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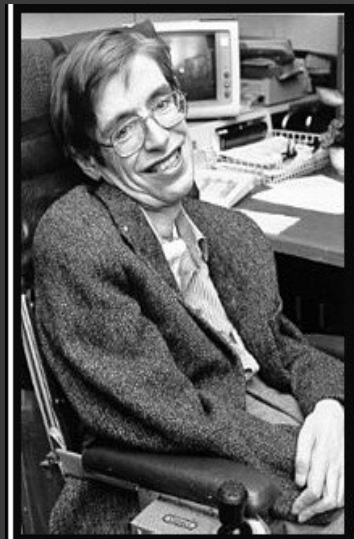
Action on Sugar – Founding Member (Science Director 2013-2016)

CARDIAC COMPLICATIONS OF THE COVID MRNA VACCINES (AND SOLUTIONS)



The greatest enemy of knowledge is not ignorance,
it is the illusion of knowledge.

(Stephen Hawking)

Sunday 5 March 2023 *** telegraph.co.uk No 3,219 £3.00

THE LOCKDOWN FILES

The Sunday Telegraph
SUNDAY NEWSPAPER OF THE YEAR

Hancock's plan to 'frighten the pants off' the public

Leaked WhatsApp messages show how ex-health secretary wanted to 'deploy' new virus variant to ensure compliance

MATT HANCOCK wanted to "deploy" a new Covid variant to "frighten the pants off" the public and ensure that they complied with lockdown, leaked messages seen by *The Sunday Telegraph* can disclose.

The Lockdown Files – more than 100,000 WhatsApp messages sent between ministers, officials and others – show how the Government used scare tactics to force compliance and push through lockdowns.

In another message, Simon Case, the Cabinet Secretary, said that "the fear/guilt factor" was "vital" in "ramping up the messaging" during the third national lockdown in January 2021.

The previous month – December 2020 – Matt Hancock, the then health secretary, appeared to suggest in one message that a new strain of Covid that had recently emerged would be helpful in preparing the ground for the looming lockdown, by scaring people into compliance.

In a WhatsApp conversation on Dec 13 obtained by *The Telegraph*, Damon Poole, one of Mr Hancock's media advisers, informed his boss that Tory MPs were "furious already about the prospect" of stricter Covid measures and suggested "we can roll pitch with the new strain". The comment suggested that they believed the strain could be helpful in preparing for a future lockdown and tougher restrictions in the run up to Christmas 2020.

Mr Hancock then replied: "We frighten the pants off everyone with the new strain."

Mr Poole agreed. "Yep that's what will get proper bahviour [sic] change."

The discussion came two days after Mr Hancock was informed of the emergence of a variant – known as Alpha or the Kent variant, in December 2020.

A surge in cases later led to the effective cancellation of Christmas on Dec 19.

Mr Hancock expressed his worry that talks over Brexit would dominate headlines and reduce the impact and probed Mr Poole for his media advice. "When do we deploy the new variant?" he asked. During the pandemic, the Government was accused of scaremongering but it was denied, with Mr Hancock's department saying that such accusations were "misleading".

Among the latest Lockdown Files' disclosures, *The Telegraph* can reveal messages that suggest Boris Johnson veered between lockdown sceptic and zealot, with the then prime minister wondering out loud two days after the introduction of the second national lockdown in November 2020: "What's the data like today? Tory narrative that we panicked too soon etc."

The messages also show the behind-the-scenes animosity shown towards Lord Stevens of Birmingham, the chief executive of NHS England.

Mr Hancock declared in one message to an adviser: "He needs to know he is massively f------ up" and in another "removing SS [Simon Stevens] will be a massive improvement." He had also tried to "persuade" Lord Stevens to quit in January 2020, a few days after the first cases of Covid-19 had been detected in the UK, The Lockdown Files show.

In further developments, the messages reveal that Rishi Sunak, when chancellor, described Dominic Cummings's reign as Mr Johnson's chief adviser as "a nightmare".

The Lockdown Files also disclose:

◆ How Mr Hancock accused Michael Gove of making a "play" for his job after promising to reduce NHS waiting times.

◆ Ministers tried to have Sir Jeremy Farrar, now the World Health Organisation's chief scientist, sacked from its main Covid advisory group for voicing criticism of the Government. Mr Hancock branded Sir Jeremy a "complete loudmouth".

◆ Mr Hancock took his mistress to private dinners with his US counterpart – and then later had a ministerial response altered to remove the suggestion he had invited her.

A government television advertisement in January 2021, imploring the public 'to stay at home and protect the NHS'. Psychologists have called the 'fear tactics' in health campaigns 'grossly unethical'

The Lockdown Files have cast a light on the Government's decision-making during the pandemic. Last night Mr Sunak came under pressure over his flagship Eat Out to Help Out scheme after disclosures in yesterday's *Daily Telegraph* that it fuelled the spread of the virus but that Mr Hancock had "kept it out of the news".

The health secretary and his advisers had been discussing how Sadiq Khan, the London Labour mayor, had been critical of an impending local lockdown before discussing the new variant.

The WhatsApp chats show that at the time they were worried Mr Khan was "lining up to being Burnham", a reference to Andy Burnham, the Manchester mayor, who had been a thorn in the Government's side in the autumn over a local lockdown for the North West.

Mr Poole then pointed out that "Tory MPs" were "also furious already about the prospect" of another lockdown, putting Mr Johnson's administration under considerable pressure.

By December, the country had come out of the second national lockdown – a one-month circuit breaker – and entered a tiered system of restrictions that meant different areas of the country were subject to varying measures.

Psychologists have already warned that some government messaging, including using alleged "fear tactics" in poster and health campaigns, was "grossly unethical" and inflated fear levels had contributed to excess non-Covid deaths and increased anxiety disorders.

The exchange was not the only time the health secretary and other senior officials discussed tactics to frighten the public into compliance.

Six months earlier in June 2020 – when the UK was coming out of its first Covid lockdown – Mr Hancock and Sir Patrick Vallance, the Government's chief scientific adviser, appeared pleased that a study on the spread of the virus that shows it going in a "positive direction" had not received publicity while "the gloomy Cambridge survey" had been picked up by the media. "If we want people to behave themselves maybe that's no bad thing," said Mr Hancock in a WhatsApp message.

Sir Patrick appeared to agree, responding: "Suck up their miserable interpretation and over deliver."

One survey – the REACT study from Imperial College London – showed the R number – the reproduction rate for the virus – had declined to 0.57 while the Cambridge University study, in conjunction with Public Health England, showed a high transmission rate in some parts of the country, prompting fears of local lockdowns.

Four months later, in October 2020, Mr Poole said in a group chat involving health advisers and officials that a decision to stop publishing a so-called watchlist of the areas with the highest prevalence of the virus would – he suggested – be helpful to Government because it would make every area of the country concerned about the spread of Covid in a second wave. "It helps the narrative that things are really bad if we don't publish," messaged Mr Poole.

THE LOCKDOWN FILES REPORTING TEAM
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Reports: Pages 2-8
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Government didn't consider how scare tactics would affect most vulnerable

Commentary

By **Isabel Oakeshott**

While Matt Hancock breezily discussed how to "frighten the pants off everyone" with a new strain, a boy called Mark was listening in deepening despair to the drumbeat towards another national lockdown grow louder.

It was December 2020, and the 15-year-old's life had been turned upside down by the pandemic. A few months earlier, his mother Anna Marie had decided they should move house because during the first lockdown they couldn't even go to the local park. She describes how over-zealous council officials had shut the playground, leaving her struggling to cope with Mark's little brother, a hyperactive five-year-old. On her impoverished estate in Bootle, Merseyside, they were no longer even emptying the bins.

Now the family was in a better place in the North East, but Anna Marie had been unable to get Mark into a new school. With "home schooling" now an easy default, education authorities shrugged that he could just study for his GCSEs online.

Unable to play football, during the first lockdown he started putting on weight. When other children returned to school that autumn, he became increasingly isolated – and frightened.

As Hancock and his acolytes plotted to use a new strain of coronavirus to terrify the population, that fear descended into paranoia. Mark became so scared of the virus that he would not even open his bedroom window.

"His nails were bitten to the bone.

> 'Mark knew we were going into another lockdown. The fear was the thing that affected him most'

He was literally frightened of the air. He wore a mask everywhere," his mother says.

In London, Hancock's spin doctors were feverishly WhatsApping each other about how best to "roll the pitch" for more Covid restrictions. In the North East, Anna Marie was trying to stop Mark listening to more frightening news bulletins. "We tried to keep the TV off but we were being bombarded," she says of the prophecies of doom relentlessly pumped out by an acquiescing media. "Mark knew we were going into another lockdown. The fear was the thing that affected him most. He was disconnected, distant. I didn't know what to do."

