NEW ZEALAND HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL
TE RŌPŪ WHAKATIKA KAIMAHI HAUORA

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HPDT NO	**1358/Med22/575P**
UNDER	the Health Practitioners Competence Assurance Act 2003 ("the Act")
IN THE MATTER	of a disciplinary charge laid against a health practitioner under Part 4 of the Act
BETWEEN	**A PROFESSIONAL CONDUCT COMMITTEE appointed by the MEDICAL COUNCIL OF NEW ZEALAND** **Applicant**
AND	**Dr Peter Canaday of New Plymouth, registered medical practitioner** **Practitioner**

TRIBUNAL	Ms T Baker, Chair Dr B Bond, Associate Prof J McKenzie, Dr L Chapman, Ms D McKinnon, members Ms K Davies, Executive Officer Ms J Kennedy, Stenographer
IN ATTENDANCE	Mr H Wilson and Mr T Wheeler for the Professional Conduct Committee (PCC) Mr M McClelland KC and Mr A Holloway for the practitioner

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DECISION OF TRIBUNAL

Contents

Introduction

[1] A panel of the Health Practitioners Disciplinary Tribunal (**the Tribunal**) convened in New Plymouth to hear a charge of professional misconduct laid by a Professional Conduct Committee (**PCC**) of the Medical Council of New Zealand (**the Council**) against the practitioner, Dr Peter Canaday. The charge arose from Dr Canaday's public statements made in July and August 2021 about the treatment of COVID-19 and the Comarnity[1] vaccine developed by Pfizer and BioNTech and adopted by the New Zealand Government for provision to the public, referred to in this decision as the "**Pfizer vaccine**".[2]

[2] A full copy of the charge is attached to this decision as Schedule One. The specific allegations are also included in the discussion of the evidence below. The overall charge was one of professional misconduct, the test for which is discussed below.

[3] The charge covered statements made by Dr Canaday in three different public media: in an interview that Dr Canaday gave on Raglan Community Radio on 9 July 2021; a presentation that was delivered online on 12 July 2021; and a presentation that was livestreamed on 19 August 2021. There was no dispute that Dr Canaday made the statements contained in the charge. The PCC's allegations include that Dr Canaday's statements were misleading, likely to mislead or had the potential to mislead about his experience and expertise, the safety and efficacy of the Pfizer vaccine, and the use of Ivermectin, quercetin, vitamin C and vitamin D for the prevention and/or treatment of COVID-19 and that Dr Canaday's comments were unprofessional, emotive or likely to undermine public confidence in the Pfizer vaccine. It was also alleged that certain statements were disparaging of other health practitioners and were unprofessional, and that on each of the three occasions the statements that were reproduced in appendices attached to the charge were likely to bring discredit to the profession.

[1] Comarnity is the trade name.
[2] It is also referred to as the Pfizer-BioNTech vaccine.

[4] The charge comprises a mixture of allegations of fact that are not disputed and other allegations that require an evaluative judgement by the Tribunal. The Tribunal must first decide whether each of the particulars is established and then apply the test for professional misconduct.

[5] The Tribunal acknowledges Dr Canaday's freedom to express his opinions but for the reasons outlined below found that with the privileges and responsibilities of holding registration under the Health Practitioners Competence Assurance Act 2003, come certain limitations on the mode and manner in which opinions should be expressed on health-related matters. The Tribunal felt that Dr Canaday should have considered his audience and been more careful in considering the accuracy of his statements and the impact of his words.

[6] There were statements within the transcripts of the interview and presentations that members of the Tribunal disagreed with. However, the findings below reflect only the matters that the Tribunal was asked to decide, as set out in the charge against Dr Canaday. Similarly, there were parts of some particulars that the Tribunal found established but did not always find the conclusion that the PCC asked us to draw followed a natural logic. Linking the allegations in the particulars and sub-particulars with the statements in the Appendix was not a straightforward task and has made the deliberations, determinations and drafting of a decision very challenging.

Summary of findings

[7] The Tribunal found the allegations in the following particulars established:

> Particular 1: Dr Canaday made the statements on Raglan Radio as set out in Appendix 1 to the Charge.
>
> Particular 2(b): Dr Canaday's use of information from the United States was not balanced with data from New Zealand and did not provide sufficient information about the vaccine mortality rate and was therefore likely to imply that deaths after vaccination were caused by the vaccine, and that was misleading.
>
> Particular 3 – Dr Canaday's statement at Appendix 1(e) was disparaging of other health practitioners.

Particular 4 is established only in as much as the statements in Appendix 1(b) (encapsulated in Particular 2(b)) was likely to bring discredit to the profession. Individually it does not amount to professional misconduct.

Particular 5: Dr Canaday made the statements in the Courageous Convos presentation as set out in Appendix 2 to the charge.

Particular 6 (c): Dr Canaday's inference that there is a link between the Pfizer vaccine and sterility and/or deaths was unprofessional and emotive.

Particular 6(d): Dr Canaday overstated and misrepresented his ability to provide informed advice on the treatment of COVID-19.

Particular 8: The Tribunal found that Dr Canaday's statement in Appendix 2(c) implying that there is a link between the Pfizer vaccine and sterility and/or death is conduct likely to bring discredit to the profession.

Particular 9: Dr Canaday gave the presentation "Fact or Fantasy"

Particular 10(b)(ii): Dr Canaday's inference that other COVID-19 treatments were suppressed in favour of the Pfizer vaccine lacked balance and was likely to undermine public confidence in the Pfizer vaccine.

Particular 10(d): Dr Canaday's description of the Pfizer vaccine as an "experimental biological agent" was misleading and was likely to undermine public confidence in the Pfizer vaccine.

Particular 10(e): Dr Canaday's statements concerning graphene oxide lacked evidential foundation and were presented uncritically.

Particular 11: Dr Canaday's statements in Appendix 3(d) and (e) were disparaging of other health practitioners and had the potential to encourage criticism of other health practitioners.

Particular 12: The following statements are likely to bring discredit to the profession:

Dr Canaday's inference that other COVID-19 treatments were suppressed in favour of the Pfizer vaccine (Appendix 3(b))

Dr Canaday's description of the Pfizer vaccine as an "experimental biological agent which uses previously unproven techniques…and for which highly effective proven therapies [are] available for a disease of limited lethality when herd immunity from vaccinations alone cannot be expected. (Appendix 3(c):

Dr Canaday's discussion of graphene oxide being present in the Pfizer vaccine. Appendix 3(g).

[8] The Tribunal did not consider any allegation of "having the potential to mislead" or the "potential to encourage criticism of other health practitioners" meets the disciplinary threshold.

[9] When considered as a whole, the Tribunal is satisfied that the established particulars cumulatively amount to conduct likely to bring discredit to the profession under section 100(1)(b) and are sufficiently serious to warrant a disciplinary sanction. Therefore the test for professional misconduct is met.

[10] Although the Tribunal considered Dr Canaday's interviews and presentations fell within the scope of the practice of medicine, the Tribunal was not satisfied that the PCC had established that his conduct amounted to negligence or malpractice within the test for professional misconduct. That is because although he should have exercised more care in the way in which he presented some of the information, the PCC did not establish the standard against which his conduct should be measured and therefore the extent to which it departed from that standard. The Tribunal did not consider that his conduct was unethical, immoral or a neglect of his professional duty as required for a finding of malpractice.

The Evidence

[11] The onus of proof is on the PCC who must establish the factual matters on the balance of probabilities.

[12] Particulars 1, 5 and 9 simply allege that Dr Canaday conducted the interview or presentation and made statements that are set out in the appendices to the Charge. The parties filed a brief agreed summary of facts in which Dr Canaday accepted that he had undertaken the interviews and presentations in the charge and that he had made those statements. Those particulars are established. The allegations of wrongdoing are set out in the other particulars.

[13] The PCC called two witnesses:

- Dr Kerryn Lum, the convenor of the Professional Conduct Committee, who outlined the PCC's investigation, and introduced a number of documents that were contained in a Bundle of Documents.

- Mark Thomas, an Associate Professor and infectious diseases physician who was called as an expert witness.

[14] The PCC also provided two volumes of a Bundle of Documents which included transcripts of Dr Canaday's interview and presentations, copies of his PowerPoint slides as well as publications from the Ministry of Health, Medsafe and some peer-reviewed articles.

[15] Dr Canaday gave evidence. He read from his 56-page prepared brief of evidence to which were annexed further copies of his PowerPoint slides and over 170 articles and references.

Expert evidence

[16] The PCC called Dr Mark Thomas as an expert witness. He is an Associate Professor and infectious diseases physician at the Faculty of Medical and Health Sciences at the University of Auckland. Dr Thomas has held several senior professional positions, most recently as Consultant Physician at Auckland City Hospital (1988-2021), Senior Lecturer at the University of Auckland (1988-1999) and a Fellow of the Microbiology Department, John Radcliffe Hospital, Oxford (1995-1996). He has over 38 years' research experience and has held a number of professional distinctions and memberships.

[17] Dr Thomas elaborated on his experience and knowledge under cross-examination. He had not cared directly for any patients with COVID-19. He explained that in early 2020 after his wife had received a diagnosis of a significant health condition, Dr Thomas had been down in the Emergency Department assessing a young Chinese woman with a persistent cough. Although the patient did not have a positive PCR test for COVID-19, Dr Thomas's team had decided that because he was the oldest member of the team he would not care for patients with COVID-19 for the rest of the pandemic. The Tribunal understood this was out of concern for his susceptibility to be more adversely affected by the virus owing to his age.

[18] Dr Thomas said that because this was an infectious disease of great importance for the world, and he was an Associate Professor of infectious diseases, his natural response was to learn all he could about it, to attend meetings where care of patients with COVID-19 was being discussed, and to prepare information to guide clinicians, mostly general practitioners, in how they might understand the range of medicines and tests available for them, and vaccines.

[19] Counsel for the practitioner challenged Dr Thomas's compliance with the Tribunal's Practice Note that adopts the High Court Code of Conduct for Expert Witnesses. It was submitted that the correct approach to the consideration of expert evidence was discussed by the Tribunal in *Re Vatsyayann*.[3] This included the careful evaluation and scrutiny of the evidence.

[20] It was submitted that compliance with what became the Code of Conduct in Schedule 4 to the High Court Rules 2016 (Practice Note No 3 in this jurisdiction) is important. In *Air Chathams Ltd v Civil Aviation Authority of New Zealand* the High Court went so far as to rule before trial that the proposed evidence of an expert was inadmissible, observing:[4]

> … [the] brief is opinionated, argumentative and certainly not unbiased. Indeed, it is little short of an attempt to run the plaintiff's whole case in the guise of an expert brief.

[3] *Re Vatsyayann* HPDT 355/Med10/152P, 16 March 2011 at [20]-[22].
[4] *Air Chathams Ltd v Civil Aviation Authority of New Zealand* HC Wellington CP146/98, 27 May 2003 at [47].

[21] The Tribunal was reminded that it must limit itself to deciding the case based on the evidence presented by the parties and referred to the following excerpt from the High Court's decision of *A v Professional Conduct Committee:*[5]

> All members are entitled to bring their knowledge and experience of life to bear in judging the evidence. Health professional members are entitled to take into account their professional experience and knowledge in assessing the evidence, including the expert evidence, adduced during the hearing. They are not, however, entitled to *supplement* that evidence with extrinsic evidence drawn from their own knowledge. (emphasis in the original)

[22] Mr Holloway submitted that Dr Thomas's evidence could not be relied on because Dr Thomas did not read or consider Dr Canaday's evidence and did not express any meaningful view about the validity of that material. Therefore, the PCC cannot establish Dr Canaday's information was wrong or provided an unreasonable basis from which to form opinions. Dr Thomas conceded there was some role for unpublished material and Dr Canaday gave evidence that:[6]

> PubMed is not the sole source in which you can find reports. Nor would you expect to find one in something that is very preliminary, has not yet been published and needs confirmation, like I have explained.

[23] It was submitted that Dr Thomas was obliged to consider, and fairly assess, all of Dr Canaday's evidence. His failure to do so means important parts of the PCC's case lack any probative evidence.

[24] The admissibility of expert evidence is an exception to the general rule that a statement of opinion is not admissible in any proceeding.[7] Under section 25 of the Evidence Act 2006, an expert opinion is admissible if "the fact-finder is likely to obtain substantial help from the opinion in understanding other evidence in the proceeding or in ascertaining any fact that is of consequence to the determination of the proceeding."[8]

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[5] *A v Professional Conduct Committee* [2018] NZHC 1623 at [18] citing Joanna Manning "*Professional Discipline of Health Practitioners*" in P Skegg and R Paterson (eds) Medical Law in New Zealand (Brookers, Wellington, 2006) 613 at [23.3] (footnote omitted, emphasis added).
[6] Notes of evidence at 395, line 22-26.
[7] Evidence Act 2006, section 23
[8] Evidence Act 2006, section 25(1)

[25] The Tribunal's approach to expert evidence as summarised in *Vatsyayann* bears reproducing:[9]

> 21.1. While expert evidence may guide the Tribunal, the views of experts do not necessarily determine the ultimate outcome (*B v Medical Council of New Zealand*). But the Court of Appeal in *F v Medical Practitioners* stated that evidence of accepted practice is "highly relevant".
>
> 21.2. The Tribunal may depart from even unanimous expert opinion, if it forms the view that the expert opinion or evidence as to the usual practice of other similar practitioners does not reflect the appropriate professional standards.
>
> 21.3. The evidence of expert witnesses has to be carefully evaluated, and the soundness of their opinions has to be scrutinized most carefully – just as is the case in respect of the evidence of any witness. At the end of the process, it must be demonstrated that the professional opinion is capable of withstanding logical analysis; if it does not, the Tribunal may conclude the opinion is not reasonable or responsible.[10]

[26] In that case, the Tribunal also accepted the following points:

> 22.1. Experts are witnesses who are normally independent of the parties, but they do not have to be. An expert could still be an expert even if that person was a friend or an acquaintance of the party who calls them. A degree of independence, or the lack of it, might well affect the weight that was to be given to the expert's opinion.
>
> 22.2. Because an expert expresses an opinion on the facts, it is necessary first to determine what the facts actually are. If an expert gives an opinion on something on which there is no evidentiary foundation, then the expert opinion on that topic was worthless.

[27] In the present case, the Tribunal notes that Dr Thomas is undoubtedly highly regarded and eminent in his field, and that he ensured that he read and understood a great amount about the COVID-19 virus.

[28] The Tribunal accepts in part the criticisms of the way in which Dr Thomas had prepared his evidence for the Tribunal. The Tribunal does not find that Dr Thomas's evidence fell into the category of that described in *Air Chathams Ltd v Civil Aviation*

[9] Above, note 3. The footnotes which appear in the excerpt above differ from the original
[10] *Loveday v Renton & Anor* [1990] 1 Med LR 117, at 125; per Stewart-Smith LJ; *Calver v Westwood Veterinary Group* [2001] Med LR 20, para 31, per Simon Brown LJ, Court of Appeal.

Authority of New Zealand.[11] It was not simply a vehicle for the PCC's submissions. However, it was not evident that Dr Thomas had fully understood his obligations as an expert witness in a proceeding. The Tribunal would have been assisted more if Dr Thomas had been less dismissive of Dr Canaday's evidence and had conducted a more thorough review of Dr Canaday's sources so that he could provide a fuller explanation for his reasoning. At the start of his cross-examination, Dr Thomas was not at all certain of what documents he had read.

[29] In assessing whether Dr Canaday's statements were inaccurate or misleading, the Tribunal would have been helped by Dr Thomas's views on matters such as whether Dr Canaday had accurately summarised the conclusions of the research material, or whether there were flaws in the research methods that would mean the conclusions were unreliable. As Dr Thomas noted, it is indeed a time-consuming and arduous task, but sometimes that is what is called for.

[30] In the present case, the PCC was not relying on Dr Thomas's evidence to establish a standard against which the Tribunal could measure Dr Canaday's conduct. Rather, the Tribunal was assisted by Dr Thomas's expertise in infectious diseases and his assessment of the scientific information that was available at the time of Dr Canaday's interview and presentations. To that extent, the Tribunal has obtained substantial help from Dr Thomas's evidence.

Background to COVID-19 in New Zealand

[31] The following brief overview of the New Zealand experience of COVID-19 in 2020 and 2021 is taken from the undisputed parts of the evidence of Dr Mark Thomas.

[32] On 28 February 2020, the first COVID-19 case in New Zealand was reported. On 11 March 2020, the World Health Organisation declared COVID-19 to be a pandemic, which means that people in all nations of the world were expected to become infected, that is a global epidemic.

[33] The Government closed the border to all but New Zealand citizens and permanent residents shortly after on 19 March 2020. The initial cases of COVID-19 overseas, and

[11] Above, note 5

in New Zealand, were caused by SARS-CoV-2 viruses that were genetically very similar to those that had been detected in people in China at the epicentre of the epidemic in late 2019 to early 2020. A range of variants of the initial SARS-CoV-2 virus strains subsequently emerged, for example the Delta variant, which commonly caused more severe disease, and the Omicron variant which commonly spread more readily from person to person but caused less severe disease.

