THE informed PARENT
ISSUE ONE 2022 A NEWSLETTER ON VACCINATION ISSUES AND HEALTH

THE VIRAL DELUSION

OVERVIEW BY MAGDALENE TAYLOR, EDITOR OF THE INFORMED PARENT

This is the title of a new five-part documentary series that has recently emerged due to the growing concerns and questions surrounding germ/virus theory. It has been produced by an independent researcher Michael Wallach and in my opinion is well worth giving your full attention to watching it in its entirety. The first episode is nearly 2.5 hours long and focuses on the 'science' behind SARS-CoV2 and a look at modern virology. The clear explanations and interesting points raised are very accessible to all and you can always re-watch and check out scientific papers and references mentioned for further investigation.

There is a very small fee to watch the rest of the episodes but certainly well worth it in my opinion. I would be most interested in your feedback and I would be particularly interested in whether any of you have discovered published science that actually proves the accepted virus story and the existence of pathogenic virus proven to be responsible for the various types and variants we are led to believe exist. Discussion and healthy debate is what is needed for us to strive towards a better understanding of health and disease, isn't it? I have been featuring a lot more articles on questioning the germ theory, particularly in recent editions due to the alleged pandemic – and I consider this documentary series very timely. The theories that are the very foundation of vaccination are long overdue for a thorough examination. How sound is 'the science' – is it really so 'settled'? Where are all the control experiments? Whilst there are some medical and scientific professionals raising concerns about the safety and efficacy of vaccination, many of them do not appear to have delved into questioning the validity of the germ theory. This new series tackles areas that are not generally being covered in other video documentaries and interviews, and yet these theories are the most important aspects to scrutinise given that vaccination is totally reliant on the foundational science to be absolutely proven.

Episode Two looks at the story behind polio and how a small branch of the scientific establishment came to convince the world that polio was the result of a virus and not from environmental toxins? This then led on to forming the foundation of modern virology leading to more and more vaccines emerging into the vaccine schedules over the last seventy years or more.

Episode Three takes a look into the history books regarding diseases such as the plague, smallpox and the Spanish flu and reflects on other information from the past which highlights other, more likely reasons for these disease expressions to be experienced by large numbers of individuals over the centuries. Then the thorny subject of AIDS is tackled in the next episode. I say thorny as it is another subject for which those who raise questions about this area are often verbally attacked and labelled. On page 10 of this newsletter edition I have included a couple of extracts from an article comparing the AIDS story to the COVID story, which along with this particular documentary episode will hopefully give you a broader perspective, and inspire further questioning. The final episode of this series focuses on how much of modern virology relies heavily on computational sequencing and modelling as opposed to reality. In silico is becoming the norm rather than in vivo. Is this good science? Or just convenient computer-generated science that is easy to manipulate or arrive at results that are useful to the virus industry? It is for you to decide.

The Viral Delusion: https://tinyurl.com/4u7kfu5s

THE DATA IS QUITE CLEAR

"If there's anybody that deserves the Nobel Peace Prize [Bobby Kennedy] is the one" Robert Malone Praises Robert F. Kennedy Jr on Tucker Carlson Tonight.

"I think there's a good chance as a vaccinologist, I'm embarassed now to learn what the actual data are about the efficacy of vaccines and what has really caused the decline in infectious disease in children. The data is quite clear – that decline basically parallels the improvement in sanitation prior to the implementation of vaccines for almost all of these pediatric diseases. And if I live long enough, I suspect that we're going to see Bobby Kennedy totally vindicated if it's possible to for people to actually look at the data."

Tucker Carlson interviews Dr Robert Malone, 10 February 2022. Full interview (44 mins into video for above quote.) https://www.bitchute.com/video/AJ46rdzaY9M4/


Magda Taylor

Editor's note

GOOD TO SEE the spring flowers appearing and bringing some colour into our lives. As many of you are aware spring is also a time for spring-cleaning and not just our living environment, many of us go through a seasonal detox around this time depending on how much of a build up of toxins we have accumulated. Spring fever, if not suppressed is an opportunity to have a good clear out as we move into the season of growth. Of course most of these seasonal colds and flu will no doubt be called covid just to keep people in mind of the pandemic (alleged) we have just lived through! Additionally, via msm, we continue to receive warnings to be prepared for many more pandemics in the future.

Headlines such as 'Future pandemics will be far worse than Covid warns Bill Gates.' (Euroweekly News, 20/01/22) with comments such as:

'Speaking about the work done by CEPI, the Microsoft founder said in a statement: "As the world responds to the challenge of a rapidly evolving virus, the need to deliver new, lifesaving tools has never been more urgent."

CEO of CEPI, Dr Richard Hatchet, said: "These generous pledges will dramatically advance CEPI's plan to reduce epidemic and pandemic risk in the future by developing vaccines against emerging infectious diseases while ensuring equitable access for all." '

Keeping the public permanently fearful seems to be the priority. Why isn't there more questioning as to why in this day and age, when we are supposedly 'healthier' with all the products, including numerous vaccines, modern medicine has on offer, along with improved living conditions etc. would the world population suddenly start experiencing one pandemic after another??

And what is meant by 'rapidly evolving virus'?? How do non-living nano particles evolve - if non-living? And why would they suddenly (if they were able to) be evolving now? Where are the journalists who should be asking the authorities the many questions that have arisen over the last couple of years? There is an epidemic of unanswered questions it seems.

May I take this opportunity to thank you all for subscribing to The Informed Parent newsletter. Some of you have been taking the newsletter for many years, and without this support I would not have been able to continue producing this publication. Since the internet came into our lives the number of subscribers has gradually fallen over the years and it is now getting to the point where I may have to consider producing an e-newsletter only to avoid the ever-increasing postage costs and printing etc. I realise that many of you still prefer receiving a paper copy and therefore if you are able to promote this publication more and help increase the subscription numbers I would be greatly thankful.

This September marks 30 years of The Informed Parent publication and this has only been achievable by the subscriptions and kind donations from you – so thank you very much!

***Magdalene Taylor, Editor,** April 2022*

THE MISINTERPRETATION OF ANTIBODIES

TRANSLATED AND EDITED FROM GERMAN ARTICLE BY NORTHERN TRACEY AND JOHN BLAID.

https://telegra.ph/Die-Fehldeutung-der-Antikörper-07-12

BRIEF EXTRACT

A closer look at antibodies is more important today than ever. After showing in my other articles that there is no proof of the existence of a pathogenic virus, because none of the claimed pathogenic viruses have fulfilled Koch's postulates, the "antibody" card has now been played by the vaccination advocates. Their claim (which has been drilled into heads for decades) that they are the indirect proof of a pathogen, or offer protection against a pathogen X, is based on an error. This assertion has been repeatedly exposed as false. Since being asked again and again what these antibodies are, I would like to show in this article that antibodies are no proof of protection, nor that they work specifically as in the key/lock theory.

WHAT IS A TITER INCREASE?

Quote - Dr. Stefan Lanka:

"The increase is nothing more than the body's reaction to poisoning [adjuvants], when the body is poisoned, holes are torn in the cells by these poisons and the cells are destroyed. The body's reaction when cells break down is to form sealing substances (globulins), small protein bodies that immediately expand in acidic environments, become flat and cross-link with their hydrogen sulphide groups (in which energy is stored) with other proteins and other things.

These cause blood to clot and wounds to heal and they seal our cells when toxins are injected into the body. Even if you get a blow on a muscle, (forming a bruise) or a blow on the kidney (especially sensitive), or the liver, there is an immediate increase in titer. The body reacts to this by sealing the damaged cells and sealing growing cells.

It's like a house that leaks until the windows are in and sealed. They called this an antibody and even a specific antibody, which is not true.

The binding property of these hydrogen sulfidetype proteins is non specific, they bind to all sorts of things. You can manipulate this in the laboratory by changing the acid level, adding detergents that change the mineral concentration to achieve a binding or not.

The blood of a pregnant woman is full of globulins to seal the placenta, which is constantly growing, to accommodate the baby. The blood of a pregnant woman has to be diluted 40 times to avoid a massive positive result in tests, such as an HIV test."

IMMUNITY – FROM WHAT?

BY LESLIE THOMSON

The Kingston Chronicle (Rude Health)

March – April 1966, No. 6, Vol. 27

TiP Editor: The following article was written by a traditional naturopath, Leslie C Thomson back in the mid-60s – hence the style of writing. It does have a somewhat paternalistic tone here and there – however please overlook this. For those interested in looking back to the basic naturopathic view on health held over 50 years ago, this may prove thought-provoking. Due to the length of the article the following text is slightly edited and is only the first half of the full article – the second half will feature in Issue 2 2022.

IMMUNITY FROM WHAT – PART ONE

Persistent propaganda is a powerful force, and it takes a comparably confident determination to withstand its drive. Parents are in a particularly vulnerable position, because tremendous leverages can be exerted against them through their children. A man or woman who would have no hesitation in trusting instinct or reason in making a decision about his or her own life can be thrown into doubt and confusion when parental emotions are aroused. Being a parent is one of the toughest jobs in the world, and it is made no easier by the supreme arrogance of so many professional advisers.

In the current intensive campaign (with full government backing) for the medication of water supplies with fluoride, one is repeatedly shocked by the callous inhumanity of official voices. They know that fluoridated water must produce disease and early death in a proportion of those who drink it, but they refuse to look at such awkward facts. Instead they keep their own gaze, and would direct ours, on the promised benefits to the teeth of children aged between five and fifteen. By thinking in terms of statistics, instead of about human lives, it is easy to rationalise one's self into supporting a profitable dishonesty.

In the same way, 'Health' officials are always ready to assert without the slightest hesitation that children must be 'protected' against a variety of ills. Their own records show that their confidence is misplaced, and the really scientific observers in their midst – the men who are looking for facts and examining results rather than trying to sell a product – are far from positive about the benefits of immunisation. Whereas the enthusiasts see the unfortunate few who obviously suffer from the treatment as "a negligible proportion of the total", the more discerning person makes a rather different comparison: he is likely to inquire how the damage inflicted by the treatment compares with the damage which might have occurred without it, and this leads to some extremely disturbing conclusions.

Drug-minded and vaccine-favouring authorities are always quick to take refuge in that inhuman concept – "the calculated risk" – which implies a fair assessment of the probabilities. In fact the calculation is concerned essentially with the limits of mass credulity, and the risk factor they are worried about is a purely financial one: whether the new treatment will show its 'side-effects' too soon and too clearly, before the advertising costs have been recouped from revenue.

NUISANCES

The term "immunity" is freely used, and most people probably take it to mean that the individual who has received the treatment cannot possibly develop one or other of various unpleasant disease conditions. That is certainly the implication of most propaganda for immunisation, although the prudent manufacturer or doctor would never let himself be pinned down so specifically. If pressed for assurances, he will take refuge in "statistical support" for his claims, and suggest that even if unfortunate accidents do occur, they are a small price to pay for the overall benefit. When I hear people speak of immunity, I cannot help thinking of the 'immunity badges' which were (and may still be) a feature of student charity rag days. The idea was that, to avoid the nuisance of being pestered for contributions during the week, one could buy a badge which would keep the collectors and their tin boxes at a respectful distance. The trick, of course, was that the badge cost considerably more than one would be expected to contribute in chance encounters with the coin-box brandishers.

There is a certain similarity with immunisation against disease. The promise is of freedom from a particular kind of nuisance, but the cost may be a far greater distress. It should be clearly recognised also, that immunisation is not a promise of a better-than-average chance of escaping from a specific form of illness. It is in all cases based on the belief that illness is bad for you and stopping symptoms is good. We of the Nature Cure school believe just the reverse – that many forms of illness have a logical and constructive purpose, and that stopping symptoms can be deadly dangerous.

Immunisation is a big subject, and it may be more easily dealt with – and at the same times its scope indicated – by briefly listing seven main questions:-

1) What does immunisation really mean?
2) What are the immunisers' methods?
3) Is it successful – and what does 'successful' mean?

4) Why is it difficult to find out the facts?
5) What is the real cost of artificial immunity?
6) Is there such a thing as 'natural immunity'?
7) If so, how may this be encouraged?

MEANINGS

When the immuniser offers to protect you, it most often means that if you allow him to inject a quantity of a virulent foreign matter into the tissues of you or your child, you should not show certain symptoms even when many of those about you are doing so. The materials used are obtained in a variety of ways, none of which could be described as pleasant, mostly utterly repulsive to those of normal sensibility, and often involving intense and cold-blooded cruelty. It is no exaggeration to describe the entire technique as witchcraft of the most primitive order; the bringing together of all manner of revolting and unclean things, producing a ferment of putrefaction and then administering the product to gullible persons as a protection against evil spirits. Macbeth's three lady friends could have learned much from to-day's immunologists!

That the treatment, by injection, vaccination or inoculation, does have an effect upon the patient's system we do not question. Most people find that they are promptly and disagreeably disturbed by the treatment, and our interpretation of this contrasts strongly with the orthodox claims. When the living body produces a vigorous reaction to be poisoned or invaded it is usually a sign of fairly good vitality, the system is capable both of resentment and of active self-protection. The immuniser would say that his treatment has "taken". But when the recipient of toxic material is in an already depressed state of health, with an accumulation of toxins choking his vital functions, there may be little or no response to the proportionately small increase of filth in his system. A few grains more of deadly rubbish is neither here nor there; no marked fever occurs, there is no noticeable swelling or inflammation at the site of the injection, and the immuniser sadly observes that his treatment has "not taken".

Whether through sheer ignorance or by intuitive craftiness, the immunologists use these effects to support their practice. They find that those in whom the vaccine 'takes' are less likely to show symptoms of later illness than those in whom it does not 'take'. From this they reason that the immunisation is effective. We see it quite differently; the vigorously-responsive person is in far less need of eliminative illness, and his prospect of developing 'a disease' in the near future is slight. The toxin-clogged, and unresponsive, individual is the one for whom the development of a disease is imminent- if you like, he is the one in greatest need of 'protection' – and the treatment only makes his state of misery more abject.

"Anyone who believes that human bodies become ill only when invaded by a pathogenic micro-organism is to be pitied. That the belief is shared by some of the most eminent medical men in the land is a cause only for greater pity."

CLAIMS

The claimed effect of immunisation is to stimulate the formation in the bloodstream of 'antibodies' – complex, protein-like substances which are able to neutralise the toxic characteristics of the germ associated with the particular disease. The blood, thus equipped with suitable weapons, is therefore able to repel attempted invasions by the germs – or, in the more fashionable jargon, the 'virus' – of the threatening disease. The disease is thus credited with an individuality and with a deliberate, malicious intent – exactly like the evil spirits feared by less enlightened peoples.

