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Fighting Hogwash – Dr J. Anthony Morris

In 1988 and 1989 I was contacted by a small group of underground medical people, who were honestly concerned by what they were seeing in their practices. Some felt helpless in the face of what looked to them like a ticking timebomb. Somewhere, they felt, there had to be someone, brave enough to speak out, without having their head chopped off.

But . . . where?

Years before, Robert Mendelsohn had directed me to his friend, the courageous Dr Anthony J. Morris. But I was a bit scared to write to Dr Morris. I also knew Dr Glen Dettman, another person recommended by Dr Mendelsohn. He sent me medical articles which told some of Dr Morris's story. Digging around in Auckland Library archives, I gleaned more.

Most medical people have no idea of Dr John Anthony Morris's place in vaccine history and he is modest enough not to wish to dwell on his achievements. In the early days, what others had told me, and what little else I had found, was all I knew. Dr Morris brushed aside any suggestion that his story should be written up, but if everyone in the world knew, perhaps they would understand a little of what lies behind some of the current silence in the vaccination debate.

His story sets up the **WHOLE** of the submerged history on withheld information about modern vaccines.

Just before World War II, Dr Morris began his studies at Walter

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Reed Hospital in Washington DC where he trained as a microbiologist with a special interest in viral diseases, and started working for the government in 1940. In the 1940s and 1950s he had a distinguished career researching viral and respiratory diseases. In the mid-50s the National Institute of Health set him to work investigating vaccines and the risk factors in their use. At the same time Tony was also a key figure in setting up the NIH research program on kuru and scrapie, as well as making important discoveries in responses to influenza vaccines.

In 1959, Dr Morris was recruited to the DBS¹ by Dr Joseph Smadel who drew up long-term influenza research plans for Dr Morris's laboratory. Behind the scenes, a heated controversy had been boiling in medical circles, because though the first flu vaccine was licensed in 1945, it had never taken off. People in the upper echelons argued that mass vaccination against the flu and the common cold was vital to combat the most debilitating respiratory diseases, and to forward this aim, they needed someone of Dr Morris's knowledge and calibre to do the work to prove it was possible.

Dr Morris quickly became alarmed at what he found. Regardless of the potency stated on a bottle's label, it was impossible to measure the actual strength of the vaccine.

By 1963, the studies he had done on elderly people and the flu vaccine, showed that if there was any benefit to be derived, it was so small it could not be reliably measured.

In association with Dr Galdichec (who subsequently won the Nobel prize for his investigation on croup), Dr Morris's studies on the Caroline Islands showed that, irrespective of the slight difference between the circulating virus and the vaccine, the flu vaccine was about 20% effective. Sometimes it was 40% effective, other times 0%.

To try to find out why good protection wasn't possible, other experiments showed that though the vaccine produced IgG antibodies in the blood, it didn't produce IgA in the lungs and mucus membranes where an infection might start. His studies on side-effects were also starting to concern him. In December 1966 his completed studies showed that flu vaccines were of minimal benefit, and that studies should be done to find out why.

When he communicated his concerns to his superiors, he very quickly ran into fierce opposition. He said, "*There is a close tie*

1 Division of Biologics Standards, now FDA (Federal Drug Agency).

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between government scientists and manufacturing scientists. And my results were hurting the market for flu vaccines.” DBS informed him he should hand over all records and materials and he would be relieved of his job. In order to prevent total destruction of his work, one of his technicians took various virus pools “*to other places*”. But Dr Morris had no option but to destroy thousands of research animals as ordered.

His laboratory staff were reassigned elsewhere, and publication of his articles was blocked by superiors. All his research materials were crated, and taken away, the locks changed on his laboratory, he was placed in a small room with no telephone, and people wishing to see him had to get permission from the chief of the laboratory.

By 1970, over 20 million doses of influenza vaccine were being sold in the USA, making it one of the largest selling vaccines produced in the USA. At the beginning of that year, Dr Morris had just decided to leave the DBS and look for work elsewhere, when one day he was ordered to leave the DBS. He instituted a wrongful dismissal case. All charges against him were overturned, and the grievance committee unanimously found that Morris had been harassed by his superiors over an extended period of time, from 1963 to 1970, that the allegations of releasing bad vaccine was false, but made the amazing statement that Dr Morris’s “*reputation as a scientist would probably not suffer by these internal allegations*”.

It soon became obvious that his reputation had suffered, and Tony felt that his name should be cleared publicly by showing the legislators and the public that the long-term publicity that flu vaccines were being sold on was incorrect.

With a lawyer called James Turner, he drew up a detailed memorandum, showing irregularities in the handling and testing of vaccines by the NIH² and the DBS, that the DBS had used “*dubious techniques*” to test the flu vaccine and had “*tampered*” with the test results, permitting the vaccine labels to show higher potencies than the true value, thereby certifying and releasing watered-down vaccines to the public. They also stated that the DBS harassed many scientists whose research work affected any vaccine market and had forced them to leave the DBS, and actively discouraged pertinent lines of research relating to many vaccines. The Turner/Morris memorandum also

2 National Institute of Health.

charged that in 1966 and 1967 the DBS released at least three lots of potentially contaminated flu vaccine despite one of its scientists, Dr Casper Hiatt, putting a “*hold*” order on them.

The NIH set up a special committee in response, to investigate the “*unsubstantiated*” claims.

At the same time Dr Morris and some other DBS researchers took a copy of the memorandum to Senator Ribicoff, who initiated a General Accounting Office enquiry at the highest level, not just into the claims of Dr Morris, but into the regulatory responsibility of the DBS.

The GAO concurred with some of Morris’s criticisms finding that scientific studies disagreed significantly on the effectiveness of flu vaccines.

Dr Morris said that the benefit of the flu vaccine had been overrated. In children it often induced fever; in some pregnant women it could endanger the fetus, and in all users there was a risk that vaccine “*literally loaded with extraneous bacteria*” will be injected. Further, he said that it had been impossible for him to test the product, known as bivalent influenza virus vaccine, for potency.

A former DBS scientist B. G. Young, who endorsed the criticism of the DBS management characterized the DBS attitude towards research as being one of:

*“Suppression, harassment, and censorship of individual investigators . . . I finally came to realize that you either had to compromise yourself or leave. Morris and Eddy are the real heroes in that place because they stayed and fought. The others voted with their feet and left.”*³

There were repeated cases of potentially dangerous vaccines being authorized for release without adequate screening.

Another issue was the use of a Typhus vaccine developed in the 1940s. In 1969, the Armed Forces Epidemiological Board found that some vaccine lots were not giving good antibody responses even though DBS had passed the potency of them. It wasn’t known for how many years before 1969 the army had been using useless vaccine. The incident simply added to the catalogue of DBS lack of diligence over the years.

3 Wade, N. 1972. “Division of Biologics Standards: The Boat That Never Rocked”. *Science*, March: 1225–30. p. 1227.

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Naturally enough, the public was never told any of this at the time. The twelve-member special NIH committee came back on 29 November with the astonishing findings that:

“Only a few minor irregularities could be confirmed: however these did not involve any risk to the public.”

It was further stated that as a result of the committee’s findings, NIH considered Dr Morris’s charges were *“without merit”*.

Dr Morris and James Turner, in turn responded with a 30-page analysis, showing that the committee’s report was so seriously flawed that the experts themselves should be investigated by the subcommittee. They presented voluminous data in support, pointing out that the committee had ignored issues they had raised, while responding to issues they had not mentioned, regarding Dr Bernice Eddy. However, they pointed out in reply, that both of Bernice Eddy’s memoranda (which the committee had said didn’t exist), in which she informed the DBS that the polio vaccine was contaminated, were handed to the committee chairman, and both proved that the conclusions drawn by this committee were at the very least erroneous.