[34] On 21 March 2020, the Government introduced the 4-tiered Alert Level system to help stop the spread of the COVID-19 virus. Briefly, those levels were:

- Level 1 or 'Prepare' – where COVID-19 was uncontrolled overseas but contained in New Zealand. Level 1 applied where there were sporadic imported cases, but isolated household transmission could be occurring.

- Level 2 or 'Reduce'– where the disease was contained but the risk of community transmission remained. Household transmission could be occurring and there were single or isolated cluster outbreaks.

- Level 3 or 'Restrict' – where there was a high risk that the disease was not contained, and community transmission may have been occurring. New clusters of the disease were emerging but could be controlled through testing and contact tracing.

- Level 4 Lockdown – where the disease was not contained, and sustained community transmission was occurring with widespread outbreaks and new clusters.

[35] New Zealand went into Level 2 and two days later into Level 3. The Prime Minister announced on 23 March 2020 that New Zealand would go into lockdown on 25 March 2020. A state of National Emergency was declared the same day.

[36] On 24 March 2020, the Prime Minister with the agreement of the Minister of Health, issued an epidemic notice under section 5 of the Epidemic Preparedness Act 2006. This allowed the use of special powers by Medical Officers of Health in accordance

with section 70 of the Health Act 1965 for the purposes of preventing the outbreak and spread of COVID-19.

[37] On 29 March 2020, a month after the first case, the first COVID-19 related death occurred. The state of National Emergency was extended (ultimately until 5 May 2020).

[38] On 4 May 2020, no new COVID-19 cases were reported and on 13 May 2020 New Zealand moved back to Alert Level 2. After the Ministry of Health reported that there were no more active cases of COVID-19 in New Zealand, on 8 June 2020, New Zealand moved back to Alert Level 1.

[39] Included in the Bundle of Documents was a document dated July 2020, which said the government's response to the COVID-19 virus was underpinned by three objectives:

- Minimise the number of people infected with and potentially exposed to COVID-19;
- Minimise the negative health outcomes for those infected with COVID-19; and
- Minimise the economic and social impacts of any control measures.

[40] On 11 August 2020, four new cases of COVID-19 were recorded in the community. Auckland moved to Alert Level 2 with some extra restrictions on travel and gatherings, and the rest of the country moved to standard Alert Level 2. New Zealand moved up and down the alert levels (Levels 1 to 2) between August 2020 and 14 February 2021 when three new cases of COVID-19 were recorded in the community. Auckland moved to Alert Level 3.

[41] A similar pattern of moving through the levels followed until all of New Zealand moved to Alert Level 4 on 17 August 2021. This lockdown was prompted by a report of a new community case caused by the Delta variant of SARS-CoV-2. Between 31 August and 7 September 2021 all of New Zealand south of Auckland moved to Alert Level 3 with Northland following on 2 September 2021 and then only Auckland remaining on level 4 on 7 September 2021.

[42] There were other changes in Alert levels between 7 September and 31 December 2021. The period of the charge against Dr Canaday covers July 2021 to August 2021.

The Pfizer vaccine

[43] In his evidence, Dr Thomas outlined the history of the Pfizer vaccine. He said that the Pfizer vaccine had a thorough and well-tested development throughout 2020 so that when it was first used in New Zealand on 20 February 2021 it had been determined to be safe and effective. Dr Thomas said that shortly after the World Health Organisation declared a pandemic in March 2020, Pfizer Inc and BioNTech SE announced that they had agreed to co-develop and distribute a potential mRNA vaccine aimed at preventing COVID-19 infection.[12]

[44] Dr Thomas explained that this vaccine, and the Moderna vaccine, which is very similar, contain messenger RNA as the essential ingredient. Messenger RNA, also known as mRNA, is the type of molecule that cells use as instructions for the cell to manufacture proteins. When mRNA enters a cell, it leads to that cell manufacturing (or synthesising) very many copies of a protein, that then are commonly released into the fluid surrounding the cell. Once in the fluid surrounding the cell, the protein is recognised as foreign by the cells of the immune system, which produce antibodies that can attach to, and inactivate the protein. The mRNA in the Pfizer vaccine provides instructions for the cells at the site of vaccination to manufacture the part of the SARS-CoV-2 spike protein that is crucial for attachment of the virus to an airway cell. This protein is not normally synthesised by human cells and when detected by cells of the immune system they respond to it as a threat.

[45] These immune system responses can cause localised swelling tenderness and redness, lethargy, and chills. They also lead to the immune system releasing antibodies that will bind to the spike protein, and other immune system responses. Antibodies generated in response to the part of the SARS-Cov-2 spike protein present in the vaccine can provide a very high level of protection against infection by the SARS-Cov-2 virus.

[12] Referring to a Press Release dated 17 March 2020 that was included in the Bundle of Documents

[46] The press release from Pfizer and BioNTech in March 2020 identified that the collaboration built on the research and development collaboration which Pfizer and BioNTech had already entered into in 2018 included potential development of mRNA-based vaccines for the prevention of influenza.

[47] By July 2020, Pfizer and BioNTech announced positive data from a Phase I/II clinical trial being conducted in the United States. In July 2020, the Phase II/III clinical trials began and on 10 December 2020, the clinical trial data was published in the New England Journal of Medicine (**NEJM**). Copies of the July 2020 announcements and information from Pfizer about the trial were included in the Bundle of Documents along with a copy of the NEJM article dated 31 December 2020.

[48] Dr Thomas summarised the NEJM publication as reporting on a randomised, double blind, clinical trial in which 21,720 participants received the Pfizer vaccine and 21,728 participants received a placebo. During the first seven days after receipt of the first dose, there was no difference in the number of cases of COVID-19 that occurred in vaccine recipients and placebo recipients. However, during approximately 100 days following receipt of the second dose of the vaccine, which had been given seven days after the first dose, there were 162 cases of COVID-19 in placebo recipients and 8 cases in active vaccine recipients. Two doses of the vaccine were 95% effective in preventing COVID-19 disease. Dr Thomas said that a diagram (Figure 3) in the NEJM publication clearly showed the remarkable early efficacy of the vaccine in preventing COVID-19 disease.

[49] Redness, swelling and pain at the injection site occurred more commonly in vaccine recipients than in placebo recipients. Fever, fatigue, headache, chills, muscle pain and use of antipyretic medication were also more common in vaccine recipients. It was Dr Thomas's evidence that these results with regard to the very high vaccine efficacy, and the relatively low rates of significant adverse effects exceeded the hopes and expectations of many experts worldwide.[13]

[13] When asked about data on particular ethnicities, Dr Thomas did not accept under cross-examination that there was any reason to believe that there would be any difference in reaction for Polynesian or Asian people living in New Zealand.

Dr Canaday

[50] Dr Canaday provided a copy of his curriculum vitae (**CV**) and provided some evidence of his professional career. He graduated first in 1972 with a BA in Physics and then in 1976 as a Doctor of Medicine, earning his degree at the University of Massachusetts Medical School. He practised in various states in the USA. Between 1979 and 1981 he trained for his Fellowship in Pulmonary Medicine through the University of North Carolina.

[51] Between 1993 and 1997, Dr Canaday retrained in Diagnostic Radiology and interventional Radiology at the University of Wisconsin. During that time, he continued to work as a staff pulmonologist and emergency physician. Dr Canaday then practised in radiology from 1997 in a range of positions in the USA. From 2013 to 2021 Dr Canaday worked in New Plymouth, first as a consultant radiologist for a private radiology service from October 2013 to January 2016, and then as a Senior Medical Officer in Radiology for Taranaki District Health Board from February 2016 to March 2021, when he retired from that role. He remained on the Medical Council's Register and retained a practising certificate.

[52] Dr Canaday's CV recorded that between 2001 and 2006 he had co-authored a number of articles either on his own or with others presented at meetings, conferences and on television on a range of topics within the field of radiology and on other topics before then, between 1976 and 1983. He has served on a number of committees and boards and was an Assistant Professor of Radiology at Creighton University Medical School in Omaha, Nebraska from July 1999 to May 2007, tenure being granted in March 2005.

Professional misconduct

[53] The Tribunal must decide whether individually or cumulatively the established conduct as particularised in the charge amounts to professional misconduct. The Tribunal's grounds for discipline of a health practitioner are found in section 100 of the Act, which provides:

> **100 Grounds on which health practitioner may be disciplined**

(1) The Tribunal may make any 1 or more of the orders authorised by section 101 if, after conducting a hearing on a charge laid under section 91 against a health practitioner, it makes 1 or more findings that—

(a) the practitioner has been guilty of professional misconduct because of any act or omission that, in the judgment of the Tribunal, amounts to malpractice or negligence in relation to the scope of practice in respect of which the practitioner was registered at the time that the conduct occurred; or

(b) the practitioner has been guilty of professional misconduct because of any act or omission that, in the judgment of the Tribunal, has brought or was likely to bring discredit to the profession that the health practitioner practised at the time that the conduct occurred; or

[54] Determining professional misconduct is approached in a two-step test:[14]

- The first step involves an objective analysis of whether or not the health practitioner's acts or omissions in relation to their practice can reasonably be regarded by the Tribunal as constituting malpractice and/or negligence and/or conduct having brought or likely to bring discredit to the profession;

- The second requires the Tribunal to be satisfied that the health practitioner's acts or omissions require a disciplinary sanction for the purposes of protecting the public and/or maintaining professional standards and/or punishing the health practitioner.

[55] There are three individual particulars, 4, 8 and 12 which allege that the conduct is likely to bring discredit to the profession, which in itself is one of the definitions of professional misconduct. The Tribunal is being asked to make that finding in respect of each of the three interviews/presentations. The Tribunal must then consider whether that definition applies to all of the particulars as well as whether the conduct meets the definition of the professional misconduct under section 100(1)(a).

[14] *F v Medical Practitioners Disciplinary Tribunal* [2005] 3NZLR 774, subsequently confirmed in the High Court on appeals from the Health Practitioners Disciplinary Tribunal, see for example *Martin v Director of Proceedings* [2010] NZAR 333 (HC) at [16].

[56] "Malpractice" has been accepted as meaning "the immoral or illegal or unethical conduct or neglect of professional duty. Any incidence of improper professional misconduct",[15] and as:

> *1. Law. Improper treatment or culpable neglect of a patient by a physician or of a client by a lawyer … 2. Gen. A criminal or illegal action: wrong doing, misconduct."* [16]

[57] A finding of negligence requires the Tribunal to determine:[17]

> Whether or not, in the Tribunal's judgment, the practitioner's acts or omissions fall below the standards reasonably expected of a health practitioner in the circumstances of the person appearing before the Tribunal.

[58] Negligence or malpractice must be established as behaviour which falls seriously short of that which is to be considered acceptable and not mere inadvertent error or oversight or even carelessness.[18]

[59] The Tribunal has adopted the test for bringing, or likely to bring "discredit to the practitioner's profession" from the High Court decision on appeal from the Nursing Council. The Tribunal must ask itself:[19]

> … whether reasonable members of the public, informed and with knowledge of all the factual circumstances, could reasonably conclude that the reputation and good standing of the [profession] was lowered by the behaviour of the [practitioner] concerned.

[60] The second step in assessing professional misconduct requires the Tribunal to be satisfied that the practitioner's acts or omissions require a disciplinary sanction for the purposes of protecting the public and/or maintaining professional standards and/or punishing the practitioner. In *B v Medical Council*[20] the Court of Appeal expressed it this way:

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[15] *Collins English Dictionary* 2nd Edition. Definition accepted in many cases, including *Leach* 389/Nur11/179P and *Rodrigues* 384/Ost11/173P.

[16] *New Shorter Oxford English Dictionary* (1993 edition) See paragraph 34 of *Jackson* (Decision No. 35/Nur35/20P

[17] *Cole v Professional Conduct Committee* [2017] NZHC at [41]

[18] *Collie v Nursing Council of New Zealand* [2001] NZAR 74 (HC) at [21]

[19] Above at [28]

[20] *B v Medical Council* [2005] 3 NZLR 810

> In cases of both professional misconduct and conduct unbecoming it will be necessary to decide if there has been a departure from acceptable standards and then to decide whether the departure is significant enough to warrant sanction.

[61] This was further discussed in *Martin v Director of Proceedings* where the High Court said:[21]

> … While the criteria of "significant enough to warrant sanction" connotes a notable departure from acceptable standards it does not carry any implication as to the degree of seriousness. Given the wide range of conduct that might attract sanction, from the relatively low-level misconduct to misconduct of a most reprehensible kind, the threshold should not be regarded as unduly high. It is certainly a threshold to be reached with care, having regard to both purpose of the HPCAA and the implications for the practitioner, but the measure of seriousness beyond the mere fact that the conduct warrants sanction is a matter to be reflected in penalty. The degree of seriousness does not form part of the Tribunal's inquiry at the second stage of the two-step process.

[62] More recently the position has been summarised in *Williams*,[22] where the following conclusion was reached:

> …The Tribunal must assess whether the departure from acceptable standards has been significant enough to warrant a finding of professional misconduct against the practitioner. It should bear in mind that a finding of professional misconduct carries considerable stigma. It sends a very strong message about the practitioner's failure to properly discharge his or her professional responsibilities. An adverse finding will likely be keenly felt by the practitioner, and it will inevitably be noted by his or her peers. A finding of professional misconduct is a significant matter, which is reserved only for serious conduct. [23]

[63] In order to reach a finding of professional misconduct under section 100(1)(a), the Tribunal must decide whether there was malpractice or negligence, and it was in the scope of practice of medicine and it was sufficiently serious to warrant a disciplinary sanction.

[64] For section 100(1)(b), the Tribunal needs to find that reasonable members of the public, informed of the facts would consider the reputation of the medical profession was lowered by Dr Canaday's acts.

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[21] *Martin v Director of Proceedings* [2010] NZAR 333 at [32]

[22] *Williams v Professional Conduct Committee* [2018] NZHC 2472 at [36]

[23] Footnotes included in the original: *Collie v Nursing Council of New Zealand*; *Martin v Director of Proceedings* [2010] NZAR 333 (HC) at [30]–[31*]. Vatsyayann v Professional Conduct Committee* HC Wellington CIV-2009-485-259, 14 August 2009 at [8]; and *Johns v Director of Proceedings*, above n 12, at [69]. 27 *Cole v Professional Conduct Committee of the Nursing Council of New Zealand*, above n 16, at [45]

Scope of medicine

[65] The PCC submitted that in order to find that Dr Canaday has engaged in malpractice or negligence in relation to a scope of practice, the Tribunal will need to be satisfied that Dr Canaday's presentations were:

- acting within the Council's definition of the practice of medicine; and
- providing health services.

[66] The PCC said that for Dr Canaday, this is the "practice of medicine", which applies to all doctors registered in New Zealand. Section 5 of the Act defines relevant terms. "Practise" or "practise a profession" means "to perform services that fall within the description of a health profession." The Act does not further define "services" but does define a "health service" as a service provided for the purpose of assessing, improving, protecting or managing the physical or mental health of individuals or groups of individuals.

[67] Under section 11 of the Act each authority appointed in respect of a profession must, by notice, describe the contents of the profession in terms of 1 or more scopes of practice. The current definition is set out the 2018 Gazette notice. The "practice of medicine", includes:

> 1. advertising, holding out to the public, or representing in any manner that one is authorised to practise medicine in New Zealand;
> 2. signing any medical certificate required for statutory purposes, such as death and cremation certificates;
> 3. prescribing medicines whose sale and supply is restricted by law to prescription by medical practitioners; and
> 4. assessing, diagnosing, treating, reporting or giving advice in a medical capacity, using the knowledge, skills, attitudes and competence initially attained for the MB ChB degree (or equivalent) and built upon in postgraduate and continuing medical education, wherever there could be an issue of public safety.
>
> The practice of medicine goes wider than clinical medicine, and includes teaching, research, medical or health management, in hospitals, clinics, general practices and community and institutional contexts, whether paid or voluntary.

> Within the practice of medicine, "clinical practice" means any work undertaken by a doctor that relates to the care of an individual patient. "Non-clinical practice" means any work undertaken by a doctor that does not relate to the care of an individual patient.

[68] The PCC submitted that the meaning of "giving advice in a medical capacity" (referred to in paragraph 4) will be ascertained from the text around it and in the light of its purpose and context. It is important that "giving advice in a medical capacity" is used in the context of "wherever there could be an issue of public safety." It is therefore open to the Tribunal to interpret the "practice of medicine" as giving advice in a medical capacity where there is an issue of public safety.

[69] The PCC then referred to the purpose of the Act, which is to protect the health and safety of members of the public by providing mechanisms to ensure that health practitioners are competent and fit to practise their professions.[24] The Act seeks to achieve that principal purpose by providing for the determination of each health practitioner's scope of practice.[25]

[70] Mr Wilson submitted that drawing those two strands together creates a purposive argument that ascertaining what is (and is not) within the "practice of medicine", means that whatever the bounds of the definition they should be drawn with a line that is consistent with the purpose of the legislation to ensure protection of the health and safety of the public.