Anyone who believes that human bodies become ill only when invaded by a pathogenic micro-organism is to be pitied. That the belief is shared by some of the most eminent medical men in the land is a cause only for greater pity. It constitutes one of the greatest blunders ever perpetrated in the history of so-called "scientific medicine". In its modern form, the idea owes most to Pasteur who, ironically, was one of the first to recognise its basic error. But by the time Pasteur realised his mistake, the idea had been enthusiastically taken up and exploited commercially, so that he was quite unable to gain any real publicity for his amended belief – that the germ was of secondary importance to the environment or 'soil' in which it may exist and multiply. Pasteur's early guess laid the foundation for all modern antibiotic treatment – of which immunisation is one section- and his guess was wrong.

Germs do exist, and specific types are responsible for characteristic effects in various circumstances; they are capable of producing certain changes and of evoking specific symptoms. That must be clearly set down, as otherwise one is liable to be accused of deliberately ignoring facts; of denying that germs exist and have functions. Yet none of this runs counter to our fundamental belief that only when there is unwholesomeness already present can a 'disease' microbe successfully invade and colonise the living body. This is a far less simple picture than the immunisers would have us accept, and it also makes their claims more ridiculous than impressive.

If one further accepts the Naturopathic understanding, and believes:- (1) that acute illness is most often the outward sign of constructive and self-cleansing activity within the body; (2) that the processing and elimination of wastes can be assisted by various forms of bacteria, then the idea of killing off such bacteria does not seem at all a good one. Whether the slaughter is attempted by direct attack with antibiotic drugs, or is imagined to be possibly by the indirect and problematical processes of immunisation, it is seen to have little or no possible advantage to the patient. In fact it must appear to be a foolish and damaging intrusion into a delicately-balanced situation.

HOUSES

Let us look at a well-worn domestic parallel. Consider a street of residential houses, undistinguished in structure from each other and all occupied by

averagely respectable and tidy families. Every so often, there is an outbreak of spring-cleaning – a serious disruption of normal routine – which affects the entire neighbourhood. But no-one thinks of calling the phenomenon a disease; it is not an epidemic. It may be decidedly uncomfortable for many of the residents but everyone recognises and accepts it as a necessary process.

Now just imagine some smooth-talking salesman trying to convince these people that he could supply them with immunity from spring-cleaning, then allow your imagination the further exercise of considering the typical housewife's response. She would want to know exactly what was being promised. Would the house remain perfectly clean and tidy by itself? If so, how? Would it mean upsetting the general efficiency of the household? What kind of guarantee could the salesman give? Did the cost bear a reasonable relationship to the service? And so on.

Perhaps it is easily overworked, but the housecleaning analogy is in many ways appropriate. A house which is properly looked after throughout the year will require a less drastic upheaval at spring-cleaning time. The magnitude or 'seriousness' of a spring-cleaning depends upon several factors, of which the degree of disorder previously existing and the vital energy of the housewife are the most obviously important. Spring-cleaning may 'break out' simultaneously in many homes. Or one may lead the others; or some may hold their purification ceremonies at quite different times from the majority. There is nothing mysterious about these things, which have simple, logical, human explanations. No-one feels a need to drag in complicating concepts like 'germs', 'antibodies', 'carriers' or 'immunity'.

OTHER FACTORS

The house cleaning significance of acute illness appealed very strongly to many early naturopaths, for whom 'encumbrance' was the simple and comprehensive explanation for all chronic disease. Furthermore, the clearing-out from the body of accumulated wastes seemed to account for nearly all the signs and activities of acute illness. More recently, increasing importance has been attached to the nervous and emotional content of disease conditions. This does not mean that the earlier idea has been discarded; rather that it is now seen as but some aspect of illness and recovery. If we stick to our domestic analogy, we are now at least as concerned that the people in the house should be in a well-adjusted emotional state, as that they should be in clean and tidy surroundings. The two states may go together, and often do, but we all know happy homes which are far from spruce, and gleaming houses full of hatred.

"A person may be in an unhealthy state - physically and emotionally - yet show no symptom of an acute nature, nor any gross sign of distress. He has managed to store his wastes within his tissues, and he compensates his emotional strains with deliberate restraints."

However, no matter how the causes of disease may be distributed between physical and emotional factors, acute illness is an opportunity for cleansing and readjustment. But the process is rarely an enjoyable one; nearly always there is both physical discomfort and either depression or irritability. These are essential features of any worthwhile recuperative effort, and are what the immunologist seeks to eliminate. He disregards the constructive function and therefore sees no call to try to understand the unpleasant symptoms.

A person may be in an unhealthy state - physically and emotionally - yet show no symptom of an acute nature, nor any gross sign of distress. He has managed to store his wastes within his tissues, and he compensates his emotional strains with deliberate restraints. He may appear in every way normal, yet his is handicapped by physical and nervous obstructions. He is comparatively stable, but he is not in High Level Health. To attain that, or to make even the first steps toward it, he must accept the upheaval of the healing crisis – the bodily spring-cleaning. This may be set off without any obvious triggering from outside, occurring just because the body as a whole decides that the time and circumstances are suitable. It may be set off by a deliberate course of treatment, aimed at restoring the self-respect and ambition to a system which has been allowed to degenerate. It may be set off by the peculiar combination of factors which are commonly described as 'an epidemic' – in which a basic similarity of physical condition is widespread, in which external forces such as climate are disturbing and in which suggestion plays a considerable part.

The physical signs of waste elimination are obvious; there may be skin rashes or pustules, catarrhal discharges in a variety of forms, heavy odour of breath and perspiration, unusual composition of urine, abnormal activity of the digestive system, with vomiting or diarrhoea. The more freely these activities are allowed to run their course, the less exhausting and the more effective they will be, and the greater the improvement to the general state of the body.

But if these processes are obstructed in any way- whether by upsetting the internal controls and balances, or by killing off bacteria which is essential to certain stages of action- there is frustration, and vital energy is wasted. The individual may show fewer or less intense symptoms, and be less miserable, but he will also have failed to profit from the occasion and his system will remain unwholesome, physically and emotionally.

The suppressive purpose of all ordinary medicating treatment is to ensure just that result; the aim of immunisation is to prevent the process from getting under way at all. To the extent that immunisation succeeds, the individual's expectation of a long and useful life is diminished. James C Thomson used to say that if ever a cure was found for the common cold, it would push up the death rate dramatically. Immunisation does not mean protection from damaging influences; it means obstructing one's natural protective mechanisms.

Part Two follows in the next edition.

Natural Healing: a cure for all ill by Patrick Quanten MD

A 'spontaneous' cure in any disease is regarded by the medical profession as a miracle, which in their language, means "you've been very lucky". A miracle truly means an extraordinary and welcome event that is not explicable by natural or scientific laws. Now then, be well aware of who makes the declaration of a medical miracle because the definition also is a statement of ignorance. Whatever I can't explain I will regard as a miracle. Whatever the doctor can't explain he will regard as a miracle. So we need to ask the question as to what the doctor actually knows in order for him to regard it as a miracle. To the majority of people, a doctor 'knows everything'. But how much of this is actually true?

Inexplicable by natural or scientific laws renders an event a miracle. A doctor has been trained by the medical authorities and I can assure you that within that training it is very obvious that nothing is known about natural laws, the laws of natural life. It is all about artificial stuff. As a result, not only is the doctor's knowledge of the natural laws non-existent, the doctor isn't even aware that there is such a thing as natural laws. So, if there is an explanation for the event within the laws of nature your doctor would not be aware of that, in which case he would call the natural event 'a miracle'. His professional opinion is then nothing more than a statement of ignorance.

Furthermore, the doctors' training has been focusing on what his authority calls 'medical science'. This does not include any science beyond the science of the nineteenth century as nothing from quantum physics and beyond is being taught at medical school. Biology is presented as a mechanical machine, following physical contact interactions, and life itself is a mere chemistry lab in which we need to find all explanations for all events. In my article 'Medical Science is no Science' I explain why the approach the medical authorities have taken towards investigating disease

Patrick Quanten MD

"In fact, all treatments are 'supposed' to do is to control your disease, not to cure it. Would this be the reason that doctors call it a miracle whenever they do see a cure?"

events is not a scientific approach, but an industrial one. Doctors believe that medical science has got a lot to do with science, while in fact it has nothing at all to do with how scientific research is, and always has been, conducted. This leads us to the conclusion that doctors have no idea about 'scientific laws' either. They do not know science and therefore are not in a position to judge whether or not something has a possible scientific explanation.

So, if in your mind there is no explanation for an event within the laws of either nature or science you are free to declare it a miracle. This would be perfectly acceptable if you would allow someone else to come and explain it to you, if they themselves do not have an explanation that falls within the realm of either criteria. However, this too is unacceptable to the medical authorities as that would highlight their ignorance. A well-educated, university-trained, medical professional who has no explanation and yet on the other hand, a simple farmer, for instance, could tell you exactly how it happened because he understands nature, that is obviously an unacceptable situation. Hence, the medical authorities have ensured themselves a legal framework that elevates them above all other members of the community in terms of knowledge of disease and healthcare. They are the authority. They proclaim to be the authority, and governments everywhere have enshrined this in their laws, this means that, if this authority doesn't have a reasonable explanation, nobody else is allowed to have one either. Any 'explanatory' story the authority comes up with must be accepted and may not be questioned by anybody else as nobody 'has the authority' to question it. So as long as they come up with stories truth can be covered up. It is only when their stories fail to come up with any physical contact explanation they call it a miracle. And still everybody else is being excluded from trying to explain the event.

A medical miracle is a miracle because the profession proclaims it to be one. You are not allowed to argue because they have placed themselves above all arguments. All anyone can know is known by them - because they say so.

Every cure of every ill happens because they use the right treatment. The cure is a direct result of their treatment. If the cure doesn't happen it does not mean that the treatment doesn't work, it means that there have been other interfering factors, such as bad medication compliance, patient cheating, mental problems, bad luck and so on. Treatment works because it says so in the medical books. This also implies that no treatment has a predictable outcome as far as the medical books are concerned. When the outcome turns out to be dramatically different from the predicted expectation it does not mean that the prediction and the basis on which the prediction rests is wrong. No, it simply means that a miracle happened.

So when you have a cut on your skin it heals up because the doctor stitched it.

When you have a broken bone it heals up because the doctor immobilised it in plaster. When you have a throat infection it heals up because the doctor gives you medication. Indeed, you could believe that. However, why is it that your epilepsy does not heal up with the doctor's medication? Because they tell you so. They say the medication is 'to control' the disease, not to cure it. Then give me the stuff that cures it, just like the medication that cured my cold!! What do you mean you don't have that kind of medication? Sorry, not for arthritis either, nor for MS or Parkinson's. No allergy cure either. Same for asthma, blood pressure, cardiovascular problems, stomach ulcers, gut problems, thyroid problems, hearing or sight problems.

In fact, all treatments are 'supposed' to do is to control your disease, not to cure it. Would this be the reason that doctors call it a miracle whenever they do see a cure? Although they talk about curing your disease, they, in fact, never even aim to do so. The aim of the medical profession is to control the progression of your disease. They don't believe a cure exactly exists, not for physical and not for mental problems.

Now have a think about this. When you have broken a bone, is it really the doctor who heals the fracture? What processes are required in order for the body to establish new bone formation at the site of the fracture, and, at that, a bone formation that bridges the gap between the two pieces, strongly linking them back together? Ah, you don't actually know. Well ask your doctor as he is the one who heals the fracture. Even if he waffles on a bit about some biochemical processes that are involved, ask him if he is in charge of these processes. Oh he isn't! He 'facilitates' them. You mean that without his permission these wouldn't happen? Oh, not even that. These processes occur naturally. So, the processes that are needed in order for damage to the tissues to heal up are naturally occurring processes. They happen spontaneously, without prior permission of the medical authority. Be careful here, because this would mean that there is an authority above the medical authority. Can we really allow this?

Photo by Casey Horner on Unsplash

Nature happens, with or without permission from the medical authority. Nature does its own thing, follows its own laws. In terms of healing, nature does whatever is required to rectify damage and to restore normal function. Nature brings balance to a system or a part-system given the circumstances as they are at every moment in time. The natural system always responds to any given circumstance, to the best of its ability, in order to achieve the highest possible standard of balance. It always acts at the easiest balance to maintain, the balance, which requires the least effort to maintain. So, natural processes are constantly operating to keep the system in the best balance it can. It doesn't ask for permission. It doesn't call a board meeting in order to discuss the options.

It has no need for miracles. It's all in a day's work.

Every healing that takes place is a natural restoration of balance. It happens spontaneously and is always right. Nothing a doctor, a therapist, a treatment, a herb or any other method or product you care to use 'to facilitate' your healing does, in fact, do any healing at all. The only healing that occurs is done by your own system, in a spontaneous way. At best, a method or product can be a stimulus to the system to either wake up to the problem or to take it more seriously. Contrary to what we like to believe, this occurs in a small minority of healing processes. Most of the time, all we do is divert healing energy into a direction we believe to be right, which is in fact no help whatsoever. By using a method to heal

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or a product to heal the system now has to deal with your choices as well as trying to heal the imbalance in the way it was always going to. It doesn't need us to tell it what to do or what 'would be good for it'. Leaving nature to execute its intrinsic knowledge is the shortest way to healing any imbalance, whether it is caused through trauma or disease. Mostly our attitude and our actions are hindering the healing, not aiding it. A fracture heals up the quickest and to the best mobility standard when it isn't permanently immobilized. Intrinsic small movements stimulate the healing process and ensure a structural balance, which allows for a better functional use at the end of the healing process.

Using a method, a product or an expert allows us to cover up the simple observable knowledge that healing occurs spontaneously and completely without our interference. Of course, left to its own devices it destroys the status of expert, the reputation of the methods and the desirability of the products. Staying with the natural removes the need for artificial intervention. Staying with your own process removes the need for outside expertise.

Moreover, when we stay close to the natural processes we soon learn through our own observation how nature works and how little benefit there is to be gained from an outside expert source. It soon becomes clear that all that expertise is self-proclaimed and a commercial lie. The expert on healing is the very system that requires the healing. So allowing space and time for this system to do its work is all that nature is asking of us, and even that seems too much for us to give. We are anxious to interfere, to know 'best'.

The simple truth is that all healing is a naturally occurring internal process that does not need any steering, guidance or help from the outside world at all. Any healing, even occurring under our own eyes, remains a miracle as nobody understands exactly what happens, what is required, and why the system does what it does at that particular moment. We can't explain it, so it is a miracle. Nature is a miracle, and natural healing is part of the magic we are living in. On the other hand, knowing that this is within nature's power, these miraculous events should no longer surprise us. Of course, your broken bone will heal up. Of course, the cut on your finger will heal up. Of course, you will get over your cold. These are all miracles we expect to happen. Nature is a miracle, and we are allowed to enjoy it. Let's then take care not to destroy it.