Increasingly, American scientists were understanding that they were expected to be state scientists, not rocking the boat nor making independent findings.

In 1972 a Senate hearing was conducted at the highest level, with these, and other vaccine-related irregularities investigated. At one point Senator Percy asks a Dr Isacson what he thinks the monetary value would have been of the 32 other vaccines, discovered to be of no known protective value, which had been licenced for use by the DBS. The exchange,⁴ was:

DR ISACSON. Well, I think it must be astronomical. I do not think I could give you an actual figure. Since some of these appear from the investigation to have been on the market for 20 years, certainly it must add up.

SENATORY PERCY. But we are talking about a cost investment of hundreds of millions of dollars, maybe. Certainly I think that incident very dramatically indicated

⁴ From the printed transcript of the Senate Hearings before the Subcommittee on Executive Reorganization and Government research (S.3419) April 20, 21, and May 3, 4, 1972, p. 346.

*something was wrong . . . We are locking the barn now,
after the horse has gone out . . .*

Meanwhile, working for the Food and Drug Administration, Dr Morris was working on a new live flu vaccine to be administered as nose drops, which it was hoped would solve all the problems of the killed flu vaccine. It was reasoned that this vaccine would create immunity in the mucus membranes where it was most needed, and a trial had just been done in children. Dr Morris began testing the vaccine in mice – a precaution which had not been taken previously – and found that the live influenza vaccine accelerated the growth of tumours in test animals. This finding markedly increased Dr Morris’s unpopularity among health bureaucrats, but little was said, and the live vaccine was side-lined. I wonder if the manufacturer of the new Flumist vaccine (sprayed up the nose) repeated that work?

In 1976 came the last straw as far as the bureaucrats were concerned. Something which made them determined to get rid of Dr Morris forever. It was the “*Swine Flu fiasco*”.

In February 1976, in Fort Dix in New Jersey, a swine flu strain had been found in a soldier who died on a march. It couldn’t be identified in the public health laboratory in New Jersey so they sent it to CDC⁵ Atlanta, who designated it as a swine flu virus and immediately started talking up a resulting worldwide pandemic. It was believed that the 1918 epidemic had been due to a swine flu virus, but Paul Brown and Dr Morris, as part of the work in the islands, had been able to prove that the 1918 Spanish flu epidemic wasn’t caused by the swine flu virus. It was PR8, another strain of influenza, that was discovered in Puerto Rico many years before. So the CDC’s assumption that this was a swine flu that would cause another worldwide pandemic was wrong from the start.

Unfortunately, powers that were, didn’t check that out. No other swine influenza virus was recovered except the one at Fort Dix, which was sent to Fort Detrixx (the biological warfare unit) who found it was an ordinary pig virus, and that there was no reason to be alarmed.

The virus was then given to Tony Morris’s lab to look at, and he also found nothing to distinguish it from any other swine flu strain.

5 Center for Disease Control.

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But it seems that the CDC decided that this would be an ideal opportunity to revive the ailing flag-ship of flu vaccination campaigns which had taken a bit of a public denting.

The next thing that was discovered was that they couldn't make a vaccine on that swine flu strain, because it grew too slowly and would take years. So the slow-growing swine flu strain was hybridized with PB8, which meant the swine virus took on the fast-growing properties of 1918 virus. So the viral antigen used in the Swine Flu vaccine wasn't the ordinary pig strain from the soldier, but a fast-growing hybrid.

They sold the vaccine by dramatic hard sell, insisting that a flu epidemic like the 1918 pandemic that killed millions worldwide was imminent unless everyone lined up for the swine flu vaccine. The estimated deaths throughout USA were put at one million. In terms of the chances of it being like 1918, estimates were "*1 out of 2*".

The only problem was Dr Morris. Because of what he and the other laboratories had found, he felt the public needed to know that there was no cause for alarm. When he told his then boss he was going to speak out, he was told, "*I would advise you not to talk about this*".

He continued to study the virus, and when sure of his facts, went public stating he could find no evidence that this strain was dangerous, or would spread from human to human, but that on the other hand, the vaccine was dangerous and might induce not only hypersensitivity but also neurological side effects; and that there was no precise way to measure the vaccine's potency and its efficacy appeared to be comparatively low.

When vaccine recipients started to experience Guillain Barre, amongst other reactions, Dr Morris's laboratory looked more closely at the vaccine, and publicly reaffirmed their feelings about the lack of effectiveness, and safety. The inevitable happened. The Federal Drug Administration fired Dr Morris for insubordination.

Tony worked out of his lawyer, James Turner's, small office, and his own home, continuing to carry arguments to the press, assessing case histories of side-effects and continuing to attend NIH flu meetings to argue the facts.

By October 1976, 33 people had died after receiving the Swine Flu vaccine, and by mid-December there were about 500 cases of Guillain-Barre. But even up to December all authorities were publicly stating that there was no relationship between any of the deaths or

side-effects and the vaccine. In December of that year, at an urgent meeting, Dr Langmuir, one of the chief immunologists at the CDC said, *“We cannot look at these data and not conclude that it was this influenza virus vaccine that precipitated Guillain Barre in those who developed it, so we must consider stopping the programme.”* The round-the-table vote was 13 to 1 to stop the programme.

On 16 December 1976 after 46 million shots had been administered, three vaccine-associated deaths were officially admitted to, and the programme was stopped. But the main message continued to be denial, and more denial.

Tony Morris said to the *Washington Post*⁶ about flu vaccines:

“It’s a medical rip-off. . . We should recognize that we don’t know enough about the dangers associated with flu vaccine. I believe the public should have truthful information on the basis of which they can determine whether or not to take the vaccine.” And he adds, “I believe that, given full information, they won’t take the vaccine.”

In 1979, the Civil Service review panel ordered the FDA to reconsider their sacking of Dr Morris, firstly because he had been motivated by public welfare, and also because the Civil Service Reform Act of 1978 was designed in part to afford additional protection to whistle-blowers, or employees who exposed practices which they believed to be a violation of law, rule, or regulation, or to constitute among other things, a danger to the public health or safety.

Testimony given by Dr Morris to the Senate Committee on Ways and Means, on 5 March 1987 showed that by August 1982, there were 1571 lawsuits filed by individuals who had suffered serious adverse reactions as a result of the swine flu vaccination.

Of these 290 had been settled at a cost of \$57,000,000 by 5 March 1987 and another 693 were still pending, with the amount requested by plaintiffs standing at \$1,027,000.00. Dr Morris said:

“These figures give some idea of the consequences resulting from a program in which the Federal government assumes liability of a product known to produce in an indeterminate

6 Cockburn, A. et al. 1977. “Scientist J. Anthony Morris – He fought the flu shots and the US fired him”. *Washington Post*, 13 March: 22.

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number of recipients, serious damage to health . . . when I left the Food and Drug Administration in 1976, there was no available technique to measure reliably and consistently neurotoxicity or potency of most of the vaccines then in use, including DPT vaccines.

Today, 11 years later, the situation remains essentially the same.”

The really telling thing about the whole Swine Flu issue, is that health policymakers did not, and will not, learn anything from the fiasco.

