl Lynn mumps version (MMR II). They based this on a rate of one meningitis case per 10,000–15,000 doses, then dismissed even those figures because of the voluntary nature of the reporting which lacked active surveillance and proven causality and despite Canadian data indicating one case per 3,000–12,000 doses.

It took indefatigable researchers—Dr Alaric Colville, a Consultant in Communicable Disease Control, and Dr Simon Pugh, a microbiologist at Nottingham Health Authority Public Health Laboratory Service—to confirm a real meningitis risk of 1 in 4,000 doses based on meticulous local surveillance data. Having prioritised Urabe-containing vaccines to dominate 85-90% of the UK market, the JCVI downplayed Nottingham's signal as also unrepresentative while favouring cost savings and uptake over immediate suspension.

Chief Medical Officer Sir Kenneth Calman, however, took decisive action on 11 September 1992—independent of the JCVI—to suspend Pluserix® and Immravax® MMR vaccines (Urabe strain) and rely solely on Jeryl Lynn-based MMR II. Four days later, the manufacturers unilaterally withdrew their Urabe vaccines. Sir Kenneth Calman's action was more than vindicated in 1993 when Dr. Elizabeth Miller's study, based on active surveillance, confirmed the Urabe hazard as real and causal—no cases

occurred in children given the Jeryl Lynn-based MMR II.

Parents of more than 100 injured children filed claims for Urabe MMR injury, but the Legal Services Commission cut funding due to "insufficient causal evidence."

The JCVI's role in protecting British children from harm: zero.

CHICKEN POX

Then we come to chicken pox vaccine. The reason for introducing this vaccine is apparently to save £24 million in parents taking time to look after children with chicken pox (see my 2023 article). The data regarding time off work were obtained by questioning the parents of children at nurseries and daycare, not GP or A&E records.

Why? Because chicken pox is such an innocuous disease that most parents manage it themselves and do not seek medical intervention. Indeed the new requirement that GPs notify cases of chicken pox has brought them out in arms claiming that they will be inundated and overloaded with parents seeking appointments. Remember that these childhood illnesses are developmental milestones. Appropriate supportive management of the fever is crucial and well managed chicken pox markedly reduces the incidence of atopic dermatitis and attendance at dermatology clinics up to 10 years later . When Dr Jonathan Silverberg and colleagues affiliated to State University of New York published their study, they drew a lot of criticism - career risk for bucking consensus is real

DÉJÀ VU

Which formulation of chickenpox vaccine does the JCVI recommend for every 12- and 18-month-old British child? MMRV: ProQuad® (Merck Sharp & Dohme) and Priorix-Tetra® (GSK). These combine the MMR with varicella vaccines.

MMRV (measles, mumps, rubella, varicella combined vaccine) was originally prioritised in the USA, but the Vaccine Safety Datalink (VSD)—which routinely monitors vaccine safety via near real-time surveillance of computerised patient data—detected a signal of increased seizure incidence. It found that for the first dose, MMRV more than doubled

"Why? Because chicken pox is such an innocuous disease that most parents manage it themselves and do not seek medical intervention.."

seizures in children (from four to nine per 10,000 vaccinations) compared to separate MMR and varicella vaccines given at the same visit. As a result, in 2008, the US Advisory Committee on Immunization Practices (ACIP) stopped recommending MMRV for the first dose.

As recently as September 2025, the US ACIP stated: *"Unless the parent or caregiver expresses a preference for MMRV vaccine, CDC recommends that MMR vaccine and varicella vaccine should be administered separately for the first dose in this age group."*

Yet starting in 2026, UK children are scheduled to receive two doses of the very same MMRV combination vaccine—which doubles seizure risk from 4 to 9 per 10,000 doses.

This stark policy divergence raises serious questions: Why does the JCVI consider doubled seizure risk acceptable for British children, when a nation five times larger (330 million vs 67 million) with real-time Vaccine Safety Datalink surveillance has confirmed the harm and adjusted accordingly?