Stop the experts from interfering with miracles. Stop them from preventing miracles to happen. Live a life filled with miracles by following a natural pathway and banning artificial interference from your life. Allow Nature to be the wise one. Ban 'artificial' to the bin. Watch the result of this action. It's a miracle!

Trust nature, as its knowledge about life is far greater than the perceived knowledge of any expert you may want to believe in.

March 2022.

RE: UNVACCINATED "WAKEFIELD COHORTS" BLAMED FOR 5000 CASES OF MUMPS IN ENGLAND LAST YEAR

REPRODUCED HERE IS ONE OF THE RAPID RESPONSES TO A SHORT ARTICLE IN FEB 2020 (SEE LINK ABOVE) BY WENDY E STEPHEN, RETIRED NURSE, STONEHAVEN, SCOTLAND

21 February 2020

https://www.bmj.com/content/368/bmj.m619

Dear Editor

Two days ago the BBC reported on a 700% rise in the cases of mumps in Northern Ireland with Dr Jillian Johnson stating that the "the majority of the cases were people aged 15-24 who have had two doses of the MMR vaccine."

Dr Johnson also stated that "We know that the mumps component of the vaccine decreases and becomes less effective over time".

This is in direct contrast to the current reporting on mumps in England where it has been implied that the absence of vaccination has been the driving force behind the rise in the number of cases.

"Many of these cases were as a result of outbreaks in universities and colleges and most were in young adults who did not have the MMR (measles, mumps and rubella) jab"

"A large number of the 2019 cases were people born in the late 1990s and early 2000s who missed out on the MMR vaccine when they were children"

"PHE said that many of the cases in 2019 could be attributed to the so-called 'Wakefield cohorts' – young adults born in the late nineties and early 2000s who may have missed their MMR vaccine following the autism controversy"

"Most cases of mumps last year were associated with young adults who had skipped the MMR vaccine when they were younger".

Moreover, Northern Ireland clearly has access to the immunisation records of the individuals who have contracted mumps and are thus able to accurately pin point waning immunity as a potential cause of the problem and share that with the public.

Meanwhile PHE although publishing the figures for the numbers of cases of mumps are not publishing the data for the immunisation records of the affected individuals.

Coverage of the mumps problem includes ambiguous wording such as "may have missed their MMR" and "could be attributed to" and "most cases of mumps" or "many of the cases" when the actual figures for the vaccinated, partially vaccinated and fully vaccinated must be on record and readily available, as it clearly is in Northern Ireland.

An accurate picture of what is driving the problem in England is achievable but overlooked in favour of nebulous suggestions as to cause implying that failure to vaccinate is the only and most significant contributory factor.

Much criticism has been levied, (quite rightly) at those who spread vaccine misinformation but might this not be, at least in part and by omission, one of those occasions?

Competing interests: No competing interests

https://www.bmj.com/content/368/bmj.m619/rr-4

NHS OFFERING COVID JABS AT SCHOOLS TO HELP IMPROVE VACCINE RATES IN YOUNG PEOPLE

BY COREY BEDFORD

4 March 2022

https://www.leicestermercury.co.uk/news/health/nhs-offering-covid-jabs-schools-6750580

There are 200,000 young people between 12 and 15 still unvaccinated across the region

Young people in the Midlands will have the chance to get their coronavirus vaccine at school, as the NHS urges teens to protect themselves from Covid-19.

The NHS are going to visit 300 schools across the Midlands throughout March, making it easier for pupils aged 12-15 to get their jabs.

In the East Midlands, 64 per cent of 12-15-year-olds, equal to 140,762 young people, have had at least one dose of the Covid vaccine, with 31 per cent (69,008) now double jabbed.

Meanwhile, over in the West Midlands, 60 per cent of 12-15-year-olds, or 168,304, have had one dose of the vaccine, and 27 per cent (72,598) have had their second.

School children have faced major disruption to their education because of the pandemic and being vaccinated will ensure they are protected and help keep them in school.

The Joint Committee on Vaccination and Immunisation (JCVI) have said that a second Covid vaccination three months from their first is the best way to protect young people from the virus.

While most children usually only have mild symptoms after testing positive from Covid-19, some do become more ill and go on to develop more serious symptoms.

This includes 'long Covid', which has side-effects such as severe fatigue and weakness. Roz Lindridge, the NHS England and NHS

"We know that people can get COVID again and again and even if it doesn't make them seriously ill, there's still the risk of Long Covid or developing further complications."

Improvement director responsible for overseeing the vaccination programme across the Midlands, said: "Vaccines remain our first line of defence against the virus, so, getting jabbed is one of the best ways we can protect ourselves and our communities as we learn to live with COVID-19.

"This is why local NHS teams will be visiting over 300 more schools this month, making it easier for pupils to get protected.

"We know that people can get COVID again and again and even if it doesn't make them seriously ill, there's still the risk of Long Covid or developing further complications.

"The NHS vaccination programme has proved pivotal in reducing the risk of severe infection and hospitalisations and the best step that people can take is to get vaccinated as we learn to live with the virus.

It's never too late to get started on your course of vaccinations if you've not already done so."

There is an 'evergreen' offer for people to get their Covid-19 vaccination, meaning anyone who has not yet vaccinated can come forward and start their vaccinations.

In line with national guidance, consent letters are being sent out to parents and guardians via the school clinics, providing them with information about the Covid-19 vaccine.

Parents and guardians are also being asked to attend vaccination sites with their children if they are getting jabbed outside of school.

Any children who have had Covid must wait 12 weeks after their infection before they can be vaccinated, according to the JCVI guidance.

Those aged 12-15 and are clinically at risk, or lived with someone who is immunosuppressed, are also entitled to a booster three months after their two main doses.

Meanwhile, those who are severely immunosuppressed can get a booster after a third dose.

"THE TRUTH IS LIKE A LION; YOU DON'T HAVE TO DEFEND IT. LET IT LOOSE; IT WILL DEFEND ITSELF. ~ *AUGUSTINE OF HIPPO*"

IS HIV TO AIDS WHAT SARS- COV-2 IS TO COVID?

BY TORSTEN ENGELBRECHT, KELLY BROGAN MD, ANDREW KAUFMAN MD, MAGDALENE TAYLOR.

REPRODUCED HERE ARE A COUPLE OF EXTRACTS FROM AN ARTICLE WHICH IS AVAILABLE AS A PDF DOWNLOAD ON THE INFORMED PARENT WEBSITE. (INFO > PDF DOWNLOADS)

EXTRACT 1

IMAGINE AN ENEMY THAT IS INVISIBLE, like a ghost or demon, except to those who have special visionary powers. It lurks in unsuspecting places, turning every person and every place into a potential threat. Once it takes hold, there's no stopping it without the help of an arsenal of powerful poisons provided by the trusted protectors who are practiced at such exorcisms and know that their work inevitably results in some collateral damage. It's a necessary sacrifice to exterminate the enemy. All bow to those who might protect us from this demonic takeover. There is no sacrifice too great if it promises to save us from such possession.

What if we told you that there is as much evidence for germs causing (or being the primary cause of) illness as there is for demonic possession with invisible entities that make us cough, purge, and waste away? And what if our collective belief in contagion, infection, and associated precautions, preventatives, and treatments is actually a belief system that has been leveraged for a century in service of population control and even depopulation?

We assert that the notion of the SARS-CoV-2 virus causing "COVID" is a recapitulation of the international infectious disease coup that took hold in the 1980s, namely, that HIV causes AIDS. The aim here is to present our findings to propose that AIDS was a dress rehearsal for the present entrapment of citizens worldwide using the dominant COVID narrative.

But let's back up to confirm that our definitions are well-clarified.

What exactly is the consensus theory of infection and contagion, otherwise known as germ theory?

Germ theory posits that microbes - including unmoving fragments of enveloped genetic material referred to as viruses - cause illness through exposure, bodily invasion, and replication, ultimately leading to disease, disability and death. Seems obvious, right? This theory also happens to be foundational to the Western allopathic medical system and the justification for public health measures imposed in violation of bodily sovereignty (for example, mandated vaccination in exchange for "privileges" which may actually be inalienable rights).

"What if we told you that there is as much evidence for germs causing (or being the primary cause of) illness as there is for demonic possession with invisible entities that make us cough, purge, and waste away?"

But what if germ theory and associated premises represent an incomplete (or complete mis!) understanding? What if the establishment's foundational validation of germ theory, called Koch's postulates, have never actually been fulfilled by a single, so-called infectious agent? Koch's postulates essentially state that a microbe must be isolated and purified from a sick person and then used to cause the same symptoms when introduced to another host. Furthermore, this microbe must be found in symptomatic people and not found in people without sickness symptoms. Given the lack of validation of Koch's postulates, germ theory demands further inquiry.

But inquiry of this kind is not permitted because we have not yet acknowledged that medicine, itself, is a belief system. Many have believed, for example, that there is such a thing as a chemical imbalance that causes mental illness and that this imbalance must be managed with medications for life. These beliefs put the believer in a position of helplessness relative to a bigger force that they cannot match but can only mitigate. These beliefs keep us dependent victims, helpless in the face of our problems. They keep us fighting a war that can never actually be won because we are empowering the seeming enemy through our belief that this enemy has power over us! Belief in germs spreading and causing disease is what allows us, as a collective, to remain in the child psychology of fighting the bad enemy we seek to one day beat with the help of the parent we always hoped would protect us. It is black-and-white survivalist thinking that keeps us stuck, afraid, and dependent on a system that tells us which people are safe and which are unsafe, and even invites us to police ourselves and others in the name of safety. It is also what leads us to dehumanize and objectify one another, wrapped up in the illusion that we are somehow made up of entirely different goodness than those whom we judge. It may feel to you like these are facts, not beliefs, but that's how all beliefs feel until we recognize that we have a choice to live by them...or to think differently.

EXTRACT 2

1. There is a claim of a new virus, but the virus was never conclusively demonstrated to exist nor cause a novel disease.

HIV is said to belong to a class of viruses called retroviruses. In order to prove this claim, HIV must be isolated as a pure virus so that it can be imaged with an electron microscope. However, all electron micrographs of so-called HIV taken in the mid-1980s did not come from a patient's blood, but instead from lab-made cell culture soup. In some cases, the cells had been cooked up for a week in a Petri dish.

Moreover, it was presumed that the (indirectly detected) presence of an enzyme called reverse transcriptase was sufficient to prove the existence of a

retrovirus and even a viral infection of the tested cells in culture. In 1983, Luc Montagnier of the Institut Pasteur in Paris published an article in Science asserting that his research team had found a new retrovirus, which would later be named HIV. This claim was made after only reverse transcriptase activity had been observed in cell culture

But there was no scientific proof for this conclusion. Eleven years before, in 1972, Temin and Baltimore had stated that "reverse transcriptase is a property that is innate to all cells and is not restricted to retroviruses." And even Françoise Barré- Sinoussi and Jean Claude Chermann, the most important co-authors of Montagnier's 1983 Science paper, concluded in 1973 that reverse transcriptase is not specific to retroviruses, but rather exists in all cells. In other words, if the enzyme reverse transcriptase is found in a laboratory culture, one cannot conclude, as Montagnier did, that a retrovirus, let alone a specific strain of retrovirus, has been found.

Viral characterization was essentially on hold until 1997, when Hans Gelderblom of the Robert Koch Institute in Berlin rekindled efforts to visualize the HIV virus. But Gelderblom's article, published in the journal Virology, leaves out the purification and characterization of the virus and merely states that the protein p24 was found, not providing proof that the particles are HIV. The second image of an AIDS patient's blood came from the American National Cancer Institute. In this case, the protein and RNA particles that were made visible did not have morphology typical of retroviruses.

Additionally, mainstream AIDS researchers claim that proteins like p24 and p18 are specific to HIV, and they use them as surrogate HIV markers, but in fact these markers are also found in a number of so-called "uninfected" human tissue samples. Even Luc Montagnier later admitted in an interview with the journal Continuum in 1997 that even after "Roman effort" with electron micrographs of the cell culture that detected alleged HIV, no particles were visible with "morphology typical of retroviruses."

The fact that a clear image of HIV particles with retrovirus morphology has not been produced, despite an enormous amount of financial resources and public interest, is suspicious at best and malicious at worst.

"'This patient has tuberculosis, that one chronic diarrhea, this one malaria and that one leprosy' - all diseases that have been known in Africa for ages. But then everything was rediagnosed as AIDS - out of fear of AIDS.'" - Neville Hodgkinson quoted in Virus Mania

In the case of SARS-CoV-2, in a request for a study which shows complete isolation and purification of the particles claimed to be SARS-CoV-2, Michael Laue from one of the world's most important representatives of the COVID-19 "pandemic," the German Robert Koch Institute (RKI), answered that: "I am not aware of a paper which purified isolated SARS-CoV-2." This is a remarkable admission of failure and in line with the statements that Torsten Engelbrecht et al. presented in the article "COVID-19 PCR Tests Are Scientifically Meaningless," which OffGuardian published on June 27th, 2020. This was the first worldwide article outlining in detail why SARS-CoV-2 PCR tests are worthless for the diagnosis of a viral infection.

One of the crucial points in this analysis was the claim by 'science' of a new and potentially deadly virus SARS-CoV-2, given that the studies claiming "isolation" failed to isolate the particles said to be the new virus.

This is confirmed by the answers of the respective studies' scientists to our inquiry, which are shown in a table in our piece — among them the world's most important paper when it comes to the claim of having detected SARS-CoV-2 (by Zhu et al.), published in the New England Journal of Medicine on February 20, 2020, and now even the RKI.

Additionally, Christine Massey, a Canadian former biostatistician in the field of cancer research, and a colleague of hers in New Zealand, Michael Speth, as well as several individuals around the world (most of whom prefer to remain anonymous) have submitted Freedom of Information requests to dozens of health and science institutions and a handful of political offices around the world.

They are seeking any records that describe the isolation of a SARS-COV-2 virus from any unadulterated sample taken from a diseased patient.

As of the date of this writing, all 68 responding institutions/offices failed to provide or cite any record describing "SARS-COV-2" isolation, and Germany's Ministry of Health ignored their FOI request altogether.