For instance, at a meeting in 1996, Dr Peter Patriarca discussed a proposed Influenza Pandemic Plan. On page 2 of the briefing document handed out is this:

“The successes and failures of the Swine Influenza Program of 1976 have been reviewed in detail elsewhere. Perhaps the most important failure of the program was the lack of a preemptive and proactive plan, which could have addressed many of the technical, political and administrative issues that ultimately hindered program implementation. This experience, more than any other, has underscored the need for the development of a comprehensive, contemporary and action-oriented plan.”⁷

Think about that. The predicted swine flu pandemic didn't happen, and vaccination with a dangerous vaccine was stopped because of deaths and injuries. Miffed that they didn't have a plan to make an unnecessary vaccination campaign succeed, the authorities were using that disappointment to develop a much more successful, comprehensive, contemporary and action-orientated plan. But for when?

To ensure the world might be pre-emptively vaccinated with an untested vaccine using squalene as an adjuvant, to supposedly prevent a Bird Flu epidemic they say might also kill millions of people, but that also might not happen?

Have the authorities learned any real lessons from all this? When will they admit the truth, namely that the guts of the matter is that in

⁷ WP3.0\FLU PLAN\DRAFT #6, January 1996 discussed on Thursday, 29 February 1996, at the Advisory Commission on Childhood Vaccines.

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1976, everything they said was wrong? Fortunately, they didn't have a plan then, for if they had, perhaps we would never have known the truth about the Swine Flu epidemic that never was.

It is important to know the background to issues. Without that background, statements like the 1996 one above become the foundation stones for medical myths ultimately enshrined in textbooks. Even today if you do an internet search, you will find medical people who truly think that those 46 million doses given, prevented a swine flu epidemic of the proportions of 1918 pandemic.

(All information relating to Tony Morris's work has been checked by him, and comes from published studies, newspaper articles, Senate records of the relevant hearings, either collected, or given to me by him, and public and private comments he has made.)

35 On Flu Epidemics

“The only sin this season is to leave vaccine on the shelf.”¹

In March 2005, my father rang me in a total panic. He’s 94, with a long memory. “Darling,” he said, “I don’t want you to die. There’s something you have to do!”

I cut in and said, “Oh Dad, what ARE you going on about?!!” “It’s this bird flu from Taiwan, Darling,” he replied, “It’s all over the news. They are saying it will kill everyone soon, so you’ve got to disinfect your telephone every day.”

Choke . . . “My telephone??! . . .” I gargled . . . (I was at the computer and my early morning coffee disappeared where it shouldn’t. My keyboard survived but my lungs took a little longer.) “Well, what about all the other door knobs, the taps, the whole bathroom, the fridge handle . . . and maybe I shouldn’t kiss anyone either?”

Silence.

“But it’s ON television Dear!”

Dad’s funny sometimes. Right up until 2004, he’d never had a flu

¹ Associated Press. 2004. “Rationed flu shots may go to waste”. *St Petersburg Times*, 17 December. Retrieved on 18 September, 2005 from <http://www.sptimes.com/2004/12/17/Worldandnation/Rationed_flu_shots_ma.shtml> “Many of us are now concerned we will not use vaccine supplies. The only sin this season is to leave vaccine on the shelf,” said Dr. William Schaffner.

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vaccine in his life. He had a reputation, in his previous home of being feisty, and telling the nurse she could have his dose, or “stick it you know where!” In 2004, I happened to ring him and he was a bit under the weather. “Why are you sick, Dad? You never get sick.” And it came out that he had caved and had the flu vaccine, and then got sick.

“Why Dad? What on earth possessed you to do that after all these years. You had the flu in 1918, and lived through it, and have never wanted a shot.”

“Well Dear,” he said, “she was such a nice girl, and I did it because I liked her.”

What can you say? Especially when he’s been saying for years that he’s only marking time, and wants to “go”! Maybe he did want to go.

But it reminded me of something else. Dad wrote his memoirs years back, at our prompting, in written form, and on audio tape. So I went and got them.

Dad’s father was a Yorkshire man working for the British Hongkong/ Shanghai Bank, and his mother, a quite unconventional and very resourceful, knowledgeable woman from Surrey.

During one posting to India there was a Typhoid outbreak in Calcutta. Dad’s mother got typhoid, and survived, but all her hair fell out and grew back auburn. Other postings were Singapore, Malaysia, and China where there was an outbreak of cholera, and his mother took many of the local sick into her house to nurse them. She did not get cholera herself. Then they spent time in Japan, where my father was born, and migrated with their young family to New Zealand in 1917, for the duration of the First World War.

They were living on Kawau Island in 1918 when the flu epidemic struck. Governor Grey’s old large house had been turned into a hotel, and the gardens and grounds were fantastic. My father was in kids’ heaven surrounded by beaches, fish, gardens, wallabies, and kookaburras. A coastal ferry brought supplies twice a week. The main occupation for the children was fishing from the pier. The sting rays were huge and the children always watched out for either sting rays or sharks.

When the flu epidemic hit, Dad’s mother turned the hotel into a hospital, with the help of the maid. The men were nursed upstairs, and the women downstairs. Dad clearly remembers getting it. He was at the pier, and simply buckled. By the time he managed to crawl up the steps of the hotel he was exhausted. By the end of the epidemic,

only two people on the whole of Kawau Island had not had the flu. They were Dad's mother, and the maid, who between them, with help from others when they could, had nursed the whole Island back to health with not one death.

Why was it that no one on Kawau Island died? Could it be that deaths are often caused because people either don't have the care, or the knowledge to look after themselves and one another? And why was it that the two people who had maximum exposure to the virus, never got it themselves?

This story is worth telling, because it is stories of that time which people recount to this day, often forming the basis of future scare-mongering about the flu. Good news is, it would seem, no news. We only get told about how many people died in 1918, not the ones who survived because of the skills of the people who looked after them.

Because of the current ramping up of fear about a potential bird flu epidemic, it's a good idea to talk about some of the epidemic propaganda that passes for history, starting with the 1976 "Swine flu".

Perhaps it's best called HOGSWASH AND GUANO.

No Known Vaccine Available To Halt the Deadly Menace

World Is on Brink of Killer Flu Epidemic²

A flu that normally affects only hogs may wipe out millions of people beginning next year.

So read the first paragraph, and further along to make the point, readers were told that

"In 1918, the killer disease was preceded by a milder epidemic such as the U.S. is experiencing now . . . ONE BILLION people fell ill – one of every three persons in the world," . . . and ". . . IF THE swine virus is a deadly as some scientists believe it to be, it already may be too late to prevent an epidemic – even if a vaccine is found tomorrow."

Sound familiar?

² Small, P. 1976. "No known vaccine available to halt the deadly menace. World is on brink of killer flu epidemic". *The National Insider* 11 April: Front Page.

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Literally thousands of articles predicting a fate worse than Black Plague appeared in the USA in 1976. It's no different in 2005. Nationwide US TV broadcast two doctors saying:³

“Michael Osterholm: We would expect between 1.5 and 1.7 million Americans to die . . . Irwin Redlener: We could have a billion people dying worldwide.”

Have these experts read “The Boy Who Cried Wolf”? (Aesop’s Fables.) We know, though they don’t appear to, that this bird virus was first noted in 1959⁴ forty-seven years ago. USA had a two-year outbreak in 1983.⁵ This virus is nothing new. The history of bird flu shows it’s not likely to become a human to human epidemic.

In 1976 death on its own, though, was not enough. Having scared people witless, the experts suddenly announced that there was going to be a shortage of swine flu vaccine, because one major manufacturer had got the wrong virus in it, and were going to have to start again.

So, the headlines read:

“Kids” flu shots in short supply

Vaccine’s availability will be limited at first

The strategy in 2005 in New Zealand was no exception, even with regard to the normal flu. Looking back through my collection of newspaper clippings from 1977, I find that one of the most skilful manipulators of propaganda of the “crying wolf” story has always been the *New Zealand Herald*.