[71] Consistent with this purposive reading is that the Notice refers to the fact that both clinical and non-clinical practice will amount to practising medicine. Non-clinical practice is work that does not relate to the care of an individual patient. To say that a person is only practising medicine when they are providing a health service to an individual or group of individuals proceeds on the assumption that issues of public safety can only be conveyed when a doctor is seeing an individual patient during their treatment, but that does not fit with the purpose of protecting the health and safety of members of the public.

[24] Health Practitioners Competence Assurance Act 2003, section 3(1).
[25] Health Practitioners Competence Assurance Act 2003, section 3(2)(b).

[72] Mr Wilson then referred to two overseas cases as well as the District Court decision on Dr Canaday's appeal against the Medical Council's decision to suspend Dr Canaday under section 69 of the Act.

[73] In *Strom v Saskatchewan Registered Nurses' Association*[26] a nurse made Facebook posts regarding care her grandfather received in a nursing care facility. She identified herself as a nurse, which established a link between her professional role and off-duty expressions.

[74] Mr Wilson referred to the District Court's findings in *Canaday v The Medical Council of New Zealand* [2022] NZHDC 4436, that Dr Canaday's conduct was acting within the practice of medicine. In particular: [27]

> [68] Mr Holloway also submitted that the reference to "professional capacity", a phrase not used elsewhere in the Act, meant the impugned conduct had to be sufficiently connected with the medical practitioner's professional role in order to qualify. In this case, I am satisfied, as was the Council, that Dr Canaday's public statements were sufficiently connected to his conduct in a professional capacity to be able to be taken into account by the Council. He made public statements on medical topics, the Covid-19 pandemic and the vaccination response to it and frequently described and advertised himself as a doctor. He clearly drew on his medical credentials to lend weight to his statements. Also, as Mr Mount noted, the complaints from members of the public suggest that Dr Canaday's status as a doctor was a factor. I find that Dr Canaday was speaking on medical issues in his capacity as a medical professional. I am satisfied this meets the test of his conduct having been in his professional capacity.

[75] The PCC submitted that although the phrase "professional capacity" in section 69 of the HPCA is not the same as the phrase used in section 100, the terms are closely related, and the elements that the District Court used to conclude that Dr Canaday was acting in a professional capacity are those that are also relevant to whether he was practising the profession of medicine. Mr Wilson said it is evident that Dr Canaday was providing advice in a medical capacity (even if that advice was not to a single patient) using the skills and knowledge that he had gained in his training that is what his audience would have understood that he was doing.

[26] *Strom v Saskatchewan Nurses' Association* 2020 SKCA 112, 6 October 2020
[27] *Canaday v The Medical Council of New Zealand* [2022] NZHDC 4436 at [68].

[76] Mr Wilson submitted that in the presentations Dr Canaday:

- introduced himself or was introduced with his medical qualifications[28]
- accepted that he gave his presentations as a doctor not in his personal capacity as Peter Canaday[29]
- accepted that he was asked to speak because he was a doctor[30]
- did not know who was in his audience,[31] or their level of understanding, or concerns that they might have, or what level of information they had received already.[32]

[77] It was submitted therefore that there must be engagement of his professional obligations to avoid risking public health and safety and there was more than sufficient nexus between his conduct and his professional capacity.

[78] For the practitioner, it was submitted that Dr Canaday was not practising medicine and referred to the decision of the Health and Disability Commissioner to refer the complaint to the Medical Council:

> The Commissioner looks into complaints about the quality of health and disability services provided to consumers. While I acknowledge the Dr Canaday is a health care provider, there is no healthcare being provided to specific consumers in this particular situation. For this reason, the Commissioner does not have jurisdiction to consider your complaint.

[79] Mr Holloway submitted that responsible authorities are concerned with the practice of regulated health services. They are not concerned with the private lives of health practitioners except to the extent such conduct risks bringing discredit to the relevant profession. Parliament cannot have intended the HPCAA to allow responsible authorities to self-define spheres of regulation that take over the state's role in

[28] Raglan Radio at CB 253, Courageous Convos at CB 270 and 271; Fact or Fantasy CB 299-300.
[29] Transcript 20 April 2023, page 443.
[30] Transcript 20 April 2023, page 443.
[31] Transcript 19 April 2023, page 329.
[32] Transcript 19 April 2023, page 312.

deciding (for example) fundamental issues such as the scope of freedom of expression when engaging in public speech.

[80] Mr Holloway submitted that paragraph 1 of the Gazette notice on practice of medicine, which refers to advertising or representing in any manner that one is authorised to practise medicine in New Zealand is relevant only as a way of capturing those attempting to pass themselves off as doctors. It cannot mean that every time a doctor introduces themselves as such, all subsequent conduct is the practice of medicine. It was submitted that the only relevant paragraph is paragraph 4, but that does not apply here because Dr Canaday was not "assessing, diagnosing, treating, reporting or giving advice in a medical capacity," and the scope of paragraph 4 cannot be sufficiently broadened by the subsequent explanatory paragraphs. That would make the Gazette notice ultra vires section 11 of the HPCAA by seeking to regulate more than the performance of health services. In addition, Dr Canaday was engaged in public discourse on a topic of significant public interest, not "teaching, research, medical or health management."

[81] The Tribunal acknowledges that responsible authorities are not generally concerned with the private lives of health practitioners. One exception is, as Mr Holloway submits, the extent to which such conduct risks bringing discredit to the relevant profession. But that is not the only exception. There are other circumstances where the private life of a health practitioner is highly relevant to the proper discharge of the responsible authority's obligations to ensure that health practitioners are competent and fit to practise their profession.[33] The authority may review the fitness of a health practitioner to practise their profession. This may include enquiries into the health and wellbeing of a practitioner including substance use. A PCC may refer a practitioner to the Tribunal because of a conviction for an offence that reflects adversely on their fitness to practise. The circumstances of the conviction may have arisen purely within the practitioner's private life. The determinations of the responsible authority and the Tribunal in those instances are not limited to whether the conduct brings discredit to the profession.

[33] As required under the purpose of the Act in section 3

[82] In order to consider the practitioner's submission that the scope of the practice of medicine should be limited to the paragraphs numbered 1 to 4, the Tribunal has looked at the 2018 Gazette Notice.[34] It runs to 15 pages, including an Appendix of vocational scopes of practice and associated prescribed qualifications. The Scopes of Practice start on page 2. The next heading is "Provisional general scope of practice". The "practice of medicine" text as reproduced above at paragraph 69 of this decision is all contained under the heading "General scope of practice". The next heading is "Provisional vocational scope of practice". The Tribunal has considered the entire text under the heading "General scope of practice" as set out above in determining the scope of Dr Canaday's practice. That is what the Medical Council has defined as the practice of medicine as it is required to under section 11 of the Act.

[83] The Tribunal finds that the conduct under consideration was in relation to Dr Canaday's scope of practice for the following reasons:

- On all three occasions Dr Canaday gave advice in a medical capacity, using the knowledge, skills, attitudes and competence initially attained for the MB ChB degree (or equivalent) and built upon in postgraduate and continuing medical education, where there could be an issue of public safety. Had Dr Canaday not been a doctor, his opinion would have had diminished relevance to the discussion.

- Dr Canaday's presentations "Courageous Convos" "Fact or Fantasy" which took the form of an online lecture, with accompanying PowerPoint slides were a form of teaching in the community.

[84] A finding that Dr Canaday's conduct was in relation to his scope of practice is not inconsistent with the decision of the Health and Disability Commissioner to refer the matter to the Medical Council. The purpose of the Health and Disability Commissioner Act 1994 is to "promote and protect the rights of health consumers and disability services consumers, and, to that end, to facilitate the fair, simple, speedy, and efficient resolution of complaints relating to infringements of those

[34] https://gazette.govt.nz/assets/pdf-cache/2018/2018-gs2124.pdf?2020-12-17_22%3A38%3A44=

rights". The definition of health services in that statute makes no reference to the definition of health services in the Health Practitioners Competence Assurance Act 2003 or to the "scope of practice." The Commissioner may decide to investigate an action of a health care provider if it appears to be in breach of the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996. The investigation focuses on whether a particular consumer's rights have been breached by the actions of one or more health or disability service provider. The Commissioner did not say that there was no health service provided in this instance, but that there is no healthcare being provided to "specific consumers".

[85] The significance of finding that Dr Canaday was practising in the scope of medicine means it is open to the Tribunal to find that his conduct was "negligent" or "malpractice" and therefore amounts to professional misconduct under section 100(1)(a) of the Act. This has an impact on Dr Canaday's right to freedom expression.

Freedom of speech

[86] Dr Canaday considers that he has the right to express his opinions. Section 14 of the Bill of Rights Act 1993 provides:

> Everyone has the right to freedom of expression, including the freedom to seek, receive, and impart information and opinions of any kind in any form.

[87] The Tribunal accepts Mr Holloway's description of the context in which Dr Canaday expressed himself in public. During 2020 and 2021, the New Zealand government's response to the COVID-19 pandemic was the most prominent and important political and social issue in the country and decisions being made by the government were having profound impacts on people's lives. Vaccinations became mandatory for certain employees from the end of April 2021. During August 2021, New Zealand entered a nationwide lockdown in response to community transmission of the Delta variant.

[88] It was submitted that no person is excluded from public discourse and debate merely because of their profession and society has benefitted greatly from doctors prepared to challenge the status quo. Reference was made to Dr John Snow, who historically disputed the then common understanding of the pathway of cholera through the air

and had the local well pump disabled. It was submitted that it cannot be negligence, malpractice or discreditable merely to hold and express opinions that are in the minority or unpopular. If that is the standard, then the Bill of Rights is meaningless. Society and medicine are strengthened by diversity, including diversity of ideas. Indeed, the profession should accommodate and be responsive to the range of values held by the communities it serves.

[89] The case for Dr Canaday was that, by speaking publicly, he was not practising medicine and so section 100(1)(a) of the HPCAA has no application. Allowing the Medical Council to decide whose voice may be heard by other New Zealanders has the potential to cause great harm and is inconsistent with its statutory jurisdiction. The Medical Council was free to respond in public to Dr Canaday's presentations.

[90] The Tribunal notes that the right to freedom of expression is not an absolute right. In cross-examination the proposition that "Doctors should ensure that their personal conduct does not risk adversely affecting their reputation or the reputation of the profession" was put to Dr Canaday, who did not consider that public speech was included in such personal conduct, unless it was "defamatory, insulting and with ill-intent".[35]

[91] There are various limitations on such rights imposed by legislation and case law. The courts and statutory bodies are often involved in balancing the individual right to freedom of expression against other general public interests such as in determinations under the Films, Videos, and Publications Classification Act 1993. A clear limitation on a health practitioner's freedom to impart information is that imposed by Principle 11 of the Privacy Code and Rule 11 of the Health Information Privacy Code.

[92] The present case poses questions about what other limitations are imposed on the freedom of expression of a medical practitioner when the opinions are being expressed about medical matters and weight is being attributed to those opinions because the speaker is a medical practitioner.

[35] Transcript of Evidence page 297, line 32 to page 298, line 23

[93] A medical practitioner who expresses controversial opinions on non-medical matters is unlikely to have that freedom curtailed unless it offends against other laws and human rights and/or amounts to conduct likely to bring discredit to the profession under section 100(1)(b). Similarly, a person who is not a health practitioner may be free to express an opinion on health-related issues. However, as has often been said in this jurisdiction, with the privilege of registration under the Act comes certain responsibilities and sometimes limitations.[36] In the present case, Dr Canaday had responsibilities to his audience in the way in which he presented the information he wanted to impart. As noted by the District Court, that audience was likely to attach more weight to his words because he was a medical practitioner, that if he had not had that qualification.[37]

[94] The Tribunal acknowledges the following statement[38] of Professor Coleman,[39] submitted on behalf of the practitioner:

> … when physicians make public statements about medical matters, they are not speaking to an individual who has entrusted them with providing individually tailored medical guidance. Moreover, while their status as physicians may enhance the credibility of their message, they are likely to be just one of many medical voices competing for the public's attention. Unlike a patient receiving medical recommendations from her treating physician, an individual exposed to multiple, and potentially conflicting, views expressed by physicians in public has no reason to defer to one physician over another. To the extent licensing boards exist to protect vulnerable patients within the context of unequal relationships, there is therefore less justification for giving them broad control over the content of public statements unrelated to the provision of direct patient care.

[95] The Tribunal agrees that doctors are entitled to address audiences on medical matters, even controversial ones, but they must be mindful of the composition of their audience. A presentation to the public is different from a presentation to one's peers. Assumptions cannot be made about the knowledge of the audience members.

[36] For example, a medical practitioner may be free to have consensual sexual intimacy with another adult, but not if that adult is a patient.

[37]

[38] C Coleman "*Physicians who disseminate medical misinformation: testing the constitutional limits on professional disciplinary action*" (2022) 20 First Amendment Law Review 113

[39] Formerly Bioethics and Law Adviser at the World Health Organization (WHO) in Geneva, Switzerland.

Particular 1: Raglan Community Radio Interview

[96] Particulars 1 to 4 of the Charge concern Dr Canaday's interview with Raglan Community Radio on 9 July 2021.

[97] There was no dispute that on 9 July 2021 during an interview broadcast on Raglan Community Radio, Dr Canaday's comments included the statements set out in Appendix 1 of the Charge. Particular 1 is established.

Particular 2: inaccurate or misleading statements/potential to mislead

[98] Particular 2 alleges that the statements in Appendix 1 were inaccurate and/or misleading or had the potential to mislead.

[99] Misleading is defined in online dictionaries variously as:

> causing someone to believe something that is not true;[40]
>
> to lead in a wrong direction or into a mistaken action or belief often by deliberate deceit;[41]
>
> deceptive; tending to mislead;[42]

[100] The PCC has not alleged any intent to deceive. The Collins online dictionary says, "If you describe something as misleading, it means that it gives you a wrong idea or impression".[43] In considering whether Dr Canaday's statements were misleading, the Tribunal has considered whether Dr Canaday's statements would have given the wrong idea or impression.

[101] The PCC has also charged that Dr Canaday's statements had the potential to mislead. That is the same as being "possibly misleading". That is a very wide net for the PCC to cast. Many statements might be misunderstood. Some or all of Dr Canaday's statements may well have had the potential to mislead and that might arguably amount to negligence, but in order to establish negligence in this jurisdiction, the PCC must establish that the conduct falls below the standard expected of a medical

[40] https://dictionary.cambridge.org/dictionary/english/misleading
[41] https://www.merriam-webster.com/dictionary/misleading. It is only verb "to mislead" that is defined.
[42] Https://www.dictionary .com/browse/misleading
[43] https://www.collinsdictionary.com/dictionary/english/misleading

practitioner and that it is sufficiently serious to warrant a disciplinary sanction. It is difficult to countenance a situation where the Tribunal would find that statements that are "possibly misleading" will meet that threshold. If any of Dr Canaday's statements had only the potential to mislead, the Tribunal does not find that amounts to professional misconduct.

Particular 2(a): Dr Canaday's ability to provide informed advice on the treatment of COVID-19

[102] In particular 2(a) the PCC alleged that because Dr Canaday has not practised in pulmonary care in New Zealand, he has not provided medical care of a respiratory nature to any COVID-19 patients. Therefore he misstated his ability to provide informed advice on the treatment of COVID-19. The relevant statement, found in paragraph (a) of Appendix 1, is:

> As a respiratory physician who treated many of these patients that have very, very severe respiratory failure, they were placed on ventilators, that's the job I did for 12 years. I'm very familiar with the kinds of very severe cases that we are now beginning to see or have seen with the very severe cases of COVID-19.

[103] The PCC said that Dr Canaday did not clarify that he had not treated any COVID-19 patients. In cross-examination Dr Canaday's explanation was that there are only so many things you can say in 15 minutes. And yet, the PCC notes, Dr Canaday had time to discuss swine flu.

[104] The Tribunal acknowledges that someone hearing that statement alone might have been under the impression that Dr Canaday had recently treated patients with COVID-19, particularly because of his use of the phrase "many of these patients", when in fact he had not done so, and he had not practised pulmonary medicine for over 20 years. However, Dr Canaday did add, "…that's the job I did for 12 years" and he said in that interview:

> …I have experience as a respiratory specialist and intensive care specialist for 12 years, trained in the United States, and then I changed career to radiology in 1997, and I had been assistant professor of radiology in Creighton University in Nebraska, US, and I moved to New Zealand in 2013, and worked for one of the DHB's here until my retirement just last April.

[105] It would have been prudent to make it clearer that he had not practised in respiratory care for 25 years and he had not actually treated any patients with COVID-19. However, the Tribunal is not satisfied that Dr Canaday's description of his experience was inaccurate, or misleading. On this occasion, he did not misstate his ability to provide informed advice on the treatment of COVID-19.

[106] The PCC has also charged that the statement had the potential to mislead. That is the same as being "possibly misleading". As noted above, many statements might be misunderstood. Particular 2 (a) is not established. The Tribunal does not find that "potentially misleading" in this context meets the test of professional misconduct.