The German entrepreneur Samuel Eckert asked health authorities from various cities, such as Munich, Dusseldorf, and Zurich, for a study proving complete isolation and purification of so-called SARS-CoV-2. He has not obtained any answer. Eckert even offered €230,000 to Christian Drosten if he can provide any published evidence that scientifically prove the process of isolation of SARS-CoV-2 and its genetic substance. The deadline (December 31, 2020) has passed without Drosten responding to Eckert. In another attempt, the German journalist Hans Tolzin offered a reward of €100,000 for a scientific publication outlining a successful infection attempt with the specific SARS-CoV-2 reliably resulting in respiratory illness in the test subjects. No responses had been submitted.

Moreover, the electron micrographs printed in the relevant studies, which show particles that are supposed to represent SARS-CoV-2, reveal that these particles show extreme variations in size. In fact, the diameters range from 60 to 140 nanometers (nm). A virus that has such extreme size variation cannot actually exist.

According to virology principles, each virus has a fairly stable structure. Recently, the Wikipedia entry on coronavirus was changed to now report that "Each SARS- CoV-2 virion has a diameter of about 50 to 200 nm." That would be like saying that a person varies his height from 1 to 4 meters according to circumstances!

TiP Editor: I highly recommend reading the whole article and as stated at the beginning you can download the file directly from TiP website.

THE RIDICULOUS RUSE OF THE RAMPAGING RHINOVIRUS

BY MIKE STONE

18th March 2022

https://tinyurl.com/yhfpex5z

EXTRACT

In the 1950's, virologists had no clue as to what could potentially be causing all of the common cold symptoms people were regularly experiencing. In fact, it was estimated that less than 30% of the respiratory diseases could be linked to anything of bacterial and of "viral" origin. However, the 1950's was also an explosive decade in the discovery of "viruses:"

While it is claimed that the factors driving this "virus" discovery spree are unknown, it can be linked to the cell culture technique introduced by John Franklin Enders in 1954. Because of this technique, virologists were able to mix together the human sample with numerous other substances in a petri dish and claim the isolation of a new "virus" nearly at will. Big name "viruses" such as polio, varicella zoster, measles, respiratory syncytial "virus," adenovirus, the paramyxoviruses, and more were said to be "isolated" in this manner.

It shouldn't come as any surprise then to discover that through the use of Enders cell culture technique, the elusive main cause of the common cold was also said to be discovered in the form of "rhinoviruses" in 1956. The discovery was credited to a man named Winston Price, who fittingly named his "virus" the JH "virus" after Johns Hopkins, the institute where the "isolation" was said to have occurred. Unfortunately for rhinoceroses everywhere, as the "virus" is said to infect the nasal passages, it was later renamed the "rhinovirus" after the prefix rhino which means nose.

My initial intent was to provide only a breakdown of Price's original 1956 "rhinovirus" paper to see if the isolation claim held up. However, upon researching the current knowledge regarding the "rhinovirus," it became clear that there was quite the fictional narrative woven around his paper in the proceeding decades to cover up the numerous holes left in its wake. Thus I have broken this post down into two sections. I will provide a look at the claims made in Price's original paper and then show how the "rhinovirus" morphed throughout the following decades in order to try and patch up the holes left by Price's lack of evidence.

What you will find in Price's paper is the usual cell culture tricks as mentioned above. He took nasopharyngeal swabs from patients and immediately placed them in monkey kidney maintenance media thus nullifying any claims of purification (free of contaminants/ foreign materials) and isolation (separated from everything else within the sample). The samples were frozen in an alcohol-dry ice mixture, thawed, and then added to Hela cells taken from a woman with cervical cancer. However, even with this toxic mixture, degeneration of the cells could not be shown in over 240 hours along with 3 blind passages.

With this failure, Price decided to use monkey kidney cells instead to find his "virus." He added 3 percent inactivated horse serum, 5 percent beef embryo extract, and 92 percent 199 solution which contained 100 units of penicillin and streptomycin per one ml. of media. This of course destroyed the monkey kidney cells (as the antibiotics alone would do) and Price was able to claim that his "virus" grew within this toxic unpurified culture. Oddly enough, he admitted that the cytopathogenic effect (CPE) could usually be observed more readily in the antibiotic heavy 199 medium without the above additions of horse and beef extracts. However, he also noted that "viruses" could be "isolated" (i.e. show CPE) in richer medium (what that entailed was not specified) and not just with plain medium 199. However, he left the significance of this evidence as unclear. Price even stated that the JH "virus" had a very long incubation period before producing a cytopathogenic effect in monkey kidney cells. It required a period of 25 days, along with a blind passage, in order for the CPE to show up on the tenth to sixteenth day of the second passage. It should be clear that as all virologists do, Price played with his recipe until he got the desired dish.

Interestingly, the rest of the evidence for the JH "virus" relied solely upon serological (i.e. indirect, non-specific antibody) results. It should not have to be pointed out that one can not use fictional antibodies in order to prove the existence of a fictional "virus," but as is often the case in these papers, that is exactly what was done. However, even when using this method, Price admitted that no complement-fixing (CF) antigen could be prepared from monkey cells infected with the JH agent. There are many other reasons to question these antibody results which we will cover in a paper published well after this initial discovery. No other evidence, such as electron microscope images of the particles assumed to be his "virus," was presented in his paper.

For some reason, Price ignored the results of his own animal experiments which showed that his JH "virus" was not pathogenic. He tried numerous ways to infect mice and other animals without success. He inoculated intranasally, intracerebrally, or intraperitoneally twenty 1-day-old mice or ten 10-day-old hamsters and no signs of disease were noted over the 21-day observation period. Similar negative results were obtained when ten 15-17-gm. mice or six young adult guinea pigs were inoculated intraperitoneally. Finally, the intranasal inoculation of ferrets gave negative results with the animals showing normal fever curves and no signs of illness.

Price concluded that the importance of the JH agent in causing illness in the civilian population as well as other problems dealing with his "virus" were still under investigation. In other words, he had no definitive claim to having isolated a pathogenic "virus" at all. Price was seemingly unconvinced that he had isolated the common cold "virus" as he stated that in view of the similarity between the mild respiratory infection associated with the JH "virus" and the common cold, he hoped that the study of the JH "virus" may lead to some clues as to how the common cold "virus" may be isolated.

To continue reading the article please go to www.viroliegy.com

DID FLAWED PCR TESTS CONVINCE US COVID WAS WORSE THAN IT REALLY WAS? Britain's entire response was based on results - but one scientist says they should have been axed a year ago

COMMENT AND A BRIEF SUMMARY – MAGDALENE TAYLOR, EDITOR OF THE INFORMED PARENT

https://www.dailymail.co.uk/health/article-10606107/Did-flawed-tests-convince-Covid-worse-really-was.html

An article with the above headline was surprisingly featured in the 12 March 2022 edition of the MailOnline. It is refreshing to see msm publish an article, which raises questions about the 'testing' used over the last couple of years.

I have put 'testing' in inverted commas as when you delve into the validity of the use of PCR in order to establish a 'disease' (of which some researchers are calling out for evidence for proof of a pathogenic virus) you may come to the conclusion that any PCR results are meaningless as regards to proving an infection. Also some, or maybe most of you, might be aware of comments made by the inventor of PCR, nobel prize winner Kary Mullis, at an event held in Santa Monica in 1997, during a discussion about HIV and AIDS (https://www.youtube.com/watch?v=ZmZft4fXhQQ).

Mullis states: "[PCR is] just a process that's used to make a whole lot of something out of something. That's what it is. It doesn't tell you that you're sick, it doesn't tell you that the thing you've ended up with really was going to hurt you or anything like that." As expected factcheckers Full Facts dismiss this and go on to add: '*Mullis was an advocate of HIV/AIDS denialism, meaning he believed HIV doesn't cause AIDS, which has since been widely debunked as false.*'

I expect the establishment regretted awarding Mullis with a Nobel Prize in Chemistry as Mullis became a thorn in the side to the mainstream HIV narrative, which incidentally is still under scrutiny by some researchers. Unfortunately Mullis passed away in August 2019, otherwise it is likely that he would have been highly critical of how his invention has been used over the last two years!

The MailOnline article begins:

'It has been one of the most enduring Covid conspiracy theories: that the 'gold standard' PCR tests used to diagnose the virus were picking up people who weren't actually infected.

Some even suggested the swabs, which have been carried out more than 200 million times in the UK alone, may mistake common colds and flu for corona.

If either, or both, were true, it would mean many of these cases should never have been counted in the daily tally – that the ominous and all-too-familiar figure, which was used to inform decisions on lockdowns and other pandemic measures, was an over-count.

And many of those who were 'pinged' and forced to isolate as a contact of someone who tested positive – causing a huge strain on the economy – did so unnecessarily.

Such statements, it must be said, have been roundly dismissed by top experts. And those scientists willing to give credence such concerns have been shouted down on social media, accused of being 'Covid-deniers', and even sidelined by colleagues.

But could they have been right all along?'

"[PCR is] just a process that's used to make a whole lot of something out of something. That's what it is. It doesn't tell you that you're sick, it doesn't tell you that the thing you've ended up with really was going to hurt you or anything like that."

The article reports that academics at Oxford University branded the UK's testing programme (costing £2bn-a-month) as 'chaotic and wasteful'.

'Professor Francois Balloux, director of University College London's Genetics Institute, told The Mail on Sunday: *'Many people may not have been infectious, despite getting a positive test.'*

Another academic quoted was Professor Alan McNally, a University of Birmingham microbiologist in relation to PCR labs when testing was scaled up further and more was farmed out to the private sector.

'There appears to have been little or no oversight of these new labs, and with different PCR methods and equipment being used,' says Prof McNally. 'Clearly in some of the newer labs, that didn't happen. Cynically, one might say it almost turned into a money-making exercise for the private sector as we had lateral flows by then and everyone knew how to do them.

'Why did we need expensive PCRs? The test results basically became meaningless.'

According to the Mail Online The Collateral Global report found there were huge variations in the methods being used to conduct PCR tests at labs across the country ie how many cycles of amplification should be conducted before a test is considered positive. In some cases as little as 25 cycles were conducted whilst in others as many as 45 cycles.

The article continues:

'The Collateral Global report found there were huge variations in the methods being used to conduct PCR tests at labs across the country. However the report found about one third of positive PCR results in some labs had undergone more than that this number of cycles.

Dr Jefferson claims this means these individuals who were subsequently told they had Covid were no danger to anyone.

'Covid press conferences were all about cases, hospital admissions and making comparisons with other countries,' Dr Jefferson said.

'In reality, comparisons even between hospital trusts may be difficult because the results depends on what test you use, what machine, what chemicals.

'The reason we wanted to spend billions identifying infectious cases was to stop or delay transmission. What the Government actually did was roll out tests on an industrial scale and found huge numbers of positives – which is hardly surprising if some are being run through 45 cycles.'

Naturally other scientists held very different views and rejected Dr Jefferson's argument. MailOnline

reported on two such academics. Professor Richard Tedder, a former virologist for Public Health England who helped pioneer PCR tests said: *'focusing on cycle thresholds is 'absolute stupidity'.'*

And then further on in the article another academic Dr Alexander Edwards, associate professor in biomedical technology at the University of Reading, acknowledged that PCR tests 'aren't perfect'. *'The million-dollar question is whether those who test positive after a high cycle threshold are infectious – and there is no consensus on this,* Dr Edwards says.'

Interestingly the last academic to be quoted in this article was Professor Allyson Pollock, clinical professor of public health at Newcastle University, and how Pollock argues *that rolling out PCRs to greater numbers of people was 'one of the biggest mistakes' of the UK's pandemic response. Testing on such a vast scale made it impossible to know what proportion of swabs had actually just picked up dead virus fragments, she argues. Some people may have sought a PCR test after developing symptoms that were due to the common cold.*

But PCR tests may have picked up fragments of Covid from a prior infection, resulting in a positive result and unnecessary isolation.

'We could have scrapped PCR altogether and this might have avoided the pingdemic, when millions of people were told to stay at home after being in contact with a positive case,' Prof Pollock says. She points to the conclusion of a Public Accounts Committee report, published in October, which stated that the entire Test & Trace system had little effect on the spread of Covid.

'We wasted billions,' she says. 'Meanwhile, schools, transport and health services were closed or suspended and people were stopped from seeing their relatives in care homes and hospitals.'

TERRAIN THEORY: RECONTEXTUALISING THE GERM

BY TORSTEN ENGELBRECHT, DR CLAUS KÖHNLEIN, MD AND DR SAMANTHA BAILEY, MD

16 February 2022

Full article: https://thesecularheretic.com/terrain-theory-recontextualising-the-germ/

A FEW EXTRACTS:

For about 120 years in particular, people have been very susceptible to the idea that certain microbes act like predators, stalking our communities for victims and causing the most serious illnesses named COVID-19, AIDS, hepatitis C, avian flu etc. But such an idea is thoroughly simple, too simple. Unfortunately, as psychology and social science have discovered, humans have a propensity for simplistic solutions, particularly in a world that seems to be growing increasingly complicated. But medical and biological realities, like social ones, are just not that simple.

By focusing on microbes and accusing them of being the primary and lone triggers of disease, we overlook how various factors causing illness are linked together, such as environmental toxins, the side effects of medications, psychological issues like depression and anxiety, and poor nutrition. If over a longer period of time, for instance, you eat far too little fresh fruits and vegetables, and instead consume far too much fast food, sweets, coffee, soft drinks, or alcohol (and along with them, all sorts of toxins such as pesticides or preservatives), and maybe smoke a lot or even take drugs like cocaine or heroin, your health will eventually be ruined. Drug-addicted and malnourished junkies aren't the only members of society who make this point clear to us.

For billions of years, nature has functioned as a whole with unsurpassed precision. Microbes, just like humans, are a part of this cosmological and ecological system. If humanity wants to live in harmony with technology and nature, we must be committed to understanding the supporting evolutionary principles ever better and to applying them properly to our own lives. Whenever we don't do this, we create ostensibly insolvable environmental and health-related problems. These are thoughts which Rudolf Virchow (1821-1902), a well-known doctor from Berlin, had when he required in 1875 that "the doctor should never forget to interpret the patient as a whole being." The doctor will hardly understand the patient, then, if he or she does not see that person in the context of a larger environment. Without the appearance of bacteria, human life would be inconceivable, as bacteria were right at the beginning of the development towards human life. Bacteria could very well exist without humans; humans, however, could not live without bacteria! It is, therefore, unreasonable to conclude that these mini-creatures, whose life-purpose and task throughout biological history has been to build up life, are, in fact, the greatest, singular causes of disease and death. Yet, the prevailing allopathic medical dogma of one disease, one cause, one miracle pill has dominated our thinking since the late 19th century, when Louis Pasteur and Robert Koch became heroes.