They state: *"It was felt that the benefits of offering a combination vaccine—improved uptake, parental acceptance, and fewer injections for the child—outweighed the low risk of febrile convulsions."*

Remember, we are talking about mumps, measles, rubella, and chickenpox—illnesses parents once deliberately sought out for their children. In 1959, GPs could say, *"Many mothers have remarked how much good the attack has done their children, as they seem so much better after the measles."* . When reading reports of children in intensive care or dying from measles in 21st-century developed countries, recall that correct fever management is crucial and well-managed childhood illness confers long-term survival benefits. Fear is not a good basis for decision making.

Yet the professionals charged with guarding our children's health seem more focused on getting vaccines into arms than on what happens to the child subsequently. Rather than vaccines being made for children, it increasingly appears children are made for the vaccine—to paraphrase the Good Book.

MOVING FORWARD – OR BACKWARD?

Are we better or worse off now than 30 years ago? Well, the JCVI has not improved but in1992 Drs Colville and Pugh were able to release their shocking Urabe meningitis figures with the help of the media and the decisive intervention of the then Chief Medical Officer to protect our children and go on to have successful and rewarding careers. But a few short years later it was a different story.

The Urabe disaster came on the heel of another vaccine scare when the principled and astute doctor, John Wilson, a paediatric neurologist, with colleagues from Great Ormond Street Hospital, had published a case series in 1974 linking whole cell pertussis vaccine to severe neurological injury/encephalopathy in 35 children. This led to a plummeting in vaccine uptake with many more cases of whooping cough being diagnosed – but no concomitant rise in deaths – whooping cough is, after all, a normal childhood disease. We have just as many cases as before but general practitioners and paediatricians seem not to have the clinical acumen to diagnose it. After the pertussis and Urabe débâcles enough was enough. It must not be allowed to happen again.

In the late 1990's when another set of honest doctors published a case series of children with developmental delay and bowel symptoms, there was no supportive press, no decisive Chief Medical Officer. The *ad hominem* brigade went into full-on frontal assault. Thirteen respected doctors wrote that paper. The other senior author was the globally respected paediatric gastroenterologist professor John Walker-Smith. *Entzwei und Gebiet* - divide and rule - defeat each sequentially through attrition—conquer piecemeal. Wakefield isolated from the twelve, picked off alone.

The GMC case was a farce, Wakefield's legal team did not even manage to produce the ethics approval that was, in fact, obtained for the study from the Royal Free's ethics committee. Wakefield ›

and Walker-Smith were struck off but as the professor was never the target, his medical indemnifiers paid for a high court appeal in which he was exonerated. Judge Mitting severely criticised the General Medical Council's inadequate and superficial reasoning leading in a number of instances, to reaching wrong conclusions; the belief that [determining honesty] was not necessary – an error from which many of the subsequent weaknesses... flowed; the panel even failed to make express finding on research vs clinical practice. It was on the basis of these that the good professor was exonerated. By the same token the rest of those accused should also have been, but the indemnifiers would not fund any appeal for Dr Wakefield – the third generation of his family to train at St Mary's Hospital Medical (my *alma mater*) and dedicate themselves to the relief of suffering and restoration of health to their patients – but in the 21st century that is no longer the role of a physician. To be a yes man, an algorithm follower is now regarded as the highest good. It is very sad.

PLUS ÇA CHANGE

None of this is new – the Hungarian obstetrician Ignaz Semmelweis (1840s) was persecuted in Vienna for challenging authority and recommending that doctors wash their hand with chlorinated water between dissecting corpses and delivering babies.
Maternal deaths went right down but he died in an asylum for the insane, beaten to death by guards. Now everybody washes their hands. Alfred Wegener (1910s) put forward the theory of Continental drift having observed that continents fit like puzzle pieces – but he and his ideas were mocked as he was not a geologist until the 1960s. Now every school child knows about tectonic plates.

