Dr Jayne L.M. Donegan
MBBS DRCOG DFFP DCH MRCGP DipNAT
[redacted]

02 May 2023

Emily Silver
Solicitor
GMC Legal
Telephone: [redacted]
Email address: [redacted]

Ms Silver

Re GMC vs Dr Jayne LM Donegan
Hearing dates 19 June 2023 - 21 July 2023

I am writing to advise I am boycotting these proceedings. It has become clear from a series of abuses of process by a number of parties that there is little prospect of a fair hearing. This letter explains just some of the evidence. It should be put before the MPTS panel which deals with this case, in my absence. I look forward to confirmation that will be and has been done. I otherwise reserve, and this is without prejudice to, my rights and I seek permission to appeal.

Overview
A. GMC's Expert is in breach of his obligations as an expert witness and lacks relevant knowledge and expertise
B. Lack of substance to charges regarding the content of my lectures and consultations.
C. Lack of substance to the dishonesty charge.
D. Parents misleading health professionals – no wonder.
E. MPTS abuse of legal process
F. A politically motivated show trial
G. GMC Not Fit for Purpose

Overview
The charges lack proper substance and are politically motivated: brought as a result of the behaviour of the now disgraced former Health Secretary, Matt Hancock, who is no longer a Conservative MP but refuses to resign his seat. Hancock at the time claimed: "*The science is beyond doubt: vaccines are safe. They are effective and they save lives and there is no alternative.*" when that was not true and has proved to be even less so with the serious adverse effects of the experimental Covid vaccines which have killed and caused serious injury around the world. As journalist Ryan Coogan of The Independent wrote: *"Matt Hancock is a sitting MP who abandoned his constituents …..and whose actions as health secretary during the UK's worst public health crisis in living memory have a connection to the deaths of more than 200,000 people."*
https://www.independent.co.uk/voices/matt-hancock-im-a-celebrity-2022-girlfriend-b2234217.html

No better is routine abuse of process and the bringing of political show trials by the GMC demonstrated than in the case of award winning author and medical doctor, Dr Sarah Myhill. Since 2001 the GMC has investigated her 43 times after she left the NHS to specialise in treating chronic

fatigue syndrome (CFS) and demonstrated that, contrary to the incorrect view of the medical hierarchy, CFS is primarily a disorder involving mitochondria and is not psychosomatic. So Dr Myhill was pursued not for being wrong but for being right. The GMC had no shame in pursuing those 43 cases when it should have been obvious after the first two or three that this was classic perverting of the course of justice by bringing bogus allegations 43 times in 20 or so years. Those investigations involved three cancelled FTP hearings, seven Interim Orders Hearings and one non-compliance hearing, all of which she won with up to then 5 prosecutions still outstanding. The GMC even brought up at a hearing, as a complaint, based on an article she wrote, that she had strayed from her field of expertise by attending as midwife to a Mrs Hogg.

> "*considering all the material that you have before you, this Panel can be satisfied that there may be an impairment of this doctor's fitness to practise, which does pose a real risk to members of the public*,"
>
> [GMC IOP 2010 23 Dec p33 G]

The GMC was so eager to pursue Dr Myhill that they omitted to notice that Mrs Hogg was a pet sow and the infants were her piglets. That shows the repeated GMC prosecutions were clearly nuisance cases brought for the purposes of harassment of Dr Myhill without concern for whether the cases were sound or not. http://orthomolecular.org/resources/omns/v19n21.shtml

This letter contains evidence demonstrating not just my expertise but that I also present vaccination as appropriate in an evidence-based and balanced manner according to scientific data and national recommendations.

A. GMC's Expert is in breach of his obligations as an expert witness and lacks relevant knowledge and expertise

Summary

i **In a breach of his obligations as an expert** to be independent objective and unbiased and not to mislead the Tribunal, he admitted in an email to the GMC's solicitor his report omitted significant relevant information and so in effect was intentionally misleading:

> "*Most of what Dr Donegan says is correct and in my opinion they are not misleading as a whole. I have therefore not added any comment on this*." [further detail below].

To put this into context, of the 93,527 words in the transcripts of my lectures and consultation, 1,813 words are complained of in the GMC's charges. 98.07% of what I said is not subject to any complaint but the GMC's expert would not comment on that fact in his report nor that there was no issue with it, and despite confirming he knew that to be the case. The GMC's expert omitted that from his report;

ii **he appears unaware of the proper standard every doctor must meet** – of informed consent under the Supreme Court's decision in Montgomery (2015) – and instead applies an incorrect and so unlawful and unethical standard *viz.* the NICE Clinical Knowledge Summary. This is a failing not merely of his report but of his own understanding of his own obligations as a doctor as well as showing a lack of expertise to be an expert in this case;

iii **he breached his obligations** in failing to read the documents his GMC letter of instruction directed him to read and to apply that information to his report, including Good Medical Practice which would also have told him the standard doctors must meet – of informed consent under Montgomery;

iv **He cites misleadingly articles and references in his report as if he had read them when he had not**. He could not have read them because he did not have copies of them. He was unable to produce the referenced articles and other material he claimed to rely on in his statement as required by his instructions. When he was forced to produce copies of the referenced works he claimed to have relied on he changed his report because this would have become obvious when referenced works did not support what he claimed in his report.

It is obvious that he did not read most if not all of the articles and references he claimed to rely on as evidence for his report:

- from what he wrote in his report;
- because he did not have his own copies, it took him 16 months after his report was delivered to produce all of them [belatedly] to comply with his GMC letter of instructions and that was piecemeal;
- after he produced the referenced works, he withdrew some; when required to give reasons for doing so he admitted he not read the papers. He claimed to have read the abstract, but we only have his word for that;
- his lack of expertise is demonstrated by the fact he did not know that HPV vaccine trials did not use a saline placebo. He only found out after he was forced to get and provide copies of the references and he then read them for the first time – long after his report was finalised;
- the references that he produced regarding placebo controlled trials are not for vaccines used in this country or not for children;

- the GMC expert and the GMC trainee solicitor who instructed him knew neither the law on consent nor the GMC's own guidance.
- A year and four months after his report was produced by the GMC in March 2020, by July 2021 he was still saying he did not have access to all the referenced works:

> "*You will note above that all of the trials are now included, save for trial 10. Dr Riordan has confirmed that the reason for this is that there is a problem with the Oxford Academic website which is undergoing maintenance. Although the website is saying there is no maintenance ongoing, Dr Riordan has confirmed that he still cannot access articles. I will update the MPTS as to the missing document. Dr Riordan has confirmed that he will provide this as soon as he has access.*"
> [Emily Silve [redacted] To: Jayne LM Donegan Thu, **Jul 21, 2022** at 4:03 PM]

v The GMC's expert is not an appropriate expert because he is biased [in addition to failing to be independent and objective]

Comment on: ii Expert unaware of standard every doctor must meet

The GMC charge against me states [2b]

b. *failed to comply with NICE Clinical Knowledge Summaries on immunisation.*

The NICE Clinical Knowledge Summaries on immunisation consent comply neither with the GMC guidance or the law:
NICE Clinical Knowledge Summary Last revised in July 2021

- *Explain the benefits of vaccination, in particular that it helps prevent serious illness in children, especially potentially severe Disease such as meningitis, tetanus, and measles.*
- *Reassure that vaccinations are safe, and serious adverse effects are very rare*

[NICE Clinical Knowledge Summary Last revised in July 2021]

What the GMC Guidance on Consent 2020 states is:

23 You should usually include the following information when discussing benefits and harms.
a Recognised risks of harm that you believe anyone in the patient's position would want to know. You'll know these already from your professional knowledge and experience.
c Risks of harm and potential benefits that the patient would consider significant for any reason. These will be revealed during your discussion with the patient about what matters to them.
d Any risk of serious harm, ***however unlikely it is to occur.***

[Consent GMC 2020]

The law [Supreme Court in Montgomery 2015] states:

87….. 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.

89.…… the assessment of whether a risk is material cannot be reduced to percentages. The significance of a given risk is likely to reflect a variety of factors besides its magnitude: for example, the nature of the risk, the effect which its occurrence would have upon the life of the patient, the importance to the patient of the benefits sought to be achieved by the treatment, the alternatives available, and the risks involved in those alternatives. The assessment is therefore fact-sensitive, and sensitive also to the characteristics of the patient.

> *93…..the guidance issued by the General Medical Council has long required a broadly similar approach.*
>
> *It is nevertheless necessary to impose legal obligations, so that even those doctors who have less skill or inclination for communication,*
>
> *or*
>
> *who are more hurried, are obliged to pause and engage in the discussion which the law requires.*
>
> *This may not be welcomed by some healthcare providers;…..*
>
> [Montgomery 2015]

The Montgomery ruling was greeted with surprise by many doctors and their indemnifiers – who obviously do not read GMC guidance either - from seven years prior. Even more strange is that after taking five years to revise its guidelines in the light of Montgomery the GMC actually diluted their prior 2008 guidance which had previously said in much stronger terms:

> "*You must tell patients if an investigation or treatment might result in a serious adverse outcome, even if the likelihood is very small*."
> "*You should also tell patients about less serious side effects or complications if they occur frequently, and explain what the patient should do if they experience any of them*."
> [Consent GMC 2008]

Now it is only '*usually*'.

The GMC expert does not know the law on consent, in dereliction of the requirement of the GMC

> *"12 You must keep up to date with, and follow, the law, our guidance and other regulations relevant to your work."*
> GMC GOOD MEDICAL PRACTICE 2013 UPDATED 2014

> "17 *You must be satisfied that you have consent or other valid authority before you carry out any examination or investigation, provide treatment or involve patients or volunteers in teaching or research*."
> GMC GOOD MEDICAL PRACTICE 2013 UPDATED 2014

Dr Riordan's report shows he is wholly unaware of the requirements of Good Medical Practice and the law laid down by The Supreme Court on informed consent in Montgomery. He mentions neither even though he was directed by his letter of instruction to read Good Medical practice. Nowhere in his report, nor in NHS nor in Department of Health information or guidance is there any mention of the legal requirement of informed consent which includes informing patients of,

> '*reasonable alternatives or variant treatments.'*

With half truths being told to parents by Government ministers, the NHS, doctors, nurses and health visitors, and being promoted by the GMC in its prosecution of doctors who fulfil their lawful obligations, is it any wonder that parents look to independent sources to fill in the gaps? To give them the balancing view. That is what I do in my lectures. There is no need to repeat the information new parents are presented with by GPs, health visitors and others but I do draw attention to it nonetheless.

Comment on: iv The GMC's expert is not an appropriate expert because he is biased [in addition to failing to be independent and objective]

1. His overt bias is shown in his correspondence with the GMC. On 09 March 2021 he sent the GMC solicitor a BMJ article titled "*Should spreading anti-vaccine misinformation be criminalised?*"

> "*Yes—Melinda Mills*
> *No—Jonas Sivelä "Criminalising anti-vaccine misinformation seems a strong response but does not deal with these issues*."

[Subject: Criminalising Vaccine Information, From: Riordan Andrew <[redacted]Date: 09/03/2021, 14:23 +0000 To: Emily Silver[redacted]criminalsing anti-vaccine misinformation bmj.n272.full.pdf]

It was sent with the comment: "*You might find this article useful when reviewing this case*." as if this was relevant to the case: as if I had been providing misinformation when this is not true and the expert admitting privately, but not in his report, that the vast majority of what I said was correct; as if the content of my lectures and consultation had been as bad as being criminal. The article was described as a debate but only regarding criminalisation. Information that did not support vaccination policy was regarded by both for and against criminalisation as '*misinformation.*'

The GMC expert sent this to the GMC solicitor to help them prosecute the case against me and in doing so reveals his own non evidence based opinion. To fulfil their duty as an expert, experts are required to be independent, objective and unbiased and to not mislead. Here we see the expert not behaving as an independent objective and unbiased expert but as someone who is partisan and seeking to be involved in the prosecution itself.

It is misleading to purport to provide a compliant expert report when the report is not a work of independence, objectivity and balance.

2. His overt bias is shown when he tells the GMC that what I say is correct which makes it difficult for him to prepare the report. That would not make it difficult to prepare the report but much, much easier. There would be little to raise issue with. But his claim it would be difficult confirms his purpose was to provide a report which is not balanced, independent or objective but one to support a prosecutor – a partisan report. That is the report Dr Riordan is admitting to the GMC is the more difficult to manufacture and specifically because what I say is correct.

He is quoted as saying:

> "*Having reviewed most of the material, Dr Riordan stated that the report is going to be* ***difficult*** *to prepare, as* ***most of what Dr Donegan says is correct****…*"
> [Telephone note Date 13/08/2020 15:33:59 From Dr Frederick Riordan To Adam Molloy]

Yes, it is difficult for him to do the hatchet job that the GMC wants him to do when I am correct in what I say. But instead of saying so and then acting on it, he allows himself to be led by the nose by the GMC in what is essentially a witch hunt against a good and trusted (by patients and lecture attenders) doctor who is acting as a doctor should and giving them correct information, following the GMC guidelines and the law. That is why they come to my lectures because they do not feel safe relying on the half truths told them by Government ministers, the NHS, doctors, nurses and health visitors who do not comply with the guidance and law on consent. They come to me for a balancing view.

And for this the GMC is calling me to a five week hearing.

The note continues,

> "*although she only tells half the story*."

This was well rehearsed in my 2007 GMC panel hearing. The JCVI members in the original court case gave '*only half the story*', as did the GMC expert Dr Elliman in 2007. Parents and patients need the balancing view – the information they cannot and do not get from doctors and the NHS. And that was specifically approved of in the 2007 GMC panel decision which exonerated me of any wrongdoing and which proved to a standard of beyond a reasonable doubt [the GMC panel was 'sure'] my opinions on vaccinations stated in my reports were independent, objective and unbiased:

> "*Taking into account the Panel's reasoning in 6(a), (b) and (c), the Panel is sure that in the reports you provided you did not fail to be objective, independent and unbiased*."
>
> [GMC 2007 D1/11 D]

From 2007 case transcripts:

Mr Stern QC:

> "*One could say that the fathers were completely misled by Dr Conway's report [JCVI member], because he had not given the full information and when those fathers read that report of Dr Conway, or those reports of Dr Conway, they would have thought <u>in the absence of any balancing aspect of vaccinations</u> and would have got the clear impression that there were no risks at all attached to immunisation and that therefore they should proceed full steam ahead*."
>
> [GMC 2007 Day 9, 20 Aug 2007 p671 of 748]

GMC Panel Decision:

> "*You told the Panel in evidence, <u>which it accepts</u>, that, when you wrote your report, you were responding to the reports of the other experts <u>in order to give the Court a balancing view</u>*."
>
> [GMC 2007 D1/4 E]

It was clearly established, and clearly stated in the GMC panel determination, that I gave a '*balancing view*'. And it is clear the 2007 GMC Panel found this to be appropriate. So the present case is attacking me for doing what the 2007 GMC Panel considered acceptable in the circumstances. The main difference in this case being that I was giving lectures and gave a consultation but as a homeopath and not as a medical doctor. In the 2007 GMC case I had been acting as an expert witness.

The GMC's bogus attack on my lectures is an attack on my common law rights and human rights to freedom of speech and it is an attack on the human rights and common law freedom of speech right of the public to know – to receive information as part of the right of free speech. The rights include the rights to receive and to impart information as confirmed by the House of Lords in *Derbyshire County Council v Times Newspapers* [1995] AC 534.

15 years on parents are still getting one sided information that does not fulfil the legal requirement for consent by the medical professionals who administer vaccines, Government minsters and the

NHS - a national disgrace. It also breaches the public's right to receive information as part of the public's legal rights to freedom of speech.

Parents are still told less than '*only half the story*' before vaccination and in advertising campaigns, promotional leaflets, websites, books and posters, hence it is necessary for health professionals who *are* fulfilling their legal obligation to provide the rest of the information needed for informed consent. To give the 'balancing' view. Would that it were not necessary.

Even now pregnant women say, "*I was given a pertussis vaccine.*" Completely unaware that the vaccine was a diphtheria, tetanus, polio and whooping cough vaccine.

Even now parents say, "*I took my child to get a polio vaccine because of the polio in the sewage scare.*". Completely unaware that the vaccine was the hepatitis B, diphtheria,, tetanus, polio, whooping cough and *Haemophilus influenzae* B vaccine.

Even now people are given the Covid vaccine being told it will protect themselves from Covid infection and their granny or their family or their colleagues from transmission which is not true and was known not to be true, and are not told about the adverse reactions including deaths, that so quickly overwhelmed the MHRA reporting system which was set up to expect only a few thousand reports.

Even now judges order forced Covid vaccination on children and young adults who lack capacity to consent, on the basis of doctors who quote government and JCVI policy uncritically and with no individualisation. Individualisation is a requirement of Good Medical Practice.

> "*2 Good doctors work in partnership with patients and respect their rights to privacy and dignity. <u>They treat each patient as an individual</u>.*"
>
> [GMC Good Medical Practice 2013 updated 2014]

NHS vaccination information is consistently *'half the story'*, or less.

3. His overt bias is shown in that he declares no conflict of interest notwithstanding that he had been a member of the JCVI for ten years [2008-18], sometime acting and deputy chairman. The JCVI sets government policy on vaccination. To accept as valid any view other than government policy on vaccination would be to go against that policy and his own organisation that advised it. And he does not declare this as a conflict of interest. He is biased but does not acknowledge it.

4. His overt bias is shown when he says:

> "*although she only tells half the story.*"

When he reads only abstracts of published studies, if that, in making determinations as a member of the JCVI since 2008, sometime acting and deputy chairman, which affect the lives of the approximately 70 million inhabitants of the United Kingdom.

When required by me to give reasons for withdrawal of references such as:

> 'Reisinger KS, Block SL, Lazcano-Ponce E, et al. Safety and persistent immunogenicity of a quadrivalent human papillomavirus types 6, 11, 16, 18 L1 virus-like particle vaccine in and adolescents: a randomized controlled trial. Ped Infect Dis J. 2007;26:201–209'

Dr Riordan replied (emphasis added):

> "*Despite **abstract** saying "Saline placebo" was used, **this was not the case.** The placebo used in this study contained identical components to those in the vaccine with the exception of HPV virus like particles and aluminum adjuvant*."
>
> [undated 'Comparison' document produced with:Documents for Dr Donegan PHM- 1 September 2022 Thu, **Aug 25, 2022** at 9:13 AM]

It took The GMC expert 15 years after the above report was published, and 16 months after he had cited it uncritically to find out, by actually reading the study, that what he was purporting to evidence with it was not true. He cited it to support his contention that there *are* gold standard placebo controlled trial for the vaccines in the regular childhood schedule in the UK when this is, lamentably, not true.

This is the level of oversight the public is forced to depend on from the JCVI, from the Government which relies on the JCVI to set vaccine policy and from the NHS that implements it. An egregious example of hypocrisy and overt bias but unrecognised by him as well as a shameful lack of trustworthiness.

This is despite the JCVI's terms of reference:

> *6. "To advise UK health departments on immunisations for the prevention of infections and/ or disease following due consideration of the evidence on the burden of disease, on vaccine safety and efficacy and on the impact and cost effectiveness of immunisation strategies. To consider and identify factors for the successful and effective implementation of immunisation strategies. To identify important knowledge gaps relating to immunisations or immunisation programmes where further research and/or surveillance should be considered*."

And the JVCI members, it seems from the GMC Expert's example, read abstracts only and don't know that there are no double blind randomised placebo controlled trials or even cohort studies for any of the regular vaccines in the childhood schedule. Or maybe this is only the members that the GMC selects to act in fitness to practice against well-meaning doctors who at least attempt to fulfil the GMC requirement:

> "*8 You must keep your professional knowledge and skills up to date. "*
>
> [GMC GOOD MEDICAL PRACTICE 2013 UPDATED 2014]

The people who come to my lectures know who is only telling half the story and it is not me. That is why they depend on doctors and former NHS GPs like me – I am not the only one – to get information they trust because they know I perform due diligence and I give a balancing view which includes information they cannot get elsewhere and do not get from the NHS or their GPs.

5. His overt bias is shown when he says in his email to the GMC 04 March 2021

> "*Whilst the lectures contain mis-information(which we have highlighted), in my opinion they are not misleading as a whole.*
> "*I have therefore not added any comment on this.*"
>
> [From: Riordan [redacted] Sent: 04 March 2021 10:13 To: Emily Silver [redacted] Subject: FW: FW: Private and Confidential: Dr Donegan- Expert Report.]