Hippocrates, who is said to have lived around 400 B.C., and Galen (one of the most significant physicians of his day; born in 130 A.D.), represented the view that an individual was, for the most part, in the driver's seat in terms of maintaining health with appropriate behavior and lifestyle choices. "Most disease [according to ancient philosophy] was due to deviation from a good life," says Golub. "[And when diseases occur] they could most often be set aright by changes in diet—[which] shows dramatically how 1,500 years after Hippocrates and 950 years after Galen, the concepts of health and disease, and the medicines of Europe, had not changed" far into the 19th century. The German Max von Pettenkofer (1818-1901), once appointed rector of the University of Munich, jeered: "Bacteriologists are people who don't look further than their steam boilers, incubators and microscopes."

Details regarding the latest updated version of 'Virus Mania' by the authors above, and also Dr Stefano Scoglio:

https://www.torstenengelbrecht.com/en/virus-mania-neu/

GASTROINTESTINAL ISSUES AND AUTISM SPECTRUM DISORDER

Moneek Madra, PhD, Roey Ringel,
Kara G. Margolis, MD
Child Adolesc Psychiatr Clin N Am.
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TiP Editor: *Back in the 1990s when Dr Andrew Wakefield, a gastro-enterologist was approached by parents of children who had issues with their gut alongside having ASDs (which the parents felt was triggered by MMR), he was vilified and labeled 'fraudulent' etc, and eventually struck off. Interesting that these issues are being recognized as related – although of course there is no mention of vaccines playing a role. Just the usual suggestion of blaming it on genetics!*

SUMMARY

It has become increasingly clear that GI problems are common in the ASD population and also morbidity causing. It is thus critical that clinicians understand the different presentations of GI distress in this population so efficient treatment and/or referral to a gastroenterologist can be implemented. Once GI problems are diagnosed other clinical comorbidities commonly co-occurring with GI dysfunction in ASD should also be promptly considered. Although the treatment for GI conditions in ASD is similar in many ways to those of neurotypical individuals, additional considerations must be made.

Comprehensive nutritional evaluations should be considered because of the high incidence of food aversions as well as the common use of exclusionary diets. Although not a currently recommended treatment, gut microbiota modulation (i.e. FMT, probiotics, etc.) may be a distinct novel therapeutic option for this population in the future, as a treatment for not only GI problems but behavioral issues as well.

COMMUNITY VACCINE CHAMPIONS PROGRAMME

A letter was recently brought to my attention sent out presumably to local organisations from the Public Health Principal at the London Borough of Barking & Dagenham. Is this happening across London and across the UK? The letter (dated 4/2/2022) reads:

We are delighted to be able to offer organisations the chance to bid for a contract to support the delivery of the Community Vaccine Champions programme, funded by the Department for Levelling Up, Housing and Communities (DLUHC).

Funding has been provided to Local Authorities to support those communities who have been shown to experience the lowest rates of COVID-19 vaccine uptake. The Community Vaccine Champions scheme will provide targeted help to those areas and communities facing the greatest challenges in relation to vaccine uptake.

Recognising that local authorities, their partners and local people are best placed to decide the right approach for their communities, it is intended to be designed locally, to respond to the needs of a specific place. We are looking for expert providers to help us with the development and implementation of this programme, the purpose of which is to:

1. Tackle misinformation around vaccine safety; develop initiatives to minimise practical barriers to accessing vaccine, increase trust and vaccine uptake, with a particular focus on Barking Central.
2. Increase vaccination rates overall; with an aim to get as many people vaccinated as possible in the area.
3. Improve the reach of official public health messaging; specifically messaging on vaccine safety that goes out to under-served communities through local trusted voices and developed in partnership with the community.
4. Reduce disparity and inequalities in health outcomes; provide a platform for health inequalities to be researched and such barriers overcome.

The letter then talks about contract opportunities and each contract being worth up to £49,000, and that organisations can bid for more than one contract.

NHS IN CRISIS: COVID 19 VACCINES A DUTY OF CARE AND WHY DOCTORS ARE LEAVING THE NHS

https://www.ukcolumn.org/video/nhs-in-crisis-covid-19-vaccines-a-duty-of-care-and-why-doctors-are-leaving-the-nhs

Brian Gerrish, a presenter at the UK Column News, interviewed Dr David Cartland MBChB MRCGP a fully qualified doctor and GP. After 10 years of training and 14 years of enjoyable professional practice as a highly respected GP, what made Dr David Cartland feel that he could no longer work in the NHS? A feeling so strong that early in February 2022 he took the immensely difficult decision to resign as a GP. A very interesting and refreshing one-hour interview with an individual working within the NHS discussing why he was unable to remain working in such a system. As it states on the UK Column website: 'Please watch the UK Column video interview with Dr David Cartland as he discusses his observations and experiences of Covid-19 and vaccinations in the NHS and GP system, leading to his resignation from what appears to be an increasingly flawed and harmful NHS care system. If the personal and professional testimony of David makes an impact with you as the viewer and listener, as I am sure it will, we would ask that you share this interview as widely as possible, to inform others and support David and other NHS doctors and nursing staff who feel as he does. Every man and woman, every adult family member and certainly every parent, surely needs to understand what is really happening in the NHS and GP care system under the governments imposed Covid19 and vaccination policies.'

ARE THE COURT OF PROTECTION VACCINE RULINGS ON AUTISTIC AND MENTALLY HANDICAPPED ADULTS UNLAWFUL?

PHILIP RIDLEY, MSC, PGDIP
30th March 2022
https://westonaprice.london/articles/best-interest/

Has the Court of Protection (the Court) been over reaching its authority on societies' most vulnerable adults who lack mental capacity, particularly during the COVID-19 pandemic?

INTRODUCTION:

This article explores the ways in which the Government and Courts could together be acting immorally and possibly even unlawfully when it comes to making best interest decisions, very much to the detriment of these individuals and their families. We cover the role of the Court of Protection and whether it should interfere with the exercise of parental responsibility for adults who lack capacity in particular, but also regarding of interference with the exercise of responsibilities by deputies, those with lasting power of attorney or other "interested persons".

The article also suggests that the court is using out-dated approaches to informed consent and that the Mental Capacity Act (the Act) may in fact prohibit the use of most experimental medicines, such as "emergency use authorisation" COVID-19 vaccines that it is nonetheless mandating in most cases. These concerns suggest significant safeguarding issues and an urgent need for reform.

THE COURT OF PROTECTION:

Adults who lack mental capacity are particularly vulnerable to arbitrary medical policy, including for vaccination and testing. Never has this been more the case than with regard to Covid-19, due to the coercive approaches that have been taken. To date, and with only one exception, the Court of Protection has mandated the vaccine on all adults who lack mental capacity, often disregarding strong, well-researched and carefully considered objections from close family members, with the small number of recorded cases being the tip of an iceberg. A similar approach has also been taken by the family courts with this often being the case for other vaccines recommended by government.

The sole successful case hinged upon the individual having objected to vaccination prior to losing capacity. This argument is unlikely to protect most who have lost their mental capacity, since many in the general public fail to create a living will making advance decisions to refuse treatment. It also provides no assistance for adults with mental capacity issues who have never attained capacity to make autonomous decisions in the first place. As a result, the only hope for most parents and others who object to their child or loved one being vaccinated is to ensure that they never get entangled in best interest meetings, the Court of Protection or the Family Courts. Once there, the outcome is almost always inevitable regardless of the opinions and arguments put forward with 'conviction' rates similar to a Medieval Star Chamber or something out of the Soviet Union.

There is common ground that parents of children under the age of 18 who agree on decisions about treatment can avoid being subjected to a best interest case in the Court of Protection. This is because s.27 of the Mental Capacity Act (2005) (the Act), prohibits the Court of Protection from interfering with the discharging of parental responsibility in matters not relating to a child's property s.3 of the Children Act defines "parental responsibility" for the act as "all the rights, duties, powers, responsibilities and authorities which by law a parent of a child has in relation to the child and their property".

Where problems occur is when the child becomes an adult at the age of 18. At this point the Court of Protection claims that it has full liberty to interfere in any decision made by a a parent who has an adult child who lacks capacity.

This fails to reflect the family reality however, because the parents of an adult child who lacks capacity will if they choose retain substantial or complete responsibility for them. Yet the Court de facto rides roughshod over any rights that the parents retain. Some go so far as to say that parental rights for an adult child who lacks capacity end entirely on their child's 18th birthday. As a result, parents who retain caring responsibilities can even be denied access to medical records relevant to the individual's care. This surely cannot be in anybody's best interest. It also causes significant difficulty for parents who can end up losing trust in the system that should be there to assist.

This unfortunate state of affairs could however have been caused by a misinterpretation of the law. Statutory provisions with the Act itself appear to prohibit the court from interfering with the exercise of any parental responsibility, regardless of whether the parent's child is under or over 18 with this being contracted, in our view irrationally, by the Mental Capacity Act 2005 Code of Practice as follows.

The Code of Practice states that "Nothing in the Act permits a decision to be made on someone else's behalf on any of the following matters: (including) "discharging parental responsibility for a child in matters not relating to the child's property".

However, the words "for a child" cannot be found in s.27 of the Act regarding "excluded decisions", which actually states that the Court cannot make a decision on someone else's behalf regarding "discharging parental responsibility in matters not relating to a child's property". The Act states "not relating to a child's property" whilst the guidance states "not relating to the child's property".

The Court of Protection claims that the government guidance provides the correct interpretation because s.50 of the Act brings the interpretation of "parental responsibility" in line with s.3 of the 1989 Children Act for the purposes of the Mental Health Act, meaning that parental responsibility and therefore parental rights only apply in that context to children under the age of 18.

However, if the statute is read correctly then this cannot also be true for s.27 regarding excluded decisions. This is because the Children Act interpretation of "parental responsibility" is only applied within and therefore only applies to s.50, which relates solely to whether permission is required for an application to the Court. Had Parliament consented to the Children Act definition of parental responsibility applying to s.27 regarding the jurisdiction of the Court, we would also see it in s.64 (General Interpretation) or in s.27 itself. It is however nowhere to be found in these sections of the Act. As a result, the only possible interpretation of the statute is that Parliament consented to the Children Act definition of parental responsibility applying only to s.50. Therefore, the broadest possible interpretation should be given to "parental responsibility" as it applies to s.27 regarding excluded decisions, including the exercise of parental responsibility for adults over the age of 18 who lack capacity.

We asked the Ministry of Justice for correspondence, documentation or legal advice causing the Code of Practice to be inductive of this new wording. They confirmed that that they do not hold any information and that "Due to the length of time that has elapsed since the Mental Capacity Act Code of Practice was originally published this information is no longer available."

When considering conflict between legislation and government guidance, our constitution is clear that "the executive (government) cannot change law made by Act of Parliament, nor the Common Law", as recently confirmed by the Supreme Court in Rule 1 of R Miller v DExEU (2017). This is due to Article.1 of our 1688 Bill of Rights, which states, "That the pretended Power of Suspending of Laws or the Execution of Laws by Regall Authority without Consent of Parliament is illegal". It is therefore unlawful for government guidance to provide an interpretation that cannot be reasonably established by reading the actual words of a statutory provision.

For this reason, government guidance is supposed to be considered hearsay evidence in a court of law. Sadly, this rarely occurs with government guidance often being treated as if it were a body of law. This is despite it being established by the Kings Bench in 1610 with the Case of Proclamations that the law of England is comprised of "common law, statute law, and custom; but the King's proclamation (which includes government guidance) is none of them" with this definition of the law of England also being recognised by the Coronation Oath.

There is no statute that defines parental rights. It is however set out clearly in Gillick's case, citing Sir William Blackstone, that parental rights flow from parental responsibilities, which diminish as a child develops competency. What this means is that at Common Law, where a Parent has a responsibility, they should have autonomy to discharge that responsibility without unreasonable interference, with this being the essence of parental rights.

A person's parental responsibilities and thus parental rights will therefore vary from case to case and as Gillick stated, that there is no universal age at which competency can be said to universally emerge. Therefore, it follows that if a Parent has responsibilities for an adult child who is 18 or above, they must therefore at Common Law retain a right to parental autonomy unless or until they hand over some or all of their responsibility to a responsible third party.

The Mental Capacity Act itself confirms that parents of an adult who lacks capacity do indeed retain responsibility, which can only be parental responsibility in this context. This is because s.44 of the Act causes the parent or other carer of an under or over 18-year-old to be liable for summary or indictable criminal prosecution if they ill-treat or wilfully neglect them whilst they care for them, for which they could also be sued for tort violations such as negligence by a court appointed litigant friend. This approach to parental responsibility is after all the one taken by health and social services when it suits them, i.e., when parents agree with the 'advice' that has been given. This is because parental consent for an adult who lacks capacity will generally be accepted as providing adequate lawful authority for medical treatment except where the parent has what appears to be regarded as the audacity to go against the "responsible body of medical opinion".

The Court and Parliament should not reasonably fear being excluded from interfering with the discharge of parental responsibility for an individual over 18 who lacks capacity, because that is after all no different to the status quo for arguably more vulnerable children who lack capacity who happen to be under the age of 18. Neither does it render the Court powerless; they continue to have powers under s.15 of the Act to declare that a parent lacks capacity to exercise their parental responsibility, noting of course that s.1(4) of the Act[17] states that "A person is not to be treated as unable to make a decision merely because he makes an unwise decision.". They can also assume authority by convicting a parent under the offences discussed above, set out in s.44 of the Act and the parent can be sued for tort violations.

If this provides sufficient safeguarding for a child under 18 who lacks capacity then it must be sufficient for an adult who is over the age of 18. It also goes without saying that a parent who has taken responsibility for a child from before birth to the age of 18 without interacting with Social Services is highly likely to be competent to continue to care for them into adulthood, if they choose to do so. Such a person is also likely to have more care experience than many professionals in the care sector, with a pair of parents having between them a minimum of 36 years' experience once their child reaches 18. They will likely know their adult children and care for their best interests better than anybody else ever could with unreasonable interference inevitably causing a general breakdown of trust within the care process that can only be detrimental to their adult child's best interests.

This parental rights issue could be tested in court or the Code of Practice could be challenged and amended. A campaign could also be had for Parliament to amend s.27 so that it expressly excludes the court interfering in the exercise of parental responsibility for adults 18 and over. There could also be a campaign to amend s.27 to expressly exclude the Court from interfering with decisions by approved deputies and those with lasting power of attorney. There

should be no reason to object to this given that the Court is responsible for overseeing these appointments.

If the person is capable of being appointed, then they ought to be provided autonomy to exercise judgement and make decisions. There could also be a strong case for reforming how the court deals with decisions made by other "interested persons" such as spouses and next of kin, where lasting power of attorney is not in place and where there is no disagreement between the parties so as to protect the sanctity of the family unit.