Anna Marie, a single mother used to a hard life, did what so many others in desperate circumstances did at that time – she kept going.

Sadly Mark could not. Almost exactly a year later, when most of the population had been vaccinated against Covid but the omicron variant prompted yet another fear campaign, he told his mother he was popping out to the shops – and never returned.

His body was found by dog walkers three days later, hanging from a tree. Though he had never talked of taking his own life, his family had been prepared for the worst, after discovering he'd searched the internet for how to tie a noose.

Those responsible for "Project Fear" had no idea about the lives of people

Continued on Page 5

INSIDE

ISSN-0307-2698

Tories accuse Case of Left-wing bias over Covid rules

BRITAIN'S top civil servant has been accused of Left-wing bias by senior Tories after he dismissed concerns about Covid rules as "pure Conservative ideology".

Simon Case is facing questions over his political impartiality and conduct during the pandemic, following the emergence of leaked WhatsApp messages obtained by *The Telegraph*.

Rishi Sunak was last night forced to declare that Mr Case, who is Cabinet Secretary and head of the Civil Service, retained his "confidence".

Mr Case's comment that Sir Alok Sharma, the then business secretary, opposed compelling hospitality venues to keep customers' details because of "pure Conservative ideology", have led to claims that he overstepped the mark of Civil Service impartiality.

At the time, Mr Case was the No 10 permanent secretary in charge of the Civil Service response to Covid.

At various points during the pandemic, he appears to side with Matt Hancock against other Cabinet ministers, including the then chancellor, Rishi Sunak, who on one occasion he describes as "going bonkers" over a policy that hospitality venues should keep customers' details for contact tracing purposes. Mr Case added that Sir Alok would be "mad" to oppose it.

Elsewhere, the leaked messages show that he joked about passengers being "locked up" in "shoe box" rooms in quarantine hotels.

The criticism of Mr Case comes at a time when the Civil Service is facing increased scrutiny over its impartiality, after the decision of top mandarin Sue Gray to quit Whitehall and accept a job as Sir Keir Starmer's chief of staff.

Esther McVey, the former Cabinet minister, led the criticism of Mr Case's conduct, saying: "This is the highest civil servant in the land letting the cat out of the bag by suggesting that one of the most centrist of Conservative MPs was pursuing 'pure Conservative ideology' simply for questioning some of the lockdown rules.

"Leaving aside the fact that this is a Conservative government and so what would he expect from its ministers, if Mr Case thinks Alok Sharma was pursuing such a hardline Conservative ideology it can only mean that he is yet

Continued on Page 3

MATT

'Is it just for messaging friends and family, or will you be using it to impose an unnecessary lockdown on the whole country?'

MARGARET HEFFERNAN

Wilful Blindness

'A polemic against the dangers of docility and "groupthink" in every walk of life'
Financial Times

'Entertaining and compellingly argued'
Sunday Times

The Evidence-Based Medicine triad

(see D.L. Sackett et al, BMJ 1996; 312: 71-72)

Efficient Health Care Requires Informed Doctors and Patients

Seven Sins that contribute to Lack of knowledge

- Biased funding of research (research funded because it is likely to be profitable, not because it is likely to be beneficial for patients)
- Biased reporting in medical journals
- Biased patient pamphlets
- Biased reporting in the media
- Commercial Conflicts of interest
- Defensive medicine
- Medical curricula that fail to teach doctors how to comprehend and communicate health statistics.

Ref: G. Gigerenzer, J.A Muir Gray. Better Doctors, Better Patients, Better Decisions, Envisioning Healthcare 2020,

DOI: 10.1111/eci.12834

PERSPECTIVE

How to survive the medical misinformation mess

John P. A. Ioannidis*,†,‡, Michael E. Stuart§,¶, Shannon Brownlee**,†† and Sheri A. Strite¶

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- 1. Much published research is not reliable, offers no benefit to patients, or is not useful to decision makers
- 2. Most healthcare professionals ARE NOT AWARE of this problem
- 3.They also lack the necessary skills to evaluate the reliability and usefulness of medical science
- 4. Patients and families frequently lack relevant, accurate medical evidence and skilled guidance at the time of medical decision making

Peter Wilmshurst – Centre of Evidence Based Medicine, Oxford 2014

- Pharmaceutical companies and medical device companies have a fiduciary obligation as businesses to make a profit and declare a shareholder dividend by selling their product.
- They are not required to sell consumers (patients and doctors) the best treatment, though many of us would like that to be the case.
- REAL SCANDALS: 1. Regulators fail to prevent misconduct by industry and 2.Doctors, institutions and journals that have responsibilities to patients and scientific integrity collude with industry for financial gain

"Honest doctors can no longer practice honest medicine. We have a complete healthcare system failure and an epidemic of misinformed doctors and misinformed and harmed patients."

~Dr Aseem Malhotra

April 12, 2018 European Parliament, Brussels

tinyurl.com/FullVideoKillingForProfit

bmj.com

PERSONAL VIEW

Big pharma often commits corporate crime, and this must be stopped

Tougher sanctions are needed, says **Peter C Gøtzsche**

When a drug company commits a serious crime, the standard response from the industry is that there are bad apples in any enterprise. Sure, but the interesting question is whether drug companies routinely break the law.

drugs, also in 2009, the company entered into a corporate integrity agreement with the US Department of Health and Human Services to detect and avoid such problems in future. Pfizer had previously entered into three such agreements in the past decade.[2]

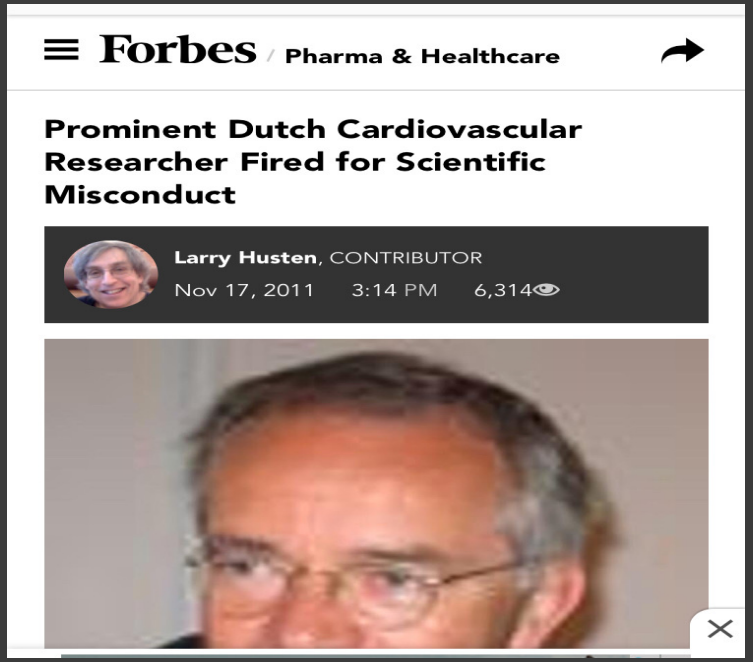
Of the top 10 drug companies, in July 2012 only

page for each company. The most common recent crimes were illegal marketing by recommending drugs for non-approved (off-label) uses, misrepresentation of research results, hiding data on harms, and Medicaid and Medicare fraud.[1] All cases were

It is time to introduce tougher sanctions, as the number of crimes, not the detection rate, seems to be increasing.[8] Fines need to be so large that companies risk going bankrupt. Top executives should be held personally accountable so that they would need to think of the risk of imprisonment when they consider performing or acquiescing in crimes.