"*Not misleading as a whole"* but he has '*not added any comment on this*' in his report. Why not?

Why has he not said at the very beginning of what could have been a very short report:

> "*Most of what Dr Donegan says is correct and in my opinion she is not misleading as a whole.*"

That would have been a fair way of dealing with my lecture information, rather than in what I submit is the inappropriate, unbalanced and biased way that he did deal with it:

> *"I have therefore not added any comment on this*."

Is that not "*only telling one side of the story*"? No one has been told 98.07% of the lecture and consultation transcripts has no objection whatsoever raised to it.

But then is that not why the GMC hires 'experts' like him?
To do a hatchet job on doctors like me so the GMC can help the Department of Health to gag them?

Providing a balancing view

The public would do well to ask:

> "*Why would all those doctors say that vaccines are safe if they are not? Why would doctors say they are necessary if they are not? Why would doctors say that vaccines are responsible for the great fall in death and disability from infectious diseases if they are not?*"

The answer is because any doctor who shows the slightest bit of independent thought, research, on any aspect of medical practice – vaccines, statins, antidepressants, chronic fatigue, cancer protocols – particularly if this involves less reliance on pharmaceutical products – will find themselves subjected to vicious attacks from regulatory bodies and medical colleagues. Your patients may love you and really value your approach to their care. They may never complain about you, but this will not stop the GMC trying to destroy your reputation, your career and ruining your life and that of your family, to make you an example to other doctors who might be tempted to act with integrity and fulfil their obligations as doctors.

Just as the GMC 'expert' in my 2007 case, Dr David Elliman, had to admit under cross-examination that in many cases in criticising my opinion he had just been '*quibbling*', but that had been enough for the GMC to accuse me of serious medical misconduct, and, as now, to try to destroy my reputation, career and family life.

The GMC charge that I:

> "2*a. failed to give balanced information on the risks and benefits of immunisation*;"

is incorrect. It is Government ministers, the NHS, doctors, nurses and health visitors who fail to give balanced information on the risks and benefits of vaccination, telling half truths and I, and ethical, knowledgeable doctors like me, give the needed balancing information.

Parents who come to my lectures already know what the NHS and Department of Health say. They have done enough of their own research to know it is only part of the story, They get no other information from their GPs, practice nurses or health visitors even when they categorically ask. They come to my lectures specifically to hear the 'balancing' view, hence the name of one of my lectures, 'Vaccination the Question.' I would not have to give these lectures if the NHS, Department of health and doctors, GPS, paediatricians, nurses and health visitors fulfilled their obligation in law to obtain informed consent.

In addition, it is not true I provide a one-sided perspective. Providing a balancing view is not one-sided. It is providing balance which the 2007 GMC Panel expressly accepted as unproblematic in the circumstances. And these are broadly the same circumstances when it comes to information provided by government agencies and by me.

I also draw to lecture attenders' attention and ensure they have links, to refer to for the official UK and US publications on vaccinations: the Green Book, (UK immunisation against infectious diseases handbook) and the Pink Book by the CDC USA - which is better and more thorough, though having US graphs not UK data - and links to the electronic medical compendium (emc) so that they can access the patient information leaflets for *all* currently available UK drugs and vaccines as well as the manufacturers summary of product characteristics. I also give information on how to correctly manage fevers which is crucial to know if you do not vaccinate your children

and even more so if you do: many children get high fevers after vaccination as part of the immune response, and it is crucial to know how to manage these correctly.

So for parents I explain I give a balancing view as well as links to UK and USA Health Department immunisation handbooks and for GPs I present vaccination as appropriate in an evidence-based and balanced manner according to scientific data and national recommendation.

Providing a balancing view to:
Official Misinformation and Disinformation About Vaccines – Some Examples

Vaccines are not safe. They cause adverse reactions some of which are serious, including death. But the general public do not know that - they think they can trust their doctors. And as for what these doctors (below) are saying. Do they not undertake even a minimal amount of critical thinking?

More to the point, will the GMC be prosecuting any of the doctors named and shown in the following examples to be providing false and misleading information to the public about the safety of vaccines contrary to Good Medical Practice? I think not.

Providing a balancing view to:
A GP not fulfilling his duty of giving the information required for informed consent:
In 2013 **GP in Swansea Dr Dai Lloyd** said MMR vaccine is,

> *"perfectly safe and perfectly effective"*.

^^

https://www.bbc.co.uk/news/uk-wales-south-west-wales-22008478?fbclid=IwAR2ccD0jYl4wL4EfArelSxEjpWlhKbr_aqV_pwl9R8mNwdkigAVm1kEulJc


BBC Sign in News Sport Weather iPlayer Sounds More Search
NEWS
Home UK World Business Election 2019 Tech Science Health Family & Education Entertainment & Arts Stories More
Wales Wales Politics Wales Business North West North East Mid South West South East Cymru Local News

Measles: 'Extra MMR jab' offer in Swansea epidemic
3 April 2013

Health officials have been concerned about the low MMR uptake in the Swansea area

Health officials have been concerned about the low MMR uptake in the Swansea area
A measles outbreak affecting more than 400 people in Swansea has prompted some babies to be offered the MMR vaccine seven months earlier than recommended.

In some cases it would mean children would get three doses of MMR instead of the usual two.
Public Health Wales (PHW) said babies living in 'hotspots' of the epidemic would be offered the extra jab.
Meanwhile, a free MMR vaccination session will be held at the Princess of Wales Hospital, Bridgend, on Saturday.

A spokesman said having three doses of the vaccine was safe but only usually offered during an epidemic.

For that reason, only babies whose parents live in or travel to the 'hotspot' areas of the epidemic in Swansea and Neath Port Talbot would be offered the earlier vaccine.

Only GPs in those areas would be able to give the extra jab.

Normally children are offered the vaccine at around 13 months of age and have a booster jab between the ages of three and five.

PHW had been concerned about the low number of children having the jab and had urged parents to get them vaccinated during the Easter holidays.
Some GP surgeries responded by offering extra clinics for the MMR vaccine.
Public Health Wales and Abertawe Bro Morgannwg University Health Board (ABMUHB) have organised a free MMR vaccination session for Saturday 6 April from 10:00 to 16:00 BST at the Princess of Wales paediatric outpatients department.
A spokeswoman for Bridgend council said it was aimed at children, but jabs would be available for anyone born after 1970 and who has not had measles or been vaccinated against it.

A GP in Swansea, Dr Dai Lloyd, said his surgery had seen people queuing for the vaccine following the outbreak.

Dr Lloyd said offering babies an earlier jab was safe.
"That may mean that some young children will have three MMR jabs," he said.
"That is not a problem. It is perfectly safe and perfectly effective."

^^

Comment on: GP in Swansea Dr Dai Lloyd's misinformation and disinformation
Will any Government ministers, NHSE or the GMC be complaining about him?
Will he be investigated by the GMC - No. Because he is following government and NHS policy – despite the fact that what he is saying is unbalanced and misleading misinformation and

> *"only half the story."*

He is indiscriminately telling people to get their children vaccinated – following the NICE Clinical knowledge summary which is directly in conflict with GMC guidance and breaches the law on informed consent under Montgomery. As well as the fact he has no idea whether three MMR vaccines in young children is safe or appropriate. Where is his evidence?

Providing a balancing view to:

Official Misinformation and Disinformation about 'flu vaccines - The 2014-2015 'Flu Vaccination Campaign

'The Flu Jab is Completely/ Perfectly Safe'
The Finchley Press 30 October 2014
If you're at risk, get a flu jab
As winter approaches, residents are being reminded to get a flu jab..Flu poses a specific danger to those who are pregnant or are suffering from heart problems, diabetes, kidney disease, liver disease, asthma, and other chest complaints. Also at risk are men and women over the age of 65 and children aged between two and four as well of those with a weakened immune system or who Are in close contact with a sick person.
All GP surgeries offer flu jabs to anyone in a high-risk category.
Dr Debbie Frost, chairwoman of Barnet Clinical Commissioning Group, said: "If you are part of any of the groups identified as being at risk of developing flu, you should get a flu jab from your surgery. **It's completely safe**, it's free and it can't give you flu."
http://www.enfieldccg.nhs.uk/news/Get-your-flu-jab-this-winter.htm
http://www.thisislocallondon.co.uk/news/11573276.GPs_urge_people_to_take_free_flu_jab/
Dr Mo Abedi, Chair of Enfield Clinical Commissioning Group (CCG) and a local GP, said: "If you are part of any of the groups identified as being at risk of developing flu, then you should get a flu jab from your GP surgery. **It's completely safe**, it's free, and it can't give you flu
http://midessexccg.nhs.uk/news-events/23-flu-safe-get-the-jab
NHS Mid Essex Clinical Commissioning Group
Be flu safe and get the jab – it's free to those at greatest risk
Flu is a highly contagious infection that anyone can catch. It is not just a cold – it can be a really serious illness for some people and it doesn't just affect older people.
If you're pregnant, have lowered immunity or a long term health condition such as severe asthma, a chest or heart complaint, or diabetes then you should also get a free flu jab from your GP. **The flu jab is completely safe**, and it can't give you flu.
http://www.newhamccg.nhs.uk/news-articles/Newham-GPs-and-councillors-come-together-to-helpfight-flu.htm
Newham GPs and councillors come together to help fight flu
"If you are part of any of the groups identified as being at risk of developing flu, then you should get a flu jab. **It's completely safe**, it's free, and it can't give you flu.
http://www.haltonccg.nhs.uk/your-health/Flu.aspx
Flu Get flu safe, get the jab
Dr Cliff Richard, Chair Halton CCG, said: "Flu is not just a cold – it can be a really serious illness for some people and it doesn't just affect older people. If you're pregnant, have lowered immunity or a long term health condition such as severe asthma, a chest or heart complaint, or diabetes then you should also get a free flu jab from your GP and get flu safe. **The flu jab is completely safe**, and it can't give you flu."
http://www.redbridgeccg.nhs.uk/RedbridgeNews/Local-GPs-it-wont-hurt-to-get-your-flu-jab-forwinter.htm
Local GPs – it won't hurt to get your flu jab for winter
22 October 2013
Dr Anil Mehta chair of Redbridge Clinical Commissioning Group, and a local GP, said:
"**The flu jab is completely safe**, it's free, and it can't give you flu.
http://www.waltonredpractice.co.uk/Flu_Vaccinations.php
Red Practice Dr J Sillick & Partners, Telephone: 01932 414139
Address: The Health Centre, Rodney Road, Walton-on-Thames, Surrey, KT12 3LBFlu Jab Facts
The flu jab can't give you flu
The flu jab is perfectly safe
http://news.warwickshire.gov.uk/blog/2014/09/01/one-in-three-entitled-to-a-free-flu-jab-2/

Dr John Linnane, Warwickshire County Council's Director of Public Health, said:
"... **The flu jab is completely safe**, and it can't give you flu."
http://www.dorkingmedicalpractice.co.uk/pdf/Website%20flu%20message%202014.pdf
Dorking Medical Practice, New House Surgery, 142A South St, Dorking, Surrey RH4 2QR 01306 881313
The flu jab can't give you flu and **is perfectly safe**.
http://www.thebee.co.uk/flu.php
Blackburn with Darwen health bosses are calling on those at greatest risk from flu to protect themselves and their families with a free flu jab.
All you need to know about the flu jab. ... It's quick, safe and free for those most at risk from the virus. ... **The flu jab is completely safe**, and it can't give you flu.
http://www.thestationpractice.co.uk/news.htm
The Station Practice, Station Approach, Hastings, East Sussex TN34 1BA 01424 464756
Flu Jab Facts
The flu jab can't give you flu
The flu jab is perfectly safe
http://www.royalvoluntaryservice.org.uk/get-help/advice-and-support/get-the-flu-jab-get-flu-safe
Royal Voluntary Service
Flu Jab Facts
The flu jab can't give you flu
The flu jab is perfectly safe
http://www.wirral.gov.uk/news/28-09-2012/get-jab-get-flu-safe
Wirral Borough Council
The flu jab is completely safe, and it can't give you flu.
http://shotteswellvillage.co.uk/news/winter-measures-flu-jabs
Winter measures – flu Jabs, shingles vaccination
Shotteswell Village, Warwickshire
The flu jab is completely safe and doesn't carry the live flu virus so it can't give you flu
http://www.redditchandbromsgroveccg.nhs.uk/news/rbccgcampaigns/antibiotics/get-the-jab-get-flusafe/
Redditch & Bromsgrove Clinical Commissioning Group
Flu Facts. The flu jab can't give you flu. **The flu jab is perfectly safe**.
http://www.coventry.gov.uk/info/166/health_protection/2071/who_is_entitled_to_a_free_flu_jab/5
Coventry City Council
Are you pregnant?
Speak to your midwife or GP about the flu jab or contact your GP surgery to find out flu jab clinic times, or make an appointment or find out if your local pharmacy is offering free jabs. **The flu jab is completely safe** and doesn't carry the live flu virus so it can't give you flu.
http://www.derbyshirehealthcareft.nhs.uk/about-us/latest-news/get-the-jab-get-flu-safe/
Derbyshire Healthcare NHS
Hayley Darn, Nurse Consultant said: ..."**The flu jab is completely safe**, and it can't give you flu."
http://community.macmillan.org.uk/blogs/b/community_news/archive/2012/11/02/stay-flu-safethis-winter.aspx

Macmillan Cancer Support
Stay flu safe this winter
The flu jab is completely safe and doesn't carry the live flu virus so it can't give you flu.
http://195.217.160.2/index.asp?record=2098
NHS Isle of Wight
Flu Facts The flu jab can't give you flu The flu jab is perfectly safe
http://bwd50plus.org.uk/news/2013/october/flu-jab-make-a-date-with-your-gp.html
Blackburn with Darwen 50+ Partnership is a strategic group promoting the needs and aspirations

of people over 50 living in the Borough.
Contact your GP to arrange a convenient appointment and get your jab. It's quick, safe and free for those most at risk from the virus. **The flu jab is completely safe**, and it can't give you flu.

http://www.baytvliverpool.com/vod/?vid=BBV50b34901e9173

Bay TV Liverpool
Dr Rita Robertson, Director of Public Health in Warrington said: "Flu is not just a cold – it can be a really serious illness for some people and it doesn't just affect older people. If you're pregnant, have lowered immunity or a long term health condition such as severe asthma, a chest or heart complaint, or diabetes then you should also get a free flu jab from your GP and get flu safe. **The flu jab is completely safe**, and it can't give you flu."

http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=39&ved=0CFwQFjAIOB4&url=http%3A%2F%2Fwww.southworcsccg.nhs.uk%2FEasySiteWeb%2FGatewayLink.aspx%3FalId%3D33676&ei=VkR9VKSPEtDWapzdgQg&usg=AFQjCNEUc4usuRDc5y-qT5epoh-SuWbD7A
press release: http://www.southworcsccg.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=33676

NHS South Worcester Clinical Commissioning Group
Dr Carl Ellson, Local GP and Clinical Lead for NHS South Worcestershire Clinical Commissioning Group said: "Flu is not just a cold – it can be a really serious illness for some people and it doesn't just affect older people. If you're pregnant you are advised to have the flu jab regardless of the stage of pregnancy you've reached, as evidence suggests pregnant women have an increased risk of developing complications if they get flu. Also, if you have lowered immunity or a long term health condition such as severe asthma, a chest or heart complaint, or diabetes then you should also get a free flu jab from your GP and get flu safe.
The flu jab is completely safe, and it can't give you flu."

http://www.southernderbyshireccg.nhs.uk/publications/gp-blog/christmas-flu-jab/

NHS South Derbyshire Clinical Commissioning Group
Dr Ian Lawrence, GP with Hannage Brook Medical Centre, Wirksworth and Chair of the Amber Valley and South Derbyshire Dales Locality of NHS Southern Derbyshire CCG, said The flu vaccine changes every year to fight the latest strains of flu so, even if you had a jab last winter, you need another one this year. **The flu jab is completely safe** and doesn't carry the live flu virus so it can't give you flu.

http://solihullccg.nhs.uk/newspage/156-get-the-jab-get-flu-safe

Solihull Clinical Commissioning Group
Get the jab, get 'flu safe'!
Dr Anand Chitnis, representing the NHS in Solihull, said: "Flu is not like a cold – it can be a really serious illness for some people and it doesn't just affect older people. If you're pregnant, have lowered immunity or a long term health condition such as severe asthma, a chest or heart complaint, or diabetes, then you should also get a free flu jab from your GP and get flu safe. **The flu jab is completely safe**, and it can't give you flu."

http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=45&ved=0CDcQFjAEOCg&url=http%3A%2F%2Fwww.hardwickccg.nhs.uk%2Fmodules%2Fdownloads%2Fdownload.php%3Ffile_name%3D4&ei=Fkh9VL_iLoPeasX4gpgB&usg=AFQ?

NHS Hardwich Clinical Commissioning Group
Dr Steve Lloyd, Chair of NHS Hardwick CCG, said:"**The flu jab is completely safe** and doesn't carry the live flu virus so it can't give you flu.

^^^

Comments on “Official Misinformation and Disinformation about ‘flu vaccines - The 2014-2015 ‘Flu Vaccination Campaign”

Please note that the first example of this egregious misinformation was by Dr Debbie Frost when she was chairwoman of Barnet Clinical Commissioning Group. Such vaccine misinformation certainly did her no harm, by 2019 she had been promoted to Associate Medical Director NHS England London Region in time to have me hauled up in front of her and Ms Hannah Coyne to investigate and then suspend me for what was deemed inappropriate statements about vaccination. M*y* ‘balancing’ view is not acceptable to the GMC and NHSE but doctors who completely break every part of Good Medical Practice and the GMC guidance and law on consent are rewarded with promotion because they are toeing the party line.

They are why people attend my lectures.

Correcting Official Misinformation and Disinformation about ‘flu vaccines

It took a year, to 2015, to get an acknowledgement that what was said in the incorrect claims was wrong and to have it removed. And that only because I wrote to Professor Paul Cosford, Medical Director and Director for Health Protection, Public Health England, directly at his own email. The NHS and Department of Health ignored my complaints about giving misleading and unbalanced information about ‘flu vaccines.

My letter 07 Jan 2015:
From: "Donegan Jayne (NHS LAMBETH CCG)"
[redacted]
Date: 7 January 2015 00:26:21 GMT
To:[redacted]
Subject: This Season's Influenza Vaccination Campaign “It's completely safe”

Dr Paul Cosford
Public Health England,
Medical Director and
Director for Health Protection
[redacted]

Dear Dr Cosford

Re This Season's Influenza Vaccination Campaign “It's completely safe”

As a doctor and GP myself I am very disturbed by the advertising campaign for this season's influenza vaccinations.
Please see the examples below. [as above in GMC letter of 2023]
It is obvious to anyone medically qualified or otherwise that there is no medical intervention that is 'completely safe' - even water can intoxicate or drown you.

I would like to know which 'flu vaccine is being referred to that is '*completely/ perfectly safe*'
Reading the Summary of Product Characteristics (SPC) for all of the 2013-14 'flu vaccines I cannot find a single vaccine that has no adverse reactions. https://www.medicines.org.uk/emc/search
Listed are:

> *Neuralgia, paraesthesia, febrile convulsions, neurological disorders, such as encephalomyelitis, neuritis and Guillain Barré syndrome, vasculitis associated in very rare cases with transient renal involvement, allergic reactions (symptoms including conjunctivitis), in rare cases leading to shock, angioedema, transient thrombocytopenia, transient lymphadenopathy, generalised skin reactions including pruritus, urticaria or non-specific rash.*

It is the duty of a doctor to give people accurate information so that they are able to make informed consent to medical procedures. This kind of inaccurate propaganda does us all a disservice by fuelling a lack of trust in information coming from our GPs and health advisors.

This information is inaccurate and dangerous.

It is dangerous because it is leading to the general public making health decisions based on false information. A person reading the examples below would feel it unnecessary to to ask their GP or nurse any further questions about risk – that is what *'completely*' or '*perfectly*' safe means/ It does not say '*very'* safe or '*extremely*' safe – all of which would leave room for doubt.

The material below – all quotes in newspapers, practice websites and from health authorities for the 2013-2014 influenza vaccination campaign - is wrong, misleading and false.

I would be grateful of you would investigate this matter and find out the source of this inaccurate information and thus stop its further dissemination, and require those who have made such inaccurate statements to correct them.