INFORMED CONSENT:

Next, we come on to the now outdated approach to informed consent being imposed by the Court of Protection and Family Courts when considering the best interests of a person who lacks capacity. The Court's approach to the material risks of medical treatment, including the risks of not having treatment, appear to involve what could be seen as slavishly following recommendations from doctors who advocate for the "responsible body of medical opinion" known colloquially as "the science". In reality this is a fancy way of saying that they follow government policy by default; treating people as if they were part of a herd rather than considering the actual best interests of the individual, failing to recognise the autonomy of any "interested persons".

In doing so the Court will disregard the views of parents, other next of kin, deputies and people with lasting power of attorney and other "interested persons" if they dare to disagree with government policy. This extends to disregarding the views of qualified experts who question the status quo.

Yet the right to petition HM Government and its policy, which must include autonomy to make decisions contrary to policy that do not break the law, is set out clearly in our 1688 Bill of Rights "That it is the Right of the Subjects to petition the King and all Commitments and Prosecutions for such Petitioning are Illegall." with this wording being copied and pasted to form the petitioning clause of USA's First Amendment. With the right to petition against government policy being considered by our ancestors to be central to the principles of parliamentary democracy; how can it be justice for a court to automatically dismiss the autonomy and rights of "interested persons" and expert witnesses to question government guidance? Can compliance with government policy ever be the sole litmus test of the best interests of the individual? It was discussed above that government guidance is not law. Therefore, government guidance on medical choices should be treated as hearsay evidence in court to allow interested persons and experts on both sides of the argument have due process of law. The second problem regarding informed consent is that the court's current approach of generally defaulting to "the responsible body of medical opinion". This reflects an extreme and likely unlawful interpretation of the outdated Bolam Test, which the Supreme Court superseded in 2015 in Montgomery's case regarding the duties involved in providing informed consent. In this case the UK's Supreme Court adopted the position taken by the Australian High Court in Rogers v Whittaker, that the test of materiality when considering the risks of having or not having a medical intervention is whether, "in the circumstances of a particular case, a reasonable person in the patient's position would be likely to attach significance to the risk." The patient may well carefully consider government guidance on the matter but they are perfectly entitled to disregard it and cannot be found to lack competency due to making an 'unwise' decision or by disregarding government policy.

The Common Law law is constructed in this way because its primary aim is protection of the inviolable autonomy of the person. The law recognises that people who have capacity are autonomous and that they therefore have an absolute right to autonomy because this is a fundamental aspect of being a human. If this correct approach was applied by the Court of Protection in best interest cases and if we recognise the autonomy of the Parent or any other "Interested Person" who have Common Law responsibilities for the person who lacks capacity; then the court ought to consider whether, in the circumstances, a reasonable person exercising responsibility for the person would be likely to attach significance to the risk; be it the parents, next of kin, deputy or lasting power of attorney, etc. This would surely be a better reflection the responsibilities and rights that may exist than the current default position of deferring to the "responsible body of medical opinion", disregarding the views of any "interested persons" who disagree with government policy.

This test would alter if the person previously had capacity, because there would then be a duty to consider what the person would have been likely to consider had they retained capacity. In either case it ought to be assumed that a "responsible" or "interested person" is better placed than the government to make an assessment of the best interests of a person whom they have caring responsibilities, so long as they retain capacity to care and avoid civil or criminal negligence.

> 87. The correct position, in relation to the risks of injury involved in treatment, can now be seen to be substantially that adopted in *Sidaway* by Lord Scarman, and by Lord Woolf MR in *Pearce,* subject to the refinement made by the High Court of Australia in *Rogers v Whitaker,* which we have discussed at paras 77-73. An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.

The Leading case on Informed Consent. Paragraph 87. Of Montgomery v Lanarkshire

If the courts took this position, finally adopting the principles in Montgomery's case to best interest cases, prima fascia sworn statements, evidence and expert witnesses would be given greater weight than the hearsay evidence of government guidance. Only then can diverse opinions obtain due process of law with perhaps the courts no longer siding with government policy almost a hundred percent of the time.

It is likely that GP's, local authorities, carers and the Court default to the now out-dated and therefore unlawful Bolam Test, blindly following what is called "the science", to avoid risk of liability to themselves more than to further the best interests of the person. Yet clinical negligence will occur if the duties set out in Montgomery's case are not discharged when providing informed consent on behalf of a person who lacks capacity. This is precisely why the balance in decision making must shift towards "Interested Persons" and parents and spouses in particular. This could be pursued in courts, with those engaged in best interest cases advocating for the principles set out in Montgomery's case. There should also be a campaign for amended guidance and perhaps statutory reform.

EXPERIMENTAL MEDICINE AND CAPACITY:

Now we turn to questions around the lawfulness of the Court of Protection mandating experimental, "emergency use authorisation" medical testing and vaccination on persons who lack capacity. This has occurred despite the Mental Capacity Act making most research projects unlawful for persons who lack capacity. The Act, for obvious safeguarding reasons, only allows for persons who lack capacity to be subjected to research projects related to an "impairing condition". This means, "a condition which is (or may be) attributable to, or which causes or contributes to (or may cause or contribute to), the impairment of, or disturbance in the functioning of, the mind or brain." Not for a condition that they do not have and may never have that will not have contributed to their lack of capacity. Even if this criterion is met, the research project is only lawful if it cannot be conducted on people who have capacity. If a research project satisfies this restriction, s.32 of the Act nonetheless requires that "interested persons" are identified and that any research project does not occur or is abandoned if they state that in their opinion the person's wishes and feelings would be likely to lead to them declining to take part in the project if they had capacity in relation to the matter.

With, "research project" having no express definition in either the 2005 Mental Capacity Act or the 2004 Clinical Trial Regulations, we can only conclude that Parliament consented to the widest possible interpretation based on what we can establish by referring to the Oxford English Dictionary. That "emergency use authorisation" is not part of an approved clinical trial should not therefore mean that the court can ignore this section of the Act in these cases.

Of particular relevance, the UK Health Security Agency is conducting the ongoing, "COVID-19 vaccine surveillance project" with weekly surveillance reports regarding, "emergency use authorisation" COVID-19 vaccines that the government believe to be "required to monitor delivery of the vaccination programme and evaluate its impact on health". This research project involves "detection and evaluation of possible adverse events associated with vaccination" and "enhanced surveillance of vaccine failure", with this demonstrating the experimental nature of the vaccine programme. Whilst the JCVI has concluded that the vaccines are 'safe and effective', this is clearly an interim position in connection with the surveillance project, other ongoing research projects and ongoing clinical trials. Indeed, COVID-19 is so experimental that the UK Collaboration on Development Research's COVID-19 Research Project Tracker lists 15,254 worldwide research projects at this time with over £5.5bn in funding.

It follows therefore that if a research project such as the UKHSA's Surveillance Project is required to implement "emergency use authorisation" of COVID-19 Vaccines alongside ongoing clinical trials and tens of thousands of research projects worldwide, that a person will be subjected by one degree or another to ongoing research projects if vaccinated. If this is the case, then it must be unlawful for persons who lack capacity to be subjected to the vaccine programme. The Medicines for Human Use (Clinical Trials) Regulations 2004 set out Parliament's position on consent for clinical trials and this should be taken into account when considering research projects or medicines under "emergency use authorisation" subject to ongoing clinical trials. Part 2 of Schedule 1 states that "Clinical trials shall be conducted in accordance with the ethical principles that have their origin in the Declaration of Helsinki, which can be considered a modern version of the Nuremberg Code."

Part 5 of Schedule 2 then covers conditions and principles which apply to clinical trials in relation to an incapacitated adult. Amongst other things they require that the legal representative of the person provides informed consent on behalf of the incapacitated adult, which can only mean discharging the duties set out in Montgomery's case. They must also, without detriment be informed of the right to withdraw from a trial at any time.

CONCLUSION:

This would not be the first time that the Court of Protection has been found to exceed its authority. Caroline Hopton, Simon Mottram, and Rosa Monckton successfully challenged the Court's policy of a presumption that deputyships will only be approved in the 'most difficult' cases. No such presumption can be found anywhere in the Act and guidance cannot lawfully create any presumption not found in Common Law or express statutory provision. This is however precisely what the court did until challenged by mothers who bravely challenged the Court in their children's best interest. In this instance the Court agreed that the Mental Capacity Act Code of Practice (government guidance) should be amended accordingly.

That such misinterpretations of the law, as we believe them to be could have influenced court decisions for decades without challenge seems astonishing. This could in part be due to the court sitting in private with there being no right ›

to elect trial by jury, more transparency and accountability is required. The consequences have included untold stress and suffering for the individuals and their families emphasising the real and urgent need to bring this detrimental state of affairs to an end. Arguments made in this article suggest that further amendments should be made regarding parental responsibility, rights and autonomy, informed consent and research projects, but this may only be scraping the surface of the reform that is required. You may also consider making provision for yourself, creating your own will with provision for a Lasting Power of Attorney. In it you can also specify that you want no vaccines under any circumstances. You can also expressly state that for any other treatment or management that you do not yet know about nor can imagine, you can affirm that your attorneys have absolute jurisdiction and that you do not wish to have their views over-ridden by "Best Interest" meetings and Court of Protection hearings. Please view this article online for all references.

https://westonaprice.london/articles/best-interest/#_ftn19

IS A MASK THAT COVERS THE MOUTH AND NOSE FREE FROM UNDESIRABLE SIDE EFFECTS IN EVERYDAY USE AND FREE OF POTENTIAL HAZARDS?

INT. J. ENVIRON. RES. PUBLIC HEALTH 2021, 18, 4344.
HTTPS://DOI.ORG/10.3390/IJERPH18084344

EXTRACTS FROM THE CONCLUSIONS

On the one hand, the advocacy of an extended mask requirement remains predominantly theoretical and can only be sustained with individual case reports, plausibility arguments based on model calculations and promising in vitro laboratory tests.

Our review of the literature shows that both healthy and sick people can experience Mask-Induced Exhaustion Syndrome (MIES), with typical changes and symptoms that are often observed in combination, such as an increase in breathing dead space volume, increase in breathing resistance, increase in blood carbon dioxide, decrease in blood oxygen saturation, increase in heart rate, increase in blood pressure, decrease in cardiopulmonary capacity, increase in respiratory rate, shortness of breath and difficulty breathing, headache, dizziness, feeling hot and clammy, decreased ability to concentrate, decreased ability to think, drowsiness, decrease in empathy perception, impaired skin barrier function with itching, acne, skin lesions and irritation, overall perceived fatigue and exhaustion.

Wearing masks does not consistently cause clinical deviations from the norm of physiological parameters, but according to the scientific literature, a long-term pathological consequence with clinical relevance is to be expected owing to a longer-lasting effect with a subliminal impact and significant shift in the pathological direction. For changes that do not exceed normal values, but are persistently recurring, such as an increase in blood carbon dioxide, an increase in heart rate or an increase in respiratory rate, which have been documented while wearing a mask, a long-term generation of high blood pressure, arteriosclerosis and coronary heart disease and of neurological diseases is scientifically obvious. This pathogenetic damage principle with a chronic low-dose exposure with long-term effect, which leads to disease or disease-relevant conditions, has already been extensively studied and described in many areas of environmental medicine. Extended mask-wearing would have the potential, according to the facts and correlations we have found, to cause a chronic sympathetic stress response induced by blood gas modifications and controlled by brain centers. This in turn induces and triggers immune suppression and metabolic syndrome with cardiovascular and neurological diseases.

We not only found evidence in the reviewed mask literature of potential long-term effects, but also evidence of an increase in direct short-term effects with increased mask- wearing time in terms of cumulative effects for: carbon dioxide retention, drowsiness, headache, feeling of exhaustion, skin irritation (redness, itching) and microbiological contamination (germ colonization).

Overall, the exact frequency of the described symptom constellation MIES in the mask-using populace remains unclear and cannot be estimated due to insufficient data.

Theoretically, the mask-induced effects of the drop in blood gas oxygen and increase in carbon dioxide extend to the cellular level with induction of the transcription factor HIF (hypoxia-induced factor) and increased inflammatory and cancer-promoting effects and can, thus, also have a negative influence on pre-existing clinical pictures.

In any case, the MIES potentially triggered by masks contrasts with the WHO definition of health: "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

For scientists, the prospect of continued mask use in everyday life suggests areas for further research. In our view, further research is particularly desirable in the gynecological (fetal and embryonic) and pediatric fields, as children are a vulnerable group that would face the longest and, thus, most profound consequences of a potentially risky mask use.

Basic research at the cellular level regarding mask-induced triggering of the transcription factor HIF with potential promotion of immunosuppression and carcinogenicity also appears to be useful under this circumstance. Our scoping review shows the need for a systematic review.

The described mask-related changes in respiratory physiology can have an adverse effect on the wearer's blood gases sub-clinically and in some cases also clinically manifest and, therefore, have a negative effect on the basis of all aerobic life, external and internal respiration, with an influence on a wide variety of organ systems and metabolic processes with physical, psychological and social consequences for the individual human being.

MALAWI DECLARES POLIO OUTBREAK

Magdalene Taylor, TiP Editor - Please note: A reminder that the term polio or poliomyelitis is the name given to certain symptoms with the assumption that all these kind of presentations are caused by a polio virus. This is the present established view, it is not scientifically proven but is presented to the trusting public as fact.

The headline above caught my attention recently – an outbreak of polio? The opening paragraph of the article (published on medicalxpress.com on 18 February 2022) read:

(published on medicalxpress.com on 18 February 2022 https://tinyurl.com/yckmyd8t)

The first wild poliovirus case in Africa in more than five years has been detected in a young child in Malawi, the World Health Organization said Thursday.

The Malawian health authorities have declared an outbreak of wild poliovirus type 1 after a case was detected in the capital Lilongwe, the WHO said.'

I had expected a lot more than one case with the use of the word outbreak and I was curious as to how this one case diagnosis was arrived at. The article goes on to say that: 'Laboratory analysis showed that the detected strain is linked to one that has been circulating in Sindh Province in Pakistan.

Polio remains endemic in Pakistan and its neighbour Afghanistan.' And this case in Malawi according to the article was considered imported. "As an imported case from Pakistan, this detection does not affect the African region's wild poliovirus-free certification status," the WHO said.

This prompted me to look up the polio situation in Sindh Province. An article dated 26 February 2022 (https://www.dawn.com/news/1677041/anti-polio-drive-targeting-over-10m-children-launched-in-sindh) reported that there hadn't been any polio cases since July 2021.

