**APPENDIX 4, 5, 6: Vaccine Damage Payment Act; NVICP; Japan ranks highest in health; GMC & doctors' suicides**

**APPENDIX 4:**
UK **Vaccine Damage Payments Act, 1979: US National Vaccine Injury Compensation Program**

In 1978, in the wake of healthy children who became disabled following vaccination with the diphtheria, *whooping cough, pertussis vaccine, the Pearson Commission recommended that the UK government* assume full responsibility for damage from state – promoted vaccines. In 1979, under Prime Minister Margaret Thatcher, the government enacted the Vaccine Damage Payments Act (VDPA) in 1979, in part, to restore public confidence in the government vaccination program,. The no-fault Act implicitly acknowledged the government's responsibility to compensate children who were damaged as a consequence of the state recommended vaccination program.

A Disability Act? The Vaccine Damage Payments Act 1979 and the British Government's Response to the Pertussis Vaccine Scare, Gareth Millward, *Social History of Medicine*, 2016.

> "*The [Margaret Thatcher] Cabinet resolved to accept the general principle of compensation for victims of vaccine damage in order to restore faith in the vaccination programme… The belief was that by accepting the compensation principle, it would allay the fears of parents by showing that if something went wrong the state would protect them. It was also seen as a sign of strength and confidence. The government was explicitly stating that it was sure that there were so few cases that it was willing to compensate parents even if they could not definitively prove that vaccines were the sole cause of their child's disability."*

The US enacted the National Vaccine Injury Compensation Program (NVICP) in 1988, providing vaccine manufacturers immunity from litigation, while the government assumed the cost of compensation for damage the government recognized as vaccine-caused. In the UK, vaccine manufacturers have no legal immunity from litigation. However, the UK government secretly indemnified GSK twice: in 1988, against damage from the Pluserix measles vaccine. In 2009, GSK was indemnified against damage from its flu vaccine, Pandemrix.

**Government payment responsibility debated in House of Lords, 2000.**
On June 28, 2000, the House of Lords debated Vaccine Damage in an evening session. They debated in particular, how much compensation for children damaged by vaccines. In impassioned statements, several MP recognized where the responsibility lay for the fall in vaccination rates:

> "*It is the Department of Health which institutes public health policies and the department which chooses the vaccines and the department which should have tested them properly in conjunction with the pharmaceutical companies. It should now be urgently reviewing the position, particularly in the light of worries about the fall in the rates of certain vaccinations which could, in the view of public health experts, lead to epidemics in diseases such as measles.*
>
> *If the Department of Health and the pharmaceutical companies do not take responsibility for past vaccine damage but hide behind the legalities of the law of tort and the requirement to*

*show clear causation and negligence, it is hardly surprising that parents have second thoughts before arranging for their children to be vaccinated."* (Lord Clement-Jones, Col. 983)

Debaters emphasized the need to increase the paltry compensation under the 1979 Payments Act:

> *"The vaccine damage scheme is not a compensation scheme. Were it to be so, the mercifully small number of children affected--some 900--would each, depending on his or her life expectancy, be anticipating an award of anywhere between £1.5 million and £2.5 million from a court. That would represent a colossal amount of money [$2.5 billion to $4 billion] which the Government could not afford to pay*." (Lord Brennan Col. 978)

Glaxo refused to contribute anything to the government's Legal Services Commission (previously, Legal Aid Board). And the Association of British Pharmaceutical Industries (ABPI) pointedly suggested that the government's culpability extends to negligence:

> "*The government implemented the vaccination program knowing in full detail what the possible side-effects were. They knew what they were taking on, the damage is therefore their responsibility, and they should compensate people accordingly."* (Col. 979)

A parliamentary debate in in March, 2015:
Speakers criticized "*the lack of a fully comprehensive system for determining vaccine injury applications in the UK*." Payment Eligibility has changed over the years: Children who die before the age of two are not covered. The following vaccines were originally excluded: the flu and swine flu vaccines, smallpox, hepatitis A and B and yellow fever vaccines. The flu vaccine is included and the swine flu vaccine, Pandemrix was included only during 2009 until August 31, 2010. The maximum allowable compensation award is £120,000.

> "*The current vaccine injury award amounts to the cost of care for a seriously disabled person for less than one year. That cannot properly be described as compensation; it is only a token*."
> (Russell Brown, Shadow Minister, Scotland, 2015)

In 2014, the UK Department of Health response to a Freedom of Information request states total amount settled is £73 million. However, the breakdown table shows £60, 900,00. The following cursory information was provided:

6,026 applications were filed under the VDPA, and only 931 children were compensated; the total amount disbursed was £60, 900,000. The tabular statistics reveal a most peculiar trend; namely, the greatest number of vaccine-injury settlements – 317 – were awarded in 1979, when there were only five vaccines in the childhood schedule. Thereafter, during a period when the vaccine schedule had vastly expanded, the number of settlements dwindled down to single digits by 1988/89. And from 2010 to 2015, not a single child received compensation for any vaccine injury in the UK.

