Breaking the silence:

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My name is Dr Dave Cartland, and I am 39 and a practicing GP in the UK down in sunny Cornwall. I qualified in 2014 as a GP, and prior to that worked my foundation years in the West Midland's Foundation programme and GPVTS (Black country). I qualified from Birmingham Medical school in 2008 as a graduate entry medic, completed a Biomedical science degree in 2004 with a large component of this reading in immunology, virology, microbiology and medical statistics. I proudly qualified with first class honours and went on to publish work in Angiogenesis as part of the Birmingham angiogenesis research group in 2005. I am a married father of 4 awesome children who are my life and have two faiths……Jesus Christ and Aston Villa FC.

Anyway, enough about me. Why did I become a Dr I hear you cry? I became a doctor to help my patients, to be their advocate, to help them in their biology, psychology and social circumstances. I will always remember exactly the moment of my graduation when we recited the Hippocratic oath. Part of this powerful oath is a vow. A vow to 'Primum non nocere'- first do no harm. I hope my patients would agree that I am a caring, decent GP. I enjoy my job and the role I have to play in patient's lives and can safely say this vow has formed the basis of my medical career thus far. To not recognise, notify or publicise concerns of harm would be contrary to mine and my colleague's oath taken at qualification. I am writing this as a commentary and as a personal reflective piece, some of it opinion other from anecdotes others statistical and government data, but am equally happy for it to be shared.

When the COVID pandemic hit the UK, the confusion, fear and medical uncertainty was palpable by colleagues and patients alike. I want to say from the outset that I am by no means a covid-denier, I have seen many people debilitated acutely and chronically with this horrific disease. I gladly rolled up my sleeve despite reservations about the speed of the development and lack of prospective safety data but to 'do my bit' in the face of unknown aspect of a pandemic. What sort of person let alone Dr would I be if I didn't step forward to help 'protect the vulnerable' and of course my own health. I took my first Pfizer jab on 13/1/21 in complete good faith of the science and public health underpinning its roll out, trusting as all patients do the integrity and reassurance of the government and its scientific advisors. On the 7th of January, 6 days prior I lost my best friend to the pandemic. At this time, only

very short-term vaccine safety data was starting to filter through and obviously medium- and long-term safety data for the Jab was absent, but with the clear and present danger of the disease, a clear weight in the balance for taking it. All seemed logical to this point.

Something that struck me from the very beginning was that (thank God) death and seriously unwell patients at least in my capacity as a GP (and am aware that I don't see that particular tip of the iceberg), for me never hit the heights of what I was expecting or that was being projected from the various modelling data that was being shared at the time. 'Nightingale hospital-gate' as I will call it never took off, and mortality wasn't as high as the fear levels had perhaps suggested which was great news. This wasn't just an independent observation. Now as previously mentioned ITU's and A+Es were full of covid-related morbidity and mortality, however as time went on slowly but surely some things started to seem odd and not make sense to my pre-pandemic experience of medical practices…

Firstly, and very early on, death certification changed, and all the safeguarding related to a second 'part 2' Doctor verifying events around death to come to agreement about what we call the medical certificate of cause of death (MCCD), was over-ruled very early on.

This was partly understandable on the face of it given the swathes of death's that were expected some of the 'paperwork' would understandably need streamlining. Over time I started to see patient's death certificates coming through in patients that were generally severely unwell with multiple comorbidities as MCCD 1 (a) COVID-19, the main cause of death felt by the Dr or coroner. When looking into specifics and looking at the notes I was seeing when they had been admitted to hospital they had clearly 'entered the building' having been unwell with other things…cancer related issues, end stage COPD exacerbations or renal failure, broken bones, strokes, heart issues, a barn door case of urosepsis died in resus. On entry to the mortuary marked down as 1 a) COVID 19. Out of hospital deaths followed suit. All it seemed to take was the mere mention of 'cough' by a relative elicited by the Part 1 Dr (a common symptom around the time of anyone's death) the MCCD would be confirmed-COVID-19! This was happening with alarming regularity in personal experience. Something odd was happening and didn't sit right!