I look forward to hearing from you

Yours Sincerely
Dr Jayne LM Donegan
MBBS DRCOG DCH DFFP MRCGP MFHom
[redacted]

Reply from Dr Cosford 02 February 2015: (emphasis added)

20150202 2014-2015 Flu Vaccination Campaign reply from P Cosford PHE
From: Andrea Clapton[redacted]On Behalf Of Paul Cosford
[redacted]
Sent: 02 February 2015 11:59
To: Donegan Jayne (NHS LAMBETH CCG)
Subject: FW: Re 'The Flu Jab is Completely/ Perfectly Safe'

Dear Dr Donegan,

Thank you for your emails to me and colleagues in which you rightly point out that no medical intervention is completely safe.

First and foremost, I should acknowledge that the flu vaccines used for the annual flu vaccination programme in the UK have excellent safety records. The nasal spray flu vaccination has been used for over ten years in the USA without any serious concerns. Studies on the safety of flu vaccine in pregnancy show that inactivated flu vaccine can be safely and effectively administered during any trimester of pregnancy. No study to date has demonstrated an increased risk of either maternal complication or adverse fetal outcomes associated with inactivated flu vaccine.

You refer to an advertising campaign, and this year, PHE's flu vaccine campaign centres on the propositions '*don't put it off'* and '*it's free because you need it*' – primarily targeting patients with long term conditions and pregnant women. Below are examples of the press advertisements and our campaign launch press release can be found at the following link:
https://www.gov.uk/government/news/public-health-england-and-the-nhs-prepare-forunpredictable-flu-season

It appears that the quotes and text you refer to, stating the vaccines are '*completely safe*', may come

from superseded material first developed in 2012 and re-issued through our NHS colleagues in CCGs. We are making our NHS colleagues aware of our concerns in relation to this statement, so that any necessary action can be taken by them and to ensure the statement is not repeated in forthcoming flu seasons.

In addition, my colleagues have cross-checked all our information materials and we believe that the safety of flu vaccines is reflected accurately in all PHE public information materials.

I hope this assures you that we have taken the necessary action to rectify this matter, as far as PHE is able to.

My thanks once again for bringing this to our attention.
Best wishes.

Paul
Professor Paul Cosford
Director for Health Protection & Medical Director
Public Health England
[redacted]
www.gov.uk/phe<http://www.gov.uk/phe> Follow us on Twitter @PHE_uk

Comments on: Correcting Official Misinformation and Disinformation about 'flu vaccines
A nice letter from a polite man who took appropriate steps. But the information was not 'superseded', it was never correct. But that's OK – none of those doctors will be complained about or charged with serious medical misconduct for giving '*only one side of the story*'.

And the correction was not made because of anyone at the JCVI. It was made because I, Dr Jayne Donegan, drew attention to it.

This of course does not correct all of the prior false claims made in the media by so many doctors to the public. And it does not correct all of the later ones still being made.

The public continues to be misled.

Maybe if I had spent my medical career regurgitating the non evidence based pap fed to me by the NHS, and the Department of Health, I too could be an associate Medical Director of NHSE. It does not help your medical career to follow GMC guidelines and the Law.

Providing a balancing view to:

Official Misinformation and Disinformation MMR vaccine - 2020 MMR COCHRANE REVIEW – Rubella vaccine effectiveness [All emphases are added]
https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD004407.pub4/full

Here is another example of a correction made about misinformation and disinformation not because a member of the JCVI, the NHS or the Department of Health drew attention to it, but because I did.

On 20 April 2020 the new Cochrane review of MMR vaccine was published. The previous two reviews had stated regarding rubella vaccine efficacy, surprisingly:

"*We did not identify any studies assessing the effectiveness of MMR in preventing rubella.*"
[Cochrane Database Systematic Review 2012 (update of 2005)]

I was therefore interested to read in the Cochrane webpage summary and in the four page pdf abstract that the rubella vaccine was now said to be 89% effective:
"*Vaccine effectiveness against rubella is 89% (RR 0.11, 95% CI 0.03 to 0.42; 1 cohort study; 1621 children; moderate certainty evidence).*"

There were no references in the summary or abstract. To find out on what evidence this statement was based, I had to locate and read the 425 page full report to discover the single study from which this information was obtained:

Effectiveness of Rubella vaccine in a rubella outbreak in Guangzhou city, China, 2014.
Chang C, Mo X, Hu P, Liang W, Ma H, An Z, Liu J, Zheng H.
Vaccine. https://pubmed.ncbi.nlm.nih.gov/25989448/

The introduction states:

"*Most licensed rubella vaccines in use globally are based on RA27/3 strains and have estimated vaccine effectiveness (VE) rates of 95-100%. In contrast, China uses a BRD-II strain-based rubella vaccine.*"

The Cochrane 2020 reviewers omitted to include the information that the 89% effectiveness they quote for rubella vaccine in the 'moderate certainty evidence study' is for a strain of Rubella vaccine that is not used outside of China.

[NB the vaccine effectiveness of the RA27/3 rubella strain is only estimated as we know from the 2005/2012 Cochrane reviews:
"*We did not identify any studies assessing the effectiveness of MMR in preventing rubella.*"]

I discussed this with an author of the previous Cochrane MMR review who agreed that my point was important and that I should send a comment in, and that he would warn one of the authors that it was coming the next day.

I duly wrote a comment to Cochrane via their website on **05 June 2020**

&&&&&&&&&&&&&

Comment :
The last review: Cochrane Database Systematic Review 2012 (update of 2005) stated: "*We did not identify any studies assessing the effectiveness of MMR in preventing rubella." I was, therefore, interested to see that the new one had discovered a study on Rubella vaccine effectiveness, which is quoted as 89%: "Vaccine effectiveness against rubella is 89% (RR 0.11, 95% CI 0.03 to 0.42; 1 cohort study; 1621 children; moderate certainty evidence."*
But on checking the reference: Effectiveness of Rubella vaccine in a rubella outbreak in Guangzhou city, China, 2014. Chang C, Mo X, Hu P, Liang W, Ma H, An Z, Liu J, Zheng H. Vaccine. 2015 Jun 22;33(28):3223-7 Effectiveness of Rubella Vaccine in a Rubella Outbreak in Guangzhou City, China, 2014 - PubMed https://pubmed.ncbi.nlm.nih.gov/25989448/ I found that it is not the efficacy for the Rubella vaccine that is used worldwide at all - it is one only used in China! "Most licensed rubella vaccines in use globally are based on RA27/3 strains and have estimated vaccine effectiveness (VE) rates of 95-100%. In contrast, China uses a BRD-II strain-based rubella vaccine."
This fact is not even mentioned in the Review.
This is a misrepresentation of the facts.
People reading the review should be able to rely on the authors being clear and not have to read through the whole 425 pages of the long version themselves in order to 'check up' that what the Review is saying is correct.
To have to check every statement for accuracy and veracity negates the whole point of having a Review."

[Article: Vaccines for measles, mumps, rubella, and varicella in children Article type: Review
Review Group: Acute Respiratory Infections DOI: 10.1002/14651858.CD004407.pub4
Date of Submission: **05-Jun-2020** Name: Jayne Donegan Email Address [redacted]

&&&&&&&&&&&&&

I received a reply a few days later saying the feedback would be passed to the authors:

Dear Dr Jayne Donegan, Thank you for submitting your comment.
I will now pass your feedback to the review authors and will keep you informed on their response to your feedback. Thanks. ARI Feedback Editor

[Zohra Lassi [redacted] To [redacted] Cc: Liz Dooley [redacted] Wed, **Jun 10, 2020**]

&&&&&&&&&&&&&

Over a month later, **13 July 2020**, and after reminders from Cochrane, the lead author, Carlo Di Pietrantonj,

(Dirigente Analista - SeREMI - ASL Alessandria Servizio di riferimento Regionale di Epidemiologia per la sorveglianza, la prevenzione e il controllo delle Malattie Infettive. Tel. 0131 306709)

replied saying:
"*Thanks for your comment.*
We believe to have clearly explained in the review the contents of vaccine used in China.
Whether a vaccine are used only in a country, we do not believe this is an correct exclusion criteria.
However we agree with you that it is better add this information in the summary."

[Re: Comments on Vaccines for measles, mumps, rubella, and varicella in children received via the Cochrane Feedback system Di Pietrantonj Carlo [redacted]
To: Zohra Lassi [redacted] **Mon, Jul 13, 2020** at 8:52 AM]

&&&&&&&&&&&&&

Having agreed it was better to add the information in the summary – that the rubella vaccine for which Cochrane was asserting 89% effectiveness was not the rubella vaccine used in *any part of the world* than some parts of China, Dr Pietrantonj did nothing to amend the misleading information in the review nor did Cochrane require him to.
I therefore brought this to their attention a year later in **22 July 2021**

Dear Sirs

It is now more than a year since I sent in a comment via the Cochrane website pointing out the appalling lack of clear reporting in the 2020 Pietrantonj et al review of MMR vaccine regarding the statement that the rubella component efficacy was 89%, while making no mention of the fact that that the rubella vaccine about which the 89% effectiveness was being claimed was for a rubella component that is used nowhere in the world except China [BRD-II based strain] and is not the RA 27/3 that is used in the whole of the rest of the world.

This is misleading in the extreme to health care professionals accessing your site for information who are responsible for delivering the vaccine programs and giving their patients or parents of patients the information needed to give informed consent - a legal requirement in England - is absolute disinformation.

The fact that it is still in the Cochrane site and quoted all over the world unchanged is even worse and means that no health professional can rely on the opinions and summaries presented on the Cochrane site.

Here are three examples today 22 July 2021 showing the same misinformation without any qualification.

Vaccines for measles, mumps, rubella, and varicella in children, Carlo Di Pietrantonj et al
Version published: 20 April 2020 [Accessed 22 July 2021]

1. https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD004407.pub4/full#0
"*Vaccine effectiveness against rubella is 89% (RR 0.11, 95% CI 0.03 to 0.42; 1 cohort study; 1621 children; moderate certainty evidence).* "

2. https://www.cochrane.org/news/cochrane-review-confirms-effectiveness-mmr-vaccines
"*The results for rubella and chickenpox also showed that that vaccines are effective. After one dose of vaccine was 89% effective in preventing rubella*,"

3. https://pubmed.ncbi.nlm.nih.gov/32309885/
"V*accine effectiveness against rubella is 89% (RR 0.11, 95% CI 0.03 to 0.42; 1 cohort study; 1621 children; moderate certainty evidence).* "

Dr Pietrantonj should be ashamed of himself and so should the Cochrane organisation for providing such misinformation in the first place and all the more so for not changing or qualifying it after this has been pointed out.

Mind you the whole review is unreliable as its outcomes are based on using studies that previously were not only regarded as being of poor quality in the 2005/2012 reviews:

AUTHORS' CONCLUSIONS: "*The design and reporting of safety outcomes in MMR vaccine studies, both pre- and post-marketing, are largely inadequate.*"

They were so inadequate that they were not even considered worthy of consideration in the 2005/2012 reviews of inadequate studies in the first place..

1. I have made a very valid comment regarding the misinformation on rubella vaccine efficacy in the 2020 Cochrane review.
2. Nothing has been done about it to clarify the issue.
3. This is entirely unsatisfactory.
4. Please tell me to which body I need to now petition/ complain to have this issue corrected.

Yours Faithfully Jayne Donegan

COMPLAINT RE UNRESOLVED MISINFORMATION REGARDING RUBELLA VACCINE EFFICACY R: Comments on Vaccines for measles, mumps, rubella, and varicella in children received via the Cochrane Feedback system Jayne LM Donegan [redacted]
To: Zohra Lassi Di Pietrantonj Carlo, Cc: Liz Dooley [redacted] Thu, **Jul 22, 2021**

&&&&&&&&&&&&&

Dr Pietrantonj replied reiterating what he said a year before on 05 Aug 2021

Dear Dr. Donegan,
last year i thought i sent you our reply to your remark, i understand you probably did not receive it, we enclose the answer below.
Best regards

"*In this Review, we believe we have clearly explained the contents of vaccines used in China. Just because a vaccine is only used in one country, we do not believe this constitutes an exclusion criteria. <u>However, we agree with you that it would be clearer to add this information in the summary.</u> Furthermore, this pandemic, and the outbreaks of measles in the United States, has taught us that the level of connection is so great between people in China and of the rest of the world, that vaccination coverage for rubella or measles in a single country is in fact a global concern for public health*"

[Di Pietrantonj Carlo <[redacted] To [redacted] Cc: Liz Dooley Fiona Russell Thu**, Aug 5, 2021**]

&&&&&&&&&&&&&

On 13 September I replied to Dr Pietrantonj, the lead author, that this was misinformation and needed to be changed

Dear Dr Pietrantonj, Thank you for your email

But you haven't changed the summary to make clear that the rubella vaccine for which you are quoting the effectiveness rate is not the one used in the while of the world apart from China. You have not even named it by the strain. This is misinformation. Vaccines are different and have different effectiveness rates.

Please make this clear in the summary.

Kind Regards Jayne Donegan

[Re: COMPLAINT RE UNRESOLVED MISINFORMATION REGARDING RUBELLA VACCINE EFFICACY R: Comments on Vaccines for measles, mumps, rubella, and varicella in children received via the Cochrane Feedback system Jayne LM Donegan <ja[redacted]

To: Di Pietrantonj Carlo Cc: Liz Dooley Fiona Russell **Mon, Sep 13, 2021]**

&&&&&&&&&&&&&
There was no reply by October 2021, 19 months after the misleading review had originally been published and 17 months since I first brought their attention to it. The misinformation about rubella vaccine efficacy continued to be displayed unchanged on Cochrane, websites around the world and quoted in scientific journals, and even more importantly told to parents and young adults. I wrote again to the lead author and also to Cochrane editorial team 07 Oct 2021:

Dear Dr Pietrantonj

Re **Misleading statement in 2020 Cochrane MMR review regarding 89% efficacy of Rubella vaccine**

The 2020 Cochrane MMR Review summary states 89% efficacy for Rubella vaccine in MMR vaccine.

Unless one reads the extensive and dense complete review it is not possible to know that this figure is based on a rubella vaccine that is used nowhere else in the world than China and not the [RA*27/3*] strain used in all other MMR vaccines in the world, therefore, without this being made clear, it is a misleading statement.

I complained about this to Cochrane in June 2020

You wrote in answer in July 2020

"*Thanks for your comment.*
We believe to have clearly explained in the review the contents of vaccine used in China.
Whether a vaccine are used only in a country, we do not believe this is an correct exclusion criteria.
However we agree with you that it is better add this information in the summary."

"***However we agree with you that it is better add this information in the summary*.**"
Indeed.

Doctors all over the world are telling patients all over the world that Rubella vaccine in MMR is 89% effective when there are no studies showing the efficacy of the [RA*27/3*] strain Rubella vaccine in MMR or alone as pointed out in the previous two Cochrane MMR reviews 2005 and 2012. It is the MMR vaccine containing the [*RA 27/3*] *strain* of Rubella that is used all over the world, save some parts of China.

What have you done about this since July 2020? - Nothing

Please see below three examples obtained today, 07 October 2021 15 months later.

https://www.cochrane.org/CD004407/ARI_does-measles-mumps-rubella-and-varicella-mmrv-vaccine-protect-children-and-does-it-cause-harmful

Does the measles, mumps, rubella and varicella (MMRV) vaccine protect children, and does it cause harmful effects?

Published: 8 July 2020 Authors: Di Pietrantonj C, Rivetti A, Marchione P, Debalini MG, Demicheli V
Results
The results for rubella (1 study, 1621 children) and chickenpox (one study, 2279 children) also showed that vaccines are effective. **After one dose, vaccination was 89% effective in preventing rubella,** and after 10 years the MMRV vaccine was 95% effective at preventing chickenpox infection.

No mention of the information that it is the vaccine that is only available in China and is not the [RA *27/3*] strain used in MMR vaccine in all the rest of the world.

https://uk.cochrane.org/news/mmr-vaccines-do-they-work-and-are-they-safe

MMR vaccines: do they work and are they safe?
Evidence on how well the vaccines work
The studies of how well the vaccines work examined 10 million children across 51 studies. The review authors judged the certainty of the evidence and found it to be 'moderate' for the MMR vaccine and high for the varicella vaccine.
Complete MMR courses were reported to be:
96% effective at preventing measles
86% effective at preventing mumps
89% effective at preventing rubella
The varicella vaccine was reported to be 95% effective at preventing chicken pox.
No mention of the information that it is the vaccine that is only available in China and is not the [RA *27/3*] *strain used in MMR vaccine in all the rest of the world.*

https://pubmed.ncbi.nlm.nih.gov/32309885/
Vaccines for measles, mumps, rubella, and varicella in children
Carlo Di Pietrantonj 1, Alessandro Rivetti 2, Pasquale Marchione 3, Maria Grazia Debalini 4, Vittorio Demicheli 1
PMID: 32309885 PMCID: PMC7169657 DOI: 10.1002/14651858.CD004407.pub4

Main results:
Vaccine effectiveness against rubella is 89% (RR 0.11, 95% CI 0.03 to 0.42; 1 cohort study; 1621 children; moderate certainty evidence).
No mention of the information that it is the vaccine that is only available in China and is not the [*RA 27/3*] *strain used in MMR vaccine in all the rest of the world.*
Nor in any addendum

It seems that rather than an oversight, bearing in mind your statement:

"*However we agree with you that it is better add this information in the summary*."

That it is a deliberate attempt to mislead.

Please escalate my complaint to a higher level as sending it to the authors is evidently ineffective.

I look forward to hearing from Cochrane soon and seeing an amendment added to the summary on all Cochrane sites and PUBMED.

Kind Regards Jayne Donegan Dr Jayne LM Donegan MBBS DRCOG DCH DFFP MRCGP MFHom London UK

[Re Misleading statement in 2020 Cochrane MMR review regarding 89% efficacy of Rubella vaccine Jayne LM Donegan [redacted] To: Zohra Lassi Di Pietrantonj Carlo Cc: Liz Dooley [redacted] **Thu, Oct 7, 2021**]

&&&&&&&&&&&&&
Two weeks later, 22 Oct 2021, the Managing Editor, Cochrane Acute Respiratory Infections Group, Liz Dooley replied to me, saying I had a valid point:

Dear Dr Donegan,

Apologies for the delay in my reply.
I was waiting to discuss this at our editorial team meeting, which we had yesterday.
The Co-ordinating Editors agree that you have a valid point. I will contact the author team and request that they address this appropriately and in a timely manner.

Kind regards, Liz Liz Dooley Managing Editor Cochrane Acute Respiratory Infections Group

[RE: Re Misleading statement in 2020 Cochrane MMR review regarding 89% efficacy of Rubella vaccine Liz Dooley [redacted] To: Jayne LM Donegan Cc: Fiona Russell Zohra Lassi Di Pietrantonj Carlo **Fri, Oct 22, 2021]**

&&&&&&&&&&&&&
I wrote:
Dear Liz. Thank you for your email. I am glad you agree I have a valid point.

I am shocked and not a little uneasy that the authors made no move to rectify it in over a year. It makes me worry about the reliability of other Cochrane data.
Thank you that Cochrane are now pursuing the matter.
Kind regards Jayne Donegan

[Re: Re Misleading statement in 2020 Cochrane MMR review regarding 89% efficacy of Rubella vaccine From: [redacted] To: Liz Dooley Fri, **Oct 22, 2021**]

&&&&&&&&&&&&&
A month later, 23 Nov 2021, she wrote to tell me that Cochrane has republished their review on the basis of my, valid points about correcting the misleading information published by Cochrane:

Dear jane,
Apologies for the delay. This review has been republished and the authors have specified in the Abstract, Discussion, and summary of findings table 3, that the vaccine type BRD2 against rubella is only used in China.

Regards, Liz Liz Dooley Managing Editor Cochrane Acute Respiratory Infections Group

[RE: Re Misleading statement in 2020 Cochrane MMR review regarding 89% efficacy of Rubella vaccine Liz Dooley [redacted] To: [redacted] Cc: [redacted] Fiona Russell Tue, **Nov 23, 2021**]

&&&&&&&&&&&&&
Dear Liz
Today is 07 Dec 2021
I have just looked at these links

https://www.cochrane.org/CD004407/ARI_does-measles-mumps-rubella-and-varicella-mmrv-vaccine-protect-children-and-does-it-cause-harmful
https://pubmed.ncbi.nlm.nih.gov/32309885/
https://www.cochrane.org/news/cochrane-review-confirms-effectiveness-mmr-vaccines
https://uk.cochrane.org/news/cochrane-review-confirms-effectiveness-mmr-vaccines
https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD004407.pub4/full
https://uk.cochrane.org/news/mmr-vaccines-do-they-work-and-are-they-safe

And none of them have anything other than an unqualified statement that Rubella vaccination is 89% effective.