**In 2015, a lawsuit exposed the government's bad faith; the UK had failed to implement the VDPA**

The case involved a twelve-year old boy who suffers from narcolepsy since he was vaccinated with GSK's swine flu vaccine, Pandemrix. The boy won a court decision awarding him £120,000 under the Act. But the government appealed the decision arguing that the boy did not meet its criteria for compensation. In 2017, the Court of Appeals denied the government's appeal and overturned the improper criteria the government had used to deny compensation claims for vaccine injuries.( Ministers Lose Fight to Stop Payouts Over Swine Flu Jab Narcolepsy Cases, *The Guardian*, Feb. 2017)

In contrast to the UK government's handling of vaccine injured persons, the most recent report of the U.S. National Vaccine Injury Compensation Program (NVICP, August 2017) provides a glimpse into the adjudicated, "real life" evidence of life-threatening and irreversible vaccines-caused harm. The NVICP report allows us to review which vaccines are associated with the highest number of deaths and severe injuries. Since its establishment in October, 1988, more than 18,400 individuals filed compensation applications. The overwhelming majority were filed for children; although since flu vaccine (2005) numerous adults have also filed and been compensated.

The total number of adjudicated cases acknowledging that the injuries were caused by a vaccine is 5,581, and plaintiffs received compensation. The total amount compensated under the NVICP so far is $3.8 billion. There were 1,234 claims for vaccine-related deaths; of these 696 deaths were linked to the DTP vaccine, 127 deaths to the flu vaccine, 81 deaths were attributed to the DTaP, and 61 deaths were linked to the MMR.

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**APPENDIX 5: Japan consistently ranks high in health, life expectancy and low infant mortality.**

Japan has the largest population (127 million) among the best ranking countries regarding health, longevity. In 2016, Japan was ranked first in the world in life expectancy; the average life span hit 83.7 years. Japan is among the leaders in the developed world having low obesity rates and low infant and cardiovascular disease mortality. Japan's childhood vaccination policy is cautious; Japan recommends 22 vaccines,[1] compared to 36 vaccines recommended in the US CDC vaccination schedule. In 1993, after 1.8 million children were vaccinated with one of two MMR vaccines and 2,000 children developed adverse reactions, including meningitis. A public outcry led the regional Court of Tokyo to rule the government responsible for the vaccine-associated adverse events. As a result, Japan banned the MMR and overturned its mandatory Vaccination Law. In Japan, no vaccine is required for school attendance.

Hence forth, some vaccines are recommended and routinely available through regional government health plans, while those not routinely recommended are optional and must be paid for by those who chose them. In 1999, the government reconsidered using the MMR but decided it was safer to keep ban use the single valent measles, mumps and rubella vaccines. Dr. Hiroki Nakatani, director of the Infectious Disease Division at Japan's Ministry of Health and Welfare said that giving individual vaccines cost twice as much as MMR "but we believe it is worth it." Furthermore, Japan has not licensed any multi-valent vaccines.[2] The safety of simultaneous vaccination is ensured through careful monitoring

and scientific safety investigations. In 2013, Japan removed the HPV vaccine from the government-recommended list after hundreds of severe adverse reactions were reported.

Hiroko Mori, MD, former head of the infectious disease division of the Institute of Public Health (now, National Institute of Public Health), had conducted research focused on improving the Japanese encephalitis vaccine, and preventing maternal transmission of hepatitis B. Dr. Mori has been warning about the dangers of over-vaccination for decades. He points out that times have changed and children don't need so many vaccines. Children need to develop their natural immune system. Dr. Mori does not accept vaccine propaganda that attributes the precipitous drop in the number of infant deaths (less than 1 year old) – from 205,000 in 1947 to 2,200 in 2013 – to vaccination. He attributes Japan's low infant mortality rates – the lowest on the planet according to World Health Organization data – to the country's high levels of nutrition and first-class sanitation, not to vaccines.[3]

Numerous articles deplore Japan's cautionary approach: "In stark contrast to the positive health indicators, Japan is well known as a country with persistently high rates of vaccine preventable diseases (VPD) such as hepatitis B, measles, rubella, mumps, and varicella." A Review Of Factors Affecting Vaccine Preventable Disease In Japan
Norimitsu Kuwabara, MD and Michael SL Ching, MD, MP *Hawaiii Journal of Medicine & Public Health*, 2014