The next irregularity seemed to be around testing and the early use of statistics. I won't mention too much detail here but the testing for COVID 19

was using PCR (the results of which have formed the mainstay of covid surveillance and shielding protocols throughout). With some prior knowledge of this from my science background and an early statement from the inventor of PCR Kary Mullis himself stating that this was not a technology purposed for diagnostics of viral infections. To use such technology, in knowledge of this, to gather ‘cases’ just seemed very unscientific. PCR is used to amplify a small sample of genetic material and to increase its ‘visibility’, in order to genetically sequence that small initial sample with common practical application in things like forensics. We had technology to isolate the virus, electron microscopy among other things but not a mention. It is commonly accepted that when using PCR, you have to set a cycle number of amplification. The agreed limit to get a good amplification and reducing false positive ‘signal’ is 20-25 depending which data you look at. To go over and above this cycle threshold yields very high percentage of false detection.

Multiple FOI requests have been returned from many of the testing labs stating that 40-45 cycles have been used as standard throughout the pandemic. Consider this in simple terms as a game of Chinese whispers, in the amplification process translation errors commonly occur in the decoding process and an early error will pass through to the next and subsequent cycles. Just like Chinese whispers the initial message after 45 people may be very different to the original word in the game/PCR sample compared to 25. Again, warning signals. Essentially if you turn the cycle number up high enough everyone will have a positive result whether true or false positive. This again defied basic science but was still used despite these very well-known limitations.

Furthermore, the medical statistics being used were and are still vague such as ‘death within 28 days of a positive covid test’, about as nebulous as you can get for such key figures important in a worldwide pandemic seemed to be being purposefully blurred. Let me expand here briefly, surely just report people who have a case definition of what the viruses’ physical symptoms were (again ever changing) and a positive test = a case. Someone feverish with cough and short of breath with a covid positive test prior to their passing was of course likely a death FROM COVID-19; it wasn’t seemingly that ‘simple’. It certainly didn’t seem good medicine to report a person in intensive care for example that has died of a PE secondary to his elective Total hip replacement and passing away from this as COVID 19 due to asymptomatic positive screening, this just didn’t add up! For medics even now simplified data is hard to find, with guidance ever changing almost weekly and finding straightforward

data e.g., how many of those 150,000 recently surpassed deaths were actually FROM …not WITH COVID-19 seem impossible to lay hands on. Surely for such an inherently important statistic, clarity should be paramount particularly in order to counsel our patients and risk assess for ourselves as independent practitioner. Again, recent FOI reports I am being made aware of state in one example 2 of the 97 reported covid deaths fulfilled the disease definition and positive test criteria among others! Alarming stuff!

Back to personal experience, the time came for Jab 2 with the 'friendly warning' that mandate was coming for NHS staff and after careful consideration and using evidence-based approach myself and my wife reluctantly agreed on 26/5/21. I will say that at that time the data wasn't as black and white as prior to Jab 1 but for the greater good and all that! Questions on mine and my patients mind were……. Why do I need this again so soon………does this not show the jab isn't working?... jab one made me quite unwell for a number of days with some very strange symptoms what if this happens again?…….and what if jab 2 doesn't stem the tide surely not a third?……and just around that time a few early signals of a wide selection of 'Jab reactions' were starting to find their way to my attention through patient contacts………more on this later.

What makes a case:

I briefly touched on this above but wanted to expand. It sounds very basic to say this but to have a medical condition or to be called a 'case' one must satisfy a basic criterion……. you must have symptoms and the presence/evidence of the disease like a scan or a test. For example: dysuria and frequency plus E. coli in the urine = UTI (see Koch's postulates), headache/neurology plus cerebral mass = brain cancer, abdominal swelling and baby in-utero…. You get the jist.