The Illusion of “innovation”

- Of 667 new drugs approved by the FDA between 2000 and 2008 only 11% truly innovative. 75% essentially copies of old ones. Drug companies spend twice as much on marketing than they do on research and development. Twenty times more on marketing than researching new molecular entities
- “ It is no longer possible to trust much of the clinical research that is published or to rely on the judgement of trusted physicians or authoritative medical guidelines. I take no pleasure in this conclusion, which I reached slowly and reluctantly over my two decades as an editor of The New England Journal of Medicine” Dr Marcia Angell
- “possibly half of the published literature may simply be untrue” Richard Horton, editor of the Lancet - 2015
- Several recent scandals including universities covering up research misconduct “ Something is rotten in the state of British Medicine and has been for a long time” Richard Smith (2016)



- It has been estimated that use of beta-blockers in the clinical setting recommended in the ESC guidelines increased patient mortality by 27%.[15] Some estimates suggest that there may have been 800,000 excess patient deaths in Europe of which 10% (i.e. approximately 10,000 excess patient deaths per year for eight years) are believed to have been in the UK. In the Polderman's case, the ESC was slow to amend the guidelines, the journals that published the trials have been tardy at retracting the publications, and Erasmus University were slow to act until the scandal was widely publicised


AOSIS
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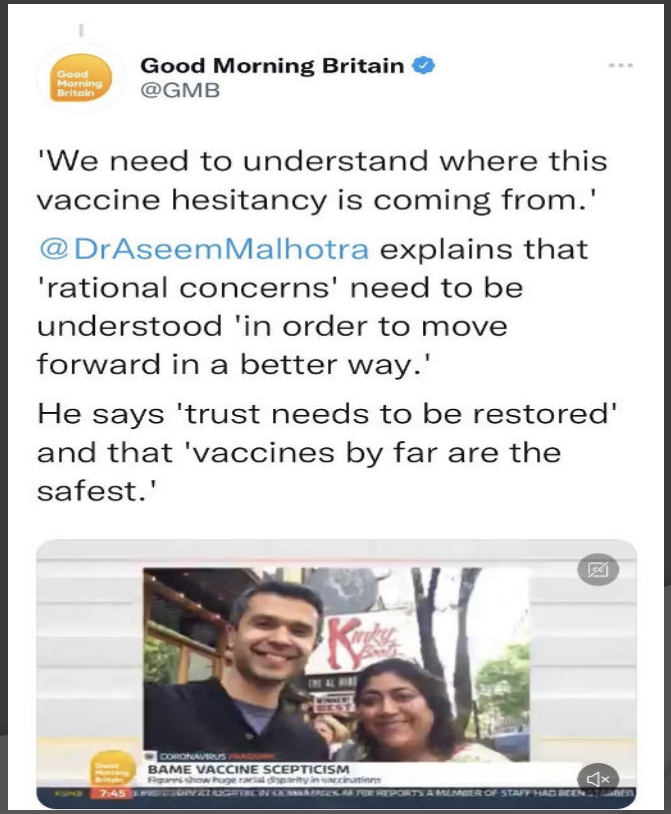

Circulation

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FREE ACCESS | ABSTRACT

ARTERIOSCLEROSIS, THROMBOSIS, VASCULAR BIOLOGY

SESSION TITLE: DAMPS, INFECTION AND CARDIOVASCULAR METABOLISM

Abstract 10712: Observational Findings of PULS Cardiac Test Findings for Inflammatory Markers in Patients Receiving mRNA Vaccines

Steven R Gundry

Originally published 8 Nov 2021 |
https://doi.org/10.1161/circ.144.suppl_1.10712 |
Circulation. 2021;144:A10712

This article has an expression of concern

is corrected by

This report summarizes those results. A total of 566 pts, aged 28 to 97, M:F ratio 1:1 seen in a preventive cardiology practice had a previously scheduled PULS test drawn from 2 to 10 weeks following the 2nd mRNA COVID shot and was compared to the pt's PULS test drawn 3 to 5 months previously pre-shot. Each vac pt's PULS score and inflammatory marker changes were compared to their pre-vac PULS score, thus serving as their own control. There was no comparison made with unvaccinated patients or pts treated with other vaccines.

Baseline IL-16 increased from 35+/-20 above the norm to 82 +/- 75 above the norm post-vac; sFas increased from 22+/- 15 above the norm to 46+/-24 above the norm post vac; HGF increased from 42+/-12 above the norm to 86+/-31 above the norm post vac. These changes resulted in an increase of the pre vac PULS score of predicted 11% 5 yr ACS risk to a post vac PULS score of a predicted 25% 5 yr ACS risk, based on data which has not been validated in this population. No statistical comparison was done in this observational study.

In conclusion, the mRNA vacs numerically increase (but not statistically tested) the markers IL-16, Fas, and HGF, all markers previously described by others for denoting inflammation on the endothelium and T cell infiltration of cardiac muscle, in a consecutive series of a single clinic patient population receiving mRNA vaccines without a control group.

Saturated fat does not clog the arteries: coronary heart disease is a chronic inflammatory condition, the risk of which can be effectively reduced from healthy lifestyle interventions

Aseem Malhotra,[1] Rita F Redberg,[2,3] Pascal Meier[4,5]

Coronary artery disease pathogenesis and treatment urgently requires a paradigm shift. Despite popular belief among doctors and the public, the conceptual model of dietary saturated fat clogging a pipe is just plain wrong. A landmark systematic review and meta-analysis of observational studies showed no association between saturated fat consumption and (1) all-cause mortality, (2) coronary heart disease (CHD), (3) CHD mortality, (4) ischaemic stroke or (5) type 2 diabetes in healthy adults.[1] Similarly in the secondary prevention of CHD there is no benefit from reduced fat, including saturated fat, on myocardial infarction, cardiovascular or all-cause mortality.[2] It is instructive to note that in an angiographic study of postmenopausal women with CHD, greater intake of saturated fat was associated with less progression of atherosclerosis whereas carbohydrate and polyunsaturated fat intake were associated with greater progression.[3]

PREVENTING THE DEVELOPMENT OF ATHEROSCLEROSIS IS IMPORTANT BUT IT IS ATHEROTHROMBOSIS THAT IS THE REAL KILLER

The inflammatory processes that contribute to cholesterol deposition within the artery wall and subsequent plaque formation (atherosclerosis), more closely resembles a 'pimple' (figure 1). Most cardiac events occur at sites with <70% coronary artery obstruction and these do not generate ischaemia on stress testing.[4] When plaques rupture (analogous to a pimple bursting), coronary thrombosis and myocardial infarction can occur within minutes. The limitation of the current plumbing approach ('unclogging a pipe') to the management of coronary disease is revealed by a series of randomised controlled trials (RCTs) which prove that stenting significantly obstructive stable lesions fail to prevent myocardial infarction or to reduce mortality.[5]

DIETARY RCTS WITH OUTCOME BENEFIT IN PRIMARY AND SECONDARY PREVENTION

In comparison with advice to follow a 'low fat' diet (37% fat), an energy-unrestricted Mediterranean diet (41% fat) supplemented with at least four tablespoons of extra virgin olive oil or a handful of nuts (PREDIMED) achieved a significant 30% (number needed to treat (NNT)=61) reduction in cardiovascular events in over 7500 high-risk patients. Furthermore, the Lyon Heart study showed that adopting a Mediterranean diet in secondary prevention improved hard outcomes for both recurrent myocardial infarction (NNT=18) and all-cause mortality (NNT=30), despite there being no significant difference in plasma low-density lipoprotein (LDL) cholesterol between the two groups. It is the alpha linoleic acid, polyphenols and omega-3 fatty acids present in nuts, extra virgin olive oil, vegetables and oily fish that rapidly attenuate inflammation and coronary thrombosis.[6] Both control diets in these studies were relatively healthy, which make it highly likely that even larger benefits would be observed if the Mediterranean diets discussed above were compared with a typical western diet.

LDL CHOLESTEROL RISK HAS BEEN EXAGGERATED

Decades of emphasis on the primacy of lowering plasma cholesterol, as if this was an end in itself and driving a market of 'proven to lower cholesterol' and 'low-fat' foods and medications, has been misguided. Selective reporting may partly explain this misconception. Reanalysis of unpublished data from the Sydney Diet Heart Study and the Minnesota coronary experiment reveal replacing saturated fat with linoleic acid containing vegetable oils increased mortality risk despite significant reductions in LDL and total cholesterol (TC).[7]

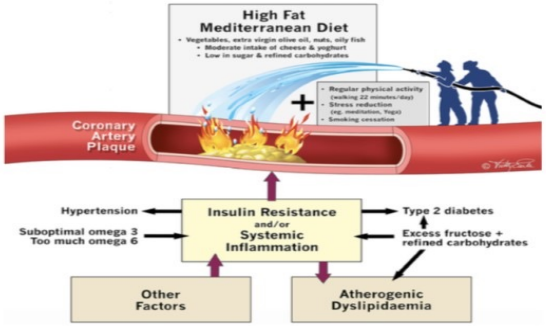

Figure 1 Lifestyle interventions for the prevention and treatment of coronary disease.