Even the Cochrane links that state that it was from one trial state that it is neither not the [*RA 27/3*] *strain* nor that it is a vaccine only used in one part of china and not anywhere else in the world

So I am not quite clear where the changes/ republishing you mentioned below occurred.
Please could you let me know.
Kind Regards Jayne Donegan

[However two weeks later nothing had changed. I wrote agsin with examples:
From: Jayne LM Donegan [redacted] Sent: Wednesday, **8 December 2021** To: Liz Dooley [redacted] Subject: Re: Re Misleading statement in 2020 Cochrane MMR review regarding 89% efficacy of Rubella vaccine]

&&&&&&&&&&&&&
08 Dec 2021
Dear Jayne,
I will bring your concerns to our next editorial team meeting (16th December), and will be in touch with a response then.
Regards, Liz Liz Dooley Managing Editor Cochrane Acute Respiratory Infections Group
[RE: Re Misleading statement in 2020 Cochrane MMR review regarding 89% efficacy of Rubella vaccine Liz Dooley [redacted] To: Jayne LM Donegan Wed, **Dec 8, 2021** at 8:29 PM]

&&&&&&&&&&&&&
I then received a comprehensive reply thanking me for my valuable contribution from Dr Fiona Russell Managing Editor Cochrane Acute Respiratory Infections

Dear Jayne,
Thank you for your email. We very much appreciate your valuable contribution to this review and want to ensure that your concerns are addressed.

In order to maintain editorial integrity and transparency, as well as document the history of each review's development, Cochrane does not delete previous versions of its reviews from the Cochrane Library.
The current version of this review https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD004407.pub5/full contains the amendments in response to your feedback described in Liz's earlier email. All previous versions are clearly marked as not the most recent version and a link to the current version provided. Each version also has a link to a version history which summarises what was changed in each version of the review (see https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD004407.pub5/information#versionTable).

The amended version of the review has also been published in Pubmed (https://pubmed.ncbi.nlm.nih.gov/34806766/). The previous version from your link clearly states at the top that there is an update and provides a link to the new version.

The link you provided to the Cochrane.org website 'Our Evidence' for this review (Does the measles, mumps, rubella and varicella (MMRV) vaccine protect children, and does it cause harmful effects?) contains the Plain Language Summary from the current version of the review, which includes the updated information, and a link to the full current version in the Cochrane Library.

You have also provided links to Cochrane news articles that were published more than 18 months ago. These articles are no longer current in the news feeds and, even if someone went looking for them, the links to the review would lead them to the latest version.

So while we are unable to erase previous versions of the review, we hope you are reassured that prospective readers will be guided to the latest publication containing the amended material. If you have any concerns about the amendments themselves, please let us know.

Kind regards, Fiona Dr Fiona Russell Managing Editor Cochrane Acute Respiratory Infections

[RE: Re Misleading statement in 2020 Cochrane MMR review regarding 89% efficacy of Rubella vaccine Fiona Russell[redacted]To:[redacted]Cc: Liz Dooley Thu, Dec 16, 2021]

Comment on: Providing a balancing view to Official Misinformation and Disinformation MMR vaccine - 2020 MMR COCHRANE REVIEW – Rubella vaccine effectiveness

The Cochrane editorial team welcomed my informed contribution.

> "*The Co-ordinating Editors agree that you have a valid point.*"
> "*We very much appreciate your valuable contribution to this review and want to ensure that your concerns are addressed*."
> "*...we hope you are reassured that prospective readers will be guided to the latest publication containing the amended material.*"

I am a single handed practitioner and researcher into vaccination and many topics other than vaccination so I can give people information. No-one funds this work other than me. Nor the corrections that I bring about on NHS and other websites re management of childhood fevers of misinformation that is in direct contradiction to that in the NICE guidelines of 2007, 2012 and 2019. Why does the NHS not tell parents what its own NICE guidelines are?

The NHS pays millions of pounds to people to provide information on NHS and Government websites that is correct. But they fail. Instead unpaid Dr Donegan has to correct them.
Why does she?
To protect patients.

The WHO, NHS, CDC and governments around the works pay teams of doctors, scientists, statisticians to investigate and promulgate information on vaccination. The JCVI and the doctors that comprise it take our lives in their hands when they produce recommendations on what vaccines should be given and to whom. Not one of them alerted Cochrane to the egregious and, misleading error in the currently latest (2020) MMR Cochrane review. Certainly not Dr Riordan.
Why?
Well in his case it is becoming clear he does not read references. It seems he is not the only one at the JCVI, the Department of Health and NHS England. Or maybe it is because it does not matter if misleading information promotes vaccination. There is no objection to people, including doctors, only knowing

> '*one side of the story*.'

Some parents, however, realise this and that is why they come to my lectures – to get balancing information to make up for being told only '*one side of the story*' by the doctors and others in the NHS, doctors in the Department of Health and the Government. The GMC does not investigate such doctors. No, they persecute me and others like me for *fulfilling* our medical, ethical and moral obligations as a human being, never mind as doctors.

Providing a balancing view to:
W.H.O. Official Misinformation and Disinformation About Vaccines

Dr Swaminathan is an Indian paediatrician and clinical scientist. From 2019 to 2022, she served as the chief scientist at the World Health Organization under the leadership of Director General Tedros Adhanom Ghebreyesus. Previously, from October 2017 to March 2019, she was the Deputy Director General of Programmes (DDP) at the World Health Organization. In the preparations for the Global Health Summit hosted by the European Commission and the G20 in May 2021, Swaminathan was a member of the event's High Level Scientific Panel. In 2021, Swanminathan was also appointed to the Pandemic Preparedness Partnership (PPP), an expert group chaired by Patrick Vallance to advise the G7 presidency held by the government of Prime Minister Boris Johnson.

On 28 November 2019 The WHO released a promotional video:
"***W.H.O. Works to Ensure Vaccinations are Safe***" with Dr Souyma Saminathan WHO Chief Scientist¦
She says in the short video **28 Nov 2019**:
"*Vaccines are very safe*"
"*That's why there are robust vaccine safety systems (that) allow health workers and experts to react immediately to any problems that may arise. They can examine the problem rigorously and scientifically look at the data and then promptly address the problem.*"
"*Vaccines are one of the safest tools we have to prevent disease.*"

Only five days later, at the WHO Global Vaccine Safety Summit, 03 Dec 2019, Dr. Swaminathan told the exclusively medical scientific audience:
"*I think we cannot over-emphasize the fact that we really don't have very good safety monitoring systems in many countries and this adds to the miscommunication and misapprehensions because we are not able to give clear cut answers when people ask questions about the deaths that have occurred due to a particular vaccine and this always gets blown up in the media.*"
"*One should be able to give a very factual account of what exactly has happened and what the cause of deaths are but in most cases there is obfuscation at that level and therefore there is less and less trust in the system,*"

[WHO Global vaccine Safety - Ensuring vaccines do no harm 03 Dec 2019]

You can see her here – it really is hard to believe a doctor could be so blatantly and knowingly dishonest.
Dr. Soumya Swaminathan being untruthful to the public about vaccine safety:
https://www.youtube.com/watch?v=2DudhNvr1AU

Dr Swaminathan is not censored for being knowingly untruthful about vaccine safety to people around the globe, far from it, she was promoted to Pandemic Preparedness Partnership (PPP), an expert group chaired by Patrick Vallance, chief Scientific advisor the UK Government to advise the G7 presidency.

One can also hear Dr Swaminathan here on the WHO's own website
W.H.O. Global Vaccine Safety Summit 2 – 3 December 2019 Geneva, Switzerland
https://www.who.int/news-room/events/detail/2019/12/02/default-calendar/global-vaccine-safety-summit
Dr Swaminathan 03 Dec 2019 Tuesday afternoon, first part, 14.00- 15.15 at 29 minutes

Listen to the whole two days - certainly the contributions of Dr Walter Orenstein CDC and Professor Heidi Larsen regarding what doctors do and do not know about vaccine safety.

Professor Larson 03 Dec 2019 Tuesday afternoon second part 15.45 – 17.45

'*Why we need new modes of trust building*'

Ihr 16m "*We have a very wobbly health professional front line that is starting to question vaccines and the safety of vaccines. That's a huge problem.*"

Yes it certainly is a 'huge problem' for the doctors doing the questioning.
And those doctors who do not – most of them know very little, as Professor Larson admits

1 hr 17 "*In medical school you're lucky if you have a half day on vaccines.*"

03 Dec 2019 Tuesday morning, first part 9.00 – 11.00

'*Vaccine safety science serving immunization*.'

Listen to all Professor Walter Orenstein's contribution where he describes what doctors do not know about vaccine safety, how we need to solicit more funds to carry out the studies to find out – *because they still have not been done.* The universal vaccination program started in 1961

NB these are not 'anti-vaccine' doctors complaining about lack of knowledge regarding vaccine safety, these are pro-vaccine doctors decrying the lack of data and the very small amount doctors who promote vaccination know on this subject.

Example of My Expertise on Vaccinations

To illustrate how I answer questions that I am asked on vaccination, I have attached as an Appendix a pdf of the module: Key Questions on Vaccination which I was asked to produce for Pulse magazine for GPs. Pulse wrote the questions. This is the way I research topics and then analyse and distil them into accessible manageable understandable units of information to enable people – including doctors, to make decisions and that I present vaccination as appropriate in an evidence-based and balanced manner according to scientific data and national recommendations.

Below is the feedback from my GP peers:

The feedback is good. Two doctors found the module too detailed. More doctors, however, liked the detail. It is interesting that the level of complexity I write for non medically qualified people, and which they have no trouble understanding is 'too much detail' for some GPs, yet the non medically qualified public looks up to doctors as wise beings who keep up to date with changes in science and understand complex medical topics. They are sadly mistaken in too many cases. At least the doctors attending the Pulse lectures were endeavouring to keep up-to-date.

http://www.pulse-learning.co.uk/course/index.php?categoryid=247
Accessed 03 Nov 2017

GP FEEDBACK FOR DR DONEGAN'S VACCINATION CPD UPDATE PULSE GP MAGAZINE AND ONLINE 2017

COMMENTS **Module rating: 4.5 stars. (52)**

[redacted] - 30/06/17
Great

[redacted] - 30/06/17
Useful but very detailed

[redacted] - 1/07/17
very good but is a little too detailed to absorb everything

[redacted] - 2/07/17
Very informative

[redacted] - 2/07/17
Good

[redacted] - 6/07/17
well written and appropriate questions.

[redacted] - 9/07/17
Very good

[redacted] 16/07/17
Good reminder of the ever changing vaccination schedules for young and old alike

[redacted] - 18/08/17
Good.

[redacted] - 19/08/17
Excellent

[redacted] - 20/08/17
very informative

[redacted] - 6/09/17
I really liked this module - very informative.

[redacted] - 17/09/17
informative, relevant to practice.

[redacted] - 24/06/17
comprehensive and excellent

[redacted] - 24/06/17
Good

[redacted] - 24/06/17
excellent module and very detailed

[redacted] - 24/06/17
Very detailed and relevant .

[redacted] - 25/06/17
Very good Update

[redacted] - 25/06/17
Some of the recommendations leave further questions, vaccinating people in contact with patients with immuno-deficiencies makes sense, however one would not vaccinate children whose parent is immuno-deficient for instance? and what about MMR in these circumstances?

[redacted] - 27/06/17
Comprehensive

[redacted] 27/06/17
Extremely thorough but easy to read. Would give it 6 stars if I could!

[redacted] 17/06/17
A very useful and thorough update

[redacted] - 17/06/17
Very straightforward and gives the info I need to advise parents

[redacted] 17/06/17

[redacted] - 28/09/17
Good update men b ,c Hepb

[redacted] - 5/11/17
Good module, enough detail to make it interesting

[redacted] - 22/06/17
useful tips for vaccination

[redacted] - 22/06/17
lacked clarity

[redacted] - 22/06/17
informative, loquatious

[redacted] - 23/06/17
very good

[redacted] 23/06/17
This was a very useful module with some pearls of information within it.

[redacted] - 23/06/17
very good

[redacted] - 23/06/17
Very good update and practical advice

v good

[redacted] - 18/06/17
well written and informative

[redacted] - 19/06/17
Very good

[redacted] - 19/06/17
useful

[redacted] - 19/06/17
Complex subject
Difficult to follow article

[redacted] - 20/06/17
good

[redacted] - 20/06/17
Very useful update, well explained

[redacted] - 20/06/17
Brilliant

[redacted] - 20/06/17
excellent summary of complex ever-changing subject

APPENDIX 01 - Key Questions on Vaccination I was asked to produce for Pulse magazine

- **My modules**
- **Key questions on vaccination**
- **ARTICLE MODULE**
- **Key questions on vaccination**

Key questions on vaccination

1. It has been difficult to keep track of the revisions to the meningococcal vaccination schedule over the last couple of years. What have been the main changes and the rationale behind them?

The main changes, which started in 2013, have been to do with the meningococcal vaccine schedule.

Meningococcal vaccines

In January 2012, the Joint Committee on Vaccination and Immunisation (JCVI) noted that since the MenC vaccine was introduced in the UK in 1999, at two months, three months and four months of age, i*nvasive* meningococcal C disease (IMD), as opposed to non-invasive disease or symptomless carriage, had fallen by over 95% in England and Wales. By 2006, however, studies were showing that three doses of MenC vaccine in the first year, though adequate for infancy, were not enough to give what is considered to be protective levels of antibody during the second year of life, resulting in the moving of the two month dose to 12-13 months. Even so, later studies still showed antibody levels waning rapidly - only 12% of children having protective levels four years after the initial course if vaccinated under the age of six years, rising to 50% with protective levels persisting into adulthood if vaccinated over that age.

For this reason, the JCVI advised the UK health departments to add a booster dose in adolescence, as they had evidence that a single dose of MenC vaccine at three months of age would provide sufficient protection in that first year. A cost-neutral way of effecting this was to move the second dose from four months to be given at 14 years as the third. This appeared in the 2013 schedule.1

By October 2014, the JCVI was observing a year on year increase of invasive meningococcal W disease, in association with the Hajj pilgrimage to Mecca, and in non-travel related outbreaks. There was also global concern about ‘replacement’ disease, meaning vaccination against one serogroup (C) leading to its replacement by another serogroups (e.g. W), as the meningococcus is quite capable of ‘switching’ the polysaccharide capsules by which its serogroups are differentiated.2 They were concerned that infants might be at risk from invasive serogroup W disease but reasoned that replacement of the teenage MenC vaccine with the quadrivalent MenACWY might protect them by herd immunity. This change was made in the 2015 schedule, with a catch-up programme offering the vaccine to university entrants up to the age of 25 years.2

During this time, the JCVI had also been considering the introduction of a meningococcal B serogroup vaccine (MenB), setting up a subcommittee to carefully review the evidence. They made an interim position statement in July 2013 saying that with the information they had available, routine infant MenB immunisation alone or combined with adolescent immunisation was, ‘*highly unlikely to be cost effective at any vaccine price,*’ for three reasons: invasive meningococcal disease in the UK was at an all time low, efficacy of the vaccine against invasive disease had not been established, and the vaccine is very ‘reactogenic’ - it has a lot of undesirable effects, which might lead parents to quit the primary course of vaccines that were given at the same time.3

An enormous media campaign immediately erupted, spreading across tabloid and broadsheet newspapers with petitions being delivered to Downing Street and questions asked in Parliament, demanding that MenB vaccine be added to the routine schedule. After looking at more evidence and under pressure to find a new way of calculating the figures, the JCVI gave the go-ahead for the MenB vaccine to be added to the schedule in autumn 2015 with doses at two months, three months and 12 months of age, and the advice that paracetamol be given prophylactically to try to reduce the reactions.4

Many people were delighted at this outcome. However, as the JCVI feared, I see growing numbers of parents who are refusing to continue with their baby’s primary course of vaccines because of what they consider to be reactions to the first or second dose of MenB vaccine.

With the MenB vaccine hoped to supply some cross coverage against invasive MenC and W disease, the three month MenC dose was removed in the summer of 2016, leaving just the dose at 12-13 months and MenACW135Y in adolescence, this now being made permanent in the hope that it would have an effect on reducing the number cases of invasive MenW disease that continued to rise through 2016.

2. What other key changes have been made to the childhood vaccination schedule over the last couple of years?'

In 2014, live attenuated influenza vaccine, Fluenz Tetra, was introduced via schools for all children, starting with those aged 2-4 years, and will be eventually rolled out to those aged up to and including 17 years. Extending influenza vaccination to children is thought to be cost effective as it could reduce the impact of influenza in children as well as transmission from those children to younger ones, adults and people in clinical risk groups of any age.10

A switch was made in 2014 from three doses of HPV vaccine to two, with the proviso that the first dose be given before the age of 15 years. Recent research had showed that the antibody response to a two dose schedule in adolescent girls was equivalent to that correlating with protection against persistent infection and precancerous lesions, in the initial vaccine trials, for the three dose course. 11

3. Many elderly patients – and their doctors – are confused and annoyed by the restrictions around who is eligible for the shingles vaccine. Who is currently entitled? And can GPs vaccinate those outside the current recommended age groups?

Those aged 70-79 years of age. This age range was chosen because it is the time when the burden of disease and complications are most exactly balanced against the ability of the vaccine to work - effectiveness decreasing with age.

Based on the evidence that the vaccine may not provide lasting protection, vaccinating people in the 60-69 year range may leave them unprotected when they need it most - when they are older and herpes zoster is more severe. 12

GPs are independent practitioners and are expected to use their clinical judgement, however they need to be clear with their patients that vaccinating them outside of the recommendations may compromise the effectiveness of the vaccine both now and in the future, when they are more at risk of complications. Vaccinating non-recommended groups also means that there may not be enough vaccine available for those for whom it *is* recommended. There will be no reimbursement under the terms of the enhanced service specification for those vaccines administered outside of the specification.

It may help to remember that even within the recommended limits, >70 year olds, the vaccine is only approximately 38% effective in reducing cases of shingles, though it is said to be milder in vaccine failures.

Another strategy could be to spend time more with children who might have chicken pox - and get natural boosting!

4. Which commonly used current vaccines are 'live' – and in which groups should they be avoided?

BCG, rotavirus, live attenuated influenza virus (Fluenz Tetra in UK), MMR, shingles, varicella chickenpox, yellow fever are live vaccines.

Live vaccines should be avoided in:13

- Patients with evidence of severe primary immunodeficiency
- Patients currently or in the last 6m treated for malignant disease with immunosuppressive chemotherapy or radiotherapy
- Patients with a solid organ transplant who are currently on immunosuppressive treatment
- Patients who have received a bone marrow transplant now or in at least the last 12 months, longer if they have developed graft-versus-host disease
- Patients currently or in the last 6m receiving systemic high-dose steroids
- Children receiving oral or rectal prednisolone at 2mg/kg/day for one week or 1mg/kg/day for one month
- Adults receiving 40mg of prednisolone a day for more than one week
  - Discussion with the relevant specialist may be necessary, even at lower doses
  - Patients receiving immunosuppressive drugs now or in at least the last six months such as azathioprine, cyclosporin, methotrexate, cyclophosphamide, leflunomide and the newer cytokine inhibitors, with or without steroids. Advice from the physician or immunologist in charge should be sought
  - Patients with immunosuppression due to HIV infection

5. How is 'morbidly obese' defined for these purposes, and do these patients require the pneumococcal vaccine, too?

A morbidly obese patient has a BMI of $\geq$ 40. A study in the USA14 found that morbidly obese people made up 5.4% of flu cases but 12.4% of deaths and that they were at increased risk of influenza-related complications, hospitalisation and death in the 2009 pandemic, whether they had a chronic medical condition or not. As the morbidly obese have a poorer

response to influenza vaccine, the JCVI were unsure whether it would be appropriate to include them as the vaccine might not be effective. After considering all the evidence however, they judged it reasonable to add morbid obesity to the list of groups for seasonal influenza vaccination and from the 2017/2018 season this will attract a directly enhanced payment.

Morbidly obese patients do not require the pneumococcal vaccine.