However, in the case of COVID-19 people were being told something I have never heard before in my career. You can be a 'case', a dangerous 'threat to your gran' without even having a symptom. A dangerous spreader of the virus without so much as a sneeze. The hallowed 'asymptomatic carriage' (AC). From my very basic virology knowledge and in view of alarming data re false positives as above all was a little confusing. Asymptomatic disease is true in other areas of biology for example bacteria and some protozoa can be asymptomatic. Sorry to freak you out but your hands are probably covered in Staph Aureus (a natural 'commensal' bacteria that colonises skin), and likely coliforms (a medical word for bowel organisms)- despite how much hand gel

you are using. They are single independently alive unicellular organisms that reproduce asexually. Viruses on the other hand are a little more complex. By definition they are obligate intracellular parasites. They cannot live very long at all outside of a human cell as they are fully dependent on human cellular machinery (nucleus, ribosomes and various enzymes) that they borrow to allow to reproduce. A single virus enters the human cell, takes over the genetic machinery, and causes programmed cell death 'apoptosis' of the cell. Having ruptured the host cell and bursting with an exponential number of virion's compared to the initial individual invading virus those new viruses go on to then infect a multitude of neighbouring cells and before you know it innumerable viruses. Cell damage left in the wake of this and the consequent immune response to fight this vicious attack. Part of what makes you feel unwell from having a virus is the immune system response aside from the effect of cell damage by the virus. Cytokine's, inflammation, and pyrogens storm the body to gain control before a critical mass of virus can take hold. As only males of the world know this is particularly present in the seasonal illness known as man-flu, the consequent myalgia, rigors nausea malaise and near-death experience of man-flu is in part due to this. I will summarise it this way…….and apologies for the lecture on virology……. if you have a virus particularly a SARS type respiratory tract virus, you KNOW you have a virus whether it's a sniffle, aches, pain but still not asymptomatic carriage.

Incidentally the way pandemics become endemic is by exactly the mechanism we see being displayed in Omicron data. As previously mentioned, Viruses are parasites and has no interest in killing their host that wouldn't make much sense from a survival plan perspective. Viruses learn to become symbiotic with their host. The perfect storm……. spread like wildfire/high transmission and low pathogenicity/harm to the host, survival of species. The misuse of this medical 'phenomenon' of AC and not acknowledging the fact of what is happening now with Omicron being a much milder disease is in my medical opinion misleading the public. A virus pandemic will always eventually become endemic, fact. The AC fallacy use has driven fear into our society as we mask up, avoid others, keep our 2 metres and decide not to visit our elderly relatives is implausible. Aside from that the collateral harm from all the psychological physical and social/economic harm is a ludicrous idea in the face of such a lie. To 'LOCK DOWN' is inconceivable and unprecedented as evidenced by having never been used as a management strategy for pandemics ever in humanity.

Talking of collateral damage and just while we are on the subject of harm from such an erroneous medical 'fact' and subsequent policy. When does the harm

to patients for such damage become an important denominator? From fear of seeing the GP, delayed cancer diagnosis, bottle-necking of NHS services/inflation of waiting lists, palpable mental health distress, social issues such as poverty and loneliness the list is endless? Surely to allow all of this as a trade-off, the threat needs to be 'bubonically' high, and the risk of treatment low to allow such measures to become acceptable.

Silence is deafening

Over the last few months something has become startlingly apparent in regard to the latest data from Omicron which didn't seem to correlate with previous waves. I will say that from the outset, hence my discomfort with current policy in particular the Mandate of a medical treatment for staff.

It came about after I was asked to consider the booster (in English a third dose in 6 months of something I had twice in the recent past that gave me side effects and something I and probably no other Dr can say they have experienced before in their medical practice. A tri-6 monthly jab with speculation of even more……. flu Jabs annually, Hep B jab lifelong, the ten yearly tetanus et al…, something didn't feel right. To take one (again) for the team or not? The answer to this dilemma was simple. The 'vaccine' needed to confer both personal benefits i.e., if I take it my risk of being ill and even death would/should be reduced, likewise in the interest of being a good citizen and medic of the world that it would also reduce my ability to catch and likewise transmit to my relatives and patients (aside from evolving safety data which will discuss later).