Norman McAllister Gregg published his landmark paper 'Congenital Cataract following German Measles in the Mother' in 1941. He was mocked as he was a senior ophthalmic surgeon and lecturer not a public health doctor and worse – Australian – what would they know?

It took over six years before his findings were amplified by a prestigious infectious disease doctor in Boston Dr Conrad Wesselhoeft. Later the honorary doctorates and professorships flooded in from all over the globe.

WHAT CAN YOU DO?

As a parent how can you protect your children and yourself? – It is tricky as the state continues its creep into the family unit, the home, education, religion, statehood and memory. You cannot rely on others to keep you safe - so keep your feet on the ground. Have faith. Turn off the external chattering noise. Get informed. And if you do not have the time or inclination to do mountains of research just take a deep breath and follow your gut. If there is ever a difference of opinion between your head and your gut – your gut will always be correct. Think fast, act slow and choose what you reveal to authorities thoughtfully, and carefully.

© 2026 Dr Jayne LM Donegan, MBBS DRCOG DCH DFFP
18 January 2026
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THE NON SCIENCE OF MODERN MEDICINE OR THE EMPORIA WEARS NO UNDERPANTS – LAUGH I NEARLY DIED

BY HOWARD BEARDMORE, DO
biometherapy.co.uk

SYMPTOM LED TREATMENT based on Huccoms razor only makes sense if you want to mystify therapeutics. The idea that the body is 'going wrong' instead of 'trying to go right' doesn't give any credit to how marvellous being alive actually is. What if symptoms were actually a body telling you something needed attention, an early warning system. If an oil warning light comes on in the car, do you stop and put oil in the engine or just put a piece of sticky tape over the light? Do you do a 'bulbectomy' when the light gets really bad, or earplugs in when the oil-less engine starts screaming?

Yes, a surgeon can perform miracles after a car accident, babies stuck in childbirth or a rotten tooth that needs help removing. Even a surgeon will admit after they have removed a bad appendicitis that the body heals the wound. But most people are not suffering from 'truck run over syndrome', they are suffering because they have been taught that the body can't exist without constant meddling and spent years suppressing the desperate attempts of the body to ask for help.

Herbert Shelton, a natural hygienist said that disease is not deficiency in medication and Hippocrates, who certainly wasn't the father of modern medicine said 'there are no diseases, only obstructions to health' 460BC.

If the modern healthcare system was actually named according to what it actually does we'd call it a 'disease management system'. Even the concept of disease is wonky. According to the WHO, a group of private companies who set the gastronomy standard for disease management, there are 30,000 different diseases of which they only have treatment for 15,000. Then we look at their definition of treatment and find it actually means 'anything that alters, modifies or changes the pathway of a disease process'. How can palliating symptoms be correlated with treatment? No other

scientific profession does this, they get to the core and addressing the causes.

I first trained as an Architect, have been a qualified Osteopath for 30 years and just completed a qualification to become a plumber. Next it's a qualification to become a Part P compliant domestic electrical installer. Nowhere here do I find plumbers just putting buckets under leaks as a treatment for leaks, and walking away, then prescribing bigger buckets when they fill, or electricians holding wires together with their hands or builders putting steel patches over cracks instead of fixing the foundations under a wall.

Why has modern medicine failed to understand even basic healing. Pain killers and anti-inflammatory medications stop collagen forming in wounds. Ice stops healing. The inventor of RICE (Rest and Ice) Mr Mirkin retracted his paper in 2009 saying that putting ice on strains causes more damage. Who was the first person to say this about not using ice to heal ie this was stupid? --- Hippocrates! 460BC. Mirkin found that shutting the blood circulation down by constricting the blood flow stopped the body removing damaged tissue and providing wound healing factors in the repair process. I can't give treatment advice here but I can tell you in 30 years of practice I have never used ice as a treatment - apart from a G and T at the end of a long day of teaching people how to be well.