Taking just a few of its headlines over the years, we find that they all build a long-term picture which ramp up, and misrepresent a situation that actually does not yet exist.

Flu vaccine flaws boost epidemic fears 12 March 2005

Study warns of grim toll if bird flu hits NZ 11 March 2005

- 3 ABC News. 2005. “Are we ready for the bird flu?” *Primetime*, Sept 25; available from <<http://www.abcnews.go.com/Primetime/print?id=1170177>>
- 4 WHO. 2006. “Previous outbreaks . . .” Table. Available from <[http://www.who.int/csr/don/2004_03_02/en/#world “1959-Scotland-chicken-H5N1”](http://www.who.int/csr/don/2004_03_02/en/#world%20%221959-Scotland-chicken-H5N1%22)>
- 5 Wood, J.M. et al. 1985. “Host range of A/Chicken/Pennsylvania/83 (H5N2) influenza virus”. *Avian Dis.* Jan–Mar; 29(1): 198–207.

Feather pillows may carry Asian bird flu 7 March 2005

Bird flu shots coming – in winter 25 February 2005

(That winter has been and gone . . .)

Repeated flu injections save lives 5 March 2004

Vaccine readied to ward off killer flu strain 25 July 2004

(Which one was that?)

Killer lurking in our midst 3–4 May 2003

Complacency deadly with chameleon virus 25 March 2002

Elderly to be vaccinated as “big one” looms 11 January 2000

(Did that even happen?)

Flu potential killer of millions 2 June 1999

HORROR on the home front 10–11 October 1998

These headings catch the eye, so that the reader reads the body of each article which ramps up emotional responses even further to scare people – into having a vaccine.

In my opinion, health authorities feed and encourage such hysteria. Hysteria certainly creates stress, suppresses the immune system and is another risk factor that can MAKE you sick. Although a study in the past⁶ showed that Vitamin C reduces the flu’s severity, you never hear about that. You are only told that you can take the vaccine. Studies indicate that the selenium and Vitamin E status of a person could determine whether and how badly they get influenza.⁷ This country’s soil is chronically selenium deficient, but has anyone studied the implications of that on the health of New Zealanders?

6 Chamberlain, J. 1996. “Viral vileness the flu and you”. *North and South*, June; pp. 92–97. Dr Lance Jennings “conducted at the University of Wisconsin in 1988 which demonstrated that a daily dose of 2000 mg of Vitamin C reduces the severity of a cold by one half, and alleviates influenza symptoms.”

7 Nelson, H.K. et al. 2001. “Host nutritional selenium status as a driving force for influenza virus mutations”. *FASEB J*, August:15(10): 1846–8. PMID: 11481250.

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Sometimes, media hype unravels on medical authorities, and events in America in 2004 provided a very interesting lesson: 40 million doses of its flu vaccine were found to be contaminated and had to be ditched. The vaccine was rationed, but no great epidemic happened.

The CDC stated, as they do most years, that *the big epidemic* was going to happen in 2004. The vaccine available made antibodies the authorities knew wouldn't stop the new viruses very well.⁸ But because the manufacturers hadn't even been able to isolate a reference strain to the 2004 new variant of influenza A, they couldn't put the new circulating strain in the vaccine.

They had tried military labs, the Hawaii labs, and other WHO collaborating centres, but no one could get the new virus to grow. Instead of the usual egg culture, they even tried using primary monkey kidney cells, an attempt that was also unsuccessful.

Authorities knew that from October 2002 to 2003, 25% of all USA isolates were this fujian strain. So chances of any protection from the old vaccine were moot.

But the public was not told any of that. What they then said publicly was that that the current vaccine should be used, even though it wasn't totally compatible with circulating strains, because some protection was better than none.

This caused Dr Walter Royal to raise a question at an FDA meeting, addressed to a Dr Decker. The answer is very interesting. He declared that⁹

“Everyone has to take it on faith that the strains selected, if grown properly and inoculated, will produce the relevant antibodies and they will not only work against that strain, but they will, hopefully, work against whatever circulates.

All that has to be taken on faith, because by the time you produce it, there's no time left to do any testing. Were

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- 8 Retrieved on 18 September, 2005 from <<http://www.fda.gov/ohrms/dockets/ac/03/transcripts/3922t1.doc>> 20 February, 2003. FDA Meeting “. . . just to reiterate, it shows that current vaccines produce antibodies that don't really inhibit many of these new viruses very well”. “It has not been possible to isolate a reference strain in eggs from of the new variant strains . . .” “Work has been proceeding at other WHO collaborating centers . . . and it has just not been fruitful, and none of us really understand why. But I think there are probably some answers in the receptor binding area.”
- 9 Retrieved on 18 September, 2005 from <<http://www.fda.gov/ohrms/dockets/ac/03/transcripts/3922t1.doc>> 20 February, 2003. US FDA Vaccines and Related Biological Products Advisory Committee 94th meeting.

there any time to do testing, there would be no time left to manufacture anything.”

So from the manufacturer’s point of view, their obligation is to produce whatever this Committee tells them to produce. So, how can there be any scientifically valid assurance in the statements of the past twenty years that said, “*Go and get the flu vaccine, it will protect you*”?

A few paragraphs later in the meeting’s report we read:

“. . . further to the clinical side of things, we don’t really ever know how immunogenic any particular strain is going to be before a vaccine is manufactured, and there really isn’t time to do the kind of clinical trials you would anticipate for any other kind of vaccine. Influenza virus vaccine is different from every other one in that it is changed almost every year and it’s a new experience with each one.”

Those given the available vaccine, just assumed that it would prevent the flu. The rest of the public seemingly stopped thinking about it even though predictions of deaths had been dire. If you aren’t allowed to have vaccine there is nothing you can do. Contrary to the CDC crystal ball predictions, it turned out to be the mildest flu season for years.

Near the end of the flu season the government suddenly realized they had all this flu vaccine that hadn’t been used, so the newspapers ended up running stories telling people to line up for jabs, because it would be wasteful not to use vaccine supplies that were good for one season only.¹⁰

CDC, FDA and WHO may find it harder in the future to say: “*The reason we didn’t have the terrible flu epidemic we predicted was because we had a good, safe, and effective vaccine which stopped you all being sick.*”

Being proven wrong is not a good look when it comes to persuading people that you know what you are talking about in advance. However, the new strategy is now in place, to try to avoid a similar situation. You could call it *The Plan*. It’s here for all to see:

¹⁰ Dainie, Y. 2004. “US weighs easing flu shot restrictions”. Retrieved on 18 September, 2005 from http://aolsvc.news.aol.com/news/article.adp?id=20041216131609990007&_ccc=4&cid=842

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www.ama-assn.org/ama1/pub/upload/mm/36/2004_flu_nowak.pdf

In terms of New Zealand, the 2005 flu vaccine shortage here suddenly resolved itself after many months. The company had made a mistake and tests in Australia found that the vaccine was potent. Which means that the vaccine provokes the formation of antibodies. Whether it protects is another matter.

But the question has to be asked, “Was it just an error in a worker’s notebook?” The reputation of the vaccine was now redeemed. Was the worker smacked over the hand with a wet bus ticket and given bonus shares in the other, for providing publicity that money couldn’t buy? After all, for weeks, lots of people who wouldn’t normally pay attention to flu vaccine propaganda, followed the not-enough-vaccine, we-might-all-die saga, like *Days of our Lives*.