I took a short look at the data from my own surgery (admittedly low numbers to try to spot a trend). We receive positive results as a batch each week and one of our ANP's contacts them all to see how they are. At this point I will say that most of the positive results displayed mild flu like coryzal symptoms, evidence for me that we were dealing with a different beast in Omicron which was really great news. I counted 102 'cases' of positives in the first two weeks results and traced their vaccine status… positive… treble vaccinated… positive treble vaccinated… positive treble vaccinated. A pattern was apparent… Long story short in that 2 weeks 94.1 percent of the patients n= 96 of 102 were treble or double jabbed (mostly treble) and just the 2% n=2 unvaccinated. I decided to repeat this the next week and this time 100% of the 38 patients were double or treble jabbed zero unvaccinated.

This seemed odd and quite contrary to what I expected but had put some data to the gut feeling of what I was hearing of in clinic. I decided at this time to see what was happening nationally using UK and Scotland gov.uk surveillance figures and was startled to find similar findings. In one study initially looking at just positive cases in UK and over 100,000 dataset showed 89.7 percent positive results over a three-week period treble vaccinated v 3.7 % unvaccinated (ref to follow). Even in the knowledge that the lower proportion of unvaccinated as percentage of total population these percentages were too far apart. A recent Scottish data set (weeks 1 and 2 of 2022) despite showing reduced outcomes in three different outcome categories (ref to follow) the ratio of unvaccinated 28% to vaccinated 72% total Scottish populus. Roughly speaking outcomes of the parameters of 1) positive test 2) admission to hospital and 3) death was seen to be represented by 80% of the total numbers in treble vaccinated status whereas only 20% were unvaccinated in proportion. Why were people vaccinated for a disease and go on to die in a ratio of 4:1 from the disease they were trebly protected from!! Alarm bells ringing……again.

At this time, I committed time to fully researching whether the risks of a jab were proportionate to the risk of the disease. Networking with other medical professionals constrained by fear to not report observations or whistle blow, the sharing of papers, research data and individuals' clinical concerns and anecdotal observations were forming a clear pattern and hypothesis. Study after study, data set after data set seemed to come to the conclusion that the vaccinated group seemed to be at higher risks of catching covid despite full vaccination status and in the above data higher admission rates and death… The decision was becoming clearer as to whether to take the jab #3. At this point I concluded the Jab wasn't in any way reducing my chances of catching or spreading the virus in some cases increasing their risk (Will avoid commenting on Antibody dependent enhancement- ADE in this article here but coherent with this principle). I was at this time being told that nasal carriage of the virus was much higher in the unvaccinated, but again this wasn't bearing out in the cohort studies that I was seeing published. So, my conclusion was the Jab wasn't (in my humble opinion) in anyone else's interest so that only left the conference of personal safety from becoming seriously ill and its obvious major repercussions when it comes down to rationale to mandate a medical treatment. This will be discussed later when I discuss medical ethics around consent and lack thereof briefly.

Signals of harm:

Alongside phenomenon discussed above, I was starting to see flickers of what I am calling ‘signals of harm’. At this time, I felt slightly isolated professionally as no one would seemingly enter deep debate on the subject, offer alternative explanations for data, evidence of safety, all at the same time as hearing from the government that the vaccine was ‘absolutely safe’ in children and pregnant women under the guise of adverts with the headline ‘the best way to protect yourself from Omicron is to be treble vaccinated’. This didn’t seem true to me. Bit more virology here while were here, I saw an advert that could only be described as propaganda and misinformation on the TV where a family were all mixing inside the house and small black particles of virus were pouring passively from all of the family members mouths into each other’s faces in a bid to promote space and window opening. I couldn’t believe my eyes. Respiratory viruses such as SARS-COV 19 are spread not by asymptomatic carriers as previously covered. I may be speculating here but I personally feel asymptomatic ‘carriers’ are mislabelled false positives as previously discussed. Respiratory tract viruses are known to spread by Aerosol generation i.e., ‘coughs and sneezes’ spread diseases. None of this was science as I know it!