The CDC advises travelers to Japan to get numerous vaccines first.[4] numerous business sponsored reports paint a grim picture of Japan's alleged insufficient vaccination policies,[5] the evidence tells a very different story: in 2015, Japan met the WHO requirements for the eradication of measles: "*the absence of endemic measles transmission in a defined geographical area (e.g. region or country) for ≥12 months in the presence of a well-performing surveillance system*". An outbreak of a foreign measles strain was spread in 2016 at the Kansai International Airport, affecting 41 people.[6] According to the most recent evidence-based report by the Japanese National Institute of Infectious Diseases (September, 2017):[7]

> *"since 2009, the proportion of cases aged 10-19 years decreased first, which was followed by a decrease in cases aged 1-4 years, leading to an increase in the proportion of adult cases (≥20 years of age), with ≥70% of the cases being adults since 2015. In 2016, among 165 cases [ of which 157 cases were laboratory-confirmed and 139 cases genotyped] , 60 cases were in their 20's, 35 cases in their 30's and 32 cases younger than 10 years. In 2008-2016, 27-52% of the cases had unknown vaccination history.*
>
> *In 2016, among a total of 165 cases notified (including 8 infants under the vaccine eligible age of <1 year), 47 cases (including 7 infants <1 year of age) were unvaccinated (28%), 40 cases vaccinated once (24%), 25 cases vaccinated twice (15%) and 53 cases had unknown vaccination history (including an infant <1 year of age) (32%). Among the 157 cases confirmed by laboratory diagnosis, 105 cases exhibited fever, characteristic rash, and catarrhal symptoms; among them, 43 (including 6 infants <1 year of age) were unvaccinated (41%), 21 were vaccinated once (20%),*

*7 were vaccinated twice (7%) and 34 including one infant <1 year of age had unknown vaccination history (32%).”*

**APPENDIX 6: Documented suicides by doctors during highly stressful GMC Fitness to Practice proceedings**

The UK General Medical Council (GMC) proceedings are perceived by doctors fostering a “culture of fear”. GMC FTP proceedings are extremely stressful; they are conducted in a hostile atmosphere such that the accused are presumed “*guilty until proven innocent*.” In April, 2012, Dr. Helen Bright (a psychiatrist) filed a Freedom of Information request to the GMC. Leading to a protracted struggle to obtain the names and ethnicity of doctors who died following referral to GMC (Her correspondence is posted online here. Her request for the first time, identified GMC-related suicides, highlighting how serious and extensive a problem it is.

- *GMC And Vulnerable Doctors: Too Blunt An Instrument? Clare* Dyer, *BMJ (2013)*
  “*The deaths of almost 100 doctors while under GMC investigation over the past decade has raised questions about the stress and fear associated with the process*. [*GMC needs*] *to look at not just suicide but the stress doctors are under when they receive notification for a fitness to practice hearing. I think we need to look at the entire process [sic] “If we only look at the severest casualties, suicides, we’re not paying enough attention to the large numbers of doctors who are going through enormous emotional turmoil and suffering mental stress and illness as a result.’*

  *“When doctors do challenge decisions in the courts, judges are holding the regulator to account, as their rulings are influencing future decisions. Interim orders panels have been issued with new guidance after a string of High Court cases last year in which judges found them too ready to suspend doctors, depriving them of their livelihood when no findings had yet been made against them.*

  *In the case of Walker-Smith, a paediatric gastroenterologist [with international reputation] who coauthored the notorious MMR paper with Andrew Wakefield, [was ordered to be struck off by the GMC but reinstated by the court] Mr Justice Mitting listed a catalogue of errors, called for fitness to practise panels that are hearing weighty cases to be chaired by “someone with judicial experience,” and declared, “It would be a misfortune if this were to happen again.”*

- *The Impact Of Complaints Procedures On The Welfare, Health And Clinical Practise Of 7,926 Doctors In The UK: A Cross-Sectional Survey*,Tom Bourne et al. *BMJ (2015)*
  *“Our results support the view that these proceedings have a disproportionate impact on doctors, especially as the vast majority of doctors who are referred to the GMC are found to have no significant case to answer. However, the GMC is at the apex of what amounts to a ‘complaints pyramid’ and our data show similar significant psychological morbidity for doctors across the entire spectrum of complaints procedures.”*

The following reports focus on doctors who committed suicide while under GMC investigation:

(1)The FOIA request led the GMC to conduct an internal review: Doctors Who Commit Suicide While Under GMC Fitness To Practise Investigation (December, 2014) that identified 114 doctors who died while under GMC fitness to practice investigations. 24 were classified as suicides and 4 were classified "suspected suicide". A total of 28 doctors – 20 men and 8 women – committed suicide between 2005 and 2013. The GMC blamed the suicides on doctors' "mental disorder."