Inflammation is an important stage of the tissue healing process as the body removes damage and brings what repair needs, mediated via the blood. The disease management system sees inflammation as the enemy and does everything it can to suppress, turn off and cut it out. We need a repair system fully functioning in our body to stay alive. Your car needs a MOT, planes need a maintenance schedule - not a parachute for everyone flying put under the seat just in case the wings fall off. The immune system is a waste/damage recognition and repair process, that if fed well, given rest and hydration is amazing. Why doesn't the disease management system get real food into hospitals and promote rest? Have you ever stayed overnight in a hospital, where the lights are on all night, trying sleep during the repair cycle, where everyone is given 2 paracetamol every 4 hours, ¾ of the fatal dose, every day, with no sleep! Paracetamol is a liver poison. Is it any wonder that hospitals are full of people who never get out or get 'infections' they didn't have when they went in. We currently have lots of flu woo on the various media outlets, but no context. Last week I saw a headline say 2,400 people a day in hospital with flu. I looked up how many hospitals in the UK there are, 1480 last count.

That means in every hospital we actually have 1.6 people with flu in a country of how many million! Is this news or science spin, has AI really turned people's thinking process into mush that they believe there is a flu problem now in the UK? There are a lot more people with haemorrhoids, a sign of liver congestion from eating all that 'slow food' causing constipation! Taking laxatives for eating rubbish, is like putting rocket fuel in a car that's coking up and expecting it not to explode. I suppose treating your car like this you could wear a crash helmet and fit an ejector seat, just to be safe, or buy a new one every time it blows up and call it 'genetic'. In Richard Dawkins 'the god delusion' he mentions the ubiquitousness of the common cold and no matter how hard they tried, science could not get rid of it. Well Richard I've got news for your meme, the 'cold' is the defrag of the hard drive, it is the seasonal system reboot. From your logic everyone going for a MOT on their car has caught a virus, compelling them to go to these centres and get a certificate.

Studies done on the usefulness of the common cold found that during a study on patients with bladder cancer some of the groups developed a Coxsackievirus cold and all of their precancerous white patches disappeared. You can look up how many research establishments have found this to be true. Why is washing out the bladder with Coxsackievirus seen as a treatment, Why not just let people have colds without taking 'cold remedies'. Many flu remedies have pseudo ephidrine in them, this is the substance that the famous film Breaking Bad cracked to make metamphetamines. Look at the people who smoked crack and see how healthy they are. Maybe if everyone was allowed to have a cold, and there are many kinds, they wouldn't then develop chronic health problems. There are many examples of the correlation between what Natural hygienists would call cleaning events and better health afterwards.

Look up the inverse association of wild mumps infection as a child being an acknowledged protector against developing ovarian cancer as an adult. All of the childhood conditions, chicken pox, measles, rubella have known protective effects against developing chronic diseases as adults when supported correctly in non-malnourished patients.

When the Cochrane collaboration did a 96 season study of the effectiveness of flu vaccine, comparing old people's homes that vaccinated everyone, or just the staff or just the inmates it found no difference to the outcome of how many 'got flu'. Cochrane concluded that the flu vaccine was 3% 'effective!' It's overall conclusion was that the flu vaccine was 'implausible at best'. Well if my work as an Osteopath, plumber or Architect was 3% effective I think I would need the whole media worldwide machine to spin me as useful too - to stay employed.

'Clinically effective' is another crazy definition of success in the medical woo world. It means better than placebo, which is 20%. That means 80% not effective. So if my new medical treatment makes 21% it is defined as better than placebo, 79% useless. It then takes years for the side effects to emerge and then when the sales of a drug fall below the payouts for compensation it leaves the market for a new 'symptomatic cure'.

When the Aesculus hippocastanum (conker tree) tree produces a green spiky thing with a brown nut inside and falls off and children feel compelled to thread them on strings and swing them about do we say they are infected with a virus to behave like this? In summary the symptomatic approach to therapeutics has done a lot to create new 'diseases' which are really the body's attempt to overcome years of suppressed cleaning and healing.