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IN MY OPINION DEATH WAS DUE TO:

1a Coronary artery atheroma

1b

1c

2

NO MATERIAL HAS BEEN RETAINED

COMMENTS

The examination showed severe coronary artery atheroma as the main finding, this would have have caused death through ischaemic cardiac arrhythmia.
The left coronary showed 80-90% stenosis, right coronary 75% stenosis. No visible myocardial infarction, but there was subtle scarring in the anterior left ventricle wall. The lungs showed severe pulmonary oedema, and mild emphysema of upper lobes but no infective changes. There was also mild duodenitis.
The head was not opened, given the coronary artery findings and the circumstances (chest pain) which are consistent with cardiac ischaemic cause of death.

To the best of my knowledge no cardiac or radioactive implant remains in the body (None removed)

Covid: Report reveals increase in risk of heart attack following the mRNA COVID...

1.1M views · 10 mo ago

Table 4: NNV for prevention of severe hospitalisation for different programmes

	Programme			
Age	Primary	Booster (2+1)	Autumn 2022 boost	Spring 2023 boost
5 to 11	112200			
12 to 15	162600			
16 to 19	106500	193500	185100	
20 to 29	166200	418100	275200	
30 to 39	87600	188500	217300	
40 to 49	53700	40600	175900	
50 to 59	18700	16200	48300	
60 to 69	5700	9200	27300	
70+	2500	10400	7500	
In a risk group	Primary	Booster (2+1)	Autumn 2022 boost	Spring 2023 boost
20 to 29	11400	43500	59500	59500
30 to 39	10700	28600	40500	40500
40 to 49	9400	10600	49800	49800
50 to 59	5600	6100	18600	18600
No risk group	Primary	Booster (2+1)	Autumn 2022 boost	Spring 2023 boost
20 to 29	no cases	no cases	706500	
30 to 39	318400	no cases	no cases	
40 to 49	186800	190400	932500	
50 to 59	51600	107000	256400	

More likely to suffer SAE from mRNA jab than be hospitalised from covid.

Serious adverse events of special interest following mRNA vaccination in randomized trials

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ABSTRACT

Introduction. In 2020, prior to COVID-19 vaccine rollout, the Coalition for Epidemic Preparedness Innovations and Brighton Collaboration created a priority list, endorsed by the World Health Organization, of potential adverse events relevant to COVID-19 vaccines. We leveraged the Brighton Collaboration list to evaluate serious adverse events of special interest observed in phase III randomized trials of mRNA COVID-19 vaccines.

Methods. Secondary analysis of serious adverse events reported in the placebo-controlled, phase III randomized clinical trials of Pfizer and Moderna mRNA COVID-19 vaccines (NCT04368728 and NCT04470427), focusing analysis on potential adverse events of special interest identified by the Brighton Collaboration.

Results. Pfizer and Moderna mRNA COVID-19 vaccines were associated with an increased risk of serious adverse events of special interest, with an absolute risk increase of 10.1 and 15.1 per 10,000 vaccinated over placebo baselines of 17.6 and 42.2 (95% CI -0.4 to 20.6 and -3.6 to 33.8), respectively. Combined, the mRNA vaccines were associated with an absolute risk increase of serious adverse events of special interest of 12.5 per 10,000 (95% CI 2.1 to 22.9). The excess risk of serious adverse events of special interest surpassed the risk reduction for COVID-19 hospitalization relative to the placebo group in both Pfizer and Moderna trials (2.3 and 6.4 per 10,000 participants, respectively).

Discussion. The excess risk of serious adverse events found in our study points to the need for formal harm-benefit analyses, particularly those that are stratified according to risk of serious COVID-19 outcomes such as hospitalization or death.

Funding. This study had no funding support.

Supplemental Table 1. Included and excluded SAE types across both trials

Included SAE types (matching AESI list): Abdominal pain, Abdominal pain upper, Abscess, Abscess intestinal, Acute coronary syndrome, Acute kidney injury, Acute left ventricular failure, Acute myocardial infarction, Acute respiratory failure, Anaemia, Anaphylactic reaction, Anaphylactic shock, Angina pectoris, Angina unstable, Angioedema, Aortic aneurysm, Aortic valve incompetence, Arrhythmia supraventricular, Arteriospasm coronary, Arthritis, Atrial fibrillation, Atrial flutter, Axillary vein thrombosis, Basal ganglia haemorrhage, Bile duct stone, Blood loss anaemia, Bradycardia, Brain abscess, Cardiac failure, Cardiac failure acute, Cardiac failure congestive, Cardiac stress test abnormal, Cardio-respiratory arrest, Cerebral infarction, Cerebrovascular accident, Chest pain, Cholecystitis, Cholecystitis acute, Cholelithiasis, Colitis, Coronary artery disease, Coronary artery dissection, Coronary artery occlusion, Coronary artery thrombosis, Deep vein thrombosis, Dermatitis bullous, Diabetic ketoacidosis, Diarrhoea, Diplegia, Dyspnoea, Embolic stroke, Empyema, Facial paralysis, Fluid retention, Gastroenteritis, Gastrointestinal haemorrhage, Haematoma, Haemorrhagic stroke, Hemiplegic migraine, Hepatic enzyme increased, Hyperglycaemia, Hyponatraemia, Hypoxia, Ischaemic stroke, Laryngeal oedema, Multiple sclerosis, Myocardial infarction, Non-cardiac chest pain, Oedema peripheral, Pancreatitis, Pancreatitis acute, Pericarditis, Peripheral artery aneurysm, Peritoneal abscess, Pleuritic pain, Pneumothorax, Post procedural haematoma, Post procedural haemorrhage, Postoperative abscess, Procedural haemorrhage, Psychotic disorder, Pulmonary embolism, Rash, Rash vesicular, Respiratory failure, Retinal artery occlusion, Rhabdomyolysis, Rheumatoid arthritis, Schizoaffective disorder, Seizure, Subarachnoid haemorrhage, Subcapsular renal haematoma, Subdural haematoma, Tachyarrhythmia, Tachycardia, Thrombocytopenia, Thyroid disorder, Toxic encephalopathy, Transaminases increased, Transient ischaemic attack, Traumatic intracranial haemorrhage, Type 2 diabetes mellitus, Uraemic encephalopathy, Uterine haemorrhage, Vascular stent occlusion, Ventricular arrhythmia

Excluded SAE types (not matching AESI list): Abdominal adhesions, Abortion

SAE may be as high as 1 in 300 and Death as high as 1 in 1000

Research | Open Access |
Published: 24 January 2023

The role of social circle COVID-19 illness and vaccination experiences in COVID-19 vaccination decisions: an online survey of the United States population

Mark Skidmore

BMC Infectious Diseases **23**, Article number: 51 (2023) | Cite this article

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COVID-19 vaccine. Estimates from the survey indicate that through the first year of the COVID-19 vaccination program there may be as many as 278,000 vaccine induced fatalities and up to a million severe adverse events. The analyses offer new evidence that the health experiences with the COVID-19 illness and vaccination within social circles play an important role in the decision to be vaccinated. Further, the reported COVID-19 vaccine adverse events within respondent social circles in the survey are substantial, suggesting that this effect is an important factor in vaccine hesitancy, whether perceived or real. Consistent with previous

Tropical Medicine and Infectious Disease

MDPI

Article

Cardiovascular Manifestation of the BNT162b2 mRNA COVID-19 Vaccine in Adolescents

Suyanee Mansanguan [1], Prakaykaew Charunwatthana [2], Watcharapong Piyaphanee [2], Wilanee Dechkhajorn [3], Akkapon Poolcharoen [4] and Chayasin Mansanguan [2,*]