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You all know, don't you, because we've been told since the 70s, that when the flu vaccine is given to the elderly it protects them against the flu, and stops them dying?¹ In fact, it doesn't work at all. To fix the problem doctors say that all we have to do is vaccinate 70% of school children² as well as still vaccinating all the grannies and grandads in whom the vaccine doesn't work.

Just stop and think about this for a minute. For 35 or more years, we've been told that this wonderful flu vaccine will solve all the problems for the elderly. Newspapers extol its virtue, and everyone sticks to the party line.

The authorities don't want to JUST tell you that flu vaccine doesn't work very well, so AT THE SAME TIME they come up with a new "solution".

A question for you all. On what scientifically accurate basis do

- 1 Roos, R. 2005. "Flushots in elderly don't cut mortality". Retrieved on 18 September, 2005 from <http://www.cidrap.umn.edu/cidrap/content/influenza/general/news/feb1605elderly.html>. "Researchers who tracked national data on influenza vaccination rates and mortality in elderly people from 1968 through 2001 say they could find no evidence that flu shots reduced death rates."
- 2 CIDRAP News. 2005. "Immunising children a better way to fight flu". Retrieved on 18 September, 2005 from <http://www.cidrap.umn.edu/cidrap/content/influenza/general/news/feb2205flushots.html> Emory University: "The idea that vaccinating schoolchildren is the best way to prevent influenza throughout the US population received a boost last week with the publication of a commentary and a Texas study in separate journals . . . 'If the 70% threshold can be reached, then high-risk people are protected even if they are not vaccinated,' the authors assert."

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you think their new idea of lining up 70% of schoolchildren as well as still vaccinating the elderly, is any better than vaccinating the elderly, which doesn't work?

To understand the whole mess, let's look at the so-called facts, and start with this oft repeated so-called statistical baseline:

"Influenza is the sixth leading cause of death for older Americans and infects 5% to 10% of elderly Americans every year. The flu leads to 300,000 hospitalizations and kills 30,000 to 40,000 Americans every year."³

The CDC says⁴ that:

"Every year in the United States, on average:

- *5% to 20% of the population gets the flu;*
- *more than 200,000 people are hospitalized from flu complications, and;*
- *about 36,000 people die from flu."*

These are interesting figures. Here are the CDC's own statistics. In 2002: 753⁵ people die of flu. In 2001: 267.⁶ In 2000: 2175⁷ and in 1999: 1685.⁸

If you research it, it's very hard to find out where the 36,000 figure comes from. The question is, even if we could trace the 30,000 deaths, would the vaccine prevent them?

Then we read:⁹

3 American College of Physicians. 2004. "Should vaccinations be required for health care workers?" *ACP Observer* [Internet] Available from <<http://www.acponline.org/journals/news/jul-aug04/vaccinations.htm>> Accessed 18 September, 2005.

4 Retrieved on 18 September, 2005 from <<http://www.cdc.gov/flu/keyfacts.htm>>

5 Kochanek, K.D., and Smith, B.L. 2004. "Deaths: preliminary data for 2002". *National Vital Statistics Reports*, February: 52(13): 16. Available from <http://www.cdc.gov/nchs/data/nvsr/nvsr52/nvsr52_13.pdf>

6 Kochanek, K.D., and Smith, B.L. 2004. "Deaths: preliminary data for 2002". *National Vital Statistics Reports*, February: 52(13): 16. Available from <http://www.cdc.gov/nchs/data/nvsr/nvsr51/nvsr51_05.pdf>

7 Kochanek, K.D., and Smith, B.L. 2004. "Deaths: preliminary data for 2002". *National Vital Statistics Reports*, February: 52(13): 15. Available from <http://www.cdc.gov/nchs/data/nvsr/nvsr49/nvsr49_12.pdf>

8 Kochanek, K.D., and Smith, B.L. 2004. "Deaths: preliminary data for 2002". *National Vital Statistics Reports*, February: 52(13): 28. Available from <http://www.cdc.gov/nchs/data/nvsr/nvsr49/nvsr49_08.pdf>

9 2005. "Flu efficacy in Doubt Study questions saving elderly", *Washington Times*, 15 February: A9.

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“A new study based on more than three decades of U.S. data suggests that giving flu shots to the elderly has not saved any lives.”

Led by National Institute of Health researchers, the study challenges standard government dogma . . .

However, the US Center for Disease Control and Prevention in Atlanta plans no change in its advice on who should get flu shots, saying the NIH research isn’t enough to shift gears.

‘We think the best way to help the elderly is to vaccinate them,’ said CDC epidemiologist William Thompson. ‘These results don’t contribute to changing vaccine policy.’”

No articles on this topic made it into New Zealand newspapers. For the whole 2004–2005 flu season, the CDC said¹⁰ that only 14.9% of influenza cultures submitted since October 2004 were positive. Of these, 75.4% were Influenza A. Out of the 157,759 individuals nationwide who had gone to the doctor and been diagnosed with the flu, only 23,549 people actually had the flu.

In the study¹¹ mentioned in the *Washington Times*, Dr Simonsen developed ‘a cyclical regression model’ which carefully and methodically estimated influenza-related deaths, and all deaths, among the elderly in the United States during thirty-three consecutive flu seasons between 1968 when Tony Morris’s work found the flu vaccine was of no use, to 2001.

The study found that mortality didn’t change at all through those years, and that in the age group 65–74 years, mortality had remained the same between 1970 and 2001. In other words, her results were the same as Dr Morris’s results. Flu-related mortality in the elderly was always less than 10% of the total number of winter deaths. So the current flu vaccine isn’t much better than when Dr Morris got fired for saying the pre-1970 flu vaccine didn’t work.

In an interview,¹² Dr Simonsen said that the dramatic increase

10 2005. U.S. Influenza Season Summary: 18 Jun, 2005. Available from <<http://www.cdc.gov/flu/weekly/weeklyarchives2004-2005/04-05summary.htm>>.

11 Simonsel, L. et al. 2005. “Impact of influenza vaccination on seasonal mortality in the US elderly population”. *Archives of Internal Medicine*, 14 Feb; 165(3): 265–72. PMID: 15710788.

12 Boyles, S. 2005. “Do flu shots save lives?” *MD Medical News* [Internet] Available from <<http://webcenter.health.webmd.netscape.com/content/Article/100/105852.htm?printing=true>>

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in vaccination coverage should have led to a dramatic drop in flu deaths. *“This is not what we found,”* she said. *“Certainly if this intervention really does reduce winter deaths in the elderly by 50% we would expect to see it. So the mortality benefits are probably very much overestimated.”*

Dr Simonsen then commented on the 1997/1998 flu season where the vaccine contained totally different strains from those cultured in the fifty states and therefore the vaccination of over 60% of eligible elderly was useless. Yet there were approximately 5000 fewer excess deaths in this age group than there were the following flu season, when the same percentage of people were vaccinated with the correct strains.

But in some strange twist of logic, Dr Simonsen then said that their study argued in favour of vaccinating everyone: *“We totally agree that influenza is a major cause of serious illness, hospitalization, and death,”* she says. *“Vaccinating the elderly is a major tool, but our findings suggest that there is more that can be done.”* How can something that has no impact, be a major tool?

This sort of statement seems to be mandatory when criticizing any vaccine. In 1995, Dr Jenkinson wrote a whole article showing that the medical profession’s assertions that whooping cough was always serious and always had major complications were totally wrong. Yet in the key messages and final paragraph he says:

*“it is important to emphasize the vaccine’s major role in maintaining herd immunity.”*¹³

That’s not what the body of Jenkinson’s article says at all. My guess is that if he hadn’t said something supporting the vaccination of everyone, he wouldn’t have been allowed to say all the rest showing the whooping cough vaccine doesn’t work for most people. I believe it’s the same with Dr Simonsen. Is she being tolerated, because her recommendation to vaccinate the kids as well, at least doubles the amount of useless flu vaccine dished out?