Particular 2(b): Lack of balance of with data from New Zealand

[107] In particular 2(b) the PCC alleged that Dr Canaday's use of information from the United States was not balanced with data from New Zealand and did not provide sufficient information about the vaccination mortality rate and was therefore likely to imply that deaths after vaccination were caused by the vaccine. The PCC charges that it is the following four passages from the interview set out in paragraph (b) of Appendix 1 that support this allegation:

> […] there is a very significant number of recorded adverse events or side-effects or things you don't expect following the roll-out of the vaccinations in the United States.
>
> "[…] there's a big record of what happens after that is performed, after the vaccines are performed, and there have been a significant number of recorded adverse incidents, including deaths, following the vaccines.
>
> […] what has happened is that over the last 30 years, there's been a well-established record of a voluntary reporting system for vaccine adverse events in the United States, so for the last 30 years, there has been, for example, between 100 and 200 deaths per year that have been recorded following vaccinations, not saying whether it's caused by them or not, but that's – those are the numbers, voluntarily reported, but, in 2021, there have already been over 6,000 deaths recorded following the COVID vaccines of the various kinds, and anyone that knows those numbers has got to sort of wake up and say, "Well, that's not normal to have incidents of mortality, of deaths, which is 30 times what the average has been for the last 25 to 30 years", so that's a concern.

(In response to a question about underlying causes):

> We don't know that exactly, but what's been observed, which is unusual, is that there have been deaths in people who have been otherwise healthy. There have been deaths in younger people.

[108] Dr Thomas's evidence was that on 26 February 2021 a report from the United States Centre for Disease Control and Prevention (**US CDC**) in the Morbidity and Mortality Weekly Report (**MMWR**) stated that the Vaccine Adverse Event Reporting System (**VAERS**) had received 113 reports of death after COVID-19 vaccinations. He said that at that time the Pfizer and the Moderna vaccines had been available for one month, and 13.8 million doses of these vaccines had been delivered.

[109] Approximately 66% of the reported deaths had occurred in long-term care facility residents (**LTCF**).[44] Dr Thomas quoted from the report which explained that mortality is high in such populations because underlying medical conditions are common. The authors said:

> Based on expected rates of background mortality, among the approximately 1 million LTCF residents vaccinated in the first month of the U.S. COVID-19 vaccination program, approximately 7,000 coincidental, temporally associated deaths from all causes would be expected during the analytic period (*7*).[45] In contrast, VAERS received 78 reports of death after COVID-19 vaccination in LTCF residents, and approximately one half were in residents who were in hospice or who had a do-not-resuscitate status. Reported causes of death in LTCF residents after COVID-19 vaccination are consistent with expected all-cause mortality in this population. Among deaths in persons with available death certificate and autopsy information who were not LTCF residents, causes of death were consistent with background all-cause mortality and did not indicate any unexpected pattern that might suggest a causal relationship with vaccination.

[110] When asked in cross-examination about an article referring to death rates in Norway, Dr Thomas said:

> The vaccine delivery was given to elderly people first and not surprisingly many of those elderly people first in any society to be given the vaccine were people who were very frail, some of them approaching death. It's not surprising that a large number of deaths early in the vaccine delivery were elderly people who … were expected to die and the death rates were approximately the same as if there had not been a vaccine delivered.

[44] This includes aged care facilities
[45] The number (7) is in the original quote

[111] Dr Thomas was asked about a slide from Dr Canaday's "Fact or Fantasy" presentation in which he had produced a graph from VAERS showing reported deaths post Covid vaccine total 6,985. Dr Thomas did not accept that this supported Dr Canaday's statement that there had been over 6,000 deaths as a result of the vaccine. Dr Thomas said:

> It's an over-simplistic reading of a graph. One interpretation of the graph could be that there had been 6,985 deaths as a result of Covid vaccination that had been reported, and another interpretation would be that there had been 6,985 deaths that had been reported, but that none of them had had anything to do with the vaccination. They're giving data.

[112] The Tribunal acknowledges that Dr Canaday did say in this radio interview, "Now, of course, there's always this question of whether people have the underlying diseases as a cause of death,"[46] and "…it's not confirmed as to whether the vaccines have caused the deaths".[47] However, he did not say what the usual death rates were during the same period. He did not clarify what, if any, significance these statistics had. The quoting of the data was therefore misleading. It was very likely to give the radio audience the impression that over 6,000 deaths had been reported as a result of the vaccine.

[113] It is further alleged that Dr Canaday did not balance the data with New Zealand data. Dr Thomas said that on 6 March 2021 MedSafe began publishing vaccine safety reports which summarised adverse events following the COVID-19 vaccination. Suspected adverse effects following immunisation were reported to the Centre for Adverse Reactions Monitoring (**CARM**) based at the University of Otago. The safety report that was published closest in time to Dr Canaday's interview on 9 July 2021 was "Safety Report #18 – 3 July 2021", a copy of which was provided to the Tribunal. According to that report there had been 1,229,212 total doses administered, with 268 total reports that were 'serious.' A report was considered 'serious' if it was a medically important event or reaction, required hospitalisation, caused persistent or significant disability or incapacity, was life-threatening, caused a birth defect or resulted in death.

[46] ABD p 257
[47] ABD p 258

[114] Dr Thomas's evidence was that the Safety Report noted that:

- There had been two reported deaths, but that there were no safety concerns with the Comirnaty vaccine raised by those reports.
- As part of the review process, MedSafe was comparing natural death rates to observed death rates following vaccination. This is because by chance some people will experience new illnesses or die from a pre-existing condition shortly after vaccination (especially if elderly).
- There were no indications to suggest that the vaccines caused the deaths reported; and
- To date, the observed number of deaths reported after vaccination was actually less than the expected number of deaths.

[115] In cross-examination, Dr Canaday accepted that he needed to be cautious, but on the question of balance, he said he did not intend or feel he needed to spend as much time describing Government positions as he did his own.[48]

[116] Counsel for Dr Canaday submitted that there is no explicit obligation in a professional standard to 'balance with data from New Zealand' and that Dr Thomas gave no evidence about what might be 'sufficient' and therefore the PCC cannot prove that Dr Canaday's statements were therefore likely to imply that deaths after vaccination were caused by the vaccine.

[117] The Tribunal finds that by quoting the US data without talking about the New Zealand data and not providing comparisons with the usual mortality rates of the population for the similar period, Dr Canaday did not provide sufficient information about the vaccination mortality rate. The way in which Dr Canaday presented this information was clearly likely to imply that deaths after vaccination were caused by the vaccine. Particular 2(b) is therefore established.

[48] Page 277, lines 28 to 34.

Particular 2(c): Overstating the number of confirmed deaths linked to the vaccine in New Zealand

[118] Dr Canaday is charged with overstating the number of confirmed deaths linked to the Pfizer vaccine in New Zealand and this suggested that the vaccine was more dangerous than COVID-19 itself.

[119] The relevant passage from Dr Canaday's radio interview is set out in paragraph (c) of Appendix 1:

> I mean of course the situation in New Zealand is quite unique insofar as, you know, there being no recent significant numbers regarding COVID-related deaths themselves. In fact there have been some deaths in New Zealand, I think it's now up to ten or a little bit more recorded after the vaccinations.

[120] This information is not consistent with the data in the Safety Report of 3 July 2021 referred to above, where two deaths had been reported and those deaths were in the context of the matters outlined above at paragraphs 113 and 114.

[121] The Tribunal therefore finds that Dr Canaday did overstate the number of confirmed deaths following the vaccine. He did not use the word "linked", but that is implied. If he was not implying the link, the data would have no significance. However, the particular of the charge also alleges that this suggested that the vaccine was more dangerous than COVID-19 itself. The Tribunal does not accept that Dr Canaday made any comparison with the dangers of the virus itself. Accordingly, the PCC has not established the allegation in particular 2(c).

Particular 2(d): New Zealand Doctors Speaking Out with Science

[122] Particular 2(d) does not contain a specific allegation of an act or omission on Dr Canaday's part. It alleges that New Zealand Doctors Speaking Out with Science is not generally accepted by the profession as a reliable source of balanced information on the COVID-19 vaccine. This relates to Dr Canaday's statement set out in Appendix 1(d), in response to a question about being one of 50 doctors and scientists who signed a petition in New Zealand available online, and whether Dr Canaday was a part of that:

> I am, it's called New Zealand Doctors Speaking Out With Science, and it's a very good organisation that has contained people who are of various fields of expertise who have looked at the various facts and statements that have been made about this problem with us – with – with the COVID-19 and with the roll-out of the COVID-19 vaccine or the Pfizer vaccine product, and so they're asking some penetrating questions that I think we all need to ask and we do need to have the answers, and I found them to be a very good source and a support for the actual science behind some of the issues that have been raised.

[123] Dr Thomas had little knowledge of the organisation. He had looked at the first page of the website. He had not spent time researching the website as he did not understand that he would be required to give an overall assessment of a website.

[124] Dr Thomas described New Zealand Doctors Speaking Out With Science (**NZDSOS**) as representing a small group of (possibly well-meaning) health professionals, whose opinions on the efficacy of the Pfizer vaccine, the use of medical masks, and other matters are erroneous. He did not consider that their opinions should be considered to have any validity with regard to COVID-19. In Dr Thomas's opinion, NZDSOS provides information and advice about COVID-19 that is inconsistent with, and frequently diametrically opposed to, that provided by the overwhelming majority of doctors and scientists in New Zealand and other nations with expertise in this topic.

[125] Under cross-examination, Dr Thomas said that in about March 2023 he had looked at the first page of the NZDSOS website. He did not consider it was necessary to look further on the website to see if it was a reliable source of balanced information. When asked if that would have been of great assistance to the Tribunal, Dr Thomas said that he was time-limited, as many people are, and that there were other issues he wanted to obtain factual information about and his opinions on NZDSOS would not likely be very useful to the Tribunal. He agreed that once he had seen the first page, he had made up his mind that NZDSOS was not an organisation that he had any time for. Dr Thomas added, "I think I came to that website with a reasonably impartial *(sic)*, let me have a look and see what's here."

[126] It was put to Dr Thomas that Dr Canaday required more than a cursory glance at an out-of-date, one and a half year out-of-date first page. Dr Thomas did not agree, saying, "I think my role was to come as an expert witness, and my expertise is in

infectious diseases and I was expecting that I would be required to provide some information about statements that I made which I suggested were not correct. I don't think I was expecting to be required to give an overall assessment of a website."

[127] When asked for the basis of his view that the views of NZSOS were erroneous, Dr Thomas said, "There were when I went to that page, statements about the efficacy about the Pfizer vaccine, statements about the utility of masks, and I'm not sure what else I saw at that time, but other matters that I considered erroneous. Yes, absolutely."

[128] Dr Thomas accepted that he could not say whether the information provided by NZDSOS on 19 July 2021 was inconsistent (the overwhelming majority of doctors and scientists in New Zealand and other nations with expertise in this topic).

[129] Dr Canaday provided an excerpt from the NZDSOS website as to its origin, in 2021. Dr Canaday said that he agrees with the objectives, and believes that these principles had, until recently, been foundational and universally accepted as doctors' ethical obligations.[49] The excerpt contains a heading "Our Message", under which are the following bullet-points:

- Natural and innate immunity works against Sars-CoV-2, the virus that causes COVID-19
- Early treatment works for COVID-19
- Think carefully about the risks and benefits of the COVID-19 injections

[130] There are then three objectives, which also have lists of bullet-points underneath them. The three objectives are:

> Ensuring the ability of Medical Practitioners to speak without censure
>
> Promoting medical freedom
>
> Supporting the public with unbiased information and care

[131] Dr Canaday queried the basis for the statement that "*[NZDSOS] is not generally accepted by the profession as a reliable source of balanced information*". He said it is not supported by any evidence provided, "other than that the views expressed at

[49] Available here: <https://nzdsos.com/message-objectives/>.

NZDSOS often run counter to the narratives put forth by government officials and designated spokespersons whose potential conflicts of interest remain unexplored."

[132] Dr Canaday said that he firmly believes that there can be no "single source of truth" in science; that ideas should be debated and explored, and that members of the public should not be shut out of that debate by politics or efforts to de-platform ideas and their speakers that are different from the mainstream. Dr Canaday said that freedom of expression is an essential human right, as has been enshrined in the International Covenant on Civil and Political Rights, New Zealand's commitment to which is affirmed by the New Zealand Bill of Rights Act 1990.

[133] Dr Canaday said that his understanding is that many members share his views about freedom of expression and that the website provides a way for people in medical, scientific and related professions to express themselves freely. That does not mean he agrees with everything published on the website.

[134] On behalf of Dr Canaday, Mr Holloway submitted that particular 2(d) is confused, that it seems to be alleging that the words spoken by Dr Canaday can be reasonably interpreted as him saying NZDSOS "is" generally accepted by the profession. There is no evidence of what the profession thought, nor any evidence of what information was displayed on the NZDSOS website, the time of the interview in mid-2021.

[135] Mr Holloway noted that the PCC has not challenged that Dr Canaday believed in good faith that (for example) NZDSOS people are 'asking some penetrating questions' and that he has found them 'a very good source and a support for the actual science behind some of the issues that have been raised'. Mr Holloway further observed that the PCC has not produced any evidence of something on the NZDSOS website in mid-2021 that it considers was wrong.

[136] The Tribunal had difficulty with the term, "not generally accepted by the profession". Although the medical members of the Tribunal did not share Dr Canaday's sentiments about New Zealand Doctors Speaking Out with Science, the onus is on the PCC to prove on the balance of probabilities that this organisation is "not generally accepted

by the profession". The Tribunal must make a decision based on the evidence presented at the hearing.

[137] The PCC called no expert witness other than Dr Thomas. He was dismissive and even derisive of this organisation, but he did not assist the Tribunal by explaining why he held those views. But even if he or another witness had undertaken a more thorough review of the website and was able to provide more reasoned analysis of their opinion of the website, the PCC needs to establish what is meant by "generally accepted by the profession". It is a phrase that may be difficult to prove without evidence such as a poll of members of the profession. The term tends to raise more questions than answers.

[138] Accordingly, particular 2(d) is not established.

Particular 2(e): Other effective COVID-19 preventative measures

[139] In particular 2(e), the PCC alleged that Dr Canaday's recommendation of other "effective" COVID-19 preventative measures was likely to mislead the public as to the efficacy of the Pfizer vaccine. This refers to his statements as set out in paragraph (f) of Appendix 1:

> We are all gifted with an innate immune system, and we tend to forget that in the age of pharmaceuticals and vaccines, but actually the strength of our native immune system is what we need to concentrate on, and we can build that up by various means, vitamin C, vitamin D have been well demonstrated to be effective in either reducing the likelihood, reducing the symptoms, and even reducing mortality if those levels are sufficient. Vitamin D especially has been relevant there. There are other agents such as zinc, Quercetin, and so on to build the immune system, and so that's the – that's the fundamental things that everybody should be doing.

[140] Dr Thomas explained that Quercetin is a flavonoid, derived from molecules present in many plants. It had been proposed that it may have beneficial effects in people with COVID-19. Dr Thomas said that at present there does not appear to him to be strong evidence that it affects the outcome in people with COVID-19. Dr Thomas's evidence was that the effects of supplementation of the diet with vitamin C, vitamin D, zinc or quercetin on the risk of becoming unwell with COVID-19 does not appear to have been investigated. He said that such studies would require large numbers of

healthy people to be randomly allocated to preventative treatment with one of these agents, or a placebo that was indistinguishable from the active supplement, and then be followed to determine whether the supplement had an influence on the rate of disease in the group receiving the active supplement. According to Dr Thomas, such studies are often so expensive to perform that they do not occur, as the costs of the study are unlikely to be covered by the income from sale of the supplement.

[141] Dr Canaday's statement about vitamins C, D, zinc and quercetin was in response to a question from the interviewer, "So what do we say for people who are – like certainly older people who are concerned about COVID-19, they would like to be protected against COVID-19…some people are frightened out there, what can we do?"

[142] In submissions for the PCC, Mr Wilson noted that Dr Canaday answered without reference to the vaccine as something people could do. Instead, Dr Canaday referred to the "strength" of the native immune system. It was submitted that by not referring to the vaccine, Dr Canaday misled the public as to the efficacy of the Pfizer vaccine as a step that is relevant in respect to COVID-19. Dr Canaday similarly did not recommend an older person should consult their general practitioner.[50] He accepted that he should have emphasised that a person should talk to their GP.[51]

[143] Mr Wilson referred to Dr Thomas's evidence about other studies that were available to be found but were not referred to by Dr Canaday. Dr Thomas's conclusion was that there was no strong evidence that either vitamin C or D supplementation affects the outcome for people with COVID-19.[52] In fact, in cross examination Dr Thomas pointed out that the evidence Dr Canaday relied on was 'of low quality with heterogenous findings.'[53] Dr Thomas explained that vitamin D supplementation does not affect the immune systems of New Zealanders sufficiently well because of New Zealanders' generally adequate levels of vitamin D.[54]

[50] Transcript 20 April 2023, page 359.
[51] Transcript 20 April 2023, page 445.
[52] Mark Thomas Brief of Evidence at [61].
[53] Transcript 17 April 2023, page 127.
[54] Transcript 17 April 2023, pages 127, 128.