Why don't doctors and the NHS train people to see diet as more than calorie counting. Where is advice on what I call the eliminatory and cleaning foods that provide what we need to stay clean and repaired, and healthy? It is what I teach my patients every day. Doctor actually means teacher, not suppressor. CAM and alternative health is a ridiculous concept. Why would anyone want to compliment disease management and what is the alternative to health? Death!

TIP ARCHIVE

TESTIMONIES CONCERNING VACCINATION AND ITS ENFORCEMENT BY SCIENTISTS, STATISTICIANS, PHILOSOPHERS, PUBLICISTS, AND VACCINE PHYSICIANS

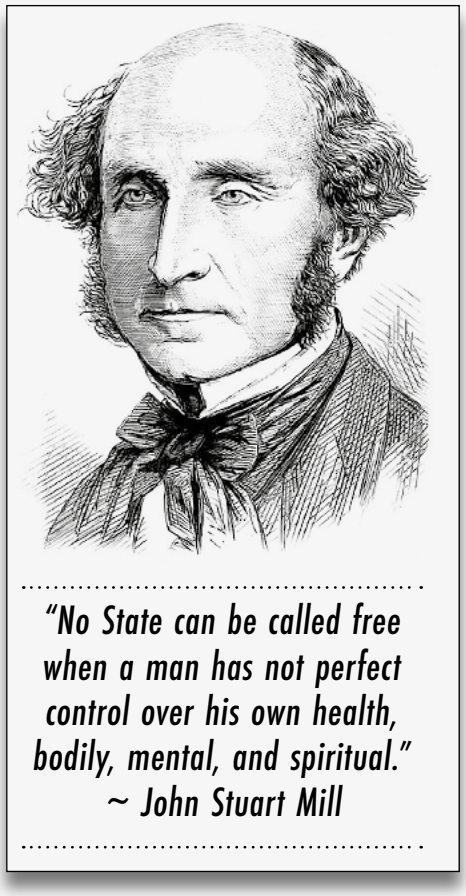
EXTRACTS

THE LONDON MEDICAL OBSERVER
Records the particulars of 535 cases of persons having small-pox after Vaccination, including their names, with an index, pointing to the authorities as witnesses; also similar details of 97 fatal cases of small-pox after Vaccination, together with the addresses of ten medical men, including two Professors of Anatomy, who had suffered in their own families from Vaccination.

Concerning these remarkable evidences, Dr MACLEAN observes: "Although numerous, they are few in comparison to what might be produced…..It will be thought incumbent on the vaccinators to come forward and disprove the numerous facts decisive against Vaccination here stated on unimpeachable authority, or make the *amende honorable* by a manly recantation. But experience forbids us to expect any such fair and magnanimous proceeding, and we may be assured that under no circumstances will they abandon so lucrative a practice, until the practices abandons them." – (Volume viii., 1810)

Professor RICORD, M.D., Paris.
"At first I repelled the idea that syphilis could be transmitted by Vaccination. The recurrence of facts appearing more and more confirmatory, I accepted the possibility, with reserve and even with repugnance; but to-day I hesitate no longer to proclaim their reality."
– Address at the Academy of Medicine, Paris, May 19th, 1863.

Dr. HOEBER, Homburg. "It is a public secret that the Vaccination law stands upon feet of clay. A slight push is sufficient to overthrow the whole fabric."
– Der Praktische Artst, January, 1878.



"No State can be called free when a man has not perfect control over his own health, bodily, mental, and spiritual."
~ John Stuart Mill

Dr. B. F. CORNELL, M.D., President of the Homeopathic Medical Society of New York.
"It is my firm conviction that Vaccination has been a curse instead of a blessing to the race. Every physician knows that cutaneous diseases have increased in frequency, severity, and variety to an alarming extent. To what is this increase owing?