Even more interesting is other discussions on this study¹⁴ in *Infectious*

13 Jenkinson, D. 1995. :Natural course of 500 consecutive cases of whooping cough: a general practice population study”. *British Medical Journal*, Vol. 310: 299–302. [Internet]. Available from <<http://bmj.bmjournals.com/cgi/content/full/310/6975/299>>

14 Reichart, T.A. et al. 2005. “Enhance the national influenza vaccine strategy; Researchers defend influenza vaccine study; and Should we question the benefits of influenza vaccination for the elderly?” *Infectious Disease News*, August. Available from

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Disease News. Simonsen et al. said:¹⁵

“There is a void of evidence from randomized, placebo-controlled clinical trials in the elderly for influenza . . .”

And they point out the statistical fallacies and manipulations by CDC of cases and death numbers which they politely call *“the vast disconnect”*.

For Americans, this vast disconnect is the statistical baselines rolled out every year to justify the vaccinating of everyone over 65.

Dr Fedson¹⁶ in response, discusses every possible *“ecological fallacy”* to attempt to discredit Simonsen’s comments, then amazingly reiterates the dogma, saying:

“Greater efforts to improve the vaccination rate for the elderly, including eliminating disparities in the vaccination rate among different groups, will help prevent more influenza-related hospitalizations and deaths. Nonetheless, whatever the ‘obvious implications for influenza vaccination policy’ of Simonsen’s results might be, we should not doubt the benefits of current policy to vaccinate all elderly people, over 95% of whom still live in the community.”

When you read anything by Dr Fedson, it’s important to take into consideration very creative remarks he has made in the past like this one:

“The failure to use pneumococcal vaccine can no longer be attributed to limited protection of the vaccine itself,’ said Fedson. ‘It is the result of limited imagination regarding the burden of pneumococcal disease and the limited understanding of the protection afforded by vaccination. The effectiveness of pneumococcal vaccination is firmly established and requires no further demonstration.”¹⁷

15 <<http://www.infectiousdiseaseneews.com/200508/frameset.asp?article=guested3.asp>> Simonsen, L., Ward, C., Blackwelder, W., Taylor, R., and Miller, M. 2005. “Researchers defend influenza vaccine study”. Available from <<http://www.infectiousdiseaseneews.com/200508/frameset.asp?article=guested2.asp>> accessed 18 September, 2005.

16 Fedson, D.S. and Nichol, K. 2005. “Should we question the benefits of influenza vaccination for the elderly?” Available from <<http://www.infectiousdiseaseneews.com/200508/frameset.asp?article=guested1.asp>> Accessed 18 September, 2005.

17 Fedson, D.S. 1998. “A commentary on the report of the Swedish pneumococcal vaccination study group”. National Adult Immunization Conference (Atlanta), March 3–4.

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Actually, the effectiveness of the Pneumococcal vaccination is debatable and repeated Cochrane reviews¹⁸ have shown that:

“polysaccharide pneumococcal vaccines do not appear to reduce the incidence of pneumonia or death in adults with or without chronic illness, or in the elderly (55 years and above), . . . the evidence from non-randomized studies suggests that the vaccines are effective in reducing the incidence of the more specific outcome, invasive pneumococcal disease, among adults and the immunocompetent elderly (55 years and above).”

To make the debate on flu vaccine more interesting, Reichert chimes in and after saying that the result was a misinterpretation of the conclusions, and having stated that influenza vaccine is of great benefit to the elderly, strangely says this:

“The only national vaccination program that has produced a decrease in excess mortality in the elderly population on a national basis was the schoolchildren vaccination program in Japan.”¹⁹

Apparently, between 1962–1987, 50–85% of Japanese schoolchildren were vaccinated annually.²⁰ Supposedly the death rates in the elderly fell, then when they stopped vaccinating, it rose again. Reichert, Fedson, and Simonsen as authors of the Japanese study,²¹

18 Dear, K.B.G. et al. “Vaccines for preventing pneumococcal vaccines in adults”. Issue 2, 2005. Available from <<http://www.cochrane.org/cochrane/revabstr/AB000422.htm>> Accessed 18 September, 2005.

19 Reichart, T.A. et al. 2005. “Enhance the national influenza vaccine strategy; Researchers defend influenza vaccine study; and Should we question the benefits of influenza vaccination for the elderly?” *Infectious Disease News*, August. Available from <<http://www.infectiousdiseaseneews.com/200508/frameset.asp?article=guested3.asp>> “An enhanced strategy will be critically important in the event of a pandemic when vaccinating those who are most likely to spread the disease will have a multiplier effect in reducing total population deaths. Results from studies on selected subpopulations that cannot be extrapolated to the total population to be protected must not distract us.” “We suggest . . . that to overcome this lack of progress, the national strategy should be enhanced. Evidence from studies of multiple types indicates that significant reductions of mortality in the elderly as a whole can be achieved by expanding the vaccination program to include not only risk groups, but also transmission groups, specifically schoolchildren.”

20 Isaacs, D. 2005. “Should all Australian children be vaccinated against influenza?” *MJA*, 182(11): 553–554 [Internet] Available from <http://www.mja.com.au/public/issues/182_11_060605/isa10175_fm.html>

21 Reichert, T.A. et al. 2001. “The Japanese experience with vaccinating schoolchildren against influenza”. *N Engl J Med*, March: 22;344(12): 889–96. PMID: 11259722.

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postulate that: *“When most schoolchildren were vaccinated, it is possible that herd immunity against influenza was achieved in Japan. If this was the case, both the incidence of influenza and mortality attributed to influenza should have been reduced among older persons”*.

Is the influenza vaccine in the elderly in Japan any use? A Japanese study²² looking at elderly in the 2003–2004 showed that the influenza vaccine over there *“was 20% effective, although this effectiveness was not statistically significant.”* So the NEMJ study is the sweetener to the unpalatable fact that the flu vaccine doesn’t work in the elderly. In the UK, a Cochrane review looking at vaccines in the elderly made some blunt comments in Pulse,²³ saying:

“Researchers on the Cochrane Vaccines study said Government claims that the flu vaccine was 70 per cent effective were ‘a total fantasy’. The review of 64 international studies in patients aged 60–65 and over found community vaccination had no effect on rates of influenza, influenza-like illness or pneumonia.”

What the New Zealand media was concentrating on in February 2005 was the Health Department statements that *“vaccinating the elderly against the flu spares lives, and giving the shot yearly prevented the deaths of about one out of every 200 patients.”*²⁴

The same paper went into greater detail in March 2005²⁵ saying that, in patients above 65 *“a single flu vaccination reduced the risk of death by about 10 per cent . . . those who were vaccinated again the following year had a 24 per cent lower risk of death.”*

However, that article says²⁶ that the vaccine may prevent 1 death

22 Ozaka, K. et al. 2006. “Retrospective assessment of influenza vaccine effectiveness among the non-institutionalized elderly population in Japan”. *Vaccine*, March: 24(14): 2537–43. PMID: 16417955.

23 Wright, E. 2005. “Flu vaccine efficacy warning”. *Pulse*, 1 October. [Internet] Available from <<http://www.pulse-i.com/search/default.asp?issuedate=1128121200000>> Accessed 4 October 2005. “Government claims that the flu vaccine was 70 per cent effective were a total fantasy . . . But Dr Jefferson insisted the study included fit, healthy individuals and not just the old and frail. ‘The vaccine was ineffective in the younger elderly as well as those in their 80s,’ he said. He criticised officials for failing to take responsibility for the fact figures on the vaccine had been distorted and patients misled.” (no longer available).