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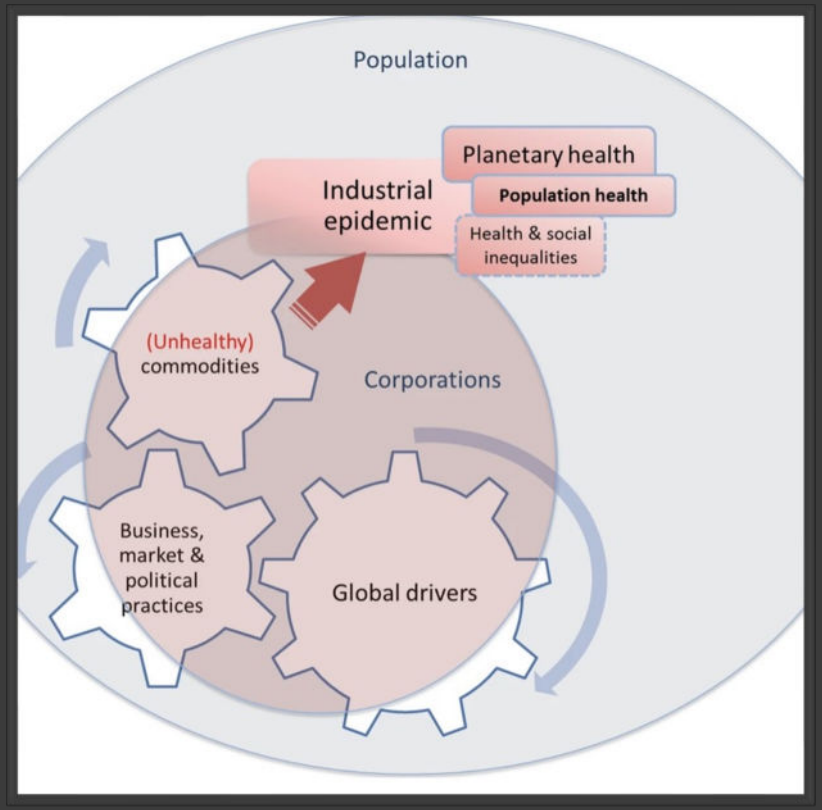
Abstract: This study focuses on cardiovascular manifestation, particularly myocarditis and pericarditis events, after BNT162b2 mRNA COVID-19 vaccine injection in Thai adolescents. This prospective cohort study enrolled students aged 13–18 years from two schools, who received the second dose of the BNT162b2 mRNA COVID-19 vaccine. Data including demographics, symptoms, vital signs, ECG, echocardiography, and cardiac enzymes were collected at baseline, Day 3, Day 7, and Day 14 (optional) using case record forms. We enrolled 314 participants; of these, 13 participants were lost to follow-up, leaving 301 participants for analysis. The most common cardiovascular signs and symptoms were tachycardia (7.64%), shortness of breath (6.64%), palpitation (4.32%), chest pain (4.32%), and hypertension (3.99%). One participant could have more than one sign and/or symptom. Seven participants (2.33%) exhibited at least one elevated cardiac biomarker or positive lab assessments. Cardiovascular manifestations were found in 29.24% of patients, ranging from tachycardia or palpitation to myopericarditis. Myopericarditis was confirmed in one patient after vaccination. Two patients had suspected pericarditis and four patients had suspected subclinical myocarditis. In conclusion, Cardiovascular manifestation in adolescents after BNT162b2 mRNA COVID-19 vaccination included tachycardia, palpitation, and myopericarditis. The clinical presentation of myopericarditis after vaccination was usually mild and temporary, with all cases fully recovering within 14 days. Hence, adolescents receiving mRNA vaccines should be monitored for cardiovascular side effects. Clinical Trial Registration: NCT05288231.

Citation: Mansanguan, S.; Charunwatthana, P.; Piyaphanee, W.; Dechkhajorn, W.; Poolcharoen, A.; Mansanguan, C. Cardiovascular Manifestation of the BNT162b2 mRNA COVID-19 Vaccine in Adolescents. *Trop. Med. Infect. Dis.* **2022**, *7*, 196. https://doi.org/10.3390/tropicalmed7080196

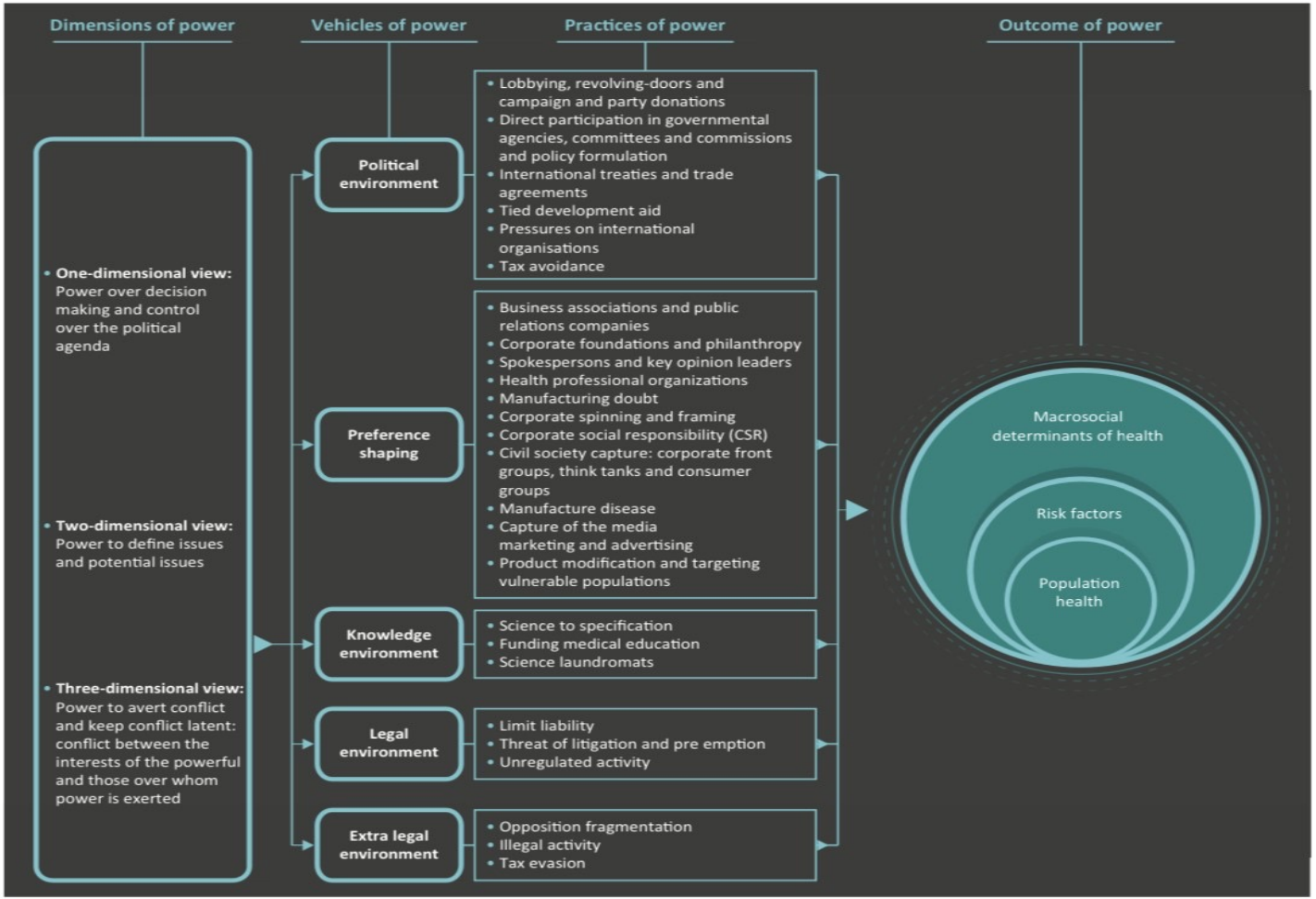
Can we trust the regulators? NO

- “ It’s the opposite of having a trustworthy organisation independently and rigorously assessing medicines. They’re not rigorous, they’re not independent, they are selective and they withhold data. Doctors and patients must appreciate how deeply and extensively drug regulators can’t be trusted so long as they’re captured by industry funding” Donald Light



THE COMMERCIAL DETERMINANTS OF HEALTH

"Strategies and approaches adopted by the private sector to promote products and choices that are detrimental to health"



Source: Madureira Lima J, Galea S. Corporate practices and health: A framework and mechanisms. Global Health. 2018;14(1):21

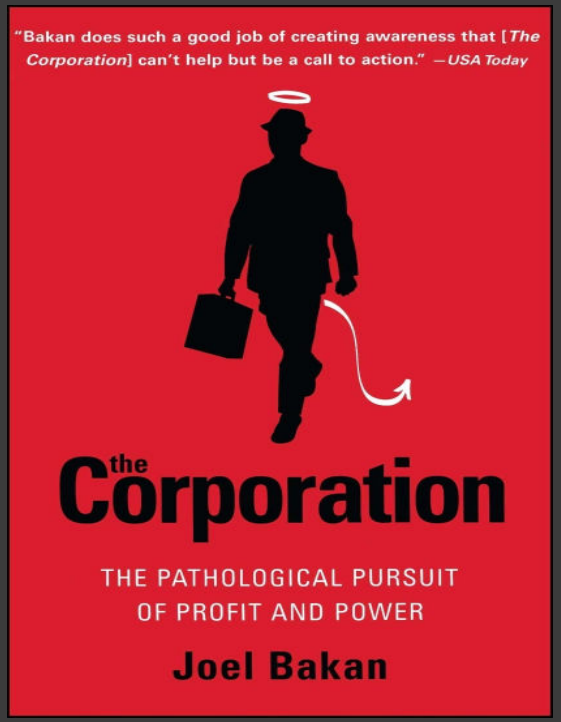
FIGURE 1: Diagram of dimensions, vehicles, practices and outcomes of power.