Contagion may account for some of the varieties; in a large majority, however, to no medium of transmission is the widespread dissemination of this class of diseases so largely indebted as to Vaccination."
– Address delivered before the Homeopathic Medical Society of New York, February 11th, 1868.

Professor FRANCIS W. NEWMAN
"Nothing is clearer to anyone who will open his eyes that that what is now called Vaccination has no effect in lessening small-pox, and has frequent and terrible effect in doing mischief."

Sir THOMAS CHAMBERS, Q.C., M.P., Recorder of the City of London.
"I find that of 155 persons admitted at the Small-pox Hospital, in the parish of St. James's, Piccadilly, 145 were vaccinated. At the Hampstead Hospital up to May 13 last, out of 2,965 admissions, 2,346 were vaccinated.

In Marylebone 92 per cent of those attacked by small-pox were vaccinated. Can anyone after this be found to contend that Vaccination is a protection against small-pox?"

J.J. GARTH WILKINSON, M.R.C.S., author of Human Science and Divine Revelation."
"The Vaccination movement grows, and shows its evil tendencies more and more, and corrupts the pseudo-scientific medicine of the hour to its very core.

PASTEUR'S experiments are the most complete exhibition of this fact.

His end would be, could he obtain it, to poison all the blood of all the flocks and herds of the world, in order to keep them in health for the use of mankind.

How little he and his like know of the nature of the seeds of evil; of the fruits that are inevitable from them."
– October 11th, 1881.

Mr. JOHN M'LAREN, M.P., Lord Advocate for Scotland.
"I should not have thought it advisable to enforce Vaccination by compulsory legislation, because it is a principle of common law that no man should be compelled to submit himself or family to a medical or surgical operation without his own consent." – January 24th, 1881.

A ROOM FULL OF FLU PATIENTS AND NO ONE GOT SICK

A BOLD FLU EXPERIMENT SHOWS THAT GOOD AIRFLOW, FEWER COUGHS, AND THE RIGHT PROTECTION CAN STOP THE VIRUS COLD–EVEN INDOORS

ScienceDaily.com
https://www.sciencedaily.com/releases/2026/01/260110211204.htm

Comments by Magdalene Taylor, TiP Editor

THE ABOVE HEADLINE in Science Daily caught my eye and prompted me to have a read – are they finally admitting that they do not understand the flu? Science Daily referred to a study which was published 7 January 2026 entitled: **Evaluating modes of influenza transmission (EMIT-2): Insights from lack of transmission in a controlled transmission trial with naturally infected donors;** PLOS Pathogens, https://doi.org/10.1371/journal.ppat.1013153

In the Abstract of the actual study I finally arrived at the words I was looking for: No Recipient developed influenza-like illness…. I have to say that I was not in the least bit surprised as to the result, but I was surprised that the paper was published…the authors could have binned it, couldn't they?

In the Author summary they state that they aimed to *'study transmission from people who they considered naturally infected with circulating virus'.* More assumptions – given that an alleged flu virus has not been properly isolated, purified, characterised and then observed to cause flu in another recipient how do they know 'circulating virus' was responsible for those they deemed as people naturally infected?

The basic outline of the study was placing groups of healthy volunteers (Recipients) with people with flu (Donors) to stay in a quarantine hotel for two weeks to allow for plenty of close contact in an indoor setting. Various exposure events were used including interactive games, cards, shared computers, microphones and pens, and physical activities including, stretching, yoga or dancing. However, no recipients became infected!!

Despite the outcome of the study, rather than admit how mysterious the result was the authors came out with a number of assumed reasons (or you might call them excuses) for the unexpected result.

Possible explanations included that Donors were not coughing much (and yet during the Covid narrative they indicated that just being less than six feet away outdoors you might catch it!!). Another excuse was 'that the middle-aged recipient groups were older than Donors and possibly less susceptible to infection because of additional years of vaccination and infection. However, I could not see anywhere in the paper where the vaccination status of the recipients was indicated – so was that another assumption??