24 2005. “Repeated flu injections save lives”. *New Zealand Herald*, 5 November: A17.

25 Editorial. 2005. “Flu vaccine debacle puts many at risk”. *New Zealand Herald*, 17 March: A16.

26 Voordouw, A.C.G. et al. 2004. “Annual Revaccination Against Influenza and Mortality

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for every 302 vaccinees . . . BUT it also said “*a first vaccination was associated with a non-significant annual reduction of mortality risk.*” But . . . vaccinate again the next year and the protection rate is 28%. Was that result any better than those from Dr Morris’s original work from the 1950s which showed a 20% rate, which was considered statistically insignificant? I sent the study to him. His reply to me²⁷ reads: “*If this claim is valid, then the authors of the paper will be nominated for the next Nobel prize in medicine. It’s validity is not established in this paper.*”

Yet the author of this study said:²⁸

“Both patients and physicians should be convinced about the benefits of annual influenza vaccination, and no opportunities should be missed to have all patients recommended for vaccination against influenza,” Hak tells WebMD.

Using the criteria use by Dr Fedson to criticize the US study showing no efficacy in the elderly, you have to wonder about the evidence for using it in children. A recent Cochrane review²⁹ found: “*limited evidence that vaccines reduce the burden of school absences . . . Vaccination of very young children is not supported by the evidence . . . at present we could find no convincing evidence that vaccines can reduce mortality, hospital admissions serious complications and transmission of influenza*”

However, a member of the American Academy of Pediatrics committee on infectious disease said³⁰ that while the Cochrane Review was exhaustive, and meticulous, it was unpersuasive, and had “*failed to account for variation in the quality of vaccines and research methods. The review . . . also fails to account for the fact that much of the efficacy data on vaccines is gathered by drug companies that*

Risk in community-Dwelling Elderly Persons”. *JAMA*, 3 Nov; 292(17): 2089–95. PMID: 15523069.

27 Personal Correspondence, 20 March 2005.

28 Boyles, S. 2005. “Do flu shots save lives?” *MD Medical News* [Internet] Available from <<http://webcenter.health.webmd.netscape.com/content/Article/100/105852.htm?printing=true>> Accessed 18 September, 2005.

29 Smith, S. et al. 2006. “Vaccines for preventing influenza in healthy children”. *The Cochrane Database of Systematic Reviews*, Issue 1. Art. No.: CD004879. DOI: 10.1002/14651858.CD004879.pub2. Available from <http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD004879/pdf_fs.html> Accessed on 18 September, 2005. PMID: 16437500.

30 Mott, G. 2006. “The Toddler Debate”. *Washington Post*, 31 January. Available from HE02 <http://www.washingtonpost.com/wp-dyn/content/article/2006/01/30/AR2006013001253_pf.html>

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may choose for business reasons not to publish their findings.”

Really? CDC chimed in by saying that because kids make antibodies and the vaccine is safe, it was a reasonable thing to recommend.

So, the flu vaccine will be given to the children when according to the Cochrane Review there is *“no convincing evidence that vaccines can reduce mortality, admissions, serious complications and community transmission of influenza of children either.”* Will that too, be exposed as another item on a wish list in 35 years’ time?

Another risk group to whom the flu vaccine is already recommended is asthmatic children to prevent asthmatic exacerbation, because studies done by authors like DeStefano F, Chen RT who have conflicts of interest, had found it protected against asthma. A new study has found the opposite:³¹

“RESULTS: After adjusting for other variables, the vaccine group had a significantly increased risk of asthma-related clinic visits and ED visits (odds ratios 3.4 and 1.9, respectively).”

Another unrelated study in Turkey confirmed this.³² Yet another concluded *“that influenza vaccination did not result in a significant reduction of the number, severity, or duration of asthma exacerbations caused by influenza.”*

All this talk is academic because it has never been the intention of the Influenza policy planners to aim for anything other than vaccinating everyone against the flu annually no matter what the efficacy isn’t. The only thing holding them up was the lack of manufacturing technology to make enough vaccine to do it. Growing flu virus for vaccines in chick eggs is a very slow process, but cancerous cell lines grow flu viruses rapidly. So the FDA has decided it’s time to seek permission to use them.³³ New Zealanders were recently used in a trial by Chiron,

31 Christy, C., and Aligne, C.A. et al. 2004. “Effectiveness of influenza vaccine for the prevention of asthma exacerbations”. *Arch Dis Child*, August: 89(8): 734–5. PMID: 15269071.

32 Abadoglu, O. et al. 2004. “Influenza vaccination in patients with asthma: effect on the frequency of upper respiratory tract infections and exacerbations”. *J Asthma*, 41(3): 279–83. PMID: 15260460.

33 “FDA To Seek Input On Safety Of Flu Vaccine Produced In Tumorigenic Canine Cells”. 2005. Available from <http://www.fdaadvisorycommittee.com/FDC/AdvisoryCommittee/Committees/Vaccines+and+Related+Biological+Products/111605_FluVaccine/111605_MadinDarbyP.htm> Accessed on 18 September, 2005. “The agency appears comfortable that potential risks associated with tumorigenic cell substrates can be mitigated . . .’ Although there is a perception that highly tumorigenic

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of a flu vaccine made on a tumorigenic dog kidney cell substrate.³⁴

Whatever technology is around, the USA CDC is likely to recommend vaccinating everyone with the flu vaccine yearly³⁵ with major vaccine proponents being very enthusiastic: “*This is long overdue,*” said Dr Paul Offit, “. . . *Influenza is an infectious disease that can be prevented easily and safely, and it should be.*”

Even before childhood studies were completed, on 13 May 2005, Lindsey Tanner was reporting that within five years, every person in the USA would be vaccinated yearly, with Dr Herb Young of the American Academy of Family Physicians saying that recommending flu shots for everyone would ease the confusion and that his group would support the idea.

The response to the ongoing debate about how useful the flu vaccine is has also resulted in some USA medical centres trying to make the flu vaccine compulsory for staff, because of another statement by Gregory Poland:³⁶

“At an Annual Session presentation on immunizations, Gregory A. Poland, FACP, made a case for requiring – not merely recommending – annual flu vaccinations for all health care professionals. ‘That’s because data have shown that health care workers aren’t stepping up and getting the vaccine,’ he said. Despite recommendations from organizations like the CDC, only about 36% of health care workers are immunized against the flu.”

Some medical centres tried to make ‘failure to receive flu vaccine’ grounds for dismissal. One medical centre rebelled and the workers took the issue to Arbitration, where the arbitrator found against the

cells may carry greater risks than less tumorigenic cells, we are proposing that such risks can be mitigated by careful testing of the cells, validation of the production process for its capacity to remove adventitious agents, and limitation of residual DNA in the final product,” FDA said . . . FDA is also asking the committee to discuss whether the agency should take additional steps “to address issues associated with the use of MDCK cells or neoplastic cell substrates.”

34 NZPA. 2005. “NZers in flu vaccine trial”. *New Zealand Herald*, Nov 28: p. A11. “New Zealanders have been used by a big British Drug Company to test a new way of making flu vaccines using animal cells which may also have the potential to trigger tumours in humans.”

35 “Should vaccinations be required for health workers?” Available from <<http://www.ajc.com/news/content/health/0204/20flu.html>> Accessed on 18 September, 2005.

36 2004. “Should vaccinations be required of health care workers?”. *ACP Observer*, July–August. Available from <<http://www.acponline.org/journals/news/jul-aug04/vaccinations.htm>> Accessed on 18 September, 2005.