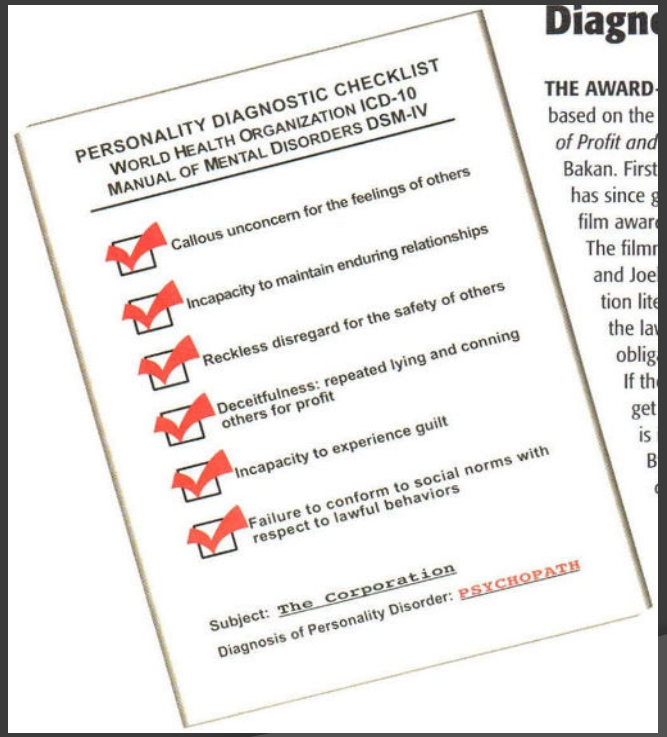
Joe Rogan " You can make a billion dollars from lying ?!"

John Abramson paraphrasing chief scientist of Merck "it's a shame that the cardiovascular effect is there but the drug will do well and we will do well"

Vioxx scandal – estimated to have killed 40-60k American citizens.

The “Psychopathic” Determinants of Health





Victims of a failing system

65p

2019 MEDIA BRAND OF THE YEAR • BRITAIN'S MOST TRUSTED DIGITAL NEWS BRAND 2018

'A big heart on the pitch and a sweet guy'
Tributes to England cricket hero Bob Willis
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Party by party, on every major issue
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The pill may alter structure of women's brains
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EXCLUSIVE
Leading heart doctor warns that 'systemic political failure' is crippling health service

It's the end of your career! Oh no it isn't!
Les Dennis and other stars on the 2019 panto season
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It's charity appeal
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United make Mourinho's Old Trafford return an unhappy one
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» Dr Aseem Malhotra says 'A GP who dedicated 25 years of her life to the NHS was failed by it'
» Family of NHS medics say that Anisha suffered hospital setbacks which led to her premature death
» 'The system is broken and money alone cannot fix it. No one should suffer like my mother'
» Tories promise £34bn budget increase by 2024 will be enshrined in law - while Labour pledges £40bn

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8 NEWS

PEOPLE

Doctor's family want review of his death after ambulance delay

Exclusive
By Paul Gallagher
HEALTH CORRESPONDENT

The family of a former top doctor and lifelong NHS campaigner have called for an investigation into his death after it took paramedics more than half an hour to arrive at his home despite operators being told he was suffering a cardiac arrest.

Professor Kailash Chand, the former vice chair of the British Medical Association (BMA), had complained of chest pains before one of his neighbours, a consultant anaesthetist at Manchester Royal Infirmary, called 111 for help.

He told the call handler within three minutes that he believed his friend was having a cardiac arrest.

"I was answering their questions when Kailash's eyes began rolling and he slipped into unconsciousness. That's when I said 'this looks like a cardiac arrest' and to upgrade the call.

"They kept asking questions as I started CPR and asked for an urgent ambulance. That was twice or twice and a half minutes into the call.

"My wife, who is also a doctor, arrived and she took over CPR while I kept asking where the ambulance was. We kept going but I couldn't feel Kailash's pulse and there was no sign of life. He never regained consciousness."

Evidence seen by i showed that it then took 20 minutes for the paramedics to arrive at Professor Chand's flat in Didsbury, Greater Manchester. This included a 15-minute gap between arriving "on scene" and being "at patient" after paramedics were given the wrong address and could not immediately locate Professor Chand's home.

National standards for ambulance trusts show that they must respond to category 1 calls – those that are classified as life-threatening and needing immediate intervention and/or resuscitation, such as cardiac or respiratory arrest – in seven minutes on average, and respond to 90 per cent of such calls in 15 minutes.

The neighbour's phone records showed that he called 111 at 17.29 on 26 July and was on the phone for 32 minutes and 31 seconds. The North West Ambulance Service (NWAS) diagnosis of death certificate states that the "call date" of the incident was 17.42 before being "received" by the service at 17.45.

The paramedic crew was "unable" a minute later before arriving "on scene" at 17.54 but they did not enter the flat until 18.04 due to having a wrong address. They attempted resuscitation but Professor Chand was declared dead at the scene at 18.46. He was 73.

Professor Chand, a former GP described as a "fearless defender" of the NHS, lived in a flat at Quantum House in Kensal Drive.

But the NWAS certificate shows that the crew had been given "Randel Kensal" as the scene and that there were "no signs to indicate address location" – despite the neighbour being on the phone continually to the operator.

CCTV shows the ambulance pulling up at 18.02 but it is a further two minutes before three NWAS staff walk in, two of whom are in full personal protective equipment.

Professor Chand's son, the anti-obesity campaigner and London-based cardiologist Dr Aseem Malhotra, has asked the Manchester coroner to investigate the circumstances surrounding his father's death.

Dr Chand Nagpaul, BMA council chair, said: "Chronic underfunding, workforce shortages and lack of capacity is resulting in an NHS that cannot always meet the urgent needs of its population.

HEALTH

Ambulance trusts receiving 'record levels' of demand

By Paul Gallagher

North West Ambulance Service is currently the subject of the seventh series of the popular BBC One show *Ambulance*. Last night's episode showed the service "busier than ever" and even being asked to take calls from Scotland to help overstretched services there. NWAS has also been asked to take calls from London Ambulance Service who have also been overwhelmed with demand.

Last month, nearly 100 members of the Army were brought in to help four ambulance trusts in England look after patients. High demand and staffing shortages mean they are being used to work alongside NHS staff in the South Central, South West, North East and East areas of England. The union, Unison, said it was a "sign things are not right" within the ambulance service.

In a letter to ambulance trust chief executives last month, Unison officials warned the health of paramedics and 999 call centre staff is being put at risk because of the "unsustainable demand" on the NHS.

All 10 ambulance trusts across England were operating at their highest level of demand the week before the letter was sent.

Latest figures show that more than one million 999 calls were answered in July in a new record for emergency services in England. July also saw the highest ever number of ambulance callouts for life-threatening conditions with 82,000 calls - 8,000 more than the previous record high in June.

Dr Chand Nagpaul, BMA council chair, said: "It is alarming that ambulance services are now receiving record levels of calls, with no national ambulance waiting time standards being met in July in England. In fact, for category 2 patients, which can include people who have had a stroke or chest pain, the average response time was over 40 minutes, more than double the agreed standard of 18 minutes.

"It is vital the Government urgently puts forward an action plan to address this deficit in emergency care infrastructure, so that no person has to endure waits beyond specified standards."

CAMPAIGN

Dr Aseem Malhotra with his father Kailash Chand, who died in July

I was grappling with anger that he shouldn't have died so suddenly'

Dr Aseem Malhotra recounts how an ambulance delay cost his father his life

Sitting alone in my London flat, I prepared myself to travel to Manchester to say goodbye to my father, my best friend and the last surviving member of my immediate family. I was also grappling with profound anger, knowing he would need to be monitored and have a blood test to exclude a heart attack, I rushed to be with him. I kept calling until a friend of Dad's, a consultant physician, answered saying: "Aseem, your dad has to hospital now." Knowing that he

He was gone. I asked the coroner for a post mortem. There was no evidence of heart attack but he had experienced unstable angina, where the blood supply to the myocardium is significantly reduced but not enough to cause damage to his heart muscle. This made it even more likely that he almost certainly would have survived had the ambulance arrived within the acceptable response time: seven minutes.