6. Which vaccines should be given to patients with no spleen, or hyposplenism? Current guidance suggests that patients with coeliac disease should have certain immunisations if they have 'splenic deficiency' – but how can the GP ascertain this?

Disease	Vaccine
Meningococcal groups A, B, C, W and Y	• MenACWY MenB
Haemophilus influenzae type b (Hib)	• Hib/MenC
Pneumococcal	• PCV13 (Prevenar)(up to five years of age) PPV23 (Pneumovax) (from two years of age) • A five-year booster is recommended but only in these individuals and those with nephrotic syndrome as patients with a normally functioning immune system, there may be at an increased rate of adverse reactions to subsequent doses.1
Influenza	• Annual flu vaccine

How to ascertain 'splenic deficiency' is a very good question, to which the short answer is: with difficulty.

According to an Italian study, people with coeliac disease in whom splenic function should be assessed are:18

- Patients with complications (refractory coeliac disease, ulcerative-jejunoileitis, enteropathy-associated T cell lymphoma, collagenous sprue)
- Patients with concomitant autoimmune disorders
- Patients with old age at diagnosis
- Patients with previous history of major infections, sepsis or thromboembolism
- Patients with mesenteric lymph node cavitation or splenic atrophy

The simplest and least invasive way of diagnosing splenic dysfunction, after taking a history, is to order a peripheral blood film and ask the haematologist if they find either find Howell-Jolly bodies or more than 50% pitted erythrocytes present.

7. What issues should the GP consider in terms of travel vaccines requested by pregnant patients?

The first consideration is whether the pregnant woman should be travelling anywhere that requires travel vaccines at all.

The second is, if she must travel to such a place, whether the risk of risk any recommended vaccine is greater or lesser than the risk posed by the disease for which it is given. In general, live vaccines are contraindicated in pregnancy except for yellow fever vaccine (see below). The Green Book advises that there is no evidence of risk from vaccinating pregnant women or those who are breast-feeding with inactivated viral or bacterial vaccines or toxoids.19

Table 1 - travel vaccines in pregnancy19

Vaccine	Type	Safety advice
Cholera	Inactivated	No data are available on the safety of oral cholera vaccine May be prevented by adequate food hygiene.
Hepatitis A	Inactivated	May be given to pregnant women when clinically indicated May be prevented by adequate food hygiene.
Hepatitis B	Inactivated	Should be given where there is a definite risk of infection.

		(unprotected sex, intravenous drug use, tattoos)
Japenese Encephalitis (JE)	Inactivated	As a precautionary measure, administration of IXIARO® during pregnancy or lactation should be avoided. However, travellers and their medical advisers must make a risk assessment of the theoretical risks of JE vaccine in pregnancy against the potential risk of acquiring JE. Miscarriage has been associated with JE virus infection when acquired in the first two trimesters of pregnancy (Canadian Medical Association, 2002).
Typhoid	Inactivated Live	No data are available on the safety of the live or inactivated vaccines currently available in the UK. May be prevented by adequate food hygiene.
Yellow Fever	Live	Should not generally be given to pregnant women because of the theoretical risk of fetal infection from the live virus vaccine. Pregnant women should be advised not to travel to a high-risk area. When travel is unavoidable, and the risks for yellow fever exposure are felt to outweigh the vaccination risks, a pregnant woman should be vaccinated, if not, the pregnant women should be issued a medical waiver to fulfil health regulations.
Meningococcal ACWY	Inactivated	Meningococcal vaccines may be given to pregnant women when clinically indicated.
Tetanus	Inactivated	If travelling areas where medical attention and tetanus immune globulin may not be available and who have not had a booster for 10 years

It is hard to find good advice regarding vaccination in pregnant woman in one easily accessible place, so the USA Advisory Committee on Immunization Practices guidance on vaccinating pregnant women, updated in August 2016 is very welcome.

When considering guidance on travel medicine in pregnancy, bear in mind the advice of Dr Ron Behrens, Consultant in Travel Medicine & Director of the Travel Clinic at the Hospital for Tropical Diseases, London,

‘Risk assessment is important to rationalise pre-travel preparation, but the advice needs to reflect the health risk and not the interventions available.

- The emphasis on vaccination for low risk travel may give a false sense of security and encourage unsafe eating and drinking.
- Failing to advise on the management of diarrhoea, a much more common event, may lead to dehydration and admission to hospital.
- Morbidity (illness/ injury) associated with behaviour—for example, sexually transmitted disease, solar and skin associated problems, alcohol related traumas, and injuries from recreational activities - makes up the main proportion of illness associated with travel.
- Prevention of these and the other diseases mentioned above requires effective advice and good communication between travellers and their advisers.
- The emphasis on vaccinating travellers rather than advising them is a widely held misconception and needs to be corrected.
- Health promotion and health education need to be the focus of pre-travel consultations. Risk assessment should be based on a broader view than administering drugs and vaccines.’22

7. What is the current guidance regarding routine tetanus vaccination, and any requirements for boosters post tetanus-prone injury?

A total of five doses of tetanus toxoid at the appropriate intervals is considered to give satisfactory long-term protection and further 10-yearly boosting is not recommended.

In the management of a tetanus-prone wound, tetanus vaccination is only recommended for people in whom there is doubt as to whether they have completed their five dose course, otherwise not. Thorough cleaning of wounds is most essential and if the wound, burn or injury is considered to be at high risk, human tetanus immunoglobulin should be given, irrespective of tetanus immunisation history.

8. We are told that pertussis is on the rise, and we certainly seem to be seeing more cases of pertussis-type illness. To what extent does the efficacy of the vaccine wane? Is there an argument for a booster dose?

Before answering these questions we must first understand what 'pertussis and pertussis-like illness being on the rise' means.

Whooping cough is mainly caused by *Bordetella pertussis*, but similar cough illnesses can be caused by *B. parapertussis* in young children and *B. holmesii* in adolescents and adults. Asymptomatic cases of pertussis are 4-20 times more common than those with symptoms.23 The use of PCR to diagnose pertussis has resulted in between nine and 91% more laboratory-confirmed cases being detected in the USA, UK24, and Ireland25, and has shown that as many as 16% of cases previously diagnosed as *B. pertussis* may be due to *B. parapertussis*. These appear as vaccine failures when they are not, as protection is not to be expected against non *B. pertussis* species.

A distinction needs to be made between infection and clinical illness. Multiple toxins and one adhesin have roles in human *B. pertussis infection,* but only two cause clinical illness - *pertussis* toxin (PT – previously known as lymphocyte-promoting factor) and the toxin that causes the cough. Illness is related to leukocytosis with lymphocytosis and is the cause of deaths in young infants. Once a person has been vaccinated or has had pertussis, they are thought not to get symptoms that can be attributed to PT as leukocytosis with lymphocytosis is said not to occur in adult illness i.e. they are likely to have a much less severe form of the disease.

It might seem naïve to think a simple booster dose would solve the problem, although it is the only vaccine solution we have at present. The future of pertussis vaccination lies with the development of new vaccines, with correctly balanced combinations of antigens, possibly omitting FHA, and using hydrogen peroxide-inactivated PT as in the Danish model. There may even be a need to return to whole cell vaccines, improved and less reactogenic, such as the 'Plow' (low in endotoxicity) being developed in Brazil, in order to improve the immune response to the primary vaccine course and provide effective booster doses.

9. When is the chicken pox vaccine indicated? Is it likely to become part of the national immunisation schedule?

The Department of Health recommends chickenpox-varicella vaccination for:

- Seronegative healthcare workers (general practice, hospital and laboratory workers) who come into direct contact with patients. Those with a history of chickenpox or shingles can be considered immune, but healthcare workers with a negative or uncertain history should be serotested.
- Seronegative healthy children over one year who come into close contact with individuals at high risk of severe varicella infections (susceptible pregnant women and those with immunodeficiency or receiving immunosuppressive therapy).

As it is a live vaccine and can be transmitted to the very people it is being administered to protect, contact with them should be avoided if a vaccine related skin rash occurs within 4-6 weeks of either dose,41 the same with shingles vaccine.

The chicken pox vaccine is not currently expected to become part of the national immunisation schedule. Professors Ross and Lantos from Chicago, Illinois were of the opinion that as:

- Chicken pox is generally a benign disease when occurring in childhood,
- The vaccine may not give lifelong immunity
- Chicken pox in adults can be much more severe,
- In pregnant women it can cause embryopathy if contracted in the first two trimesters and severe neonatal chicken pox with a mortality of 30% in the last trimester

Then a programme of universal chicken pox immunisation to benefit immunocompromised children would put the recipients of the vaccine at increased risk of severe, possible fatal chicken pox disease in later life and so would not be justified. Ironically, in that same year, a chicken pox vaccine was licensed in the USA and put on the compulsory childhood schedule.

The JCVI have been considering the same issue for many years. Epidemiological evidence suggests that adults who do not get natural boosting by exposure to children with chicken pox will be at increased risk of herpes zoster in the 40-60 year old age range, and the risk to unborn children or neonates will increase from infections occurring during pregnancy. Their current advice to the Department of Health is 'no.'

10. What is the current consensus on side effects of, and contraindications to, the vaccines used in the standard immunisation schedule?

It depends what you mean by consensus and to whom you talk - doctors or parents, the Department of Health or vaccine manufacturers, the UK or the USA.

Regarding the MMR vaccine, a review concluded that:

'*The design and reporting of safety outcomes in MMR vaccine studies, both pre- and post-marketing, are largely inadequate.*'

Not exactly reassuring. They finish by saying that adverse events following immunisation cannot not be separated from its role in preventing target diseases.41

Contraindications from Summary of Product Characteristics:

- Hypersensitivity to the vaccines or any of the excipients including formaldehyde, glutaraldehyde, neomycin, streptomycin or polymyxin B, Polysorbate 80, kanamycin.
- Neurological complications following an earlier immunisation against diphtheria and/or tetanus.
- Intramuscular injections in those with bleeding disorders - most can be given instead by the deep subcutaneous route.
- Acute febrile illness.
- Live vaccines have contraindications as listed in Q5.

Additionally, the MMR vaccine (live) is contraindicated if there is active, untreated TB, hereditary fructose intolerance due to the sorbitol content and previous anaphylactoid reaction to egg. The rotavirus vaccine (live) is contraindicated by previous history of intussusception, uncorrected congenital malformation of the gastrointestinal tract that would predispose to intussusception, current diarrhoea or fever and fructose or other sugar intolerance, malabsorption or enzyme deficiency.

The live attenuated 'flu vaccine (Fluenz Tetra) summary of product characteristics (SPC) contraindicates severe asthma defined as:

- A history of active wheezing at the time of vaccination (until at least seven days after wheezing has stopped) or
- If currently taking or have been prescribed oral steroids in the last 14 days for an exacerbation of asthma or
- If currently taking a high dose inhaled steroid – budesonide >800 mcg/day or equivalent47

Also, salicylate therapy (risk of Reye's Syndrome) and previous anaphylactoid reaction to egg, however the Green Book/ JCVI 2015 advice is that only anaphylaxis requiring intensive care is significant enough to omit this vaccine.48

Relative contraindications are as follows:

- Tetanus containing vaccines – Guillain-Barré syndrome or brachial neuritis. The Green Book makes no mention of either of these despite a review by the USA Institutes of Medicine finding evidence for a causal relationship between receipt of tetanus toxoid and both brachial neuritis and Guillain-Barré syndrome.48
- Pertussis containing vaccines – encephalopathy of unknown aetiology, occurring within seven days following previous vaccination with pertussis containing vaccine and progressive neurological disorder, including infantile spasms, uncontrolled epilepsy and progressive encephalopathy until stabilised.

Whereas the SPCs for Hib, pertussis, polio and tetanus vaccines advise careful consideration of the potential risk benefit of a vaccination which has previously been followed by temperature of ≥40°C within 48 hours, not attributable to another identifiable cause, collapse or shock-like state (hypotonic-hyporesponsive episode) within 48 hours, persistent crying lasting ≥3 hours within 48 hours and convulsions with or without fever within three days, the Green Book advice is quite definite that fever, irrespective of its severity, hypotonic-hyporesponsive episodes (HHE), persistent crying or screaming for more than three hours, and severe local reaction, irrespective of extent, should not stop vaccination from going ahead.

All current vaccine SPCs list combinations of fever, fatigue, malaise, arthralgia, crying abnormal, irritability, restlessness, headache, diarrhoea, vomiting, rash, and redness at the site of injection as being common, (≥11/10) or very common (≥11/100).

Guillain-Barré syndrome and brachial neuritis are listed as caused by tetanus-containing vaccines in USA publications and of unknown frequency in UK ones.

I would say that there is no current consensus on adverse events following immunisation.

11. Could you clarify which children should have which type of flu vaccine, and why?

Live attenuated influenza vaccine, Fluena Tetra, is recommended for all children aged 2-9 years in the current routine childhood schedule and all children aged 2-18 years in at risk groups who are suitable for live vaccines. This is because the live attenuated influenza vaccine is believed to give better protection to children than inactivated ones.

Inactivated influenza vaccine is recommended for all children in the age groups above who are contraindicated from receiving live vaccines, who have severe asthma or previous anaphylactoid reaction to egg requiring intensive care, who are in a clinical at risk group but are contraindicated from receiving live vaccines or any child in contact with severely immunosuppressed people because of the potential for viral shedding of the live vaccine.

Children aged six months to two years in at risk groups are recommended to have inactivated vaccine, as Fluenz Tetra should not be used in infants and toddlers below 24 months of age due to safety concerns regarding increased rates of hospitalisation and wheezing in this population.

12. What changes in the national immunisation programme are likely over the next few years?

Introduction of chicken pox vaccine for children will keep being reviewed by the JCVI, as will hepatitis B vaccine. The WHO wants every country to have a universal hepatitis B program. Mathematical modelling in the UK has indicated that it might be cost-effective but the formulation available – added to the current 5-in-1 vaccines as a hexavaccine, raises concerns about immune interference with the Hib component in the currently available formulations. Boosting may also be needed as hepatitis B is not endemic in the UK.

Replacement of live attenuated influenza vaccine, Fluenz Tetra, with injected inactivated vaccine if effectiveness reduces as it has done in the USA. Mucosal vaccines have the ability to induce tolerance rather than an antibody response, as this, indeed, represents the most common and important response of the mucosal-associated lymphoid tissue to environmental antigens, including food and commensal bacterial components, to maintain immunological homeostasis, otherwise we would all be allergic to everything!

Replacement of MenB vaccine with conjugated Men ACW135Y for infants (Nimenrix).The JCVI seems to be quite pleased with the performance of the MenB vaccine at the moment but if it continues putting people off finishing the primary course of immunisation by being reactogenic and does not perform well over time, they may wish to replace it with the conjugate ACW135Y vaccine which can be given to infants - which would also give antibodies to MenW - as they have stated that they do not want to leave babies without any meningococcal vaccine in their first year.

Extension of the HPV vaccine programme to boys is unlikely as mathematical modelling by Warwick University indicates it is highly unlikely to be cost effective.56 However HPV vaccination *is* likely to be extended to men who have sex with men and transgender people via genitourinary/ HIV clinics and through the prison medical service.

Addition of another DtaP containing vaccine in the second year may be added to the schedule to compensate for the blunting of the infant immune response to the primary vaccine course caused by maternal dTap-IPV vaccination in pregnancy.58

Over the horizon are vaccines for maternal Group B streptococcus (GBS) which may be available within a couple of years as another vaccine to be given in pregnancy, respiratory syncitial virus vaccine, norovirus, *Clostridium difficile*, MRSA, cytomegalovirus, higher valency pneumococcal conjugate vaccines and hepatitis C vaccine.

Previous page

Next page

END OF APPENDIX 01

B. Lack of substance to charges regarding the content of my lectures and consultations.

The charges regarding the information that I give have no substance. Without concocting a bogus dishonesty charge there would be no reason not to allow me to retire from medical practice in the NHS and privately. I wished anyway to withdraw from NHS practice because of the requirement to follow NHS policies which are against the best interests of the patient, and from private medical because I no longer practice medicine.

Further to exemplify that this is a political show trial, with the lack of substance in the charges regarding the information I give in lectures and to those who consult with me on that topic, it seems a reasonable inference that the GMC needed the dishonesty charge to force a hearing. That has also provided a basis, albeit wholly false, to refuse my applications (two so far) for voluntary erasure from the medical register.

C. Lack of substance to the dishonesty charge.

The bogus dishonesty charge is:

> *4. On Occasion 1, Occasion 2, Occasion 3 and Occasion 6 you made statements regarding your opinions on vaccines being tested by a tribunal and the determination of that tribunal as outlined at Schedule 3.*
> *5. You knew that the statements made at paragraph 4 were untrue as no tribunal had made such determinations.*
> *6. Your actions described at paragraph 4 were dishonest by reason of paragraph 5.*

> *Occasion 1*
> *'It is a matter of public record that I am the only qualified medical practitioner in the UK whose medical advice on vaccination has been proven in an extensive examination to a standard of beyond a reasonable doubt before an English legal tribunal to be sound and based on peer reviewed scientific and medical journal published literature (GMC 2007).'*
> *Occasion 2*
> *'I'm the only doctor in the country whose opinion on vaccinations has been tested in a three-week statutory tribunal and found to be independent, objective and unbiased beyond any doubt'*
> *Occasion 3*
> *'So, that's why you're here, because I'm the only doctor in the country whose opinion on vaccinations has been tested in a truly UK statutory legal tribunal and found to be independent, objective and unbiased beyond any doubt'*
> *Occasion 6*
> *'Dr Donegan is currently the only doctor in the UK whose opinion on vaccination has been tested in extensive UK legal proceedings (GMC 2007) and found to be valid, based on sound research and peer reviewed medical literature 'beyond reasonable doubt'*

These statements are correct. I believed them to be true when I said them and I continue to believe them to be true as they are. At the very least they are a reasonable lay summary of the findings of the GMC panel in 2007. As my barrister, Mr Ian Stern told me at the time, it is usual for the panel to say, "*We couldn't find beyond reasonable doubt or, in the new parlance, we could not be 'sure' that you had failed to be independent, objective and unbiased*."
However what they said was the opposite, they said that they were '*sure*' I had *not failed* to be i*ndependent, objective and unbiased* in the reports I provided.

Since this bogus dishonesty charge was made in 2020, and despite repeated attempts to get a clear statement no-one at the GMC was willing to state what is supposed to be inaccurate, let alone dishonest about what I say in the above statements. This is to the degree that the GMC has not produced a single expert willing to give evidence about the dishonesty charge – which is remarkable. A reasonable inference from that is no-one is willing to risk the consequences of claiming bogus charges are true when clearly they are not.

When some semblance of a reason was given by the GMC and then challenged, a different reason was given, showing that when the dishonesty charges were made up the GMC had no idea what was supposed to be inaccurate, let alone dishonest.

The GMC did not tell me what is dishonest. The legal team provided to me by the Medical Protection Society did not tell me what is dishonest. Indeed the solicitor handling the case withdrew because I repeatedly asked what was dishonest about what I say and he could not give me an answer to that fundamental question. In addition, he did not press the GMC, who laid the charges against me, for the information either.

The same with the next solicitor I was allocated and the barrister. It was their failure to do so, and my complaints about it that are the reasons the MPS withdrew their discretionary funding. This stipulates that you have to follow MPS legal is team advice even if they do not give you any and what they do give is not relevant to your case and is actually going to make you lose. It is why I am unrepresented now, despite the thousands I have paid in indemnity subscriptions.

The first time in two years I had the opportunity to challenge the bogus dishonesty charge was when I, unrepresented and speaking for myself, put it to the MPTS case manager at an interim hearing in July 2022 – of which more later.

I asked the GMC solicitor to be required to answer the questions I listed in my submissions for that hearing.
Please see **APPENDIX 02** for my submissions regarding the dishonesty charge that day 05 July 2022

APPENDIX 02 – Extract from: Submissions to MPTS Hearing 5 July 2022 & The Bogus Dishonesty Charge

WHAT IS THE GMC'S DISHONESTY CASE?

17) No one knows what the GMC case might be on Charge 6. And the GMC refuses to say. A dishonesty allegation, particularly one made in a formal hearing, is a serious matter. Everyone must know the case they have to answer. On Charge 6 that is opaque and is a significant barrier to defending this case.

18) The charges reduce this case to an "*Oh, yes it is. Oh, no it isn't*" pantomime, asserting baldly "*5. You knew that the statements made at paragraph 4 were untrue as no tribunal had made such determinations.*" To which the current answer could be "*Oh, yes it did."* but more appropriately is, "*who says so?*" especially because there is no witness evidence to support the claim.