[144] As for zinc, the best document Dr Thomas could find was evidence of very weak 'good' news[55] and there was nothing on PubMed about zinc.[56] The PCC submitted that this shows that caution and balance should be applied to making statements that these are viable alternatives to the vaccine.

[145] For the practitioner it was submitted that while Dr Canaday was not offering treatment advice, his views clearly accord with a substantial body of opinion, including that of Dr Fauci.[57] Dr Canaday attached, in full, the research of the "C19 study group", yet this was not reviewed by Dr Thomas and Dr Canaday was not cross-examined on it.

[146] Submissions were also made about Dr Thomas's evidence lacking impartiality, especially in his statement, "In my opinion, recommending the use of such supplements to prevent COVID-19, in the absence of evidence of their efficacy, when a proven safe effective vaccine is available, is an irresponsible and unprofessional action for a doctor to take."

[147] Further discussion of the validity of the opinions of Dr Thomas and Dr Canaday is, however, not required. Ultimately, the Tribunal agrees with Mr Holloway's submission that the Tribunal should not simply infer that Dr Canaday's discussion of vitamin D etc "*was likely to mislead the public as the efficacy of the Pfizer vaccine*". Discussion of the innate immune system and promotion of vitamins C, D and zinc may lead the audience to believe that there are viable alternatives to vaccine, but that does not equate to providing information about whether the vaccine is effective or not. The PCC has not established particular 2(e).

Appendix 1(g)

[148] There is one other statement in Appendix 1, at paragraph 1(g). Although this statement does not directly relate to any of the sub-particulars of the charge, it is nonetheless captured by the introductory words of Particular 2, that the statements in Appendix 1 are inaccurate, misleading (or had the potential to mislead).

[55] Transcript 18 April 2023, page 161
[56] Transcript 18 April 2023, page 162,
[57] Chief Medical Advisor to President Biden January 2021 to December 2022.

[149] This is the reference to "emergency use authorisation" in Dr Canaday's interview:

> The clinical trials will continue until at least January of 2023, but actually what the FDA, which is the Food and Drug Administration, which manages the vaccine approvals in the United States, has approved the use of the Pfizer vaccine from among others only for emergency use authorisation, and that occurs when there is no reliable treatment that is otherwise available, and some of the controversies have arisen over whether that is actually the case, because there's increasing evidence that other treatments are available, they are effective, and so that has raised some questions about why the vaccine has been rolled down especially when it has been only for emergency use. The long-term side-effects are really not known, and so it's raised some questions in a lot of people's minds about, you know, how did we get to this point.

[150] Dr Thomas described the vaccine approval process. He said that MedSafe is New Zealand's medicines and medical devices safety authority. As set out on its website,[58] it evaluates applications for all new medicines, including vaccines, to make sure they meet international standards and local requirements. There is a publicly available page which talks about the process by which the COVID-19 vaccines became available in New Zealand. Of particular note is that:

> (i) COVID-19 vaccines were being held to the same standards and requirements as all vaccines before they received full approval.
>
> (ii) In considering whether to approve a vaccine, MedSafe looks at safety, efficacy and quality of the vaccine. Its assessment includes looking at manufacturing and quality control information, pre-clinical data, and results from clinical trials.

[151] Dr Thomas said that the full process MedSafe went through to assess whether the Pfizer BioNTech vaccine could be approved to be used in New Zealand is outlined on their website. MedSafe gave the vaccine provisional approval on 3 February 2021.

[152] Dr Thomas said that in New Zealand, the Pfizer vaccine was given "provisional approval" for use because "data to support the longer-term efficacy and safety were not available" at the time of approval.[59] Usually companies give all the data from all the studies once it has been completed but with the COVID-19 vaccine, companies

[58] Printout contained in the Bundle of Documents
[59] Ministry of Health publication "COVID-19 vaccines available in New Zealand" (27 September2022) produced in the Bundle of Documents

sent data as it became available. MedSafe also shortened the timeframe for companies to respond (e.g. from four months to one week).

[153] The New Zealand Government then published its "COVID-19 vaccine data roll-out plan" on 10 March 2021. The vaccine was rolled out in groups according to risk and the vaccine was first administered in New Zealand on 19 February 2021.

[154] In cross-examination, Dr Canaday was asked about his statement that the Pfizer vaccine had "emergency use authorisation" which occurs only "where there's no reliable alternative treatment available. Dr Canaday noted that is why the term in New Zealand was "provisional consent"; it was not approved under sections 21 or 22 of the Medicines Act, but under section 23.

[155] Dr Canaday also quite rightly noted under the Medicines Act in New Zealand medicines are not "approved", but the Minister of Health gives "consent", but the Ministry documents included in the Bundle use the word "approved". Sections 20 of the Medicines Act 1981 provides that the Minister of Health's consent is required for the sale or supply of new medicines. Sections 21 to 23 deal with applications for the Minister of Health's consent. Dr Canaday accepted that the Medicines Act does not refer to the FDA approval process but did not accept that the FDA approval was irrelevant to the New Zealand consent process because the Minister had given only provisional consent. He said, "Well I think that there is a parallel consideration because provisional consent in New Zealand is provided when a product does not meet the full criteria for a fully approved product. Likewise in the United States, emergency use authorisation is used for the same types of issues."

[156] The PCC submitted that Dr Canaday's statement about the FDA approval had the potential to mislead because Dr Canaday did not talk about the New Zealand process and in continually referring to the FDA process gave an entirely misleading picture of the situation in New Zealand (which does not depend on the existence of alternative treatments). Mr Wilson submitted that New Zealand law sets out how medicines are approved in New Zealand. The Medicines Act does not refer to the FDA process and

does not refer to the 'emergency use authorisation' process.[60] Dr Canaday's references to "emergency use authorisation" (despite not applying in New Zealand) was misleading.

[157] Mr Holloway did not specifically address this quote, which did not directly relate to any of the sub-particulars of the charge, but as previously noted, it is nonetheless captured by Particular 2.

[158] Dr Canaday's discussion of the FDA approval process may have been correct. The PCC has not established that this statement is inaccurate. It is the implication that this applied to the consent process in New Zealand that was potentially misleading, but as noted above, a statement that is "potentially misleading" does not reach the disciplinary threshold. Particular 2 as it applies to Appendix 1(g) is not established.

[159] In summary, the Tribunal has found that Particular 2 is established to the extent that particular 2(b) is proven and that the statement was misleading.

Particular 3: Disparaging/unprofessional criticism

[160] In Particular 3 the PCC alleges that Dr Canaday's statement as set out at Appendix 1(e) was disparaging and/or amounted to unprofessional criticism of other health practitioners and had the potential to encourage criticism of other health practitioners. This is the statement:

> I think, you know, a lot of people in New Zealand, they're smart, they're saying, "Look, what's – what's really going on? Am I really being told the truth?" They've done their own investigations. They've gone past the sources which typically have been censored, and actually discovered that there's actually a lot of information out there from people who have been marginalised, and put on to the side-lines, and I think that's the kind of folks that actually showed up in Hamilton last night, and I was hoping that I would be able to give some kind of, I guess, what shall we say? Legitimacy or just say, "Yes, okay, I'm a physician. I've done this for years. I've published in the medical literature. I've presented at international meetings. I've been an academic of a medical school programme. I kind of "know the background", and I hoped to provide some legitimacy to the concerns that they had.

[60] Transcript 19 April 2023, page 353.

(In response to a question about the sort of reaction Dr Canaday was getting from his peers - friends and doctors and people you used to know when you were working in the industry):

> Well, I'd hate – I'd have to say it depends on who's retired and who isn't, and they seem a bit odd -- but, you know, those who don't have their livelihood dependent upon what they say or what they think tend to be a bit freer to – you know, to speak their minds about it. I have several friends in the States, doctor friends, and I've asked them, "You know, have you really considered this and maybe you should, you know, hold off on taking the vaccine", but I – in many cases, I've not been successful, but you see what happens is then they themselves in the active practice of medicine, they've been pressured by the authorities of their hospital or system or their university to take the jab, and once you've taken the jab, you know, you are really pretty well committed –

[161] It is the second part of this statement that the Tribunal was concerned about. Dr Canaday is saying that his professional colleagues do not say what they really think because their livelihood depends on their not speaking their minds.

[162] It is relevant that this statement was made, not in the course of professional discourse, but on public radio during a national pandemic. The Tribunal's view is that in the context of a public discussion, it was an unprofessional criticism, suggesting that members of the medical workforce are practitioners who have no courage or no independent thought. Many of his colleagues were treating patients with COVID-19 and intent on prevention of the virus, not only amongst the community at large, but also within that workforce, upon which the community relied. The Tribunal considered this was disparaging, but such comments do not meet the disciplinary threshold. It is not sufficiently serious to warrant a disciplinary sanction. The Tribunal did not consider that it encouraged criticism of other health practitioners. Even if it had the potential to encourage criticism of other health practitioners, that is not sufficiently serious to warrant a disciplinary sanction. Particular 3 is established to the extent that the comments could be construed as disparaging of other health practitioners.

Particular 4: Discredit to the profession

[163] Although we are also asked to find whether the allegations of the entire charge either individually or cumulatively amount to professional misconduct, which includes conduct likely to bring discredit to the profession, Particular 4 alleges that the

statements in Appendix 1, individually or cumulatively, brought, or were likely to bring, discredit to the medical profession. Mr Wilson described the charge as a "Russian Doll".

[164] Therefore, regardless of the way in which the allegations in particulars 2 or 3 are framed, we may still consider all the comments in Appendix 1 and find that reasonable members of the public, fully informed of the facts would consider the reputation of the medical profession was lowered by these statements.

[165] For Dr Canaday, it was submitted that where it is not an adjunct to findings of negligence/malpractice, discredit is usually reserved for conduct that has some element of moral transgression, which cannot be said of Dr Canaday. While the opinions expressed in Dr Canaday's presentation can be debated, he told no lies. He spoke in good faith. In these circumstances — including giving section 100(1)(b) a meaning that is consistent with the rights and freedoms contained in this Bill of Rights — the quotes set out in the Appendices to the charge cannot be judged to have brought discredit to the profession.

[166] It was further submitted that the quotes need to be put in context. They comprise mere moments of lengthy interviews/presentations, the overall tone of which was earnest, sincere and well-meaning. Dr Canaday did not come across as disparaging or cavalier. It would be dangerous (and 'chilling') to find that merely expressing opinions contrary to the dominant narrative can be characterised as bringing discredit.

[167] The Tribunal has considered the statements in Appendix 1 and finds that the statements in paragraph 1(b), in which Dr Canaday was discussing data of adverse events and deaths were inaccurate and unbalanced, and that reasonable members of the public would tend to find the reputation of the profession is lowered by a medical practitioner making such statements in a public forum in the time of a pandemic.

[168] The Tribunal does not find that the remainder of the statements are likely to bring discredit to the profession because they have not been found to be misleading.

[169] Dr Canaday's implication that other doctors were too scared to speak up (as set out in particular 3) might have been disparaging, the Tribunal does not find that reasonable members of the public would consider the reputation of the profession has been lowered by this statement on its own. When considered cumulatively with other statements, it does reach that threshold.

Particular 5: Courageous Convos

[170] Particulars 5 to 8 of the Charge concern Dr Canaday's recorded presentation called "Courageous Convos".

[171] Particular 5 alleges that on or about 21 July 2021 Dr Canaday, by way of a publicly accessible recording titled Courageous Convos uploaded to the Odysee channel of Voices For Freedom (**VFF**), made the statements set out at **Appendix 2** (to the charge). Dr Canaday accepts that he did this, and so this particular is established.

Particular 6: Inaccurate or misleading statements

[172] The PCC alleged that the statements made in Appendix 2 were inaccurate and/or misleading or had the potential to mislead as further particularised below.

Particular 6(a): Full story, missing information

[173] Particular 6(a) alleged that Dr Canaday's suggestion that he is providing "the full story" and "missing information" is incorrect and is likely to misrepresent the efficacy of New Zealand's pandemic response. The statement in Appendix 2(a) to the Charge is:

> So, you know, we all do our parts, and it's not just myself, other physicians are doing their part as well, and it's all part of the necessary way of informing, because really we've been told that of course we're just representing misinformation but I'd like to see the perspective that we're actually providing missing information, and that really is – is a key difference here because we hear lots and lots from the various organs of official government and institutions throughout New Zealand, but we don't actually hear, you know, the full story.

[174] The PCC submitted that this particular is established because it was in the context of a discussion which referred to deaths and sterility and would have been consumed by the general public as having a more sinister meaning. The inference from Dr

Canaday's statements is that mainstream medical channels were providing selective information which serves to undermine the profession.

[175] Mr Holloway submitted that Dr Canaday's evidence has demonstrated there was a great deal of information "missing" from the very simple government messaging about the Pfizer vaccine — for example, uncertainty about whether vaccination would materially reduce community transmission. The PCC noted that Dr Thomas agreed that the efficacy of the Pfizer vaccine was unknown in respect of Polynesian and Asian people.[61]

[176] The Tribunal found that it may have been incorrect for Dr Canaday to say that he was providing the "full story" and "missing information". It is a tall order do so. The Tribunal also finds that referring to deaths and sterility was misplaced and may have sparked unjustified fear in his audience. However, the charge is that this suggestion that he was providing missing information was likely to misrepresent the efficacy of New Zealand's pandemic response. That is quite a long bow to draw. It may raise some questions for the listener, but it does not follow that this suggestion is likely to misrepresent the efficacy of New Zealand's response to the pandemic. Particular 6(a) is not established.

Particular 6(b): Other effective COVID-19 treatments

[177] The PCC alleged that Dr Canaday's recommendation of other "effective" COVID-19 treatments is not supported by generally accepted scientific evidence. This charge is based on the statement at Appendix 2(b), in which Dr Canaday referred to the use of Ivermectin for prevention and treatment of COVID-19:

> …they have to say, "Look, there is ample evidence – ample evidence for the benefit of proven, longstanding many decades use of therapeutics that, you know, we should allow into New Zealand for the purpose of, you know, treatment and prevention because these are well-known – well-known effective agents, you know, they can be – they can be used for this purpose, and I'm talking about, you know, I mean, I'm talking about Ivermectin in particular because the evidence for that is, you know, is overwhelming.

[61] Notes of evidence at 71, line 20

> […] there are over two dozen randomised control studies using Ivermectin which is shown as benefit for prevention before you are exposed to COVID patients, after you have been exposed to COVID patients, for early treatment.
>
> Even for late treatment, even for mortality, and all those studies are out there, and they are peer-reviewed most of them. Some of them are observational, but most of them are very definitive in the benefit of this particular agent, which has been in use for decades, very known highly safe profile, and it's cheap, and it doesn't cost NZ$4,000 like Remdesivir does.

[178] Dr Thomas's evidence about Ivermectin assisted the Tribunal. He said that Ivermectin is a prescription medicine typically used to treat parasites in humans, and also for prevention of heartworm in small animals. Ivermectin is not approved to treat or prevent COVID-19. The only medicine containing Ivermectin that is approved for use in New Zealand is Stromectol. It is used for treating several parasitic diseases but not COVID-19. If Stromectol were prescribed for an unapproved use (i.e. an "off label use") like treating COVID-19 then the prescribers must consider the potential risks (and benefits) and obtain informed consent.

[179] Dr Thomas said that in mid-2021 (which was the time of this presentation) there was some uncertainty about the potential effect of Ivermectin in patients with COVID-19.[62] Dr Thomas said that in June 2021 a group of English scientists and doctors published a systematic review and meta-analysis of published studies of Ivermectin for the prevention and treatment of COVID-19 in the American Journal of Therapeutics. Their meta-analysis found that Ivermectin appeared to reduce the risk of death in patients with COVID-19. However, the editor of the same journal in February 2022 issued an "Expression of Concern" about this article based on allegations that inaccurate data collection and/or reporting occurred in at least two studies that were included in the meta-analysis.

[180] Dr Thomas referred to a subsequent meta-analysis published in June 2022 on the Cochrane Database website which found that:

> For outpatients, there is currently low- to high-certainty evidence that Ivermectin has no beneficial effect for people with COVID-19. Based on the very low-certainty evidence for inpatients, we are still uncertain whether Ivermectin prevents death or clinical worsening or increases serious adverse

[62] Mark Thomas BOE para 49

> events, while there is low-certainty evidence that it has no beneficial effect regarding clinical improvement, viral clearance and adverse events. No evidence is available on Ivermectin to prevent SARS-CoV-2 infection.

[181] Dr Thomas also said MedSafe has published on the risks of importing or prescribing Ivermectin for prevention or treatment of COVID-19. MedSafe warn that inappropriate use of Ivermectin can be dangerous. As at 6 September 2021, MedSafe had not received any medicine application or clinical trial application for Ivermectin for the prevention or treatment of COVID-19.