Unfortunately, this is not an isolated case. A few weeks prior, a very senior nurse at NHS England's own husband, suffered cardiac-arresting chest discomfort whilst playing football. Knowing there would be a significant delay she told me that she didn't even call 999. She drove as fast as she could to the nearest A&E where an ECG diagnosed a heart attack.

A colleague of hers relayed that several NHS trusts in regions in England have asked the Government to call in the army to assist

999 Delayed responses

When I spent a day inside the control room of the South Central Ambulance Service, the staff told me they were 'stacking' life threatening calls on a daily basis. That was almost three years ago.

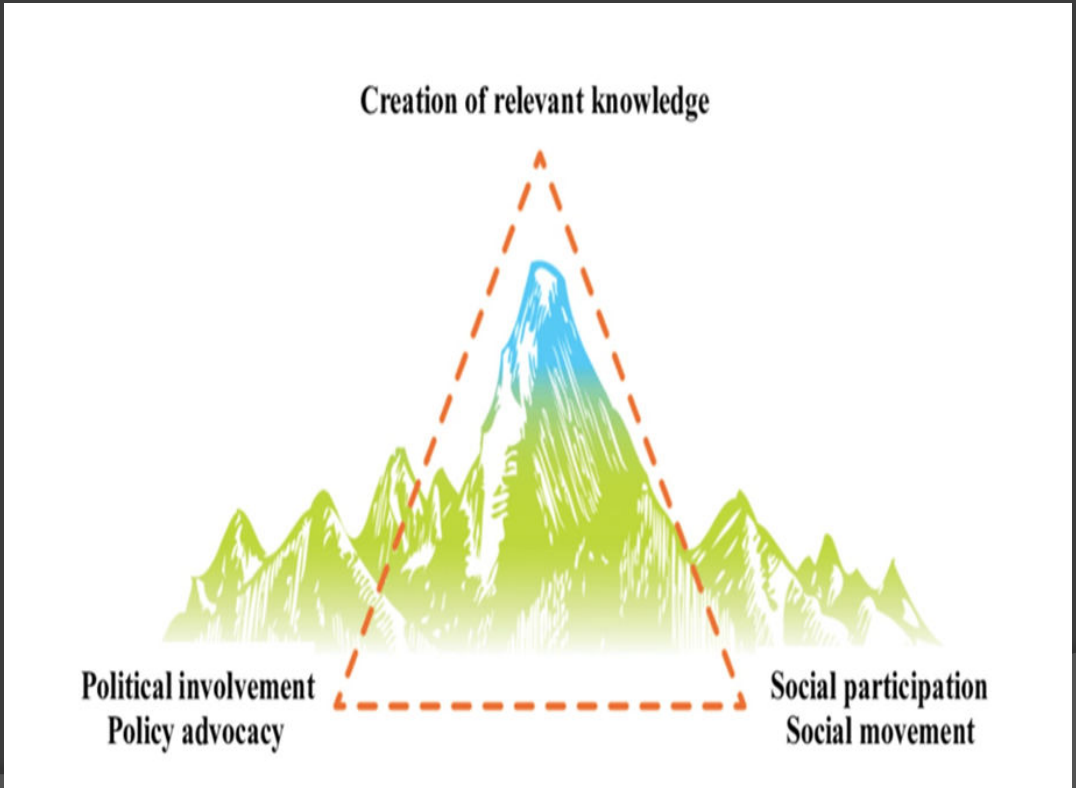
Since then demand on ambulance trusts around the country continues to rise. Part of the problem is how the public perceive the 999 service.

"So many more people assume the service is there to help with their social or domestic issues rather than an emergency," Maurice McGinlay, the night control shift officer, told me back then. "The demand over the last few years has been incredible and I think's only going to increase."

He was right. In July, more than one million 999 calls were answered by NHS staff in England – a new record.

The unprecedented number of calls has come over a year into the pandemic, as exhausted staff deal

The Triangle That Moves The Mountain



publichealth research&practice

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doi: http://dx.doi.org/10.17061/phrp2521514
www.phrp.com.au

Perspective

Reflections on a 38-year career in public health advocacy: 10 pieces of advice to early career researchers and advocates

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Key points

- Media attention on a public health issue is often more effective than private advocacy in winning policy change
- Advocacy must be evidence based, clear and concrete
- Speak out publicly, study the media and be available to speak at all times
- Use 'killer (attention-grabbing) facts', but place them in the context of a values system; care about what you are advocating for
- Use real people to illustrate your message
- Use social media
- Be patient; grow a 'rhinoceros hide'

Abstract

There are many important principles and lessons that public health researchers and advocates who hope to influence policy and practice need to consider. In this paper, I set out what I consider to be 10 of the most fundamental of these. Together, these focus on the importance of preserving public confidence in the evidence base underscoring public policy; being clear and concrete about the policy reforms you support; emphasising the values on which policy is based; understanding the structure, conventions and subtextual features of news reporting; developing 'killer facts' with 'earworm' potential; appreciating that the advocacy process leading to policy change almost always takes a long time; and growing a rhinoceros hide to assist in the inevitable attacks you will face.

Introduction

In the late 1970s, I worked with others to try to have the actor Paul Hogan removed from Winfield cigarette advertising.[1] It was, and remains, the most successful tobacco advertising campaign in Australian history. Hogan had immense appeal with teenagers. This made his role a clear breach of the voluntary code of advertising self-regulation that was then operating.[2]

Our private, polite efforts to get something done through the complaints system were virtually ignored until we went public through the media. Ten-thousand watt lights tend to concentrate the attention of those with responsibility to act. And so act they finally did. Hogan was removed 18 months after we started complaining.[1]

I learnt a big lesson very quickly: sunlight makes a very strong antiseptic for malodorous health policy. And there is no sunlight stronger than getting an issue major media attention.

I soon discovered that there were remarkably few analytical histories of how either large or small public health advocacy campaigns and policy battles had been won or lost. So I set out to change that by writing books[3-6] and dozens of papers on the process I had often been part of.

Below are 10 key lessons I've learnt in public health advocacy. There are many more, but these 10 are absolutely critical.

Public Health Advocacy

- “ careers are often built on lifetime commitment to particular phases of evidence. But if the evidence changes, it is absolutely critical for public trust in the integrity of public health that we acknowledge the facts have changed and accordingly that we have changed our minds too”

Key points

- Media attention on a public health issue is often more effective than private advocacy in winning policy change
- Advocacy must be evidence based, clear and concrete
- Speak out publicly, study the media and be able to speak out at all times
- Use “ Killer (attention grabbing) facts” but place them in the context of a values system; care about what you are advocating for
- Use real people to illustrate your message
- Use social media
- Be patient and grow a “rhinoceros hide”

Will Aseem Malhotra's Appearance Be the BBC's Most Viewed Programme of 2023?

BY **NICK RENDELL** 15 JANUARY 2023 11:00 AM

SHARE

Grow a rhinoceros hide

- “Unless you are an advocate for an utterly uncontroversial policy as soon as your work threatens an industry or ideological cabal you will be attacked, sometimes unrelentingly and viciously”

“ I’ve been called a veritable sewer of names on social media, often by anonymous trolls and tobacco industry funded bloggers….My university administration is regularly deluged with orchestrated complaints”

Simon Chapman

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Coronavirus

BBC criticised for letting cardiologist 'hijack' interview with false Covid jab claim

Aseem Malhotra's 'misguided' views linking some Covid vaccines to excess heart disease deaths should not have aired, say experts

Nicola Davis

@NicolaKSDavis

MENU

THE TIMES

FRIDAY JANUARY 20 2023

POLITICS

Andrew Bridgen, the MP who was 'groomed by gangs of antivaxers'

The Tory party lost its patience with Andrew Bridgen after a Twitter post on the Holocaust, Mario Ledwith reports

Aseem Malhotra congratulated Andrew Bridgen on the Commons terrace after he spoke at length on Covid vaccines during an adjournment debate last month

Mario Ledwith

Saturday January 14 2023, 12.01am GMT, The Times

Premier Winde fumes after Western Cape deputy speaker hosts British anti-vax doctor in legislature

5h ago

Marvin Charles

news24

Comments

Solutions

BOX 4: Defining real evidence-based medicine and actions to deliver it.