Regarding the environment of the exposure room - two fan coil units and two large capacity dehumidifiers with fans were run constantly on high speed in addition to portable air cleaners without filters which they assumed should create a well-mixed environment. However, given that no one became infected another of their excuses was that the extensive mixing of mechanical systems affecting the exposure event room reduced/diluted the extent of Recipient exposure??

Returning to the Science Daily report on this study, they quoted one of the authors Dr Milton:

"At this time of year, it seems like everyone is catching the flu virus. And yet our study showed no transmission -- what does this say about how flu spreads and how to stop outbreaks?" said Dr Donald Milton, professor at SPH's Department of Global, Environmental and Occupational Health and a global infectious disease aerobiology expert who was among the first to identify how to stop the spread of COVID-19.'

On reading Dr Milton's comment, I am in great wonder as to how he was apparently among the first to identify how to stop the spread of the alleged SARS-CoV-2 when he is at a loss when it comes to how the common flu even starts??? I am beginning to wonder if the world of science is somewhat Monty Pythonesque??

Science Daily, rather than raising concerns and questioning the outcome of the study, it ends by stating further assumptions:

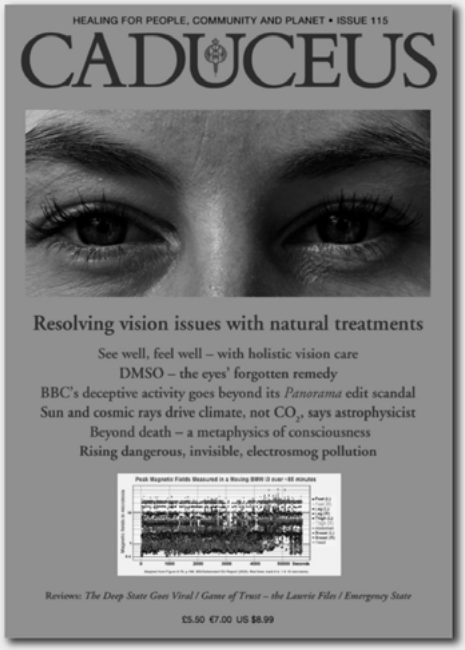
'The lack of transmission observed in this study provides valuable clues about how people can reduce their risk during flu season.

"*Being up close, face-to-face with other people indoors where the air isn't moving much seems to be the most risky thing -- and it's something we all tend to do a lot.*

Our results suggest that portable air purifiers that stir up the air as well as clean it could be a big help. But if you are really close and someone is coughing, the best way to stay safe is to wear a mask, especially the N95," said Milton.'

Valuable clues??? If this was not such a serious subject, it could be considered hilarious!!

Re-connect with your inner guidance



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HOMEOPATHY INTERNATIONAL (HINT)

A new homeopathy body supporting the profession has released a position statement regarding vaccination and informed consent. They are looking to engage with government bodies to find out why the NHS has not been keeping doctors up to date about their professional liability regarding informed consent. Their statement can be found at: http://www.hint.org.uk

AIMS & OBJECTIVES OF THE *informed* PARENT

1. To promote awareness & understanding about vaccination in order to preserve the freedom of an informed choice
2. To offer support to parents regardless of their decisions
3. To inform parents of the alternatives to vaccinations.
4. To accumulate historical & current information about vaccination & to make it available to members & interested parties.
5. To arrange & facilitate local talks, discussions and seminars on vaccination, childhood illnesses & the promotion of health.
6. 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 Informed Parent in or towards fulfilment of the objectives of The Informed Parent.

THE INFORMED PARENT COMPANY LIMITED. REG.NO. 3845731 (ENGLAND)

The views expressed in this newsletter are not necessarily those of The Informed Parent Co. Ltd. We are simply bringing these various viewpoints to your attention. We neither recommend nor advise against vaccination. This organisation is non-profit making.

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