[182] Dr Thomas also referred to MedSafe's links to international advice such as:

- '*Why you should not use Ivermectin to treat or prevent COVID-19'* from the United States Food and Drug Administration dated 5 March 2021;
- '*EMA advises against use of Ivermectin for the prevention or treatment of COVID-19 outside randomised clinical trials'* from the European Medicines Agency dated 22 March 2021; and
- '*Ivermectin not authorized to prevent or treat COVID-19; may cause serious health problems'* from Health Canada dated 19 October 2021.

[183] Dr Thomas concluded that in his expert opinion, Ivermectin is not a viable alternative to currently available medications for COVID-19 and would not have been recommended or prescribed by a responsible practitioner.

[184] For the practitioner, Mr Holloway submitted that Dr Canaday did not "recommend" Ivermectin. As part of a public presentation, he said (for example) "Even for late treatment, even for mortality, and all those studies are out there, and they are peer-reviewed most of them. Some of them are observational, but most of them are very definitive in the benefit of [Ivermectin]".

[185] Dr Canaday also referred to the experiences of India and Mexico, which suggested to him that Ivermectin was effective. Mr Holloway submitted that the Tribunal was denied the benefit of Dr Thomas's views on this data as he would not deign to look at the graphs.

[186] Mr Holloway submitted that in his evidence, Dr Canaday was clear that anyone wanting to explore Ivermectin further (such as seeking a prescription) would need to seek advice from their doctor.

[187] It was submitted that the PCC led no cogent evidence as to the meaning of "generally accepted scientific evidence". Dr Thomas seemed to rely on a study that was both current as at mid-2021 and supportive of Ivermectin as a safe and effective treatment. He did not however review Dr Canaday's slides about the experience of using Ivermectin in India and Mexico and nor were these challenged in cross-examination.

[188] As well as Dr Thomas's statement: "In my opinion, in mid-2021 there was some uncertainty about the potential effect of Ivermectin and hydroxychloroquine in patients with COVID-19," Mr Holloway referred to Dr Thomas's oral evidence that it would be "reasonable for a doctor such as Dr Canaday in 2021, or any other doctor … for that period of time to believe that Ivermectin was a safe and effective treatment".

[189] It was submitted that Dr Thomas seems to concede that, in mid-2021, there was a substantial body of opinion supporting the use of Ivermectin to treat COVID-19. This is precisely the discourse about a rapidly changing situation replete with 'uncertainty' that Dr Canaday was participating in — his speech was not 'inaccurate' or 'misleading'.

[190] The Tribunal accepts that Dr Canaday did not use the word "recommend" in his discussion of Ivermectin, but he did use language which endorsed its use. He talked about the evidence being "ample" and "overwhelming." The overall message was one of commendation.

[191] The next question is whether this recommendation was one that was "not supported by generally accepted scientific evidence". This phrase is problematic. The onus is on the PCC to prove what was "generally accepted scientific evidence. It is a difficult one for the PCC to establish, particularly when applying it to knowledge available in the midst of a global pandemic. Proving this outside of a pandemic would require

evidence of knowledge and protocols across a range of disciplines, countries and over time. The Tribunal is in no doubt that scientists were dealing with a changing landscape throughout 2020 and 2021. That fact itself might be a reason Dr Canaday should have exercised more caution before speaking publicly about the research he had undertaken, but he is charged with making a recommendation of other effective COVID-19 treatments that was not supported by generally accepted scientific evidence. The Tribunal accepts the submission for the practitioner that the PCC has not led evidence on this point.

[192] In any event, based on Dr Thomas's evidence, at the time that Dr Canaday made his statement about Ivermectin during his Courageous Convos recording on or about 21 July 2021, there was evidence to support an assertion that Ivermectin might provide some benefit. It was in June 2021 that the meta-analysis had been published which suggested that the use of Ivermectin seemed to reduce the risk of death in patients with COVID-19. Particular 6(b) is not established

Particular 6(c): Link between Pfizer vaccine and sterility/death

[193] In particular 6(c), the PCC alleged that Dr Canaday's inference[63] that there is a link between the Pfizer vaccine and sterility and/or deaths was unprofessional and emotive and is not supported by generally accepted scientific evidence. This was in relation to the following statement found in Appendix 2(c):

> I think, you know, you have to make it very obvious, what is sensible, make that obvious to the people at large, because again the only thing that we can count on, we're not going to count on anybody else (several inaudible words) and you have to get to the point where enough people are upset and knowledgeable about how this is not about health, and, you know, and that our very livelihoods and indeed potential future of our country and environment for the next generation is threatened. I mean, we're talking about potential sterility here, and, you know, and we're talking about the elimination of – the potential of having large numbers of deaths from these vaccines […]

[194] In his evidence, Dr Canaday has referred to a paper published in the New England Journal of Medicine in June 2021[64] which concluded that preliminary findings did not

[63] The Tribunal takes this to mean that Dr Canaday is charged with "implying" or asking his audience to "infer".
[64] Shimbukuro et al., "Preliminary findings of mRNA COVID-19 Vaccine Safety in Pregnant Persons" N Engl Med 384; 24

show safety signals but more longitudinal follow-up was needed. Dr Canaday told the Tribunal that there was an error in the calculation because women in the third trimester had been erroneously included in the denominator. This was pointed out in a letter to the editor on 8 September 2021 but one of Dr Canaday's sources had already recognised this error in calculation and noted it in a news report. Dr Canaday said that as it turns out, the calculation of true miscarriage rate is even more complicated when data are presented in a confusing way and the study did not have a long-enough follow-up period to assess all relevant pregnancy outcomes.

[195] The PCC submitted that Dr Thomas's evidence establishes that there were no reasonable grounds to suspect that the vaccine was linked to sterility – or 'elimination.'

[196] Dr Thomas referred to studies which he said show that Dr Canaday's comments have no basis in scientific fact. A study of accidental pregnancies that occurred in women who had been enrolled in COVID-19 vaccine trials in the UK was published in Nature Reviews Immunology in April 2021. This found that 28 of 39,845 women who received a placebo became pregnant and that 5 out of 28 (18%) of them had suffered a miscarriage, while 29 of 39,848 women who received an active vaccine became pregnant and that 2 out of 29 (7%) of them had suffered a miscarriage. The rates of accidental pregnancy were essentially identical in the two groups, and the rates of miscarriage were actually lower in the vaccinated group.

[197] Dr Thomas referred to another publication. On 18 June 2021 the United States Centre for Disease Control and Prevention (**US CDC**) published, in the Morbidity and Mortality Weekly Report (**MMWR**) a document which reported that the US Vaccine Safety Datalink had identified 22,197 of 135,968 (16.3%) pregnant women who had been given one or more doses of a COVID-19 vaccine between 14 December 2020 and 8 May 2021. This document merely reported on the proportion of pregnant women who had received one or more vaccine dose. However, the authors stated in their discussion:

> In addition, analyses of emerging data regarding safety of COVID-19 vaccines, specifically mRNA vaccines, have detected no safety signals for pregnant women. In early data from three of CDC's vaccine safety monitoring systems,

> no safety concerns were identified for vaccinated pregnant women or their infants; additional follow-up is needed, particularly among women vaccinated in the first and second trimesters of pregnancy.

[198] Dr Thomas said that the authors of the CDC report in the MMWR referred to an article published in the New England Journal of Medicine (**NEJM**) on 21 April 2021 that reported on pregnancy outcomes in 19,252 pregnant women who had received the Pfizer-BioNTech vaccine and 16,439 who had received the Moderna vaccine. In the discussion the authors stated:

> Early data from the v-safe surveillance system, the v-safe pregnancy registry, and the VAERS do not indicate any obvious safety signals with respect to pregnancy or neonatal outcomes associated with COVID-19 vaccination in the third trimester of pregnancy. Continued monitoring is needed to further assess maternal, pregnancy, neonatal, and childhood outcomes associated with maternal COVID-19 vaccination, including in earlier stages of pregnancy and during the preconception period. Meanwhile, the present data can help inform decision making about vaccination by pregnant persons and their health care providers.

[199] On the question of sterility in males, Dr Thomas referred to a research letter published in the Journal of the American Medical Association (**JAMA**) on 17 June 2021 which reported on the measured parameters of sperm collected from 45 healthy male volunteers before and after COVID-19 vaccination. The authors summarised their findings:

> In this study of sperm parameters before and after 2 doses of a COVID-19 mRNA vaccine, there were no significant decreases in any sperm parameter among this small cohort of healthy men. Because the vaccines contain mRNA and not the live virus, it is unlikely that the vaccine would affect sperm parameters. While these results showed statistically significant increases in all sperm parameters, the magnitude of change is within normal individual variation and may be influenced by regression to the mean. Additionally, the increase may be due to the increased abstinence time before the second sample. Men with oligospermia did not experience further decline.

[200] It was noted that the limitations of the study include the small number of men enrolled; limited generalizability beyond young, healthy men; short follow-up; and lack of a control group. In addition, while semen analysis is the foundation of male fertility evaluation, it is an imperfect predictor of fertility potential. Despite this, the study's time frame encompasses the full life cycle of sperm.

[201] The PCC submitted that in cross-examination Dr Canaday accepted that both pregnancy and miscarriage, and the issue of sterility, are areas of particularly heightened concern for people "as well they should be". Dr Canaday went further and said, "people need to know" and "scared would be appropriate in this instance." Dr Canaday also accepted that the topic was "really susceptible to fear and misunderstanding," and "particularly when it comes to pregnancy, and sterility, and the effect on future generations." Dr Canaday did not accept that it would have been responsible to say, "We don't know enough," or that people should talk to their general practitioner. Dr Canaday's reasoning was because he is "not an agent of other people." The PCC said that this was a fundamental misunderstanding of the nature and extent of his professional obligations.

[202] For the practitioner, it was submitted that the PCC must establish that the words spoken:

- implied a link between the Pfizer vaccine and sterility and/or deaths;
- that the nature of the inference was unprofessional; and
- the inference was not supported by 'generally accepted scientific evidence'.

[203] Mr Holloway submitted that the relevant words from Appendix 2 are "we're talking about potential sterility here" and "Some reports may exist in regard to whether miscarriages are unusually elevated". Describing something as "potential" is not the same as "inferring a link".

[204] Mr Holloway referred to Dr Canaday's evidence. It was submitted that his views were held in good faith, well-researched and expressed tentatively. There was nothing "emotive" about them. They were based on evidence, which Dr Thomas failed to show was unreasonable for Dr Canaday to take into account.

[205] It was further submitted that Dr Canaday had no duty to "maintain public confidence in the Pfizer vaccine". He had a right to freely express his views based on information he had reviewed and considered.

[206] Mr Holloway noted that Dr Thomas's own evidence includes "additional follow-up is needed, particularly among women vaccinated in the first and second trimesters of pregnancy"; and "Early data … do not indicate any obvious safety signals with respect to pregnancy or neonatal outcomes associated with COVID-19 vaccination in the third trimester of pregnancy. Continued monitoring is needed …". These caveats in the evidence Dr Thomas relied on mean it must fall short of establishing a "generally accepted" position.

[207] Mr Holloway submitted that Dr Thomas's evidence proves Dr Canaday's point: it is normal to be concerned about and want to study the mass deployment of a new vaccine that functions in a new way. No long- or medium-term safety data were available. The risk to pregnancy was being studied in real-time by scientists who were, presumably, also concerned about potential risk (see for example the Medsafe documents included as part of the Evidence for the practitioner).[65] This is the sort of information that ought to form part of informed consent. Mr Holloway submitted that the PCC seems to be implicitly advocating for making only limited information available to those being asked to take up Pfizer-BioNTech vaccine.

[208] The Tribunal found that anyone listening to Dr Canaday's talk would be likely to understand that he was implying a link between the vaccine and sterility and death. That is the plain meaning of the last sentence, "I mean, we're talking about potential sterility here, and, you know, and we're talking about the elimination of – the potential of having large numbers of deaths from these vaccines."

[209] The Tribunal also finds that it was unprofessional for Dr Canaday to say this because as a medical practitioner, he should have been aware of the weight of his words and opinions. He made statements that would have caused disquiet amongst the audience. He was not addressing a group of medical colleagues or scientists who would be more discerning and alert to the hypothetical language such as "potential" sterility. There was insufficient data for meaningful conclusions about the risk of

[65] Evidence for the practitioner at 1697-1858.

sterility. In this sense Dr Canaday's statements were unprofessional. Although he did not use emotive language, the topic is an emotive one.

[210] However, the particular requires the PCC to also establish that this implied link is not supported by generally accepted scientific evidence. Because the PCC has not established what is meant by generally accepted scientific evidence, the Tribunal does not find that particular 6(c) is established, but this statement is further considered under particular 8.

Particular 6(d): Dr Canaday's ability to provide informed advice on the treatment of COVID-19

[211] The PCC charged that as Dr Canaday has not provided medical care of a respiratory nature to any COVID-19 patients, Dr Canaday overstated and/or misrepresented his ability to provide informed advice on the treatment of COVID-19. This was in relation to Dr Canaday's statement at Appendix 2(e):

> I mean, it's like – you know, this sort of happened at the right time in my particular career, you know, having just recently retired from DHB work, so, you know, it just – it puts together, you know, a lot of the things – I mean, my clinical background in pulmonary respiratory medicine, because I used to treat these people who have these end-stage, you know, respiratory failure like you've seen with the advanced COVID, and, of course, you know, I was a professor for eight years and teaching residents so I was used to sort of getting up and talking. I presented in international meetings and this and that, so it kind of puts all those things in a way to summarise it all.

[212] The PCC submitted that Dr Canaday has not provided medical care of a respiratory nature to COVID-19 patients and has never been registered as a respiratory or intensive care doctor in New Zealand. He was described as a pulmonary and intensive care physician but did not correct that description to note that he had not practised pulmonary care in New Zealand, nor given any medical care of a respiratory nature to any COVID-19 patients. Despite Voices for Freedom being responsible for advertising his presentations, it was Dr Canaday's responsibility to correct any possible misconception about his medical registration in New Zealand, the currency of his experience.

[213] The PCC referred to the Medical Council's Statement on Advertising which sets out its expectations in relation to statements about doctors' qualifications and experience. In particular, a doctor may not imply that they are more skilled or have greater experience than is the case. A doctor can only advertise titles, qualifications or memberships that have been approved for the purpose of registration and relate to the doctor's vocational scope of practice in New Zealand.

[214] The PCC submitted that doctors, because of their training, and the respect that is accorded them as members of a regulated profession, have a special responsibility to avoid making statements about topics that are beyond their areas of expertise. Doctors should take care when making statements that expressly contradict accepted medical science, as to fail to do so may lead patients to make decisions that are deleterious for the health of themselves or their close contacts.

[215] For Dr Canaday the submissions in response to particular 2(a) above were referred to.

[216] The Tribunal found that as a medical practitioner, Dr Canaday was able to offer some information and opinions about the Pfizer vaccine, but that he has overstated his ability to provide informed advice on the treatment of COVID-19. The Tribunal accepts that in his role as a radiologist, he may have been discussing chest X-rays, CT scans and MRI scans but we heard no evidence about that. He had no experience in treating COVID-19 but implies that he is used to dealing with COVID-type illnesses.

[217] Dr Canaday was not described as a radiologist who used to practise pulmonary care in the United States 20 to 25 years ago. He said that he was a professor for 8 years, when he had been an Assistant Professor of Radiology July 1999 to May 2007. To that extent the public would have had a false impression of his credentials, the Tribunal members considered that was misleading. Particular 6(d) is established.

[218] Dr Canaday did not take adequate care in presenting his credentials and to that extent his conduct might be regarded as negligent. The Tribunal finds that reasonable members of the public fully informed of Dr Canaday's actual background would find that the reputation of the profession was lowered by these representations of his

credentials to provide advice on the treatment of COVID-19. However, on its own, this particular is not sufficiently serious to warrant a disciplinary finding.

Particular 7: Disparaging/unprofessional criticism

[219] The PCC charged that statements at Appendix 2(a) and (d) above were disparaging and/or amounted to unprofessional criticism of other health practitioners and had the potential to encourage criticism of other health practitioners. Those statements are:

> Appendix 2(a):
>
> So, you know, we all do our parts, and it's not just myself, other physicians are doing their part as well, and it's all part of the necessary way of informing, because really we've been told that of course we're just representing misinformation but I'd like to see the perspective that we're actually providing missing information, and that really is – is a key difference here because we hear lots and lots from the various organs of official government and institutions throughout New Zealand, but we don't actually hear, you know, the full story.
>
> Appendix 2 (d)
>
> you tend to be lulled into this sense of complacency, and yet things never become obvious until they suddenly change to where they become irreversible, and so it is extremely important that we see the early stages and we intervene early or at least earlier, and say, "You know, we're passed the really, really early stage, we're into the early to mid-stages", and, you know, vigilance and, you know, all the things that you're doing in Voices for Freedom are the essential things to try to stem this before it becomes, you know, another horrific turn in world history." ()

(In response to another person saying "*we hear people like Chris Hipkins saying […] "They'll come for you" […] this idea that you're something to be hunted almost*")

> You know straight out of the Soviet playbook. I mean that is straight out of the Soviet – make no mistake about that. […] Perverse at a minimum, and intentionally evil on their face. I mean, you have to be concerned in fact whether that's the way it is." […] Meanwhile, it's KGB, you know, kinds of directives. Dob in your neighbour and report anybody that's stepping out of line, and this taking the jab, and of course it's all for your good.
>
> It may be – it may be that it's made to appear like incompetence, and I think that's let's pull it out of the – you know, the Soviet playbook too is you make it appear – it's cognitive disinformation, you know, it's like you kind of – you know, you go along to make it look like you're just kind of, well, going along, well, that's

> not something that's going to get people excited that much, they'll just complain, but they won't do anything, but it's actually intentional (several inaudible words) it's entirely different.