"Zero polio cases across the province since July 2021 is good news for the future of the children of Pakistan" according to the chief minister Syed Murad Ali Shah. This article goes on to state that: 'The provincial government launched on Friday a massive anti-polio-drive,

> *""There must be some thing wrong with the polio drops if even after so many doses my child has contracted polio."*

targeting over 10 million children, including two million in Karachi, under the age of five years in 30 districts across the province. Part of the national immunisation days, the drive will continue from Feb 28 to March 6.'

It is always interesting to see if there are any other reports of the same one case outbreak in Malawi to glean more detail. Voice of America news https://www.voanews.com/a/millions-of-malawian-kids-to-get-polio-vaccine/6470289.html also reported on this outbreak (one case) in Malawi and how as a result of this the UN children's agency was procuring nearly seven million doses of polio vaccine to inoculate children in Malawi.

According to this report health experts said 'the polio strain which paralysed a 3 year old child last month is similar to one in Pakistan, and noted that the child was not fully vaccinated against polio.'

Not fully vaccinated??….. meaning the child had received at least one dose or perhaps more?

The article then goes on to say that UNICEF said the planned mass immunization will target the unvaccinated as well as children previously vaccinated, so all can have full protection from the polio virus.

One wonders how 'full protection' is acquired as over the years there have been numerous cases in the highly vaccinated.

Here is just one example from 2007: http://www.cidpusa.org/A/Pulsepolio.htm 24/7/2007

UNTESTED VACCINE SURFACES IN POLIO OUTBREAK

A two-year-old girl of this village, Saniya, suffers from Type I polio despite being administered more than seven doses of the new polio monovalent vaccine (MOPVI), which is made specially for the Type I poliovirus.

Saniya's mother, Noorjahen, is furious. "She is having polio drops ever since she was four days old. She has had over a dozen doses of the polio drops.

We came to know about her polio when she got a high fever. She could barely manage to stand, could not walk at all, after the fever.

We took her to the local hospital where they did a stool test. We were later told that she has polio," she recounts. "There must be some thing wrong with the polio drops if even after so many doses my child has contracted polio. The government should test medicines before they are used. (2007)

"BETWEEN STIMULUS AND RESPONSE THERE IS A SPACE.
IN THAT SPACE IS OUR POWER TO CHOOSE OUR RESPONSE.
IN OUR RESPONSE LIES OUR GROWTH AND OUR FREEDOM."

~ VIKTOR E. FRANKL

CUBA - PARACETAMOL AND AUTISM - IS THERE A LINK?

DR JAYNE LM DONEGAN
MBBS DRCOG DCH DFFP
MRCGP MFHOM
Retired GP Practicing Homeopathic and Naturopathic Medicine


DR Jayne L.M.Donegan

Can vaccines cause autism? This is a very contentious subject surrounded by misinformation, de-platforming, censorship and millions of pounds or dollars being given to university research departments and autism societies to find evidence that autism is genetic or a psychiatric disorder present from birth and nothing to do with environmental triggers.

As in all such complex multifaceted matters, it is best to go back to first principles and leave out the name-calling.

It is an incontrovertible fact that vaccines can cause brain damage

It is an incontrovertible fact that when your brain is damaged this can lead to structural (anatomical) and functional (how it works) changes.

It is an incontrovertible fact that such structural and functional changes can lead to changes in personality and other types of cerebral functioning or as some prefer to say, wiring.

It is an incontrovertible fact that some of these people may end up being labelled as autistic – correctly or incorrectly.

Is it an incontrovertible fact that vaccines can cause brain damage?

Yes, their own lips have said it:

The National Health Service website states that vaccinations can cause encephalitis – an inflammation of the brain, they say, *"this is very rare and the benefits of vaccination far outweigh the risk of encephalitis."*[1]

The rarity or otherwise is irrelevant here. The fact is that the NHS acknowledges that it happens.

NHS England and Public Health England state that encephalopathy can occur following pertussis-containing vaccines. The USA National Vaccine Injury Compensation Program (NVICP) lists encephalopathy as occurring after pertussis containing vaccines and *"vaccines containing measles, mumps, and rubella virus or any of its components (e.g., MMR, MM, MMRV)"* [2]

> *"Many parents have noticed that their children have had some or all of these symptoms after vaccination but the symptoms then appear to resolve and are not thought of as serious enough for the parents to take them to hospital for a diagnosis to be made."*

Dr Abhijit Chaudhuri and Professor Peter Kennedy of the Institute of Neurological Sciences, in Glasgow state that a particular type of brain inflammation - Acute disseminated encephalomyelitis (ADEM) - which may have a rapidly deteriorating course - usually occurs in the absence of a fever usually with a history of ***"febrile illness or immunisation*** *preceding the neurological syndrome by days or weeks (postinfectious or postvaccinal encephalomyelitis)."*[3] [emphasis added]

With all occurrences of encephalopathy, encephalitis, encephalomyelitis it is known, accepted and not controversial that there can be alterations in the child or adult's ability to function afterwards. These changes in function can be physical, emotional, developmental, and can include changes in personality, processing, and expression. How can it be definitively said that **none** of these sequelae (any abnormal bodily condition or disease related to or arising from a pre-existing disease) could possibly lead to physical, developmental and behavioural alterations in some babies or children?

It doesn't make sense.

It is more constructive to accept the already acknowledged facts above and agree that changes may occur in some recipients of vaccines and to acknowledge that one of the syndromes (symptoms occurring together and making up a named disease picture) that may occur is what may be labelled 'autistic spectrum' amongst others. Indeed cases of children who have been diagnosed with autism have won payments through the USA vaccine compensation program on the basis of a diagnosis of having post-vaccine encephalopathy – so long as the parents do not mention the word 'autism'.

The number of children who are actually diagnosed with encephalopathy, encephalitis, encephalomyelitis are a small percentage. In most conditions there is a range or spectrum. There are many who are not diagnosed but none the less suffer from *"fever, lethargy, not waking for feedings, vomiting, body stiffness, unexplained/unusual irritability, and a full or bulging fontanel (the soft spot on the top of the head)"* after their vaccinations.

These same symptoms are listed as *"important signs of meningitis or encephalitis to watch for in an infant"* in the National Institutes for Health (USA) meningitis/encephalitis fact sheet [2] even though the USA Vaccine Injury table states that, *"the following clinical features in themselves do not demonstrate an acute encephalopathy or a significant change in either mental status or level of consciousness: Sleepiness, irritability (fussiness), high-pitched and unusual screaming, poor feeding, persistent inconsolable crying, bulging fontanel, or symptoms of dementia."*[4]

Many parents have noticed that their children have had some or all of these symptoms after vaccination but the symptoms then appear to resolve and are not thought of as serious enough for the parents to take them to hospital for a diagnosis to be made, maybe the parents did not even seek medical help at all - an increasingly difficult task

– they just nurse their children themselves. How many of these children go on to have subtle changes in personality, emotions, physical and mental abilities, as well as development, which in a percentage of cases are diagnosed as autistic spectrum or have other developmental problems?

The family of poor Hannah Poling who was injured by vaccinations was able to prove it only because her father is a neurologist and arranged the scans and other investigations early on. Most people have no access to such investigations.

Why does this happen to some children and not others? Is it genes, environmental or an interplay of both?

There is a tendency, over the last few decades, to regard genes as the inescapable destiny of the human being. You have those genes, that's it, your number's up. This is not the case at all. Apart from a very few, specific and non-representative conditions, having a particular gene or sequence of genes does not determine your fate. What determines your fate is whether or not the genes are expressed - switched on - or not.

What determines this? The environment. Your genes may be the loaded gun but the environment has to pull the trigger.

I recently read Judy Singer's book, Neurodiversity, a phrase she coined when she was studying at Sydney University of Technology. I found some of her ideas very interesting including that computers and the internet rather than liberating autistic people from the need to read facial expressions or react instantly to complex social cues, had actually been made by high functioning autistic people and that to some extent this technology is actually making neurotypicals (NTs) ie those who regard themselves as normal, more like those on the spectrum.

However the people inhabiting her neurodiverse universe, those she describes as, *geeks , nerds, Aspi's, and autistic cousins (ACs)* are, as she correctly states, not made like that from vaccination. They are on a completely different level from those who are almost not able to communicate at all in addition to having complex physical needs. They are no more able to use a computer or participate on social media than fly to the moon.

If Singer and executives of groups such as Autistic Self Advocacy Network define autism as a neurodiversity that may bring evolutionary advantage we should not be mixing this with people who have been injured by toxic chemicals, which do not bring an evolutionary advantage. Unless there is an evolutionary advantage in those who are less injured after vaccination being the only ones who will be able to reproduce, as there are so many new vaccines in the pipeline.

I therefore welcome the pronouncement by the Lancet Commission on Autism that there needs to be a separate category of 'profound autism' to describe the people at the very low functioning end of the 'spectrum' who cannot communicate at all and have far more complex needs.[5] This has provoked a severe backlash by autism groups of high functioning people who appear not to want dilution of their ranks and fight vociferously against anyone who tries in any way to talk about help for or 'cure' of autism - because if it is neurodiversity it is not a disease. This is mirrored to some extent by those in the Deaf community who refuse to allow deaf children to have cochlear implants so that they can hear and develop speech as it gives the impression that being deaf is a disability.

I believe that those severely injured after vaccination should not be called autistic at all, as I have described above, because all the terms have become so emotionally loaded as to become self-defeating. They should be called vaccine injured. That's it.

On to Cuba. I am always looking, observing and thinking about what constitutes health, what promotes it, what injures it and in particular what effect environmental and lifestyle factors have. So when I went to Cuba with my daughter in 2019, I was particularly struck by the children - they have so much vitality, bright vibrant faces, *joie de vivre*, running around the streets joking, laughing, smiling.

Cuba is an amazing place. You should all go. In Cuba people are really poor; they have nothing, but they seem a lot more happy than most of the people you meet here where we have a lot more. I knew that Cuba had been blockaded for 60 years by the USA and deprived of almost all the things they need to function as a twentieth century society, and any other country that wants to trade with them gets penalised by the USA. So I wondered if the children were much more vivacious and 'alive' because they had fewer vaccines.

When I got back to the UK and more available internet access I looked up Cuba and autism and found that it was quite the opposite. I found that although there is a blockade of almost everything that Cuba needs from the West, vaccines are not blockaded. Far from being non or under-vaccinated, Cubans have almost the same schedule as the USA and the uptake is over 99%. It is a communist country. You don't get to choose. You just line up and get jabbed.

This lead me to a thought-provoking and carefully researched paper by William Shaw, PhD.[6] According to his research using figures from the Cuban department of health, which I checked myself, and other enquiries, there is 298 times less autism than the United States of America.

You may say that Cuba being poor, maybe autism is diagnosed differently due to an under-resourced medical system, but this is not the case. Cuba has great doctors and a very good medical system, which so-called developed countries would do well to emulate. It has lower mortality rates for many age groups than the USA, which spends many more multiples of billions of dollars on health care than Cuba. Cuban doctors are exported all round the world. North Americans come on health tourism to Cuba because the Cubans do such good surgery, such good medicine and it's so much cheaper than in America.

How is it that they have got such a low autism rate?

Dr Shaw is board certified in the fields of clinical chemistry and toxicology by the American Board of Clinical Chemistry. Before he founded

The Great Plains Laboratory, Inc. He has worked for the Centers for Disease Control and Prevention (CDC), Children's Mercy Hospital, University of Missouri at Kansas City School of Medicine, and Smith Kline Laboratories and he is a deep thinker. He points out that while many people ask questions about vaccination and autism, far fewer people ask about the the therapies that are given at the same time as the vaccines that might increase the likelihood of susceptible children being injured by their vaccines. He unearthed the interesting fact that Cubans do not use paracetamol (Calpol, Medinol, Tylenol, acetaminophen) almost at all. It is not available over the counter. It is prescription only. Cuban doctors do not prescribe it because it is a scarce import.

It is not available to be recommended before or after vaccination or for the childhood fevers that children have in the way it is in the USA, UK and other economically developed countries. It is not present as a constituent in the hundreds if not thousands of medicines for symptomatic relief of symptoms child and adult ailments outside of Cuba.

Why would paracetamol given to children at the time of vaccination and for all their subsequent fevers have anything to do with a lowered occurrence of autism?

Neither I, nor Dr Shaw are saying that paracetamol causes what is called autism. The cause is multifactorial. But any of you who have been to any of my lectures on managing fever supportively will know how much I emphasise the importance of not interfering with fever as it is an ancient, adaptive response of the body for which there are few if any good reasons for suppressing. Management which supports the child's body in the process of elimination, whether by production of fever, mucus, diarrhoea, vomiting, or a rash, helps to externalise toxins from any source making internalisation of disease – such as encephalitis, meningitis, encephalopathy and all other forms of acute invasive disease - unlikely.

NOT INTERFERING WITH FEVER

Treating a child without giving them medicines to suppress their symptoms does not mean doing nothing, it means supporting the body's processes of elimination by making sure that there is plenty of fresh air, clear fluids, rest and no food when there is no appetite. This will allow the liver, the major detoxifier, the kidneys and lungs to work efficiently.

Having lectured about this extensively for years, in 2007 the NICE Guidelines eventually caught up with me stating that *"Antipyretics (fever lowerers) should not be used for the sole purpose of reducing fever in an otherwise well child."* In addition, *"they* ***do not prevent febrile convulsions and should not be given for that purpose."*** [emphasis added]. In 2013 NICE repeated those statements (Fever in under-5s: assessment and initial management CG160, updated 2019 NG143 [7]) and added *"Paracetamol and ibuprofen should be given for distress, only as long as there is distress. They should not be given together only consider giving the other one if the distress returns before the dose of the first one is due."* Nothing about 38'C, 39'C – distress – the way people might take it for a headache – and those who attend my lectures know that there are many other ways of reducing pain or discomfort.

However, there are still GPs and nurses telling parents that they must give paracetamol/ibuprofen or, *"Your child will get febrile convulsions."* I see mothers and fathers who are threatened by hospital doctors with referral to social workers in the A&E department because those parents do not want to have antipyretics given to their feverish children as they are otherwise OK – their skin is a good colour, they are drinking, having wet nappies or pale urine, they respond normally to social cues.

Why do health professionals not read their own guidelines?

[please download the 'NICE traffic light', print and use in conjunction with my General Measures sheet – free on my website].

One of the good things that happened with Covid is that the 2007 guidance was extended in April 2020 to adults in the community, not just under 5's. Why is it so crucial to not remove the fever?