I just was not seeing the degree harm from the disease borne out in gov.uk covid surveillance data despite high case numbers and certainly had not had sight of safety data to support such a statement to the degree of justifying jabbing 5–11-year-old children and pregnant females and their unborn. We all know as clinicians that prescribing in pregnancy is riddled with lack of safety data and manufacturers often sit on the fence with recommendations of erring on the side of caution and avoid unless benefits far outweigh risks.

To accept a medical treatment of any description you have to weigh the benefit v risk of the treatment v the disease. I recalled at this time at the beginning of the pandemic that they were showing personal stories of individual patients who had succumbed to the disease and remember saying that a lot of these folk seem to be generally overweight. Recent plethora of data sets show that multiple comorbidities go hand in hand with high-risk of death or serious adverse outcome in addition to age and immunosuppression. Despite rolling the Jab out to anyone in the world over 5 this didn’t seem to take into account the individual’s personal risk. I.e., the smoking 80y old diabetic v the fit well 20y old sportsman have completely different risk profiles for becoming unwell from COVID, why was this not being extrapolated and we

were jabbing people with a treatment they simply DO NOT NEED or at very least offering negligible benefit as you went up through the age groups.

Do no harm:

Initially the flicker of harm signal subsequently became a flame and most recently a fire! My individual experience of seeing very odd post-vaccination reactions came ironically around the time of my second jab. In just one week, I saw a terrible case of a very fit gentleman who was suddenly unable to move his hands and feet and became swollen, a reactive arthritis, coming inexplicably on without any prior rheumatological history, 2 days after his vaccine. A couple I did a home visit on came out with a most bizarre skin rash with large ulcers appearing widespread to the body the like of which I have never seen, again within a week of the jab and no prior history of skin problems. While duty Dr I recall a bizarre conversation with a medical registrar who advised me that a patient needed to commence anticoagulation for a clot on his brain was triggered by his by his sinus inflammation seen on the MRA scan……. (The gentleman advised me he had never so much as sneezed in his life) …., he had his jab 4-5 days prior. And then the worst, two 40y female patients within about a week of each other and each within close proximity of the jab (1-2 weeks). Both died without significant medical history, one I always remember as she had two young children of similar age to my own, MCCD VITT (vaccine induced immune thrombotic thrombocytopenia), catastrophic clotting to multiple systems leading to death. The coroner had obviously attributed this to the jab.

Day after day I was seeing on social media comments from friend’s family and strangers making causal accusations towards the jab of a multitude of harms. Some serious harms too including new and permanent/progressive neurology/fits/collapses, dermatological presentations, menstrual changes, immunological, and simply not feeling ‘right’ the list went on and on. This was just the start. I joined a group called NHS 100k in the wake of opposing the upcoming vaccine mandate and was again hit with a barrage of harmful episodes within close proximity to the event of a COVID jab. This was seeming to be more than just coincidence purely by noted incidences.

I was reading and hearing on official media that reactions were extremely rare, but I was wondering how rare does rare have to be for it not to become common? Everyone seemed to know someone who had fallen foul. I looked on the yellow card reporting system and VAER’s but the incidence of what I was

seeing from experience didn't match the data from these resources and seemed understated.

I saw an article today from MHRA data which showed huge increases in reaction to the covid jab across all manufacturers at unprecedented scale compared to any other previous Jab ever and consistent across all manufacturers. (ref to follow).

I eventually wrote a post asking for people to contact me personally on social media and joined a telegram group 'They say it's rare' (they also have a website). Scary amounts of people stepping forward with a full range of alleged reactions in proximity of a jab. In the last 48h I have personally had over 200 DMs with personal stories of post-vaccine injury reaction and even deaths and the aforementioned group is just constantly posting these stories. Going back to my signal of harm there was an alarm sounding, and as per me writing this article was reminded of my Hippocratic oath once again. The above may just be coincidental I am well aware, but my oath was to do no harm (Disclaimer at this point I can say that I have never jabbed a patient with the COVID vaccine).