[220] The PCC submitted that Dr Canaday's comments undermine trust in the public health system and those participating in it. Membership of a profession such as that which medical practitioners hold is a privileged position and part of the privilege is that the public will take more notice of what a doctor is saying by virtue of their being a doctor. This can only be more so in the circumstances of a worldwide public health emergency.

[221] Mr Wilson noted that Dr Canaday accepted that the public must have confidence in the medical profession, because if people do not trust doctors then doctors cannot do their jobs.[66] It was submitted that by attending the Courageous Convos presentation as a doctor and talking about 'the jab", Dr Canaday drew links between the vaccine, New Zealand's vaccination programme and by implication the New Zealand medical profession in terms that undermined the confidence in the profession.

[222] It was submitted that Dr Canaday's comments were hugely inflammatory, intemperate and came in a context of a discussion that was around health issues. In cross-examination Dr Canaday agreed that if a doctor was to say in respect of other doctors who were treating patients, that they weren't telling the truth, that would undermine confidence in the medical profession. He said that if a person who is a doctor but is not treating medical patients is inserted into that question, then that would not undermine public confidence, but "it might undermine confidence in, for example, Government officials or Government policy, if that was the origin of the person making those medical statements."[67]

[223] The PCC submitted that it is far from clear from Dr Canaday's comments that his view was confined to government officials and there is a real risk that this would have been

[66] Transcript 19 April 2023, page 280.
[67] Transcript of evidence pages 281 to 282

taken, in context with other comments, to be about the medical profession or members of it intending on a course of vaccination.

[224] It was also noted that a number of people who were involved in New Zealand's public response to COVID-19 were and are medical practitioners and health practitioners of other kinds. Ashley Bloomfield, for example, was awarded general scope on 21 January 1992, and provisional scope on 6 December 1990, with a vocational scope of practice in public health medicine.[68] Such people form part of the health profession.

[225] Submissions for the practitioner focused on whether Dr Canaday's comments amount to professional misconduct.

[226] The Tribunal finds that the comments were disparaging of the government. There may be members of advisory committees and staff at the Ministry of Health who are also members of the medical profession, as the Director-General of Health at the time was. However, the Tribunal agrees with Dr Canaday, that a criticism of the government does not amount to unprofessional criticism of other health practitioners. It arguably had the potential to give rise to criticism of another health practitioner in his role as Director-General of Health, but that is not the same as encouraging criticism of the medical profession as a whole. Particular 7 is not established.

Particular 8: Discredit to the profession

[227] Particular 8 alleges that the statements in Appendix 2 to the Charge individually or cumulatively brought, or were likely to bring, discredit to the medical profession. Applying the test in *Collie*,[69] the Tribunal must consider whether reasonable members of the public, informed and with knowledge of all the factual circumstances, could reasonably conclude that the reputation and good standing of the medical profession was lowered by Dr Canaday's statements in Appendix 2.

[228] The Tribunal found that statement in paragraph c) concerning potential sterility and deaths from the vaccine amounts to conduct that brings discredit to the profession

[68] https://www.mcnz.org.nz/registration/register-of-doctors/doctor/bloomfield-ashley-robin/
[69] Above, note 18

because it was unprofessional and emotive and was made without a scientific basis. Reasonable members of the public, on hearing that a medical practitioner made such statements when there was insufficient evidence to support such a statement would tend to think that the reputation of the profession was lowered by that conduct. Dr Canaday's conduct in making the statements in Appendix 2 c) is likely to bring discredit to the profession.

Particular 9: Fact or Fantasy Livestream

[229] Particular 9 alleges that on or about 19 August 2021 by way of a publicly accessible recording titled "COVID-19 and the Pfizer Vaccine: Fact or Fantasy?" uploaded to the Odysee channel of VFF, Dr Canaday made a number of statements as set out in Appendix 3 to the charge. Dr Canady accepted this and so particular 9 is established.

[230] The presentation comprised a series of approximately 95 power point slides accompanied by Dr Canaday's commentary. The Tribunal was provided with copies of slides and the transcript of Dr Canaday's narration. During the hearing we watched the presentation and noted that the slides provided in Dr Canaday's Bundle of Documents were not identical but were largely the same. Nothing turned on the differences.

Particular 10: Inaccurate or misleading statements

[231] Particular 10 alleges that the statements that were set out in Appendix 3 to the charge were inaccurate and/or misleading or had the potential to mislead. This was denied by Dr Canaday.

Particular 10 (a) Hydroxyquinoline and Ivermectin

[232] The PCC alleges that Dr Canaday's support of other COVID-19 treatments including hydroxychloroquine and Ivermectin is not supported by generally accepted scientific evidence.

[233] During the course of the Fact or Fantasy presentation, Dr Canaday, referring to the emergency use authorisation of the Pfizer vaccine, said:

> […] the emergency use authorisation requires that there is no suitable treatment for COVID-19 available, but in fact we did have these early reports of

> reduction in morbidity and mortality from hydroxychloroquine,[70] zinc and azithromycin were suppressed.
>
> Dozens of studies have shown Hydroxychloroquine and Ivermectin work. Both have been in use in decades for other reasons. Their benefits are greatest when given for prevention for prophylaxis and also post-exposure prophylaxis when you know somebody's had COVID and you've been around them, also for early treatment.
>
> …
>
> Now, why hasn't Ivermectin been approved? Well, throughout, there's been some leaked and unredacted copies of the actual Pfizer contract with various nations, and this became available recently. Some countries actually were able to provide this data, but America's frontline doctors, chief scientific experts, Michael Eden, former Pfizer vice-president, chief scientists for allergy and respiratory product development, has looked at it and said, "Yes, these contracts look very real because that's the kind of thing that I dealt with for the last 30 years while I was working at Pfizer"."
>
> Conclusion then is that if you're wondering why Ivermectin was suppressed, it's because the agreement countries had with Pfizer does not allow them to escape their contract which states that even if a drug will be found to treat COVID-19, the contract cannot be voided, and so tens of millions of dollars later, there's a reluctance to actually change that situation.

[234] Dr Thomas's evidence and Dr Canaday's position on Ivermectin are outlined above under particular 6(b).

[235] Dr Thomas's evidence about zinc as outlined above under particular 2(e) was that the effects of supplementation of the diet with vitamin C, vitamin D, zinc or quercetin on the risk of becoming unwell with COVID-19 does not appear to have been investigated. He elaborated on the challenges of conducting such studies.[71]

[236] Dealing next with hydroxychloroquine, as noted above, it was Dr Thomas's opinion that in mid-2021 there was some uncertainty about the potential effect of both Ivermectin and hydroxychloroquine in patients with COVID-19. Dr Thomas said that in July 2020, a group of French researchers, led by a distinguished microbiologist Didier Raoult, published the outcomes they observed in a study. They had compared the duration of persistence of SARS-CoV-2 in respiratory secretions in 20 patients who

[70] Transcripts had recorded that Dr Canaday had said hydroxyquinoline, but it was accepted that he had said and was talking about hydroxychloroquine.
[71] See above, paragraph 144

were treated with hydroxychloroquine plus azithromycin, with the duration in 16 patients who were not treated with these two medicines. The duration of persistence of SARS-CoV-2 virus in respiratory secretions appeared to have been reduced by the combination treatment. A subsequent report by the same group described the outcomes in 1061 patients with COVID-19 who were treated with the combination of hydroxychloroquine and azithromycin. The authors concluded that "Administration of this combination before COVID-19 complications occur is safe and associated with a very low fatality rate."

[237] Dr Thomas said that these publications led to an explosion of other publications on the use of the same two medicines, alone or in combination, in patients with COVID-19. Dr Thomas thought that by early 2021 "it was clear that most dispassionate clinicians would have discounted any benefit from these two medicines." Dr Thomas referred to a conclusion in a meta-analysis published in early 2021 reported in the Journal of Antimicrobial Chemotherapy (January 2021)[72] that, based on studies that included 20,979 patients:

> Moderate certainty evidence suggests that hydroxychloroquine, with or without azithromycin, lacks efficacy in reducing short-term mortality in patients hospitalized with COVID-19 or risk of hospitalization in outpatients with COVID-19.

[238] Dr Thomas's view was that a responsible practitioner making statements about hydroxychloroquine in this context should clearly state the basis on which they held the views they were expressing and also state that experts in the field might strongly disagree with their views.

[239] In cross-examination, Mr McClelland asked Dr Thomas about an item summarised on the RNZ website on 3 April 2020 for which he and others had been interviewed.[73] Dr Thomas agreed that at that time, his colleague, Professor Stephen Chambers was optimistic about hydroxychloroquine as a possible cure for COVID-19. Dr Thomas said that "there was a was a positive view that the Intensive Care Department in our

[72] Kashour et al., *Efficacy of chloroquine or hydroxychloroquine in COVID-19 patients: a systematic review and meta-analysis* J Antimicrob Chemother doi:10.1093/jac/dkaa403

[73] A copy of the item "Covid-19 coronavirus: 'Game changer' drug in high demand in New Zealand" was produced at the hearing

hospital was participating in a trial that would help to resolve whether hydroxychloroquine was helpful or not, and so we were pleased that patients coming through our hospital were going to be helping to contribute to the evidence that would help decide whether hydroxychloroquine was useful or not."

[240] Dr Canaday explained the basis for his belief in the efficacy of hydroxyquinoline was the "Zelenko protocol" which is a treatment regimen for COVID-19 that was the result of observations by a primary care physician in a Jewish community north of New York City in the early days of the COVID-19 pandemic, in March 2020. Dr Zelenko had noted the paper by Didier Raoult, that showed significant efficacy of hydroxychloroquine with or without azithromycin in early observations. Dr Zelenko modified this regimen to include a combination of hydroxychloroquine, azithromycin, and zinc (because zinc was known to inhibit replication of intracellular coronavirus RNA from a paper in 2010[74] and hydroxychloroquine was known to be a zinc ionophore, meaning it assisted with transfer of zinc across human cell membranes.)[75]

[241] Dr Canaday said that this combination had also shown efficacy in improving outcomes in hospitalised COVD-19 patients,[76] and had been formalised in what came to be known as the 'Zelenko protocol'.[77] Dr Canaday said that this protocol gained attention. Early treatment of 141 patients with laboratory confirmed SARS-CoV-2 infection in 2020 were compared to 377 controls receiving conventional treatment. In the Zelenko treated group 2.8% required hospitalization compared to 15.4% in the control group ($p<0.001$, significant), and a 0.7% death rate compared to 3.4% in the control group ($p=0.12$, too few numbers to reach statistical significance).

[242] Dr Canaday also referred to Dr Peter McCullough who, at the time of Dr Canaday's talk, had published some 47 papers related to the topic. Dr Canaday described Dr McCullough as a distinguished academic cardiologist, editor and reviewer of prominent scientific journals, who published what was stated to be the most cited

[74] teVelthuis et al *Zn2+ Inhibits Coronavirus and Arterivirus RNA Polymerase Activity In Vitro and Zinc Ionophores Block the Replication These Viruses In Cell Culture* PLoS Pathogens, November 2010, Vol 6, Issue 11.
[75] Xue et al., *Chloroquine Is a Zinc Ionophore* PLOS ONE, October 2014, Vol 9, Issue 10.
[76] Carlucci et al., *Zinc sulfate in combination with a zinc ionophore may improve outcomes in hospitalized COVID-19 patients* Journal of Medical Microbiology 2020;69:1228-1236.
[77] A copy of this undated protocol was provided to the Tribunal.

paper in the early stages of the pandemic, in August 2020. Dr Canaday said that Dr McCullough's study on the pathophysiological basis and rationale for early outpatient treatment was presented in one of the most high-profile internal medicine journals, the American Journal of Medicine.

[243] Dr Canaday said that the Didier Raoult study that Dr Thomas referred to became the most cited paper on COVID-19 treatment early in the pandemic.

[244] Dr Thomas was not familiar with the *Zelenko* protocol, nor the following summary from Dr Canaday's evidence:

> Early treatment of 141 patients with laboratory confirmed SARS-CoV-2 infection in 2020 were compared to 377 controls receiving conventional treatment. In the Zelenko treated group 2.8% required hospitalization compared to 15.4% in the control group ($p<0.001$, significant), and a 0.7% death rate compared to 3.4% in the control group ($p=0.12$, too few numbers to reach statistical significance).

[245] Dr Thomas said it sounded as though the study design was one that was more open to error in terms of its conclusions and findings than a randomised, controlled clinical trial. Therefore, he would want to read it very carefully before he decided that one should necessarily agree with the conclusions of the authors. He did not agree with Mr McClelland that that is precisely what he should have done.

[246] Mr Holloway submitted that Dr Canaday's discussion of hydroxychloroquine was well-researched and his views were held in good faith. His statement that "dozens of studies have shown HCQ works" was not objectively wrong, nor shown to be wrong by the PCC's evidence.

[247] The PCC is required to prove on the balance of probabilities that Dr Canaday's support of other COVID-19 treatments including hydroxychloroquine and Ivermectin is not supported by generally accepted scientific evidence. And that must be in the context of what was known in August 2021, not at the time of the hearing in April 2023. The Tribunal agrees that it would have been helpful if Dr Thomas had read the *Zelenko* protocol in preparation for the hearing.

[248] The Tribunal acknowledges that it is often possible to find some evidence in the scientific literature to support a hypothesis. As noted above, the Tribunal has grappled with the phrase "generally accepted science", particularly in the context of the treatment of a new virus in the rapidly changing world of a global pandemic. That is quite a different situation from a discussion of the effectiveness of prevention or treatment regimens that have been tried and tested over decades.

[249] The Tribunal finds that Dr Canaday should have been more circumspect in his discussions of possible treatments. A prudent practitioner may have said that some studies showed some encouraging results but been wary of appearing to espouse the use of Ivermectin or hydroxychloroquine. The treatments Dr Canaday spoke about were not ones being promoted by most medical practitioners in New Zealand; they would not be termed "mainstream". And in retrospect they have not garnered significant support.

[250] Dr Canaday spoke confidently about the efficacy of Hydroxychloroquine and Ivermectin in the prevention of COVID-19. He used scientific language to advance one side of the debate when the evidence was weak, questionable and evolving. At that time there may have been generally accepted opinion and practices but there was no "generally accepted scientific evidence".

[251] Because the PCC has not established what the generally accepted scientific evidence was, the Tribunal has not found this particular established but has considered Dr Canaday's statement in its findings under Particular 12 below.

Particular 10(b): COVID-19 treatments were suppressed in favour of the Pfizer vaccine

[252] Particular 10(b) alleges that Dr Canaday's inference that other COVID-19 treatments were suppressed in favour of the Pfizer vaccine was not supported by evidence; and/or lacked balance and was likely to undermine public confidence in the Pfizer vaccine.

[253] The statements in the Appendix to support this allegation are found in paragraph b) of Appendix 3:

> Now, why hasn't Ivermectin been approved? Well, throughout, there's been some leaked and unredacted copies of the actual Pfizer contract with various nations, and this became available recently. Some countries actually were able to provide this data, but America's frontline doctors, chief scientific experts, Michael Eden, former Pfizer vice-president, chief scientists for allergy and respiratory product development, has looked at it and said, "Yes, these contracts look very real because that's the kind of thing that I dealt with for the last 30 years while I was working at Pfizer.
>
> Conclusion then is that if you're wondering why Ivermectin was suppressed, it's because the agreement countries had with Pfizer does not allow them to escape their contract which states that even if a drug will be found to treat COVID-19, the contract cannot be voided, and so tens of millions of dollars later, there's a reluctance to actually change that situation.

[254] Dr Thomas's evidence was that as at 6 September 2021 MedSafe had not received any medicine or clinical trial application for Ivermectin for the prevention or treatment of COVID-19.

[255] For Dr Canaday, it was submitted that there some "evidence" of suppression, so the charge cannot be established. It was submitted that Dr Thomas provided no substantive evidence on this issue. In cross-examination, Dr Thomas confirmed that he has not seen any of the Pfizer contracts. Mr Holloway submitted that Dr Canaday had referred to the reasons for his views as part of his presentation and had not suggested that the suppression of Ivermectin was related to the efficacy of the Pfizer vaccine.

[256] It was further submitted that it is objectively true to say that Ivermectin was suppressed in New Zealand. Importation was restricted and the Medical Council has treated off-label prescribing as a matter for disciplinary investigation. This treats Ivermectin in a markedly different way from every other medicine with a similar safety profile. Dr Thomas did not disagree with the proposition that New Zealand doctors had been discouraged from prescribing Ivermectin 'off-label' for COVID-19. It was submitted that it cannot be wrong for Dr Canaday to wonder as part of public discourse about the reason for such suppression.