Because a body with fever is undertaking a clear out. At a higher temperature the liver detoxifies more efficiently, the kidneys filter faster, the white cells gobble up detritus better. While this process is going on, waste products are produced. Some are free oxide radicals which need to be removed safely – think of free oxide radicals in your body as a five year old with a blow torch let loose in your sitting room – not good. In the body you need glutathione (and vitamin C) to soak these up and defuse them. One of the pathways used to detoxify paracetamol uses up glutathione. So not only does lowering the temperature slow down the beneficial processes, the liver now has to detoxify the paracetamol or ibuprofen as well as the detoxifying it is already trying to undertake and it uses up the crucial glutathione.

NOT INTERFERING WITH ANTIBODY PRODUCTION AND VACCINE DETOX

When a child has a vaccine it stimulates a massive immune response – exactly what vaccines are designed to do. In addition the body immediately starts to try to detoxify. It is not a conspiracy theory that there are toxins in vaccines – if there were not, the body would not make any antibodies to the killed vaccines – it is not so stupid that it would waste its precious resources making an immune response to something that is beneficial. When your child has a vaccine you really need to know how to correctly manage fever, so you can support your child through the process of getting the most of whatever benefit there may be from the procedure with the least harm.

Paracetamol interferes with all of these processes *including* the production of antibodies. Fever is part of the antibody-making response. Damp down the fever – damp down the antibody production. Conventional medicine spends so much time trying to get rid of *symptoms* that in the case of vaccination it sometimes seems to forget what the point of the vaccine is – production of antibodies. You can see from this that paracetamol works against the ability of the vaccine to do its job and against the body in trying to detoxify and minimise harm.

From an holistic point of view it is not necessary to know every detail of

the pathological mechanisms of harm that can occur from taking paracetamol alone or in combination with vaccination to know that working against the body's innate intelligence and innate drive towards health is never a good idea. It is nonetheless very interesting to read the range of evidence from peer-reviewed journals showing mechanisms that Dr Shaw has investigated and I encourage you to read his full paper, and probably more than once. For example:

"Acetaminophen (paracetamol) produces neurotoxic effects on rat brain neurons both in vitro and in vivo, its use during pregnancy is associated with teratogenic defects in testicular function and the gastrointestinal tract, and there is increased incidence of asthma in maternally exposed and postnatally exposed children."

"Acetominophen [sic] (paracetamol) is converted to the very toxic metabolite N-acetyl-pbenzoquinone imine (NAPQI;…. which can cause oxidative damage to proteins, nucleic acids, amino acids, and lipids, in addition to increased mitochondrial and cellular damage and death."

"A PubMed search of the scientific literature indicated the presence of 2685 articles regarding acetaminophen toxicity."

In 2022 there are now 5,929 – the problem is not going away.

In the USA parents are told by health care providers to give their baby paracetamol before the vaccines and regularly afterwards. In the UK the Joint Committee on Vaccination and Immunisation (JCVI) says parents must be told to give paracetamol when their babies receive the Men B vaccine Bexsero:

"Data from clinical trials suggest that the frequency of fever following routine infant immunisations would be ***expected to substantially increase if Bexsero® was given with other routine infant immunisations.***

"Given this, and concerns of the Committee that this could lead to an ***increase in fever requiring medical attention,*** *or* ***lead to lower uptake of subsequent vaccinations*** *it was agreed there would be a need to educate parents, and healthcare professionals on the potential reactogenicity [adverse reactions] of provision of Bexsero® concomitantly with other infant vaccinations."*

"Good communications would reduce the impact of fever on the health service, and ***provision of prophylactic paracetamol at the time or shortly after vaccination, with a further two doses every four to six hours thereafter should reduce the likelihood or intensity of fever,*** *without diminishing the immune response."*[JCVI 2014] [8] [It does reduce the immune response but JVCI deems this acceptable].

"Dose and frequency of administration 2.5ml (60mg) dose (half a sachet) to be measured using an appropriately sized measuring spoon or oral syringe, ***to be administered during the immunisation appointment or as soon as possible following immunisation with MenB vaccine, Bexsero®…***

Parents should be advised to provide ***two further preventative doses of 2.5ml (60mg) paracetamol*** *suspension 120mg/5ml to be administered at home, 4-6 hours after the preceding dose," [emphasis added][2022]* [9]

This shows clearly that what is important to the JCVI is making sure children get the vaccines, to the obliteration of anything else.

Is the advice by the JCVI and the doctors who implement the above advice, including the ones who prescribe the hundreds of litres of paracetamol to children with fever every year against the NICE Guidelines, actually promoting neurological damage in susceptible individuals?

Is this why Cuba has such a low rate of autism? No access to paracetamol?

Is it a global reduction in toxic load? Thanks to the blockade, Cuban agriculture is mostly organic – even organic tobacco!

These are certainly issues that need careful consideration.

Do read Dr Shaw's excellent article – and come to my lectures to find out what to do instead!

https://www.eventbrite.co.uk/o/dr-jayne-lm-donegan-30030351200

Post script: Just in case you are thinking that you had now better give your children ibuprofen, please do not. It is worse. See my lecture: 'Nursing People Supportively Through Acute Viral Associated Illness'.

jaynelmdonegan@yahoo.com

29 April 2022

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(all accessed in April 2022)

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Updated 31 Mar 2022 Protocol for the supply or administration of paracetamol oral suspension 120mg/5mL to infants under 12 months of age receiving primary doses of MenB vaccination.

Dr Donegan's latest lectures - please share with others who might be interested.

https://www.eventbrite.co.uk/o/dr-jayne-lm-donegan-30030351200

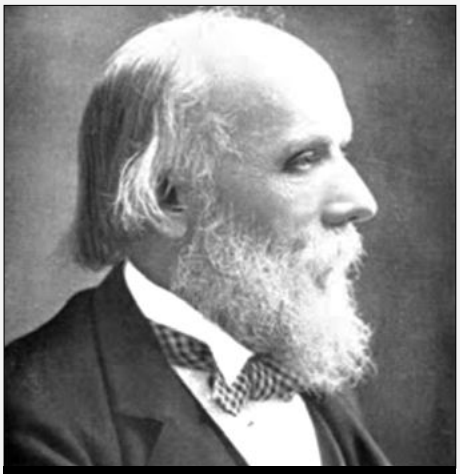
> IT IS THE UNQUALIFIED RESULT OF ALL MY EXPERIENCE WITH THE SICK THAT, SECOND ONLY TO THEIR NEED OF FRESH AIR, IS THEIR NEED OF LIGHT; THAT, AFTER A CLOSE ROOM, WHAT HURTS THEM MOST IS A DARK ROOM AND THAT IT IS NOT ONLY LIGHT BUT DIRECT SUNLIGHT THEY WANT.
>
> ~ *FLORENCE NIGHTINGALE, NOTES ON NURSING (1860).*

TIP ARCHIVE

A TYRANNY WHOLLY INDEFENSIBLE

THE AUTHOR'S PERSONAL STATEMENT OF THE RESULTS OF VACCINATION

From: The Recrudescence of Leprosy and Its Causation by William Tebb. Appendix, p389-391



William Tebb

During the past twenty-two years it has been my experience to travel in all parts of the United Kingdom, from Land's End to the Shetland Islands, and in almost every state in Europe, from the Mediterranean to the North Cape, in countries intervening between the Tagus in the west, and the Volga, Danube, and Bosphorus, in the east; also in Morocco, Algeria, Upper and Lower Egypt, Asia Minor, Upper and Lower Canada, Nova Scotia, and most of the states and territories of North America; also in Venezuela and British Guiana, South America, in the Windward and Leeward Islands, the French and Danish West Indies, in the archipelagoes of Greece and Hawaii, the island of Ceylon, in Tasmania, New Zealand, the colonies of Australia, and in South Africa.

In nearly all these countries I have made it my business to inquire into the methods and results of vaccination, procuring information from public officials and from intelligent private individuals, and I have hardly ever inquired without hearing of injuries, fatalities, and sometimes wholesale disasters, to people in every position in life, and these have occurred from the use of every variety of vaccine virus in use. My informants have included governors, chief magistrates, consuls, professors of medicine and surgery in Continental universities, members of legislative assemblies, superintendents of leper asylums, editors of medical and hygienic journals, chiefs of military and general hospitals, presidents and medical officers of state and colonial health departments, superintendents of small-pox hospitals, clergy-men of all denominations, missionaries, heads of education establishments, and the best informed amongst old residents in the places visited.

In one country it was my privilege to be furnished with a general letter of introduction from a minister of State (since Prime Minister), which gave me access to all the official and medical authorities. Often the fatality described to me has befallen the infant of a poor mother, who with dread forebodings in her mind has tried to shield her offspring from the vaccinator's lancet as long as she could, and, like a fugitive slave, only surrendered to the minister of the law when overtaken in pursuit or her place of refuge discovered; or, like that of a distinguished Moslem (Suffey Bey Adem), my travelling companion in 1884 from Damascus to Beyrout, who had lost a daughter, a nephew, and a niece (vaccinated together about a year before our interview), all of whom died of the operation, after the most acute suffering. At other times I have seen stalwart soldiers and post-office officials seriously injured, and in more than one instance crippled and ruined for life, by compulsory re-vaccination. I have personally investigated vaccine disasters at two military hospitals, one in Europe and the other in Africa, where, in one case, three, and in another case thirty soldiers ultimately died of the operation, and more than twice this number were seriously, and, in most cases, permanently injured. In Australasia I have personally inquired into a case of wholesale disaster – of acute septicaemia, exhibited by terrible ulcerations following vaccination with calf lymph – to several hundred persons, and have seen the sad consequences in permanently ruined health. I have received several thousand written statements from parents, who allege that their children have been seriously fatally injured by vaccination. I have proved beyond doubt, by personal inquiries in various countries where leprosy is increasing, that the increase is largely due to vaccination, and have furnished the testimonies of numerous medical authorities, and of official reports (all mention of which has been omitted from our leading medical journals), in support of these incriminating allegations. These facts have been detailed by me in the Times, Nonconformist, Echo, Leeds Mercury, Manchester Guardian and Examiner and Times, Leicester Post, Newcastle Leader, Scottishe Leader, Cardiff Daily News, Gloucester Citizen, Hospital Gazette, The Tocsin, Journal of Hygiene (Paris), Birmingham Gazette, The Vaccination Inquirer, and other influential and well-known English, American, and Colonial journals; and some of them were quoted by me, with chapter and verse, before the Royal Commission on Vaccination, now taking evidence in London, and will be found in the third official report of the proceedings.

I may also mention that numerous facts of a sinister character were contributed by many of the delegates representing the leading European States at the International Anti-Vaccination Congresses held in Paris, Cologne, Berne, and Charleroi, the reports of which have been published and presented to the chiefs of Governments, and of Public Health Departments in all countries. Not only

have the facts been submitted to Continental Ministers of State, and to successive Presidents of the Local Government Board in England, but in December, 1890, I laid them before Mr Langridge, Chief Secretary to the Government of Victoria, Australia, and before leading officials in other Colonies. It seems to me, therefore, that, in view of these experiences, and in the presence of such unimpeachable facts, the opposition which has arisen, and is growing daily in nearly all countries, is a commendable and patriotic struggle, which should be encouraged in every possible way. The laws (often cruelly enforced), which compel the parents of this and other countries to put the health and lives of their offspring into the hands of irresponsible State officials, with the alternative of severe and not seldom ignominious punishments, is a grave national blunder, and constitutes a species of tyranny wholly indefensible; and it behoves every good citizen to endeavour, by every constitutional means, in the interests alike of justice, of individual and parental rights, and in defence of the public health, and of our helpless children, to get these law completely and permanently extinguished.

TESTIMONIES CONCERNING VACCINATION AND IT'S ENFORCEMENT BY SCIENTISTS, STATISTICIANS, PHILOSOPHERS, PUBLICISTS AND VACCINE PHYSICIANS - 1882

CLASSIC REPRINT PAMPHLET FROM 1880s. FIFTH EDITION. P14
DR COLLINS, LICENTIATE OF THE ROYAL COLLEGE OF PHYSICIANS, EDINBURGH, AND MRCS, ENGLAND

EXTRACT

"After twenty years' experience as a public vaccinator, I am convinced that no amount of care nor attention to detail, nor cautious selection of lymph, can obviate the risk of Vaccination being followed by erysipelatous inflammation.

In fact there is not certainty in the operation; in some it runs a normal course with apparently little or no constitutional disturbance, leaving the depressed punctuated scars, which are regarded by some authorities as the only guarantee of a successful Vaccination; whereas in others, especially the strong and vigorous, I have known phlegmonous erysipelas not unfrequently to follow properly performed vaccination.

It was to this complication that Sir Culling Eardley fell a victim, although his family, who were vaccinated at the same time, with the same lymph, suffered no inconvenience.

We unfortunately have no method of ascertaining the impurity of vaccine lymph, except by its results; and these are not surprising when we remember it contains precisely the same microscopic particles as are found in fluids capable of producing the acutest blood-poisoning."

1 Albert Terrace, Gloucester Gate, N.W. September 2nd, 1882.

TiP Editor: Perhaps the strong and vigorous were actually mounting a natural response to having the poison introduced into their body? An attempt to throw out the poison??

How was this phlegmonous erysipelas (a form marked by invasion of the subcutaneous tissues, with the formation of deep-seated abscesses) treated? Was it suppressed by other pharmaceuticals, ie further poisoning – which may have led to more serious issues, including death?

PHA : FOR THE PEOPLE BY THE PEOPLE https://the-pha.org/

The People's Health Alliance was formed in February 2022 by a group of people who were concerned about the difficulties people were having obtaining care from the NHS, and about the number of nurses and doctors leaving the NHS because they were not happy with the system in itself or the way they had been treated professionally. They had the vision of creating Integrated Health Hubs around the country, which would include holistic and natural healthcare options alongside medical care for minor issues. Many others around the country and around the world have had the same vision at the same time. It is a project whose time has come.

Many have wanted this for a very long time and now it is becoming a real possibility with the launch of the new website on Saturday April 23rd, where there will be information about Child Health and Wellbeing, areas for chats, Mental Health support, Hub Blueprints and general advice for Home Healthcare with natural and inexpensive methods. There will be reference links and reading material, as well as practitioner contact details around the country. The plan is to have an Access Fund, so anyone can receive the treatments they need and want without worry about the expense. We will of course include links to courses for parents and carers to inform themselves to better help their families maintain good health.

AIMS & OBJECTIVES OF THE *informed* PARENT GROUP

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 establish a nationwide support network and register (subject to members permission).
7. To publish a newsletter for members.
8. To obtain, collect and receive money and funds by way of contributions, donations, subscriptions, legacies, grants or any other lawful methods; to accept and receive any gift of property and to devote the income, assets or property of the group in or towards fulfilment of the objectives of the group.

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

TEL: 01903 212969 WEB: www.informedparent.co.uk