19) If there is dishonesty of such seriousness as to justify a hearing then the GMC should be able to spell it all out in detail boldly and confidently with a witness qualified to testify as to the alleged facts of this alleged dishonesty.

20) It should all be perfectly plain and obvious but it is not.

21) The GMC expert in his report, which does not address Charge 6, effectively says there is not enough to justify disciplinary action. In view of the political nature of this case, it seems to me that to ensure a case was brought it was necessary to allege dishonesty. The fact that the GMC has made no effort to produce a witness to testify as to the alleged dishonesty supports that view. But there is more.

22)The present dishonesty allegation is not the first. The GMC had to withdraw a previous inappropriate dishonesty allegation. It was based, it appears, on the fact the opinions of the GMC's expert in this case differ from mine. It is perfectly obvious that a long held and well and publicly demonstrated view based on sound medical science can never be a basis for a dishonesty charge.

23)So far not even the GMC is willing to spell out what is inaccurate and dishonest - despite a direct request from me - what they have produced so far is inadequate. Only a "*rationale*" is identified by the GMC consisting of a few paragraphs of the Rule 8 Case Examiner's decision. **The GMC also does not say this is in fact its case on alleged dishonesty**. Additionally, the Case Examiner is not a GMC witness and so cannot prove the GMC's case nor be cross-examined on it by the defence.

24) So the issue is left hanging - mid-air.

25) By email of Thursday, June 23, 2022 all Ms Silver, on behalf of the GMC, had to say in response to my request for clarification - and without providing that clarification [my emphasis]:

a) "With regards to your query in relation to charges 4-6, I would revert you to page 25 and 26 of the Rule 8 decision which is attached. This clearly sets out the ***Case Examiners rationale*** ***behind*** *referring the charges to the hearing. I have also attached the minutes from the 2007 hearing which these charges relate."*

26) With respect, **this does not confirm what the Case Examiner claimed is the GMC's case either at all or any part of it**. The Case Examiner obviously is also **not a witness in the proceedings**. **The GMC's reticence in not confirming is explicable only if Charge 6 is bogus and therefore only for the purposes of forcing a hearing**.

27) To be clear and for the avoidance of doubt, I have so far seen nothing reliable to contradict the statement that:

a) 'I'm the only doctor in the country whose opinion on vaccinations has been tested in a three-week statutory tribunal and found to be independent, objective and unbiased beyond any doubt'.

28) There is **nothing** of any substance backed by **witness evidence** proffered by the GMC for cross-examination to challenge the view those statements are **neither inaccurate nor dishonest**. There is no evidence of any witness to challenge the view that **the statements the subject of Charge 6 are accurate lay summaries of the outcome of the 2007 GMC case**. Having the benefit of the views of a number of lawyers over the course of time since the 2007 GMC Panel Determination, including two QCs makes it ever more difficult for me to see that there is any validity to the GMC's Charge 6.

29) Furthermore, whilst I look forward to being corrected if thought wrong, the case examiner's rationale is inadequate and raises many questions. It seems speculative at best and intentionally false at worst and in every material particular:

a) "It is alleged in this case, that Dr Donegan had been dishonest in stating that, 'I'm the only doctor in the country whose opinion on vaccinations has been tested in a three-week statutory tribunal and found to be independent, objective and unbiased beyond any doubt'.

b) We can find no reference in the minutes for Dr Donegan's August 2007 FtP Panel hearing which, in our view, could reasonably support Dr Donegan's contention outlined above. Indeed, the evidence in the minutes shows, in our view, that the hearing did not touch on whether Dr Donegan's opinion on vaccinations was independent, objective or unbiased beyond any doubt.

c) Whilst it is true that one of the allegations against Dr Donegan in her August 2007 was that she had, 'failed to be objective, independent and unbiased' when giving expert evidence in a Family Court case, and it is true that the FtP Panel did not find that allegation proved, the FtP Panel's reasons for not finding that allegation proved made no mention of it being because it had found Dr Donegan's opinions on vaccinations to be independent, objective and unbiased beyond any doubt.

d) Rather, the FtP Panel only considered whether Dr Donegan had failed to be objective, independent and unbiased in the expert reports she had submitted for the particular Family Court case in question. Indeed, as we have outlined earlier, Counsel for the GMC is said in the minutes to have submitted that:

e) 'this case is not concerned with the efficacy of vaccines nor with the risks and benefits associated with them. Furthermore, the Panel was told that the case was not concerned with vaccination policy.'

f)We also note, that the Legal Assessor's advice to the FtP Panel in regard to its deliberations on the heads of charge which had not been admitted by Dr Donegan, one of which was that she had failed to be objective, independent and unbiased; was said in the minutes to have been as follows:

g)'The Legal Assessor advised the Panel that it must decide whether what you did when writing your reports was to give false and/or misleading impressions of the research you relied on, whether how you did that was by quoting selectively and omitting information, whether why you did it was because you unwittingly allowed your deeply held views to overrule your duty and whether, therefore, you failed to be objective, independent and unbiased.'

h)One further point, is that we cannot see how Dr Donegan could profess to be the 'only doctor in the country' to have had their opinions on vaccinations tested and found to be independent, objective and unbiased beyond any doubt, unless she was aware, at the very least, of every instance where a doctor's opinions on vaccinations had been tested.

I) We conclude it could be found proved, on the balance of probability, that it was not Dr Donegan's genuinely held view that she was the only doctor in the country whose opinion on vaccinations has been tested in a three-week statutory tribunal and found to be independent, objective and unbiased beyond any doubt.

j) We also conclude that if a Tribunal was to find the first limb of the test for dishonesty proved, on the balance of probability, it would go on to find, on the balance of probability, that Dr Donegan's conduct in that regard was objectively dishonest by the standards of ordinary honest people.

k) We should add that this is clearly not a case, in our view, where the nature of Dr Donegan's alleged dishonesty could reasonably be described as having been at the lower end of the spectrum of seriousness, such that the presumption of impairment could be rebutted.

I) We also see no exceptional reasons in the information before us at this time, for concluding that a referral to a Tribunal is not necessary.

m) We conclude, therefore, for the reasons outlined above, that the realistic prospect is met in this case, as regards the dishonesty allegation at paragraph 7 of the allegation of misconduct."

30) I have long sought an explanation of the supposed basis for a dishonesty charge.

31) A GMC witness should be produced willing to address the GMC's case in cross-examination, supported by the prior disclosure of a comprehensive statement explaining the at best somewhat speculative "*rationale*" from the Case Examiner's Rule 8 decision.

32) In two and a half years the MPS and their appointed lawyers have in my view bizarrely not challenged the current dishonesty charge **at all**. That seems to me to be the only other reason there is for there being a hearing at all.

33) It is ironic that it has taken the withdrawal of my MPS funding to enable me to challenge Charge 6 directly with the GMC and MPTS. This is also indicative of the degree to which my ability to defend this case has been subverted for two and a half years.

34) For example, the GMC knows very well that the standard of proof in 2007 was beyond a reasonable doubt. So to claim it was not, to facilitate bringing a charge of dishonesty for a Rule 8 decision, is more than inappropriate - it looks dishonest itself.

35) But the GMC still used the claim that the 2007 standard of proof was not "*beyond a reasonable doubt*" to allege dishonesty. So that further supports the view Charge 6 is bogus.

36) Similarly, I look forward to seeing a witness on oath address the Case Examiner's claim that "*the hearing did not touch on whether Dr Donegan's opinion on vaccinations was independent, objective or unbiased beyond any doubt.*". This contrasts with the express finding of the 2007 GMC panel **to the standard of beyond a reasonable doubt** [that the panel was "*sure*"] that in giving my expert professional opinions on vaccination in my reports I "*did not fail to be independent objective and unbiased*".

37) The dishonesty allegation is enigmatic to the degree Charge 6 appears to me to be bogus, but I look forward to being corrected if thought wrong. A full explanation and more is clearly necessary but no one seems willing to give evidence on the matter.

38) Again, I suspend judgement pending a full explanation backed by a witness and full witness statement and look forward to being corrected if thought wrong. Especially, let the GMC prove that the failure to make their dishonesty case clear is not because they cannot explain precisely what the case is to be answered. Let us all see what exactly their case is, if there is one and so that I can know the case I am supposed to have to answer or else Charge 6 should not feature in these proceedings.

39) To emphasise the degree of concern caused by the absence of any proper basis for Charge 6, according to the example of perverting the course of justice given by the Crown Prosecution Service on its website, namely of the levelling of false charges against a defendant: *"[i]n* R v Cotter and Others *[2002] EWCA Crim 1033 .... all that is required is that the person making the false allegation intended that it should be taken seriously by the police."*

40) Here we have the GMC's dishonesty allegation clearly intended to be taken seriously by the GMC's case examiner and now the MPTS to the degree there is to be a hearing because of it and my now long overdue retirement is postponed because I cannot voluntarily erase my registration.

41) The GMC's first dishonesty allegation appears to satisfy the test in R v Cotter. It seems however, that the present dishonesty allegation may also. I suspend judgement on the matter pending a full explanation from a GMC witness.

42) If the GMC cannot produce a suitable witness to testify as to the facts of the allegation and present for cross-examination on that testimony then Charge 6 should not be part of these proceedings. One might be tempted to think the GMC has not produced anyone because Charge 6 is false.

430 My ability to defend against Charge 6 in the present vacuum seems to be limited to the foregoing assertion of "*who says so*" as there appears to be nothing inaccurate nor dishonest and there is no witness to contradict that. Other than being merely a means to force a hearing, Charge 6 seems to me to be a fishing expedition with nothing to back it up. I wait to be corrected if thought wrong and to be enlightened specifically so that I am put into a position in which I can understand the allegation **in order to defend against it**.

44) Accordingly, the GMC needs to:

a) confirm the Case Examiner's "rationale" is the entire case on dishonesty and if not, what is; and,

b) produce a witness with a witness statement setting out and explaining the GMC's case comprehensively for the Charge 6 dishonesty allegation.

45) After two and a half years is it well beyond time this matter was dealt with appropriately with due care and seriousness.

END OF APPENDIX 02

The order I requested to be made and the questions I asked be answered regarding The Bogus Dishonesty Charge:

^^

FIRST ORDER SOUGHT - REGARDING CHARGE 6:

46) I have put the following to Ms Silver of the GMC with no satisfactory response. Accordingly, I respectfully request that the MPTS by order require the GMC to answer clearly and unequivocally within a clear time limit so that I can attempt to prepare my defence response and in default to strike out Charge 6:

"Regarding the statements referred to Charges 4 - 6, specify clearly and with particularity in the case of each quoted statement and regarding the use of each word and/or phrase in the quoted statement specify:

what is allegedly inaccurate;

- why;

- including whether the alleged inaccuracy is from the use of the word or phrase alone or in combination with others.

what is allegedly dishonest;

- why;

- including whether the alleged dishonesty is from the use of the word or phrase alone or in combination with others

Confirm whether:

the following is a full list of the words and/or phrases concerned or

whether there are any other words or phrases the use of which alone and/or in combination is alleged to be inaccurate and/or dishonest. And

specify with particularity why in each case they are so alleged, alone or in combination with any other word or words and

any word or words about which the GMC has no complaint:

a) "matter of public record"
b) "qualified medical practitioner"
c) "opinion on vaccinations"
d) "tested"
e) "medical advice on vaccination"
f) "proven in an extensive examination"
g) "to a standard beyond a reasonable doubt"
h) "English Legal Tribunal"
i) "to be sound and based on peer reviewed and scientific and medical journal published literature"
j) "only doctor in the country"
k) "found to be independent objective and unbiased"
l) "beyond any doubt"
m) "a three week UK statutory legal tribunal"

^^

Comment on: Appendix 02, the order I requested to be made & The Bogus Dishonesty Charge

The GMC has produced no witness willing to give evidence about what is supposedly inaccurate or dishonest about what I say in describing the 2007 GMC panel decision. There is no evidence from the GMC to date to support the bogus dishonesty charges and only invalid repeatedly changing arguments like a game of whack-a-mole – knock one on the head and the GMC pops up with another to whack.

Despite the GMC solicitor undertaking at the 5th July 2022 MPTS hearing to answer the questions she did not so do.
However the GMC did produce an opinion from their barrister – not answering the questions I asked, but answering one I did not ask but that they wanted to answer.

The GMC charge was:

> *"5. You knew that the statements made at paragraph 4 were untrue as no tribunal had made such determinations."*

The GMC barrister was now saying that this was true that the panel said I had

> "*not failed to be independent, objective and unbiased"*

but he countered by saying that that the decision was pronouncing on my *reports*, not my *opinion* on vaccination

This is ludicrous.
1. An expert report in court is an opinion, *de facto* – any barrister must know this – thus further supporting the inference that the GMC knowingly put forward bogus dishonesty charges, with their barrister giving a bogus opinion in a pretence of some basis for them;
2. The panel even quotes me in its decision saying :

> At the conclusion of your report you declared:
> "*I, Dr Jayne LM Donegan, declare that this is an independent medico legal report based on my opinion, knowledge and research on the diseases, their vaccines and taking into account the particular cases of the children involved*."
>
> [Emphasis added]
> [2007 D1/4 C]

When I pointed this out to the GMC solicitor, she came back to me, having taken advice, I presume, saying it it *was* my opinion but it wasn't wasn't *all* of my opinion. This is another flip-flop to a different bogus argument to allege dishonesty after the prior one was shown to be bogus. Neither I nor anyone else for me claimed the reports were *all* my opinions. Indeed, it is well nigh impossible to set out *all* of one's opinions on any such complex topic so it cannot possibly be implied that I was claiming that. This also reinforces how bogus the GMC's dishonesty charges are and have always been. It also shows the GMC's disingenuous and slithery position when forced to give justification for the unjustifiable.

Looking at the statements the GMC is alleging are untrue and dishonest, but refuse to specify which and why:

The GMC hearing in 2007 was an *English legal tribunal.* It was a *statutory tribunal.* It was a *UK statutory legal tribunal.* It was *UK legal proceedings (GMC 2007)*

The GMC hearing in 2007 lasted three weeks - I believe this fulfils the criteria for extensive.

They examined me, my two reports from the original legal case and the extensive one I wrote for he GMC hearing. There were two reports from each of the original JCVI experts, Kroll and Conway, plus the report from Dr Elliman and the report from my expert Dr Peter Fletcher, a former Undersecretary for Health. That is eight complicated technical reports, hundreds of complex technical references. My reports were dissected by the original experts *and* Dr Elliman in his report. When in 2006 the Medical Defence Union team initially saw Dr Elliman's report about me, they called it, "*the most critical report*" they had "*ever seen by a doctor about a colleague.*" But that is the expert who was eventually forced to admit under cross-examination that he was '*quibbling*'.

Opinion on vaccination: the case focussed on morbidity and mortality from vaccinatable diseases, both before and after vaccines were introduced, vaccines themselves, vaccine efficacy, vaccine adverse reactions, additives, and issues which the then GMC expert, Dr Elliman said:

> "*I have not considered the matters covered on pages 67-72 as they have little relevance to the subject in hand.*"

Matters covered on pages 67-72 of my Report were :

- *Factors affecting immunity.*
- *Are childhood infectious diseases a good thing?*
- *Does autoimmunity increase with decrease in these diseases?*
- *Treatment of childhood infectious diseases.*
- *The best interests of the child.*

This shows exactly what the priorities of Dr Elliman as GMC expert were - shockingly, no other factor than vaccines. Parents cannot get proper advice nor give informed consent to vaccinations on behalf of their babies and older children with this level of unbalanced, one-sided, one-size-fits-all medicine.

Who is or was Dr Elliman? As well as being the GMC's expert witness against me in the 2007 Serious Professional Misconduct case, in which I was completely exonerated, he is or was Consultant in Community Child Health, Great Ormond Street Hospital for Children, Immunisation co-ordinator for Islington PCT, the Lead author of MMR section of Clinical Evidence 2007 BMJ Publishing Group, the author of several books and guides for doctors, health visitors and parents, on vaccination & infectious diseases as well as frequent papers in medical journals on the importance safety and efficacy of vaccination particularly MMR as well as making numerous radio and TV appearances over the years – although not so many since it was revealed that he was the senior medical manager at Great Ormond Street Hospital during the time of the tragic BABY P case.
This prominent vaccination promoter does not think that

- *Factors affecting immunity.*
- *Are childhood infectious diseases a good thing?*
- *Does autoimmunity increase with decrease in these diseases?*

- *Treatment of childhood infectious diseases.*
- *The best interests of the child.*

are relevant to deciding whether or not a child should be vaccinated.
No wonder parents come to my lectures to get a balancing view.
And what was the overall opinion I offered the court as to who should make the decision on important matters in a child's life in the case of two parents who have parted and cannot agree?

"*the parent with day to day care which ever decision they decide to make."*

As that parent has to deal with the consequences of the decision to vaccinate or the decision to not.

More phrases from the statements I have made that the GMC assert falsely without foundation are untrue and dishonest:
(Opinion on vaccination) to be valid, based on sound research and peer reviewed medical literature (Medical advice on vaccination) *to be sound and based on peer reviewed scientific and medical journal published literature*

In the 2007 hearing the GMC had alleged;

> "*In the reports that you provided you, c. Allowed your deeply held views on the subject of immunisation to overrule your duty to the court and to the litigants"*

But at the end of the hearing the panel gave their decision saying:

> "*The Panel were sure that at no stage did you allow any views that you held to overrule your duty to the Court and the litigants.*
>
> *You demonstrated to the Panel that your report did not derive from your deeply held views and your evidence supported this. You explained to the Panel that your approach in your report was to provide the Court with an alternative view based on the material that you produced in your references. That material was largely drawn from publications that were, in fact, in favour of immunisation.*
>
> *It was clear from your evidence and from your witness, Mrs Eaton, that your aim is to direct parents to sources of information about immunisation and child health safety to help them to make informed choices. You told us that there are many books by doctors and others in this and other countries who seriously question vaccination and they cite a lot of history, proofs and medical papers to support their arguments. You did not use any of those publications because you did not think that the Court would regard those as satisfactory support or references for your recommendations. You largely used what was available in refereed medical journals.*"
>
> "*The Panel found this head of charge not proved.*"
>
> [GMC 2007 D1/10 - D1/11]

I believe what I say on the occasions above is a reasonable summary of this.

Regarding
Occ 1 to a standard of beyond a reasonable doubt
Occ 2 beyond any doubt
Occ 3 beyond any doubt
Occ 6'beyond reasonable doubt'

The fitness to practice cases brought by the GMC before 2008, such as the one brought against me in 2007, had to be proved to the criminal standard, ie, ‘beyond reasonable doubt’ – or in the new parlance, ‘sure’.

I do not believe my statements above are either dishonest or attempting to deceive anyone.

I believe all of the above statements are true. I continue to believe they are true because they are.

In addition in all the time since 2007 and even more so since the GMC brought these charges against me in 2019 they have not produced one single doctor registered in the UK whose opinion on vaccination has been tested in a three week UK statutory tribunal or other extensive UK legal proceedings and found to be independent, objective and unbiased beyond reasonable doubt, or in the new parlance, ‘sure.’ That is in addition to failing to find and produce a single expert witness willing to give evidence in support of the bogus dishonesty charge.

It is ridiculous that the GMC is taking me to a five week hearing in 2023 to argue about whether my reports are opinion, which obviously they are, and if they so whether they are *all* of my opinion, using a clever and expensive top class barrister (the GMC has unlimited funds to persecute good, ethical doctors who do not toe the government line) who will argue that black is white, white is black and how many angels are dancing on a pin head, with the sole aim of scoring points and no regard to truth, justice, humanity and most importantly, patient safety. They do their job with *ad hominem* attacks and clever tricks to crush a doctor whose fault in the eyes of the GMC and politicians is that she follows her ethical obligations as outlined in the GMC guidelines on consent as well as her legal obligation under Montgomery 2015.

The reasonable inference is that the dishonesty charge was included to ensure there would have to be this show trial to satisfy the now discredited former Secretary of State for Health, of *“I’m a Celebrity, Get Me Out of Here”* fame, who may responsible for very many deaths, in the elderly during Covid.

D. Parents misleading health professionals – no wonder.

"7. On Occasion 2 and Occasion 4 you made statements which encouraged parents to deliberately misinform healthcare professionals about their children's immunisation status and/or diet as outlined in Schedule 4."