Maria C Jalmbrant (a clinical psychologist) points to the broader, non-fatal scope of consequences affecting doctors brought up on unjustifiable GMC charges in a BMJ Rapid Response (2015):

> "*The consequences of investigations vary but often include loss of earnings, loss of professional status or reputation, anxiety over the investigative process, depression, insomnia, relationship difficulties and social isolation, suicidal ideation and death.*

(2) "The General Medical Council: Fit to Practise?" by Hilarie Williams, Christoph Lees & Magnus Boyd, of *Civitas,* a Doctors' Policy Research Group (2014) examined a wider range and provides a broader picture:

> *"A GMC referral is the extreme adverse professional experience for a doctor, so it is disturbing that the GMC appears to give no serious consideration to the impact of its own activity (and deficiencies) on either doctors or patients."*
>
> "*The number of public hearings increased 5-fold between 1992-2012. The number of erasures from the medical register increased 12-fold between 1992-2012. Some high-profile successful appeals have occurred against GMC sanctions despite the enormous legal and cost barriers of an individual taking on the GMC. Common themes include inconsistent decision making, excessive delays, flawed evaluation of the evidence and undue weight given to the testimony of the accusers. 96 doctors are reported to have died whilst undergoing fitness to practice procedures between 2004 and 2013. It is unknown how many were suicide.*
>
> *The GMC seems to lack openness and insight concerning the failings in their processes. When there is no case to answer after protracted proceedings, it is exceptional for there to be any apology, or explanation about why cases were pursued."*

(3) Suicide Whilst Under GMC's Fitness To Practise Investigation: Were Those Deaths Preventable? *Journal of Forensic Legal Medicine* (2016) is an independent, detailed analysis of the evidence by David Casey and Katrina A Choong (School of Medicine and Law School, University of Central Lancashire). Their review of the 28 doctors' suicides that were identified by the GMC's internal review is highly critical of the GMC:

> "*A common theme is the stress and threat of investigation by the GMC and the painfully named 'death by 1000 arrows' associated with an almost simultaneous investigation by various other authorities.*"

"*By analyzing firstly the high rate of suicide among doctors in general, the discussion will then assess the extent to which ongoing FTP investigation either exacerbates existing suicide tendencies or poses as an abnormally insurmountable challenge, so much so that it warrants consideration as an independent risk factor for physician suicide.*

*"unacceptable delays in investigating some concerns, in some instances leading to an increased risk of suicide… if the GMC had responded in a more timely fashion the death may have been prevented…The GMC should have 'immediately ceased' their fitness-to-practise cases and 'urgently reformed' processes after concerns were first raised about the high numbers of doctors taking their own life while under investigation."*

"*Despite a commissioned report into the issues surrounding these deaths, we discuss a variety of procedural and legal lacunae not yet openly considered for reform. We identified that the UK coronial system has in place several legal instruments requiring coroners to report the physician suicides as preventable to the regulatory body, the General Medical Council (GMC). We were unable to identify that these suicides were reported in line with established legislation.*

"*The high prevalence of suicide among physicians in general should not obscure the fact that suicide whilst under the GMC's FTP investigations is sufficiently unique and deserves special attention… Culpability for the omissions lies mainly with two parties: the coroners and the GMC itself…those deaths were preventable."*

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[1] Vaccination: A Choice Between Two Unknowns, Masami Ito, Japan Times, 2014
[2] Vaccine chronicle in Japan, Tetsuo Nakayama, Journal of Infection and Chemotherapy, 2013
[3] Vaccination: A Choice Between Two Unknowns, Masami Ito, *Japan Times*, 2014
[4] "*Make sure you are up-to-date on routine vaccines before every trip. These vaccines include measles-mumps-rubella (MMR) vaccine, diphtheria-tetanus-pertussis vaccine, varicella (chickenpox) vaccine, polio vaccine, and your yearly flu shot*." Health Information for Travelers to Japan, CDC
[5] A EUROviZ report in *Japan Today* (2016) promotes a decidedly business perspective: "Japan's National Immunisation Program Still Trails Europe… the 2014 European Business Council white paper warns: "Protection by vaccines remains insufficient… "*There are more vaccines than ever before," Honda says. But there is still some way to go, he adds. "We have to make some noise that we need to have these vaccines approved. The HPV vaccine has been suspended for nearly three years. That implies that more girls in Japan are susceptible to cervical cancer*."
[6] Japan Measles Outbreak Hits 41 Cases, Foreign Strain Accounting For Majority, *Tokyo Reporter*, Sept. 2016
[7] Measles in Japan, 2016, National Institute of Infectious Disease Surveillance Center, Infectious Agents Surveillance Reports (IASR), 2017; Monthly case reports by genotype: https://www.niid.go.jp/niid/en/measles-e/2102-idsc/iasr-measles-e/5528-iasr-measles-v-e150331.html