Aside from this, more worrying observations from different arenas. As an avid football and sports fan, reports of footballers dropping like flies some live on TV and numerous tennis stars falling ill during games (whether vaccinated or not reports are sketchy), pilots dying in never-before-seen numbers, USA just reported an increase in life insurance claims by up to 40% in last 3 months. All-cause mortality in in certain periods of time higher than ever before, funeral directors and doctors going public on unprecedented young folks 'dropping dead' and post-mortems of VTE causation, increased numbers of referrals for uterine cancer, the list goes on. And not a word from the mainstream media. To claim anything negative is shutdown, Orwellian 1984 style. Nowhere on MSM is this potential for causality even whispered. If it's all coincidence, then where is the debate, where are the scientists calling it out and debunking such 'conspiracy theories'. There doesn't seem to be any correlation to the footballer phenomenon other than a couple of ex pro's stepping out on their private social media platforms.

Censorship gone crazy:

By now it has become clear, one mantra, one narrative: After locking us down, then paying for half of our meals, then discussing herd immunity followed by

the rule of 5/2 metres/re-lockdown (nothing like consistency) they eventually found consensus. Vaccine, Vaccine, Vaccine, no discussion of potential harm, suppressed alternative treatments with some solid medical grounding e.g., Zinc/ivermectin/Vitamin D data with no apparent push to offer general advice on this as 'COVID prophylaxis' if you like. To debate and seek evidence-based medicine or to offer alternative viewpoint or to even speak freely, a right that was fought hard for seem to have succumbed to censorship. For example, who better to speak about the mRNA technology being used (more later) than Dr Robert Malone the very experienced and humble scientist who had a huge role in its research and application in vaccine technology. Not debated, simply deleted, platform removed for a concern from the 'inventor' that there are risks associated (to hugely understate his viewpoint) is a view I would clearly like to give credibility and time to and would wish to hear his voice. Dr Mike Yeadon, Dr Peter McCullough and so many eminent and qualified doctors and scientists, all vastly qualified, published and relevant to the covid debate given their credentials, limited to back street media platforms and underground presentation of their opinion in opposition of the major narrative. This is unprecedented in my career!

I myself have fallen foul of the Facebook police on a number of occasions, having been sent a recent article by a colleague- with a very sensationalist headline- 'Covid Vaccine Scientific Proof Lethal' (Jan 2022) but aside from that it was essentially an article cataloguing published literature of case studies, small cohort studies, prospective studies showing evidence of harm, post-mortems and the like showing causal links to potential harm. 90-day warning from FB for the crime of one of the articles stating that the jab is being given under the emergency use authorisation. This is a fact that I fairly-well recognised to be TRUE… article removed no ability to appeal…. none. Similar slaps on wrist for posting government datasets and tables from UK and Scottish government data openly available to find, deleted for similar vague and unchallengeable reasons, just labelled as 'spreading misinformation'. A quite strange phenomenon of censorship and in itself a warning of encroaching our free speech and what happens if you query the mainstream narrative.

Jab or not to Jab that is the question?

At this juncture I want to briefly discuss some of the ethical principles I would like to think come as standard across medical and nursing colleagues. Valid consent involves speaking to a patient about the full benefit of a treatment but also to be open and honest about the risk, to enable to allow concordance. A

mutual agreement between patient and Dr to enable a plan of action going forward. For consent to be valid it must be fully informed. And even if I don't agree with a patient, as long as they have capacity, they are equally allowed to disregard your treatment despite your advice i.e., a valid refusal of consent. Current medical practice is sadly lacking in the above in two arenas: 1) the mandating of NHS staff to be vaccinated to remain in post. This is simply called 'coercing' and it not part of reaching the afore discussed consent to treatment. Coercion of an NHS member of staff to take a medical treatment against their will is simply and by anyone's definition blackmail. From another perspective it is in breach of the Nuremberg code and law: Public health act 1984 45 (C). 2) There is severe lack when it comes to some of the 'consenting' I have witnessed in clinical practice. Every human has a right to their own bodily autonomy, to give someone a treatment they refuse or to force physically or emotionally is considered assault and battery in law. To disagree with bodily autonomy and valid consent goes against the Good medical practice that the GMC encourages us to follow.