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medical centre,³⁷ not on the basis of staff's autonomy of choice, but because the centre didn't negotiate it with the union! So the medical centre now hopes that it can use financial incentives or other incentives to get staff to comply. In 2005 the Virginia Mason Medical Centre did the job properly. They simply said, "Have the shot or leave". Most of the staff capitulated without a whimper.³⁸

Meanwhile, Medicare and Medicaid applied to the Federal Register³⁹ on 15 August to force nursing homes to vaccinate the elderly with influenza and pneumococcal vaccines, or lose their funding. If the elderly who don't want to be vaccinated live in the community, their right to choose is more easily defended. But if they live in a nursing home, their choice is no longer theirs. Expect this to become mandatory in New Zealand sometime soon!

If you as a New Zealand parent are soon told that vaccinating yourself, your babies and children every year will help protect your vaccinated Grannie from the flu because her vaccine doesn't, what will your response be?

There is nothing quite like a new scare tactic to divert people from thinking about FACTS. Even though the evidence is quite clear that the flu vaccine does not work for the flu, experts declared that the flu vaccine, by stopping the flu, (which we know it doesn't), will stop a bird flu pandemic.

The best hype story I've seen appeared in the *UK Times*:⁴⁰

"MORE than a million children in Britain must be vaccinated against flu as soon as possible," senior health officials said last night as the deadly avian form of the virus reached Europe . . .

Scientists are concerned that, if the bird virus were to infect anyone already suffering from ordinary flu, the victim could then act as a "mixing vessel" in which the

37 Galloway, A. 2005. "Virginia Mason nurses can shun flu shots". Available from <http://seattlepi.nwsourc.com/pqa/wlocal_story.asp?id=236097> Accessed on 18 September, 2005.

38 Rusk, J. 2006. "Mandatory flu shots boost health care worker immunization rate at Virginia Mason". *Infectious Disease News*, March. Available from <<http://www.infectiousdiseasesnews.com/200603/frameset.asp?article=mandatory.asp>>

39 Retrieved on 18 September, 2005 from <<http://www.regulations.gov/freddocs/05-16160.htm>>

40 Elliott, V., and Henderson, M. 2005. *The Times*, 14 October, [Internet] Available from <<http://www.timesonline.co.uk/article/0,,2-1825271,00.html>> Accessed on 18 September, 2005.

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germ could adapt to spread more easily from person to person. This would be the key mutation that could trigger a devastating pandemic.”

There is one big stick that most people in this country didn't hear. The influenza vaccine manufacturers, in the face of evidence that their vaccine has never been any real use from Dr Morris's era to now, have threatened that unless the government of the UK⁴¹ expands the mandated use of the ordinary flu vaccine, they will not produce enough bird flu vaccine. Have similar verbal bazookas been delivered in the ears of other governments as well?

In the USA, potential bird flu vaccine manufacturers demanded the identical indemnity that they got when they manufactured the swine flu vaccine.⁴²

It was therefore a relief to read in the *New Zealand Herald* one person who hadn't lost their head. Dr Peter Curson, from MacQuarie University Australia, described our Government's bird flu preparation as “*over the top*”,⁴³ and “*getting into a flap over nothing*”. He said that the country would be better off declaring a pandemic on real issues like diabetes and obesity.

British experts now realize that you have more chance of winning the lottery than getting bird flu⁴⁴ and research teams have figured out why, in the last decade, bird flu has only hit people who play with, spend all their time with, or eat sick birds. The receptors in people's lungs are too deep to cause infection human to human.⁴⁵

41 West, M.R. 2005. “Firms' threat to limit bird flu vaccine”. 26 October. Available from <http://www.telegraph.co.uk/news/main.jhtml?xml=/news/2005/10/26/nflu26.xml> “Richard Stubbins, of the UK Vaccine Industry Group, told a House of Lords select committee that it was ‘unreasonable’ for the Government to expect the industry to build new plants to produce enough vaccine for a pandemic then mothball them. He called for the Government to vaccinate everyone aged over 50 and possibly children against common flu as a matter of routine. That would guarantee that the extra capacity would be used”

42 November 1, 2005 Available from <http://news.yahoo.com/s/ap/20051101/ap_on_go_pr_wh/bird_flu_liability_2> Accessed on 18 September, 2005. “Two weeks ago, the Senate's health committee approved a bill that said the “manufacturer, distributor or administrator” of a pandemic product shall be immune from lawsuits caused by the dispensing of that product.”

43 “Australian academic mocks our bird flu ‘over-reaction’”. 2006. *New Zealand Herald* [Internet] Available from <http://www.nzherald.co.nz/section/print.cfm?c_id1&objectid=10364832> Accessed on 29 March, 2006.

44 Henderson, M. “Lottery win more likely than bird flu”. *The Times*, March 3. Available from <<http://www.timesonline.co.uk/article/0,,25149-2067213,00.html>>

45 Price, H.J. 2006. “Bird flu too deep in human lungs to spread easily”. *The Washington Times*, March 23. Available from <<http://www.washtimes.com/functions/print.php?StoryID=20060322-111957-5097r>>

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And it doesn't help the hysteria promotion when the proposed bird flu vaccine only produces antibodies in half the people⁴⁶ given huge doses (12 times the normal flu shot).

Furthermore, the bird flu strains circulating now, are quite different⁴⁷ from the 1997 Hong Kong strain which killed six people. Another pointer to the fact that a bird flu outbreak is unlikely, is a study⁴⁸ which showed that a strain of bird flu that had been circulating for 12 years in 1992, hadn't killed anyone, and had given millions of Chinese antibodies. It could be that Peter Curson was right. All the New Zealand panic mongering and buying of drugs could have been a total waste of time, drugs, and millions of dollars, while the real health needs of this country have to wait.

It's a shame the New Zealand experts have been conspicuous by their silence on all this.

One final thought. Why is it, do you think, that the New Zealand Government is proceeding to invest \$27 million in a drug called Tamiflu, which does not work on the bird flu virus?⁴⁹

46 Health Day News. 2006. "Experimental bird flu vaccine falls short". *Forbes Magazine*, March 29. Available from <<http://www.forbes.com/lifestyle.health.feeds.hscout/2006/03/29/hscout531823.html>>

47 Grady, D. et al. 2006. "How serious is the risk of Avian flu?". *New York Times*, March 27. Available from <<http://www.nytimes.com/2006/03/27/health/28qna.html>>

48 Kolata, G. 2005. "Hazards in the hunt for flu bug". *New York Times*, November 8. Available from <<http://www.nytimes.com/2005/11/08/science/08flu.html?ex=1144123200&en=0e90a913f6003e71&ei=507>> "Peter Palese of the Mount Sinai School of Medicine in New York said the H5N1 viruses are a false alarm. He notes that studies of serum collected in 1992 from people in rural China indicated that millions there had antibodies to the H5N1 strain. That means they had been infected with an H5N1 bird virus and recovered, apparently without incident."

49 "Bird Flu resistant to main drug". [YEAR?]. *CNN News*, [Internet] Available from <<http://www.cnn.com/2005/WORLD/asiapcf/09/30/birdflu.drugs.reut/>> Accessed on 18 September, 2005. A strain of the H5N1 bird flu virus that may unleash the next global flu pandemic is showing resistance to Tamiflu, the antiviral drug that countries around the world are now stockpiling to fend off the looming threat. Experts in Hong Kong said on Friday that the human H5N1 strain which surfaced in northern Vietnam this year had proved to be resistant to Tamiflu.