If parents mislead healthcare professionals, the responsibility for that lies with healthcare professionals.

Every doctor has a duty to ensure a child can get proper medical care as and when it is needed without parents being bullied by doctors about a child's vaccination status and frightened away and put off seeking attention for their child.

Which is to be preferred:

- a child is seen by a doctor [GP or A&E] and gets appropriate treatment?
- a parent is frightened to visit a doctor because of what happens if they confirm their child is not vaccinated?

If these are the choices (and they are) it is vastly preferable for the first option to apply and not the second.

Most parents will do anything necessary to protect their children from what they perceive as harm. Parents have a legal obligation under the Children Act 1989 as a parent to protect their children, and that includes from doctors. The law requires that the welfare of the child is paramount. "Parental responsibility" is

> "*all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child and his property*".

If a parent considers it necessary to mislead doctors to ensure a child can get access to proper medical care, including in an emergency, that is for the parent to decide and it may be the parent's legal and moral obligation to do so. And this is aside from the State, via the NHS and its doctors, breaching the human rights of parents and children on a daily basis.

Regarding the GMC's accusation that parents who do not give their children a pint of milk a day until they are two years of age, and do not tell this to the health visitor might suffer from malnutrition shows:
a) a complete lack of understanding of the element of humour in my lectures and when consulting and
b) that parents who pay to come to my lectures and consultations are parents who certainly know how to care for and feed their children properly and the idea that they might suffer from malnutrition is improbable to a high degree.

The MPTS panel need to listen to the recordings of my lectures to realise I use humour and should hear the audience when they are laughing. To attempt to turn humour into serious professional misconduct when it is nothing of the sort is preposterous. It is the GMC and their expert, Dr Riordan, clutching at straws.

Does anyone seriously think people who spend time looking into what is best for their children and paying for and attending lectures by a doctor, are so stupid that they cannot recognise humour when they hear it?

Is a doctor to be sanctioned for making people laugh?
Does anyone seriously think those parents are going to take a joke as serious medical advice and slavishly follow it?
Except, perhaps a Telegraph reporter who knows very little about childhood illnesses, health and vaccination, and does not want to know. She is not asking questions to get information she can use for her child, nor asking questions to clarify possible misunderstandings.
She wants neither information, nor clarification.
She is acting as an *agent provocateur* being paid to do a 'hit job.' Hence any consultation with her or someone like her will be entirely artificial.

Are children harmed by doctors not knowing their correct or incorrect vaccination status?
The allegation that children are harmed by doctors not knowing their vaccination status is put forward purely as conjecture and is not evidence-based. Specifically, there is no evidence before the tribunal that this is a problem or harms children. But there is evidence that the opposite is the case
When children are brought into A&E unconscious and unaccompanied, doctors manage them based on their clinical situation.
Before Covid no adults were asked for their vaccination status except for tetanus, in the case of a wound, but not otherwise.

Harm in all cases comes from doctors making assumptions while ignoring the clinical condition of their patient.

A doctor who thinks a child is vaccinated against a particular disease when they are not, while ignoring the clinical condition, can harm a child, not because of not knowing their vaccination status correctly but because of ignoring their clinical condition

Is that child going to me worse off than a child who *is* vaccinated and is being seen by a doctor who assumes that because a child is vaccinated against, for example, measles, mumps and rubella that they do have one of those diseases, while ignoring their clinical condition?

Bear in mind that in the USA in 2015, 37% of all reported case of measles were not unvaccinated nor even 'vaccines failures' (had the vaccine but developed the disease anyway).
No, 37% of all reported case of measles in the USA in 2015, according to US Centers for Diseases Control Scientists were cases of disease *from* the measles vaccine strain, meaning they had the MMR vaccine and they developed measles the disease from the measles virus strain in the vaccine.

[CDC USA figures Roy F et al Rapid Identification of Measles Virus Vaccine Genotype by Real-Time PCR 2017 J Clin Microbiol 55(3):735-743 https://jcm.asm.org/content/55/3/735]

The same with whooping cough in vaccinated children – which happens a lot. If the doctor assumes that if the child is vaccinated they will not have pertussis, while ignoring their clinical condition, they will not be managed appropriately

> "*Because of linked-epitope suppression, all children who were primed by DTaP vaccines will be more susceptible to pertussis throughout their lifetimes, and there is no easy way to decrease this increased lifetime susceptibility.*"

[Cherry J The 112-Year Odyssey of Pertussis and Pertussis Vaccines-Mistakes Made and Implications for the Future 2019 J Pediatric Infect Dis Soc Sep 25;8(4):334-341 https://pubmed.ncbi.nlm.nih.gov/30793754/]

Professor James Cherry James D. Cherry MD, MSC has been a pediatric infectious diseases specialist for 59 years.

The same with tetanus though that is very rare, as tetanus is very rare. The important factor, vaccinated or unvaccinated against tetanus is appropriate ‘wound toilet’ – cleaning of the wound – often omitted when all focus is on vaccination.

> *“Since tetanus is likely to be fatal if not recognised and treated properly, the caveat from Shimoni et al1 merits repeating: doctors should entertain the diagnosis of tetanus in the proper clinical setting, regardless of the patient's immunisation record*”
>
> Vinson DR Immunisation does not rule out tetanus 2000 Comment BMJ. Feb 5;320(7231):383.
> https://pubmed.ncbi.nlm.nih.gov/10657350/

Harm comes to patients irrespective of vaccination status and irrespective of a doctor knowing the correct vaccination status for the same reason: doctors ignoring the clinical condition of the child in front of them.
Doctors who don’t listen, who don’t look and who do not think. As well as being gratuitously rude and bullying to the child’s parents, or, since Covid vaccination, the patient themselves.

100% positive regard is what I was taught to give to my patients and their parents or children. This does not seem to be taught any more.

Looking at another serious side to these matters.

Infringement of human and other rights through lack of informed consent
I have good reason to believe and have already provided evidence that the human and other rights of vaccinated and unvaccinated children and their parents are being infringed on a daily basis by NHS doctors and others involved in vaccinations where parents are denied the information they need to make decisions with informed consent for their children. Parents who do not vaccinate are bullied and abused and consequently fear accessing medical help when they need it.

Children are vaccinated in the NHS on a daily basis without informed consent. Montgomery and Good Medical Practice are being contravened daily throughout the NHS where vaccinations are concerned.

I do not hear about the GMC prosecuting any of these bullying and abusive doctors. Quite the opposite, they are paid for ‘hitting’ their ‘targets’ to vaccinate.

Parents seek help from health professionals for acute illnesses in their children for two reasons
1. Because they think their child is OK really and they just want some reassurance from a knowledgeable and experienced doctor who has listened carefully to their story and competently examined their child, that everything is OK

2. They really think there is something seriously wrong with their child and they want prompt competent action.

Unfortunately what happens too many times is that the children in category 1. once the medical professionals hear that they are not vaccinated, are swept away, not based on a thorough history or competent clinical examination, but entirely based on one factor – lack of or only partial vaccination - and put on wards and given intravenous antibiotics for 48 hours when they do not have a bacterial infection ie for no good reason..

It takes 48 hours to get a first reliable culture result. That is why seriously ill children are put on antibiotics straight away – 48 hours is too long to wait to see if they have a bacterial infection. This is not the management of children with a mild viral illness whose parents need clinical competence, kindness and reassurance. Not abuse and unwarranted medical interventions that are traumatic for the child, traumatic for the parents, wipe out the 'good' bacteria in the child which can cause problems for months afterwards, increase antibiotic resistance in the child and in the community, take up a hospital bed which a really sick person needs, waste NHS resources and, most importantly are not good medical practice. All this for the perceived, by the medical profession, 'crime' of having not vaccinated or having only partially vaccinated their child.

Vaccination is not compulsory in this county for the very sensible reason that it is for the parents to weigh up the risks and the benefits and make the best decision for their own individual child in their own individual circumstances and beliefs. This is not a point that is well taught in medical school or in post graduate training.

Conversely those in category 2. are too many times told, not based on a thorough history or competent clinical examination,

> "*Its just a viral illness, go home and take paracetamol or ibuprofen.*"

One of the skills I teach people in my lectures is the knowledge of the NICE algorithms so when they present for medical care in situation 2., they are empowered to use the algorithm which will ensure the medical staff will act appropriately, and not dismiss them. As stated above, too many doctors now do not take a through history or undertake competent clinical examination – they merely send patients off for a battery of indiscriminate tests – blood, X-rays, scans – which if not done by correct history taking and examination are worthless.
It is like computers – rubbish in = rubbish out.
Their mindless following of protocols can blind them to what is standing in front of them.
Those who come to my lectures not only know what to look for in the NICE traffic light for management of fevers in under fives. They know how to communicate the relevant points to doctors who follow protocols like automatons and don't appear to see the person in front of them.

Are the people in category 1. to be denied the services of the NHS because they make certain informed decisions about their children's' health that are not in line with government and NHS guidelines? No They have the right to be seen by a respectful and competent doctor who treats them as the GMC requires as Good Medical Practice. They also pay for the NHS in their taxes.

> "*31 You must listen to patients, take account of their views, and respond honestly to their questions.*"
>
> GMC GOOD MEDICAL PRACTICE 2013 UPDATED 2014
>
> "*33 You must be considerate to those close to the patient and be sensitive and responsive in giving them information and support.*"
>
> GMC GOOD MEDICAL PRACTICE 2013 UPDATED 2014
>
> "*46 You must be polite and considerate.*"
>
> GMC GOOD MEDICAL PRACTICE 2013 UPDATED 2014
>
> "*47 You must treat patients as individuals and respect their dignity and privacy.*"
>
> GMC GOOD MEDICAL PRACTICE 2013 UPDATED 2014
>
> "*48 You must treat patients fairly and with respect whatever their life choices and beliefs*."
>
> GMC GOOD MEDICAL PRACTICE 2013 UPDATED 2014

> 49 *You must work in partnership with patients, sharing with them the information they will need to make decisions about their care.*"
>
> GMC GOOD MEDICAL PRACTICE 2013 UPDATED 2014
>
> "*51 You must support patients in caring for themselves to empower them to improve and maintain their health.*"
>
> GMC GOOD MEDICAL PRACTICE 2013 UPDATED 2014
>
> "*54 You must not express your personal beliefs (including political, religious and moral beliefs) to patients in ways that exploit their vulnerability or are likely to cause them distress.*"
>
> GMC GOOD MEDICAL PRACTICE 2013 UPDATED 2014
>
> "59 *You must not unfairly discriminate against patients or colleagues by allowing your personal views to affect your professional relationships or the treatment you provide or arrange*."
>
> GMC GOOD MEDICAL PRACTICE 2013 UPDATED 2014

The problem occurs most intensely in A&E, where, by definition, parents have taken their children because they feel they cannot wait to see or cannot get an appointment with their GP. A problem which has multiplied and magnified during and since Covid.

Unfortunately A&E departments are overwhelmingly staffed by junior doctors, with far less experience and understanding than the senior doctors who provide care in general practice. Each upcoming set of newly qualified doctors has a higher regard for what is called 'science' and less regard for the autonomy of patients because that is how they are taught to think.
To protect themselves from attacks by bodies such as the GMC they slavishly follow some guidelines while not following others at all – like the NICE guideline that says paracetamol and ibuprofen,

> "*do not prevent febrile convulsions and should not be used specifically for this purpose.*"

Parents with children in A&E departments and observation wards are regularly threatened with being referred to social services, or having their child removed from their care simply because they do not want to give consent to their children being administered these medications when they are not distressed.

This is serious professional misconduct but I do not hear of any doctors prosecuted by the GMC for it.

Not only are GPs senior doctors with more experience than most hospital staff who are only juniors, there is much less chance of a GP threatening to detain one's child in their surgery, quite the opposite. GP's are always trying to get people *out* of their surgery so they can see the next patient in the waiting room. Nor do they have detention facilities or staff to apply them.

While many doctors, despite the lamentable decrease in humanity of medical education, are kind caring, empathic, professional, knowledgable and willing to learn from their patients as a two way experience – these are not the doctors who terrify parents. And there are too many parents who are terrified.

Below in **APPENDIX 03** are some examples of patient experiences with Doctors regarding vaccination:

APPENDIX 03 - Examples of patient experiences with Doctors regarding vaccination

QUOTES FROM HEALTH PROFESSIONALS reported by parents

The GP said, *"No. There are no side effects of the HPV vaccine besides perhaps soreness at the site of the injection."* The A&E doctor later said, after carrying out tests for severe and complex symptoms, *"Doctors are not supposed to really say this, but I believe it was the vaccine."*

My mum took my daughter, her granddaughter, to the GP when she was unwell, but was totally bullied from the young doctor about her not being vaccinated. She was in utter shock about how he spoke to her, he even said *"what is wrong with this child's mother, is she stupid?"*

My GP phrased it as *'SOME doctors think that not vaccinating your child is close to child abuse... but of course I respect your choice'*.

I was told I was an irresponsible parent and my 6 week old daughter would die because I declined vaccines.

A doctor told me there is no mercury or any other harmful chemicals in any of the vaccines and that they are 99.9% effective against the disease.....

My GP couldn't answer concerns about the Prevenar so referred me to Public Health who passed on my concerns to Pfizer who sent copies of two papers; one Cochrane report that I'd cited to the GP that didn't prove safety and one in Spanish. Public Health enclosed a letter telling me if my baby ever went into A&E he would have to be vaccinated anyway. This ridiculous set of responses clinched things for me!

I had a health visitor 'shouting' at me at a baby clinic when I said I wasn't giving him the MMR.

My GP was very surprised with my decision to decline vaccines. I explained that I had concerns about the ingredients, and he explained they only contain a bit of protein…He had no idea what was in a vaccine!

The VDU said in an FOI 2019, *"It is worth noting that most of the disturbing conditions claimed to have resulted from vaccinations can also occur spontaneously in children and adults"*

Payouts for death after the MMR have been given in the UK (£30,000 for death from SSPE in 1999) but this is what the DH said 2001 *"Parents who received payments after their children died following MMR would not get money now as the science has moved on. MMR protects against death and we stand by the fact that no child has died as a result of the MMR*

^^

An Example of 'Informed Consent Procedure by a GP in London 2019

The mother went with a friend to interpret for her.

She was given the false information that choosing not to vaccinate your child is a reason to refer a family to social services:

> "*If you're not vaccinating I'll inform Social Services.*" [which he did]

She was subjected to racism:

> "*You [an Eastern European Nationality] people are brain washed because you all don't want to vaccinate.*"

She was subjected to abuse for the healthcare decisions she and her husband had made for their for their child:

> *" You are an irresponsible parent for not vaccinating."*

She was given false information about the rights of the father regarding his child's healthcare:

> *"The father doesn't have the right to decide if the child gets vaccinated or not as you gave birth to the child not him."*

She was given false information about the vaccination schedule, being told she was not 'allowed' to be selective:

> *"You have the obligation to give [*your child*] all the vaccines not only the Hep B."*

And he didn't want to give her the package insert of any vaccine as he said she [the mother] is:

> *"Not superior to any other mother that she should be begging to read it."*

END OF APPENDIX 03

Comments on Patient Experiences with Doctors regarding vaccinations

I refer to Good Medical Practice I cited previously – are these the ways a doctor is supposed to behave?
No.

Do these patients complain about it officially?
No

I brought the aforementioned case of the mother subjected to racism by her GP over her vaccination decisions to the attention of Dr Debbie Frost Associate Medical Director NHS England London Region at the NHSE meeting I was summoned to in November 2019. She and Ms Hannah Coyne the case worker were both shocked. They said the woman involved should take up the case with the GP and report it to NHSE.

Of course this will never happen. Does anyone seriously expect an immigrant woman who only speaks a little English, in the new country to which she has recently arrived, to make a complaint against an authority figure such as the GP, upon whom she relies to look in her child's ears, and throat and examine his chest when he is ill. Of course not. Terrible abuses of the unequal power relationship between the parent and GP occur all over the country every day. No one does anything about it and if anyone does complain the cases are dismissed, the NHS ombudsman not fulfilling his remit, and the GMC telling people they will not be taking the case further. However, a GP who attempts to fulfil their obligation in law to obtain informed consent – the GMC will go full speed ahead never letting the truth get in the way of political expediency

We can see that when it comes to vaccination issues and administration of paracetamol and ibuprofen, GMC Good Medical Practice goes out of the window.

Can we expect any succour from the NHS and the rights and pledges covering respect, consent and confidentiality?

It sounds good:

> "*Principles that guide the NHS*
> *Principle 1: The NHS provides a comprehensive service available to all*."
>
> "*Right: 'You have the right to be treated with dignity and respect, in accordance with your human rights.'*"
>
> "*Right: 'You have the right to be given information about the test and treatment options available to you, what they involve and their risks and benefits.'*"
>
> "*Right: 'You have the right to access NHS services. You will not be refused access on unreasonable grounds.'*"
>
> "*NHS services will always be available for the people who need them.*
> *No one can deny you the right to access these services because of your age, disability, race, gender or gender reassignment, sexual orientation, pregnancy and maternity, religion <u>or belief</u>* "

Or belief.
Try telling that to a bunch of masked heavies in a hospital that refuses to let you in or give you any treatment unless you have had a Covid vaccine.

Or the women who are refused IVF if they will not allow themselves to be injected with an MMR vaccine.
MMR vaccines available in the UK, Summary of product characteristics:

> *Fertility electronic medicines compendium*
> *M-M-RvaxPro has not been evaluated in fertility studies.*
> *https://www.medicines.org.uk/emc/product/6307/smp*

> *Fertility electronic medicines compendium*
> *PRIORIX has not been evaluated in fertility studies*
> *https://www.medicines.org.uk/emc/product/1159/smpc*

Yet doctors *force* woman who *already have* problems with fertility to take these vaccines before their fertility treatment. Do doctors tell them the women who are longing for a child of their own this information?
No.
Just the threat of no treatment.

> "*Pledge: 'The NHS pledges to work in partnership with you, your family, carers and representatives.'*"

It does not seem like that.

People are powerless in the unequal relationship between the doctor and the hospital who hold all the aces – the treatment, the medications, the security guards that they can call to detain you and your child, the social workers they can engage to obtain emergency care orders. In situations like that people do whatever is necessary to protect their child and themselves from harm. What they perceive to be harm. Desperate times call for desperate measures.

When a large medical, political, judicial, commercial juggernaut threatens to run over themselves or their family and the medical profession who is supposed to regard their patients with one hundred percent positive regard, to be their advocate, to speak up for the small man, abdicates their sacred duty in order to hit government imposed targets. When they mindlessly follow protocols and guidelines which are written as a one size fits all, worse, in the case of vaccines, one *dose* fits all. The tiny premature babe gets the same dose same as 90 kg man, except not, the 90 kg man gets fewer vaccines in combination and the diphtheria toxin component of the vaccines for those over the age of 7 years is 15 times *lower* (2iu for those over 7 years of age vs 30iu for babies)

That is never how medicine should be practised, ever.

I was amazed when people first told me what they did

> "*Vaccines?*" - "*Up to date*." True: Up-to-date on their own personal schedule
> The forms they filled in
> The red books they presented.

Parents will do anything to protect their children from what the perceive as harm.

It is hypocritical. People have so many remembrance days for those murdered in the Holocaust, Holocaust Remembrance Day, Yom HaShoah… where they make pious denouncements, sing sad songs and light candles, say it will never happen again. It would happen at a drop of a hat – people demonising people based on fear and turning in their neighbours, being cynically manipulated by a Government to do so. It just did, with Covid. And this cynical manipulation has been admitted.
And whom do we praise? Who are honoured as the 'Righteous Gentiles' in Yad Vashem?
The people who issued false ID cards, False Passports, False travel documents, False visas.
Not the ones who stuck to 'the rules' and allowed preventable harm.

Yet when people try to protect their children from interventions that they sincerely believe are just as inimical to their children's health, their cultural, medical or religious beliefs, and protect them in the only way they can in the unequal power struggle, in the same ways that people have done since time immemorial, those very same people are demonised by the Government ministers - like Hancock who lied to the public, the NHSE, the legacy media, and doctors.

The Government, the NHS, doctors and the courts say they want to keep children alive and parents are interfering with this process by refusing vaccination. But if those same parents want to keep vigil with their severely ill child whom the doctors in the UK say has no hope, then those parents are ignored, life support is turned off, even then sometimes those children, impossibly, live after all support is removed. In that case they are injected with drugs to '*make them feel more comfortable*'. Well, I do not suppose you feel anything if you are dead so maybe that is partially true. Even when doctors in other counties offer to treat the children, and fly them with a full medical team to their own hospitals,

> "*No*",

say English doctors and English judges.