Regards point 1) above. As previously mentioned, age, comorbidity, role and personal choice should all come into the equation. If the vaccine as is proven seemingly the case by major swathes of data as to not reduce your ability to catch or spread the virus (i.e., reduce risk for others) and only confers (again open to debate) personal protection, then this is just unethical, unscientific and implausible in so many ways as to proceed. The injustice and harm from this law and subsequent sacking faced is just simply not offset against the threat of the disease in its current state. Particularly in view of safety question marks as well as efficacy of the vaccine itself another large area of debate. Many cases in literature of swift waning of vaccine immunity (particularly Omicron interestingly) is well documented conversely in recent studies natural immunity reigns supreme. And how about the detrimental effect this has on stress levels, mental health, finance and morale or our friends and colleagues facing dismissal those self-same people who worked throughout facing this huge pandemic with such bravery?

Regards point 2) simply asking a patient if they know they are here for their second covid jab a brief check on contraindications and…. Stab… into the arm it goes… is NOT valid consent (I won't mention the lack of drawing back on the syringe to check not in a blood vessel prior to administration used in all other IM injections).

Even on the conveyor belt of mass vaccination clinics this is just not good

enough. People were presenting in good faith, for the greater good of humanity, accepting a treatment to the lay person which was unknowingly novel but ‘needs must’. They are completely unaware that in that small amount of fluid injected, lies mRNA material that encodes a virus’s genetic message in a variety of different transport media e.g liposome coat and is a novel and never before rolled out outside of clinical trial. Neither were they aware that it is being used under an emergency use authorisation (EUA) like a ‘needs must’ legal waiver, neither do they know that the major producers of the vaccine have, before they ever stepped foot in the lab, took indemnity from prosecution for all current and future harm under the EUA running for many decades yet to come. I could go on.

You may have noted, I haven’t in this article referred to the mRNA ‘vaccine’ as such, as prior to this pandemic mRNA as mentioned above had never been passed to being safe or effective for human use. Play this back for a second……we are giving you a jab of fluid, a novel treatment, that will be absorbed into your human cell which…. cutting out the detail of the biology……gets expressed by your human cell, using human cell machinery to transcribe that code into a protein which is how genes are expressed. A protein that is viral in origin and design…. not only that but a cytotoxic spike protein (as opposed to other areas of viral capsid) that will induce an immune response in a way never used before. Previously vaccines were killed whole virus particles, live but attenuated, fragments of protein or their toxoid with all their retrospective relative safety data, in favour of an experiment. I fully expect the same number of sleeves would not have been rolled up in knowledge of the above. I have heard cries from my patients of ‘I only took the vaccine to…… go back to work, to go on holiday next year, so I can go back out and socialise at the weekend….and tearjerkingly heard of a report of a child who gasped with relief after his jab that he could now go and play with his friends. No coercion here. Nothing in life is without risk, even common medicines like paracetamol have associated risk.

Given the Jab’s roll out being a clinical trial (this remains the case) why was it not made clear from the outset about how to report adverse events. It is something that has only very recently been made public, regarding yellow card and their use in reporting of adverse effects to patients in the national media many months after the roll out of the ‘vaccine’. This is just simply bad medical practice, however coincidental or frivolous it may turn out to be, surveillance of benefit is important, but surveillance of harm/risk should be in equal measure. I have seen a multitude of blank faces and ‘what’s a yellow card’

when asked if they have reported their relative's reaction to the government scheme. Even the ones who have, didn't persevere due to complexity or time constraints.