1. Is the application of individual clinical expertise with best available evidence and taking into consideration patient preferences and values in order to improve patient outcomes (relieve suffering and pain, treat illness and address risks to health)
2. Makes the ethical care of the patient it's top priority
3. Demands individualised evidence in a format that clinicians and patients can understand
4. Is characterised by expert judgement rather than mechanical rule following
5. Shares decisions with patients through meaningful conversations
6. Builds on a strong clinician–patient relationship and the human aspect of care
7. Applies these principles at community level for evidence-based public health

Actions to deliver real evidence-based medicine

1. Although the pharmaceutical industry plays an important role in developing new drugs, they should play no role in testing them
2. All results of all trials that involve humans must be made publicly available
3. Regulators such as the FDA and MHRA must be publicly funded, and not receive any money from the pharmaceutical industry
4. Independent researchers must increasingly shape the production, synthesis and dissemination of high-quality clinical and public health evidence
5. Medical education should not be funded or sponsored by the pharmaceutical industry
6. Patients must demand better evidence, better presented (using absolute and not relative risk), better explained and applied in a more personalised way

Source: Adapted from Greenhalgh T, Howick J, Maskrey N. Evidence based medicine Renaissance Group. Evidence based medicine: A movement in crisis? *BMJ*. 2014;348:g3725. https://doi.org/10.1136/bmj.g3725

thebmj

BMJ 2015;350:h2308 doi: 10.1136/bmj.h2308 (Published 12 May 2015)

ANALYSIS

Choosing Wisely in the UK: the Academy of Medical Royal Colleges' initiative to reduce the harms of too much medicine

A Malhotra and colleagues explain how and why a US initiative to get doctors to stop using interventions with no benefit is being brought to the UK

A Malhotra *consultant clinical associate*[1], D Maughan *Royal College of Psychiatrists sustainability fellow*[2], J Ansell *advanced trainee in general surgery*[3], R Lehman *senior research fellow*[4], A Henderson *chief executive*[1], M Gray *director*[5], T Stephenson *former chair*[1 6], S Bailey *chair*[1]

[1]Academy of Medical Royal Colleges, London, UK; [2]Centre For Sustainable Healthcare, Oxford, UK; [3]Welsh Institute for Minimal Access Therapy, Cardiff Medicentre, Cardiff, UK; [4]Department of Primary Health Care, University Of Oxford, Oxford, UK; [5]Better Value Healthcare, Oxford, UK; [6]Institute of Child Health, London, UK

CALL TO ACTION AND NEXT STEPS

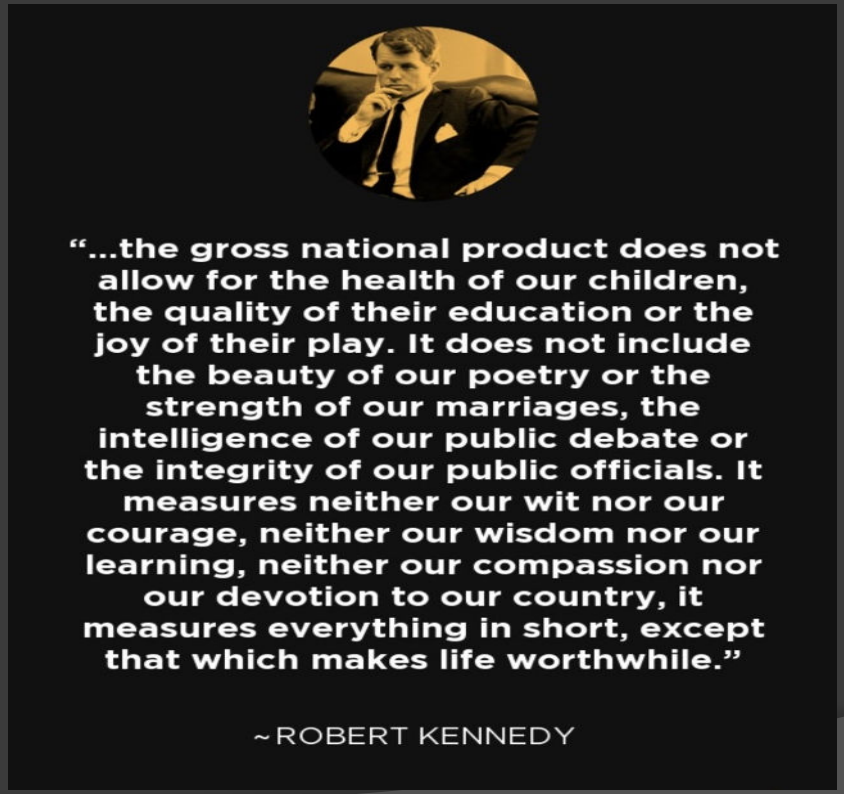
To ensure the development of a Choosing Wisely culture in clinical practice, the academy suggests:

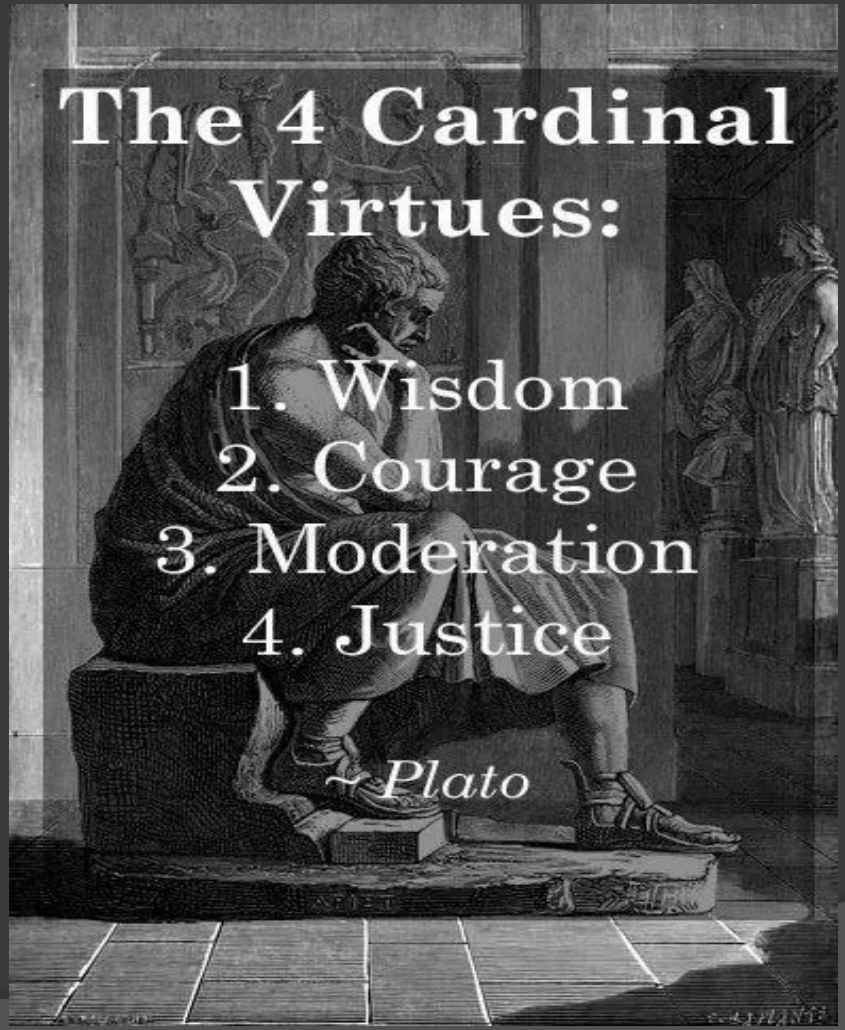
- Doctors should provide patients with resources that increase their understanding about potential harms of interventions and help them accept that doing nothing can often be the best approach
- Patients should be encouraged to ask questions such as, “Do I really need this test or procedure? What are the risks? Are there simpler safer options? What happens if I do nothing?”
- Medical schools should ensure that students develop a good understanding of risk alongside critical evaluation of the literature and transparent communication. Students should be taught about overuse of tests and interventions. Organisations responsible for postgraduate and continuing medical education should ensure that practising doctors receive the same education
- Commissioners should consider a different payment incentive for doctors and hospitals

"I see in the near future a crisis approaching that unnerves me and causes me to tremble for the safety of my country... corporations have been enthroned and an era of corruption in high places will follow, and the money power of the country will endeavor to prolong its reign by working upon the prejudices of the people until all wealth is aggregated in a few hands and the Republic is destroyed."

~ ABRAHAM LINCOLN

Ethics and spirituality




The 4 Cardinal Virtues:
1. Wisdom
2. Courage
3. Moderation
4. Justice
~ Plato

Courage is the most important of all the virtues, because without courage you can't practice any other virtue consistently. You can practice any virtue erratically, but nothing consistently without courage.

(Maya Angelou)


Rise up with me against
the organisation of misery.
Pablo Neruda
quotefancy


“
Rights are won only by those who **make their voices heard.**
HARVEY MILK