> "*It does not respect the autonomy of the child. And no-one would want them to die on the journey.*"

What? They want to stop their life support and kill them, but it would be terrible if they died on a journey to the faintest chance of new hope.
I am not a supporter of heroic measures.
I am pointing out the hypocrisy.

The autonomy of the child is cited for these decisions, (what autonomy when they cannot even move). The Vice President of the Court of Protection, protection in the Orwellian sense, states that

> "*children are not the chattels of their parents. "*

Goodness knows what sort of childhood he had.

Whether it is refusing further medical care for severely ill children against the wishes of the parents or trying to force children to be vaccinated against the wishes of the parents, the common factor is.

> '*against the wishes of the parents.*'

This is breaking up the family unit, imposing the views of the State and self-styled ‘experts’ breaches the sacred bond of care between parent and child and is not ethical or moral.

> “*52 You must explain to patients if you have a conscientious objection to a particular procedure. You must tell them about their right to see another doctor and make sure they have enough information to exercise that right. In providing this information you must not imply or express disapproval of the patient’s lifestyle, choices or beliefs. If it is not practical for a patient to arrange to see another doctor, you must make sure that arrangements are made for another suitably qualified colleague to take over your role.*”
>
> GMC GOOD MEDICAL PRACTICE 2013 UPDATED 2014

If you do not support abortion you are allowed to be a conscious objector, on condition that you do do not impart any of your views to the patient regarding their lifestyle, choices or beliefs.

I think paragraph 52 should be expanded to include another issue:

> ‘*uncritical obeisance to a particular procedure.’*

So that patients and their carers can be aware of your biases and also be afforded the right to see another doctor who is more respectful of their personal and parental autonomy, in particular not implying or expressing disapproval of your lifestyle, choices or beliefs.

This would be professionally far more appropriate that shouting at, belittling and insulting parents who have beliefs different to the doctor, and may be much healthier and have a better lifestyle than the doctor. Doctors do not know a lot about health; I certainly didn’t, originally, after medical school. As medical students we dissect dead bodies and study disease, not a great way to learning about health nor passing it on. Worse, we are arrogant in our ignorance – not a good combination for the patient.

Doctors do not know that more than 99% of the people who used to die from measles and 98.5% of those who used die from Whooping cough in England and Wales stopped dying before vaccines against whooping cough or measles were generally available and before even antibiotics were in general use – but only if you start your graph in the 1850s.
If you start in the 1940s, as most of those in the ‘Green Book’ (NHS Immunisation against infectious Diseases Handbook), when the massive decline has already occurred due to to better social conditions it is easy for doctors to be misinformed and to pass on this misinformation to their patients, as well as filling them with unwarranted zeal for the process.

> “*the annual death rate of children (under age 15) from whooping cough declined by roughly 98.5 percent in the period covering 1868 to 1953, after which the pertussis vaccine became generally available*.”

> “*in England and Wales the annual death rate of children (under age 15) from measles declined from over 1,000 per million population in the mid-nineteenth century, to a level of virtually 0, by the mid 1960s.*”

Source: Professor Thomas McKeown
Emeritas Professor of Social Medicine Birmingham University
Past Chair World Health Organization Advisory Group Health Research Strategies
from: The Role of Medicine 1979, Princeton University Press p03

This also, of course, means that the factors responsible for the trend to rapidly declining morbidity and mortality from disease: economic and living condition improvement, predate and therefore confound the claims that declining mortality and morbidity are a consequence of vaccinations when they clearly cannot be.

Parents and other people are not given proper information because their doctors do not know the information themselves. If they do not know it themselves they cannot give it to the parents to obtain informed consent. They cannot give parents more than

> ‘*one side of the story.*’

The NHS is guilty of leaving doctors and patients in the dark.

Worse, the risks of common childhood diseases are vastly overstated to frighten parents into giving vaccines to children when the vast majority do not need them and for mild diseases which can provide long lasting health benefits - such as mumps for boys and rubella in girls.

Parents who are particular about their own and their children’s health know when the information they are hearing is one sided as they are often far better informed than their doctor, GP or hospital doctor. A well educated and motivated patient can recognise those same qualities in another.

To an extent, GPs have an excuse because they are generalists, though as the purveyors of the Universal childhood immunisation scheme it behoves them to do the work needed to comply with their legal requirements for moral reasons as well and legal.

For a doctor such as Dr Riordan, the GMC expert, there is no excuse at all; no excuse for his lack of knowledge; no excuse for allowing himself to be used by the GMC to achieve certain aims. That is not how an expert is required to function.

The actuality is that he at the most read only the abstracts of papers and studies he evidenced in his report – if that. That is bad when acting as an expert in proceedings aimed at trying to deprive a fellow doctor of their livelihood. But when he has a rôle opining on the health of all of us and what vaccines we must take it is insupportable.
But there will be no censure of him by the GMC as he whistles the correct tune.

Parents misleading health professionals – it is no wonder.
When the health professionals act like professionals the parents will not have to.

E. MPTS abuse of legal process

When I first represented myself at a pre-hearing meeting in July 2022 with the GMC solicitor and the MPTS case manager Crystal Collins-Hewson, as I said above, it was the first opportunity I had to bring up the issue of the dishonesty charge of which I have spoken at length above.

Ms Collins-Hewson agreed, regarding the specific questions enumerated above, on the substance of the dishonesty charge, to the direction I requested in paragraph 46. She directed Ms Emily Silver of the GMC to provide an answer to the points raised. Ms Silver in turn gave a solicitor's undertaking that she would do so.

The information sought is important. In order to be able to answer the dishonesty charges I needed to know what was alleged to be inaccurate and what was supposed to be dishonest. The GMC had refused to specify at all. The legal teams provided by the Medical Protection Society would not advise on this either. Now was my chance after almost three years to get the information I needed to prepare a defence.

Ms Collins-Hewson confirmed several times that she wanted to have this information early in August [2022], most especially as I was now representing myself and she acknowledged I needed the information to write my statement.

It was almost three years since the GMC charged me with misconduct and put conditions on my practice. And even though I let my licence to practice lapse in March 2022 and had twice requested voluntary erasure the GMC refused to let me go. If they let me go they couldn't drag me to a hearing and endeavour to make me the 'disgraced' Dr Donegan.

You may not be able to imagine my chagrin when Ms Collins-Hewson's directions for the meeting were issued and *there was no direction to give the information about the particulars of the GMC dishonesty charge against me.*

So to this very day I still have not been provided with the particulars I need to prepare my statement for this case and which I was told unequivocally I would receive by Ms Silver of the GMC and Ms Crystal Collins-Hewson of the MPTS. I have absolutely no idea what the GMC is going to allege next.
What will the GMC claim as their next reason for saying there was inaccuracy?
What will the GMC claim as their next reason to claim there was dishonesty?
And when?
Will it be an ambush during a hearing with no defence prepared to meet some new allegation or other?

I contacted the MPTS Case Management Officer, Mr Alex Treece, to ask for a copy of the transcript or recording of the meeting. I was told,

> "*We don't make recordings of pre-hearing meetings*."

In the 21st century, the age of the internet, and for a virtual meeting – no recording?

But Ms Collins-Hewson had stated several times during that pre-hearing meeting that the GMC must provide the answers to the specific questions in para 46 [above] and the GMC solicitor said she would have that done. But if the MPTS has no official recording and it is not in the directions,

this basically means that the MPTS can say anything it likes in meetings or hearings because if there is no recording, and it is not in the directions, it is as if it was never said, even though it was.

What chance does a doctor have of getting a fair hearing if the MPTS just changes what was decided in the hearing after the fact and there is no record of this?

The MPTS officer agreed at a hearing to make an order but then does not include it in the written directions issued after the hearing. Thus, we see that the MPTS does not order anything that is inimical to the GMC's case, even though it is essential information for me to put my case.

It is untrue when the MPTS claims to be independent of the GMC. It is not independent. That claim is false.
It is in the same building as the GMC.
It is answerable to the GMC.
The GMC pays for everything.
It is controlled by the GMC.

In short, it *is* the GMC. The much claimed independence that greeted its introduction was sadly misplaced. It is legislative smoke and mirrors.

It is worse than the previous arrangement to which I was subjected in 2007. At least then there was a modicum of impartiality among the members of the panel and they had a legal assessor to keep them on the straight and narrow.

It took a while for the realisation to dawn on me that the MPTS cannot be trusted to carry out an independent, objective and unbiased hearing and it was at this that made me realise that there was absolutely no point in coming to a hearing.

It would be a waste of time, money and life.

I have also come to realise that the GMC does not care if you win or lose, though, of course, it prefers if you lose. What it is about is the process. Like the 43 cases against Dr Sarah Myhill in about 22 years, to make it difficult for her to earn a living and keep her in a constant state of stress and pressure. The process of draining your life force, taking up all your time with endless stress and administration, taking away time with family, singing, walking, gardening, destroying your relationships, and, of course your reputation.

This harms the interests of patients.

The GMC, by contrast, appears to be the henchman of a political medical industrial complex for which good competent trail-blazing doctors like Sarah Myhill and doctors giving sound information like myself are an inconvenience to their efforts at increasing profits from the promotion and sale of their latest patented pharmaceuticals - drugs and vaccines.

Despite the panel deliberation in 2007 saying I hadn't failed to be independent objective and unbiased, that it was clear that my aim was to educate parents, to give a balancing view, none of that was ever added to the ruling of the 2002 Family Court case and the 2003 Appeal, so the case is still quoted as reason for children to have forced vaccination.

I cannot give evidence as an expert in the court to give a balancing view to the doctors who slavishly quote NHS and Government policy. Remember – if you want to work in the NHS, you have to follow NHS policy. There is no justice for parents who might want to produce my opinion or reports. They are dismissed and so are left with no-one and the vaccine cavalcade rolls on crushing all in its path.

Anyone who had any doubt about this in the past only has to look at what has happened with Covid and continues to happen. Ideally, for the GMC, the doctor concerned will have a heart attack, a stroke, die or commit suicide. Then the GMC will have its pound of flesh. This is made all the more duplicitous by the note at the end of each email –

> "*GMC investigation support - Doctor support service .Confidential, emotional support for doctors going through fitness to practise procedures with the GMC, or at risk of having their licence withdrawn.*"

Once you are dead, heaven forbid, or disabled you won't be able to cause any more problems, give any more lectures, see any more people to discuss vaccination information. And if you don't become emotionally or physically crippled, as I said, you can always be put down as the 'Junk Science' doctor, or such like.

And thus, the outcome of any hearing for the GMC is less important than the process of harassment and of wearing down medical professionals with investigations, *pour pas encourager les autres* - with the aim that all doctors will obey government and NHS policies regardless of the adverse outcomes for the patient or will cease to practice medicine – all of course to the detriment of the patient.

As a Mexican friend said to me,

> "*To be called disgraced by people like that is an honor!*"

Amen to that.

F. A politically motivated show trial

This case is political.
The case was brought after I and homeopaths were targeted by Government working with two national newspapers and their journalists in November 2019, just before Covid19 started. My lectures were stalked by journalist and witness in this case Harry [redacted] over many months during 2019 acting as an *agent provocateur*. He no longer works for the Times. A Telegraph journalist [redacted] also a witness in this case, also acted as an *agent provocateur* pretending to be a mother seeking advice.

Neither of them were 'service users' or within the remit of the GMC.

[redacted] consulted me as a homeopath and [redacted] was a lecture attender. There was no 'doctor patient' relationship with either.

The Secretary of State for Health and the CEO of NHS England working with the newspapers concerned called in the media for me to be publicly reprimanded, my case having been reported by the newspapers concerned to the GMC.

Times
Health Secretary Matt Hancock:

> "The GMC said it would follow up The Times's findings "as a matter of urgency".
> "Matt Hancock, the health secretary, asked the chief medical officer to request an immediate investigation into Dr Donegan, adding:
> "*Behaviour like this has no place in the NHS. Vaccines save lives*"
> "*the science is beyond doubt.*"
> "*Anyone who claims otherwise is wilfully risking lives.*"

Telegraph
Health Secretary Matt Hancock said:

> "*Spreading disinformation in this way is completely outrageous.*"
> "*The science is beyond doubt:*"
> "*vaccines are safe. They are effective and they save lives*"
> "*and there is no alternative.*"
> "*Vaccines are a miracle of modern medicine* "and
> "*I condemn anyone who suggests otherwise*."

A Government Minister orders GMC to call in a knowledgeable doctor who does not toe the political line
Medically ignorant Matt Hancock who has not done one jot of research into vaccines, health or health ecology thinks he knows more than a senior doctor, myself, who in addition to being highly experienced with post graduate qualifications in child health, obstetrics and gynaecology family planning, psychiatry, homeopathy and naturopathy has also spent thousands of hours visiting public record offices (ONS) to gather data, going to medical libraries to find, photocopy and read studies in the days before the internet. Has been continually updating her knowledge, reading comparing, contrasting, ordering the references from the studies she is reading, thinking very hard about the information she is gathering, analysing, assessing and making connections with other studies, conferring with other doctors and scientist around the world by letter originally then by fax and now now by email, ordering stacks of studies from the BMA and the British Library to be posted or

faxed to her. A doctor who deliberately reads studies and books and publications with which she thinks she may not agree because you never learn anything if you stick within you comfort zone and only read people works with whose opinion you agree.

And most especially checking references. Quoting references can be like Chinese whispers unless you see the source of the quote. I have corresponded with Professor Stanley Plotkin often called the grandfather of vaccination who has kindly sent me copies of his studies, with Professor Heikki Peltola in Helsinki who sent me by courier a printed version of the ground breaking landmark 1886 study on measles transmission in the Faroe Islands by Peter Luwig Panum, Dr Tom Jefferson of the Vaccine branch of the Cochrane Database

But the Minister for Health spouts a mantra sound bite he has been taught by the NHS which was developed by the WHO Vaccine Hesitance group in 2017, when, just a couple of months later he ordered the emptying of old people out of hospitals into care homes where GPs and Ambulance drivers are told not to respond to 999 calls, the residents are all written up:

"*Do Not Resuscitate,*"

put on midazolam and opiate pumps while fluids are withheld from them. No fluids and you are dead in three days, opiates and midazolam means you don't make any noise about it – it was happening in the NHS long before Covid. I was responsible for getting the NHS e-learning for health module on '*end of life care'* changed to more evidence based opinion regarding fluids only to have this ruined by the British Medical Association's supporting the conflation of feeding/ nutrition with hydration in '*end of life care*'.

'E*nd of life care,'* basically a conveyor belt to death that you cannot get off.

Euthanasia, '*eu*' means 'good' in Greek and thanatos means death, hence a '*good'* death, choosing the time date, manner and place of your death is illegal in the UK, but kakothanasia, as I call it – '*kakos'* means bad in Greek – occurs every day in every NHS hospital in the country, and long before Covid - most recently to my elderly aunt RIP in December 2022. The GMC does not investigate or penalise doctors for these horrendous and inhuman practices because it is following an official narrative

During Covid people were ventilated in their thousands when it was not the appropriate treatment. The whole NHS was shut down to deal with a winter viral associated illness which was not going to be any worse than a bad 'flu year, confirmed by the chief scientific officer, Sir Patrick Vallance in February 2020 before the then Prime Minster, Mr B Johnson, lost his nerve after being attacked by the Pharmaceutical company bought media baying for his blood when he said,

"*Some people were going to die*."

We are all going to die. I presume he meant prematurely. In a normal year the average number of deaths in the UK per day from all causes is an average of 1600 – more in the winter, fewer in the summer.
This for a disease in which consistently, throughout the pandemic, those who died did so at an older age that the average age of death in this country.
But not very brave Boris could not maintain his bluster.

The legal team given to me by the Medical Protection Society were, I think, part of the politically motivated attack. They subverted my ability to defend myself for two and a half years and dumped me because I complained. This state of affairs became undeniable at the end of 2021 leading to Mr Eastwood of Hempsons solicitors being replaced in January 2022. Dr Jonathan Bernstein of the Medical Protection Society was similarly replaced shortly after.
In a political case like this one, such a state of affairs cannot be attributed to mere alleged failings on the part of those representing me and dismissed as not being any part of the responsibility of the GMC or MPTS or Government players in general.

The febrile atmosphere exacerbated by Covid regarding those who have a sound view contrary to Government health policy is not an artefact of those taking such sound contrary views but of Government control in the broadest sense. This includes the GMC and MPTS and is affected by associations and other links between State players and individuals involved in societies like the Medical Protection Society and the media.

I was also stymied, by only finding out in the summer of 2022, that the GMC ‘Rule 7 response’ was supposed to be my defence. The Rule 7 response is not my defence, never has been my defence and never will be my defence. The understanding I had, until discovering the truth, was that the Rule 7 response was meant to be for seeking voluntary erasure so that my now long overdue retirement from medical practice could take place. Had I known the purpose of the response, particularly in the context of these proceedings, I would have objected but at the time I had no reason to. Once I knew and was free to do so, I objected. But this has not improved my situation as there is no mechanism to submit a correct one.

The ability or intention by the Medical Protection Society’s solicitors to give me accurate information was on a par with the apparent effort made by GPs to ensure informed consent for vaccination - small.

Despite changes to the legal team forced on me by the Medical Protection Society, issues continued as the rot was unchanged. Whether there had been cooperation in general between the MPS and the GMC or others over the past two and a half years I do not know albeit there were indications that has been the case.

My MPS funding was withdrawn after continuing irregularities were made plain by me. Breaches by an indemnity funder are not a valid basis for withdrawal of funding.

Also of concern regarding the GMC are an inexplicably offhand attitude of the GMC and its expert and a snail's pace piecemeal approach to disclosure obligations, particularly in a case involving allegations of dishonesty.

I have been on my own in a remarkably complex case legally and scientifically.
Even without the blatant lack of transparency by the MPTS staff, it is most unlikely there can be a fair hearing in such circumstances.

G. GMC not fit for purpose

The GMC brings the medical profession into disrepute as it punishes good practice and rewards bad practice.

Doctors who fail to follow GMC guidelines and English Law on consent and GMC guidance on good medical practice are the ones who bring the profession into disrepute. Not doctors like me or Dr Sam White, Mr Mohammed Adil or Dr Sarah Myhill. The disastrous and disproportionate handling of the Covid situation has magnified this many times in the eyes of the public and public trust in the medical profession is at an all time low – because of the behaviour of doctors of whom the Government, NHS and GMC approve.

You can fool some of the people some of the time but you can't fool all of the people all of the time.

The GMC mission statement used to be

> '*Protecting patients. Guiding doctors,*'

I see it has sensibly removed this from its website or it would have to charge itself with dishonesty, except that there is no regulatory body for the GMC and it is able to run amok.

The UK, the economy, children's learning, mental health, suicide and all other indicators of well-being would have been far better had I and doctors like me been in charge of the pandemic response but saving small family businesses, or families, community life or health in the UK is not a high priority for the boys, and girls, on the gravy train, like selling the UK government masks that didn't go over your ears (£2 million) and the other millions spent by Matt Hancock which he has not made public in contravention of the transparency rules for Government contracts. As well as the destruction of civil liberties which are fundamental to a healthy society and the proper practice of medicine. The GMC has been for many years at the forefront of gagging doctors, helped by their cronies, the bought legacy media.

Dame Janet Smith, a barrister and former High Court judge, has been scathing of the GMC's conduct in the past. She headed the inquiry into Harold Shipman, the GP who became Britain's most prolific serial killer, murdering around 250 patients.
In 2004, she published six reports detailing missed opportunities to stop Shipman. In her fifth report, she blamed the GMC for 'doing too little to protect patients'. She concluded:

> '*Expediency replaced principle*.'

It still does.

She is not the only high-profile establishment figure to speak out against the GMC. In 2006 their former president Sir Donald Irvine called for the Council to be disbanded and re-formed.

Former Chief Medical Officer Sir Liam Donaldson said complaints were dealt with in a haphazard manner, and that the GMC caused distress to doctors over trivial complaints while tolerating poor practice in other cases. He accused the GMC of being

> '*secretive, tolerant of sub-standard practice and dominated by the professional interest, rather than that of the patient'*.

I believe the facts and matters set out in this letter are true.

Yours Sincerely,

Dr Jayne LM Donegan

cc Chair GMC