On that subject I truly believe, and again data is becoming apparent on the vastness of this under-reporting of post vaccination adverse events/death with blind eyes being turned left right and centre. There seems to be a carpet in every hospital and surgery that these incidences are swiftly de-bunked by the medic or swept straight under the aforementioned carpet. Combine with an equally difficult to quantify overreporting of deaths (I have personally witnessed testimonies of over 50 dubious COVID 1a) MCCD. The difference between yellow card deaths post vaccine around 2000 and the death toll of 150,000 would be much closer by this bearing true and with each passing percentage point, narrowing of the gap, the risk starts to unacceptably erode at the benefit!

I see a huge hesitancy locally and nationally to audit data regarding harm, ease in dismissing strange happenings to anything but the Jab.

Data should be at the tip of the finger re how many cases of myocarditis in different age groups seen after Pfizer/AZ/Moderna, how many strokes or cardiac sequelae……. click click result. Who is collating this data on safety, who is disseminating it?

A final couple of miscellaneous points on the subject of ethics in clinical practice. Firstly, confidentiality is the cornerstone of medical practice, to speak outside of a clinical discussion outside the confines of the clinic room is a breaking of such confidentiality. Patient's medical history is private! This seems to have been ignored particularly in the media, and among colleagues 'off with covid' and/or 'their vaccine status'. You only have to switch on BBC tv or sky sports news to hear about the latest COVID positive actor, politician or sports player. Do you ever remember switching on the TV and hearing about David Beckhams orthopaedic history, but its ok to reveal Cristiano Ronaldo's Covid status/shielding regime? Public figure or not, confidentiality is paramount in the profession but again fallen by the wayside. Finally, the principle of treat patients according to their best interests and in particularly counsel and treat based on this principle are so important. I will end here with this. I am constantly hearing of many colleagues who are 'unwilling to have any more jabs' and definitely won't be vaccinating their children…which is absolutely fine of course. However, to have this view on a treatment you aren't willing to have

for yourself or family but then proceed to jab 30 strangers' children all afternoon. The apathy is real.

Closing remarks:

It is human nature to not want to admit you are wrong. It is human nature to not get too proactively involved in something that doesn't directly involve you. It is human nature to trust the government and scientists that stand before us.

But science changes, this pandemic changes. As scientists', medics and the general public we hope as best we can to keep updated. But to censor, close down, refuse debate or critically appraise the data around evolving harm benefit profiling it's just not science, is just not ethics or good medical practice.

If they mandate a vaccine (that they are already planning jab#4) and so on, for NHS staff without respect for valid consent, without respect for the refusal of that consent. This is particularly important in reference to the arena of a clinical trial with no medium- or long-term prospective safety data. Certainly, data suggests uncertain/patchy benefit in terms of reducing transmission i.e. protecting patients and certainly from recent data equally sketchy on personal risk reduction, then what's the point…… when do we say enough is enough…… when do we declare that the vaccine doesn't work or isn't worth the risk? And when to we accept that mandate aside from unethical is tantamount to blackmail in view of this!

The virus is now as good as endemic as per many media outlets reports, let us have our bodily autonomy back, our freedom back, let us snap out of this 'mass formation' psychology of fear and regain our common sense. There is a lot to say for good old-fashioned herd.

What happened to the banging the saucepans for your NHS heroes? what happened with the value of the tests to show you haven't got the virus? (Previous limitations discussed aside), PPE actually giving personal protection? and what about antibody tests?

As a member of NHS staff going to work to face patients…. with positive antibodies proving prior immunity, daily negative tests, fit and well status and in PPE then my conclusion is that this member of staff is no more a risk to their patient than their fully vaccinated counterpart following the exact same measures!!!

Primum non nocere. This pandemic has been unprecedented for our careers for all those currently in clinical practice but if we aren't interested in this harm and preventing it, acknowledging it, discussing and debating it then we need to take a long look in our mirror before we next go on duty!

Thanks for reading.

Dr Dave Cartland