[257] The Tribunal considers that Dr Canaday did more than "wonder" about the suppression of Ivermectin. He did not merely raise a possibility. He said:

> Conclusion then is that if you're wondering why Ivermectin was suppressed, it's because the agreement countries had with Pfizer does not allow them to escape their contract which states that even if a drug will be found to treat COVID-19, the contract cannot be voided, and so tens of millions of dollars later, there's a reluctance to actually change that situation".

[258] That is an unequivocal statement that Ivermectin was suppressed because the terms of the contract with Pfizer regarding the vaccine constrained the use of a drug that could treat COVID-19. That part of the allegation against Dr Canaday is established.

[259] The next part of the particular requires the PCC to prove one or all of the following:

- was not supported by evidence;
- lacked balance and was likely to undermine public confidence in the Pfizer vaccine.

[260] The difficulty with the allegation that it was not supported by evidence is that the onus is on the PCC to establish that it is more likely than not that the contract between "countries" and Pfizer did not contain such a provision. It is often difficult to prove a negative. The contracts may well contain items of commercial sensitivity. Dr Canaday does not have to produce evidence to support his statement.

[261] That said, Dr Canaday's conclusion as to why Ivermectin was suppressed is likely to undermine public confidence in the Pfizer vaccine. The Tribunal finds it was rash for Dr Canaday to make such a statement without evidence to back it up. It was inflammatory and alarming for the public. In that sense it lacked balance.

[262] The factual allegation of particular 10(b) is established. On its own this matter does not reach the threshold for a disciplinary finding.

Particular 10(c): Risk of miscarriage

[263] Particular 10(c) alleges that Dr Canaday's suggestion that the COVID-19 vaccine carried unusually elevated risk causing miscarriage was unprofessional, emotive and/or misleading and was likely to undermine public confidence in the Pfizer vaccine;

[264] The statements to support this particular are found in paragraph f) of Appendix 3:

> Some reports may exist in regard to whether miscarriages are unusually elevated. There is a paper that I will include that (inaudible) there's been some questions about whether the report is accurate or not, so I'm not going to say that we know that for sure, but we ought to know it for sure, definitely before we really proceed further.

[265] Dr Thomas's evidence about the risk of miscarriage and the parties' submissions on this issue are outlined above under particular 6(c).

[266] For the practitioner, it was submitted that Dr Canaday's views were held in good faith well-researched and expressed tentatively. There was nothing 'emotive' about them, and he had no duty to 'maintain public confidence in the Pfizer vaccine'. He had a right to freely express his views based on information he had reviewed and considered.

[267] The Tribunal considers Dr Canaday's statement about the risk of miscarriage on this occasion was more measured than in his previous presentation. He said, "Some reports may exist…" and "there's been some questions about whether the report is accurate or not, so I'm not going say that we know for sure…". As the PCC has charged, it is a "suggestion" rather than a claim or a statement. Dr Canaday's language was not emotive; rather the question of miscarriage may be an emotive issue. We do not consider it is fair to characterise this suggestion as "emotive". It is also not fair to say it was misleading, given the caveats that Dr Canaday couched this suggestion in.

[268] The Tribunal accepts that Dr Canaday's suggestion that there was a risk of miscarriage is likely to have undermined confidence in the vaccine in pregnant women or those hoping to conceive. However, the way in which the charge is framed requires the PCC to prove that this statement was unprofessional, emotive and/or misleading AND was likely to undermine public confidence in the vaccine. The PCC has not proved the charge as drafted. Particular 10(c) is not established.

Particular 10(d): "experimental biological agent"

[269] Particular 10(d) alleges that Dr Canaday's description of the Pfizer vaccine as an "experimental biological agent" was unprofessional, emotive and/or misleading and

was likely to undermine public confidence in the Pfizer vaccine. The evidence of this is found in paragraph (c) of Appendix 3 to the charge:

> So, in short, we are being asked to inject into our bodies an experimental biological agent which uses previously unproven techniques. It shows recent numbers of post-vaccination deaths and has no studies to assess potentially significant long-term effects, and for which highly effective in proven therapies all available for a disease of limited lethality when herd immunity from vaccinations alone cannot be expected.

[270] The background to the development of the Pfizer vaccine is set out above under the heading "Pfizer vaccine."

[271] The Tribunal accepts that the use of the words "biological agent" might not be inaccurate, but in conjunction with the word "experimental", the Tribunal finds that it was misleading, particularly when presenting to lay members of the public. It is not accurate to say that the vaccine uses previously unproven techniques or that there were highly effective proven therapies available. It was not professional for Dr Canaday to speak like this in a public presentation and although he did not use emotive words, it would likely provoke an emotive response. The Tribunal accepts that his statement was likely to undermine public confidence in the Pfizer vaccine. The factual allegation of particular 10(d) is established.

Particular 10(e): Graphene oxide

[272] In particular 10(d) the PCC alleged that Dr Canaday's statements concerning graphene oxide lacked evidential foundation and were presented uncritically. The comments are found in paragraph (g) of Appendix 3. They are:

> Graphene oxide is a […] very high-tech component made out of carbon atoms which are arranged in a certain very, very thin so-called nano thickness, which is basically one atom thick, and that can be used in many different technical and industrial processes. It's also use for helping and supposedly in drug deliveries, and this and that.
>
> It's been found according to this report from (inaudible)[78] out of Spain that graphene oxide components are present in almost of all the submitted phials of the Pfizer product in the – that were submitted for assessment by a spectroscopy and by – by transmission of electron microscopy. What they found is that contained within those phials was this – the actual physical characteristics

[78] At the hearing Dr Canaday agreed that the inaudible words were "La Quinta Columna".

> that are the same under the microscope in this – these samples as is known in reference samples, so they're looking exactly the way graphene oxide looks like, so it is a – it's a very real concern – I'm wondering if indeed those are the cause of many of these symptoms that we are seeing in the post-vaccinated patients."

[273] Dr Thomas told the Tribunal that he had looked for published medical articles that discuss graphene oxide and COVID-19 or SARS-CoV-2, but there did not appear to be any. He said that a Google search produced a Reuters Fact Check report which appears to confirm that this is a conspiracy theory originating from one person in a Spanish university. In the document that was produced in the Agreed Bundle of Documents, Pfizer told Reuters that graphene oxide is not used in the manufacture of the vaccine.

[274] In cross-examination, Dr Canaday agreed that he was "wondering out loud" about graphene oxide, based on his background in physics as well as in medicine, "that perhaps this is something we should be looking at." He did not do any research on PubMed for evidence of graphene oxide in the vaccine. He knew this was a very preliminary report, but one which was a very significant concern. Dr Canaday said that PubMed is not the sole source in which you can find reports.

[275] The Tribunal finds that Dr Canaday was speaking to members of the public in his capacity as a registered medical practitioner in the time of a global pandemic. His audience deserved a better standard of information. This was not the forum for him to "wonder out loud". The Tribunal finds that his statements concerning graphene oxide lacked evidential foundation and were presented uncritically. Particular 10(d) is established.

Particular 11: Disparaging, unprofessional criticism of other health practitioners

[276] Particular 11 alleged that the statements at Appendix 3 (d) and (e) were disparaging and/or amounted to unprofessional criticism of other health practitioners and had the potential to encourage criticism of other health practitioners. Those comments are:

(d) We have to keep this mind when we discuss, and we look at those who provide us these guidelines. It is impossible to get a man to understand something if his salary depends upon his not understanding.

(e) In response to comments that "*The Medical Council have asked the doctors, instructed the doctors, just to tell them the benefits of the vaccine and not tell them the risks or the uncertainties, so, in my view, the Medical Council is actually breaching the law. They are inciting doctors to breach the law, and they're punishing the doctors who try to give informed – ensure their patients can give informed consent. It's absolutely remarkable what's happening. The difference between what they say and what they do, there's no correlation. They just have no respect*.")

You know, there's been a lot of bullying, and, you know, I guess it's less effective for me now because I'm retired, but I guess I'm now going to be permanently retired because I can't even work part-time, I suspect, with these kinds of bullying going on. And that's where of course is many doctors are afraid and they know some of these things. To be honest, I think many of them do not know, you know, what's really behind this particular inoculation product. But there's – you know, who do, however, even suspect it, are, you know, just are being cowered into silence and passiveness unfortunately."

[277] The Tribunal finds that these comments are disparaging in the sense that Dr Canaday is saying that salaried doctors do not have independent thought and are more susceptible to bullying tactics and to that extent might have the potential to encourage criticism of other health practitioners. Particular 11 is established, but on its own does not amount to professional misconduct.

Particular 12: likely to bring discredit to the profession

[278] Particular 12 does not contain a factual allegation but again asks the Tribunal to find that the comments set out in Appendix 3 individually or cumulatively brought or were likely to bring discredit to the profession.

[279] The Tribunal finds that the statements contained in the following paragraphs in Appendix 3 were likely to bring discredit to the medical profession:

Appendix 3(b): Dr Canaday's inference that other COVD-19 treatments were suppressed in favour of the Pfizer vaccine.

Appendix 3(c): Dr Canaday's description of the Pfizer vaccine as an "experimental biological agent which uses previously unproven techniques…and for which highly effective proven therapies [are] available for a disease of limited lethality when herd immunity from vaccinations alone cannot be expected.

Appendix 3(g): Dr Canaday's discussion of graphene oxide being present in the Pfizer vaccine.

[280] Although the Tribunal found that Dr Canaday's comments as contained in paragraphs (d) and (e) were disparaging and had the potential to encourage criticism of other practitioners, the Tribunal does not find those statements were likely to do so. On their own, these statements were not likely to bring discredit to the profession.

Overall findings on Professional Misconduct

[281] The charge requires the Tribunal to decide whether individually or cumulatively the established conduct amounts to:

- Negligence and/or
- Malpractice and/or
- Conduct likely to bring discredit to the profession.

[282] Overall, the Tribunal considers that the way in which Dr Canaday presented information to the public was careless. His position as a medical practitioner gave credibility to his statements and he owed his audience more balance in his opinions. However, we must apply the test for professional misconduct to the established particulars.

[283] The Tribunal does not find that comments that were likely to undermine confidence in the Pfizer vaccine amounts to negligence (Particulars 10(b)(ii) and 10(d)).

[284] A finding of negligence requires the Tribunal to determine:[79]

> Whether or not, in the Tribunal's judgment, the practitioner's acts or omissions fall below the standards reasonably expected of a health practitioner in the circumstances of the person appearing before the Tribunal.

[285] The Tribunal finds that Dr Canaday was careless in his:

- implication that deaths after vaccination were caused by vaccine (Particular 2(b)):
- implication that there is a link between the Pfizer vaccine and sterility and deaths (Particular 6(c));
- overstatement and misrepresentation of his ability to provide informed advice on the treatment of COVID-19 (Particular 6(d);
- statements concerning graphene oxide (particular 10(e)).

[286] However, the PCC has not led evidence on the standards expected of a medical practitioner when giving an opinion to members of the public. The Tribunal has therefore been unable to measure Dr Canaday's statements against a standard or an expert opinion on accepted practice. For that reason, the Tribunal has not made a finding of negligence.

[287] That said, these statements were made during a time when knowledge about this new virus and the effectiveness of the vaccine against new variants was rapidly evolving and changing. The Tribunal finds that reasonable members of the public being fully informed of Dr Canaday's background and lack of recent relevant experience and expertise along with the evidence of Dr Thomas in relation to particular 2(b), 6(c) and 10(e) would find that Dr Canaday's statements in the context of a global pandemic would tend to lower the standing of the medical profession. The public was reliant on and entitled to balanced, accurate information about the vaccine, including that the landscape was continually changing. For that reason the Tribunal finds it is sufficiently serious to warrant a disciplinary sanction.

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[79] *Cole v Professional Conduct Committee* [2017] NZHC at [41]

[288] Having found that a small part of the charge amounts to professional misconduct, the Tribunal invites submissions on penalty under section 101 of the Health Practitioners Competence Assurance Act. The parties are invited to, no later than Tuesday 12 December 2023:

a) Submit an agreed timetabling for the filing of submissions.

b) Advise whether they would prefer the hearing of penalty to be undertaken on the papers, via audiovisual link, or in person.

c) Advise whether a directions conference is required.

DATED at Feilding this 21st day of November 2023

T M Baker
Chair
Health Practitioners Disciplinary Tribunal

SCHEDULE ONE

DISCIPLINARY CHARGE

TAKE NOTICE that a Professional Conduct Committee (**PCC**) appointed by the Medical Council of New Zealand pursuant to section 71 of the Health Practitioners Competence Assurance Act 2003 (**the Act**) has determined in accordance with section 80(3)(b) of the Act that a disciplinary charge be brought against registered medical professional Dr Peter Canaday before the Health Practitioners Disciplinary Tribunal (the **Tribunal**).

Pursuant to section 91 of the Act, the PCC has reason to believe that grounds exist entitling the Tribunal to exercise its powers under section 100 of the Act.

PARTICULARS OF CHARGE

Pursuant to sections 81(2) and 91 of the Act, the PCC charges Dr Peter Canaday as follows:

1. On 9 July 2021, by way of an interview broadcast on Raglan Community Radio, Dr Canaday made the statements set out in **Appendix 1**.

2. The statements in Appendix 1 were inaccurate and / or misleading, or had the potential to mislead, in that:

    a. As Dr Canaday has not practised in pulmonary care in New Zealand, he has not provided medical care of a respiratory nature to any Covid-19 patients. Dr Canaday misstated his ability to provide informed advice on the treatment of Covid-19; and / or

    b. Dr Canaday's use of information from the United States was not balanced with data from New Zealand and did not provide sufficient information about the vaccination mortality rate,

and was therefore likely to imply that deaths after vaccination were caused by the vaccine; and / or

c. Dr Canaday overstated the number of confirmed deaths linked to the Pfizer vaccine in New Zealand and this suggested that the vaccine was more dangerous than Covid-19 itself; and / or

d. New Zealand Doctors Speaking Out with Science is not generally accepted by the profession as a reliable source of balanced information on the Covid-19 vaccine; and / or

e. Dr Canaday's recommendation of other "effective" Covid-19 preventative measures was likely to mislead the public as to the efficacy of the Pfizer vaccine; and

3. The statement at Appendix 1(e) above was disparaging and / or amounted to unprofessional criticism of other health practitioners and had the potential to encourage criticism of other health practitioners; and

4. The statements in Appendix 1, individually or cumulatively, brought, or were likely to bring, discredit to the medical profession; and

5. On or about 21 July 2021 Dr Canaday, by way of a publicly accessible recording titled *Courageous Convos* uploaded to the Odysee channel of Voices For Freedom (**VFF**), made the statements set out at **Appendix 2**.

6. The statements in Appendix 2 were inaccurate and / or misleading, or had the potential to mislead, in that:

a. Dr Canaday's suggestion that he is providing "the full story" and "missing information" is incorrect and is likely to misrepresent the efficacy of New Zealand's pandemic response; and / or

b. Dr Canaday's recommendation of other "effective" Covid-19 treatments is not supported by generally accepted scientific evidence; and / or

c. Dr Canaday's inference that there is a link between the Pfizer vaccine and sterility and / or deaths was unprofessional and emotive and is not supported by generally accepted scientific evidence; and / or

d. As Dr Canaday has not provided medical care of a respiratory nature to any Covid-19 patients, Dr Canaday overstated and/or misrepresented his ability to provide informed advice on the treatment of Covid-19; and / or

7. The statements at Appendix 2(a) and (d) above were disparaging and / or amounted to unprofessional criticism of other health practitioners and had the potential to encourage criticism of other health practitioners; and

8. The statements in Appendix 2, individually or cumulatively, brought, or were likely to bring, discredit to the medical profession; and

9. On or about 19 August 2021 by way of a publicly accessible recording titled *COVID-19 and the Pfizer Vaccine: Fact or Fantasy?* uploaded to the Odysee channel of VFF, Dr Canaday made statements set out in **Appendix 3**.

10. The statements in Appendix 3 were inaccurate and / or misleading, or had the potential to mislead, in that:

    a. Dr Canaday's support of other Covid-19 treatments including hydroxyquinoline and ivermectin is not supported by generally accepted scientific evidence; and / or

    b. Dr Canaday's inference that other Covid-19 treatments were suppressed in favour of the Pfizer vaccine:

i. was not supported by evidence; and / or

ii. lacked balance and was likely to undermine public confidence in the Pfizer vaccine; and / or

c. Dr Canaday's suggestion that the Covid-19 vaccine carried unusually elevated risk causing miscarriage was unprofessional, emotive and / or misleading and was likely to undermine public confidence in the Pfizer vaccine; and / or

d. Dr Canaday's description of the Pfizer vaccine as an "experimental biological agent" was unprofessional, emotive and / or misleading and was likely to undermine public confidence in the Pfizer vaccine; and / or

e. The statements concerning graphene oxide lacked evidential foundation and were presented uncritically; and

11. The statements at Appendix 3 (d) and (e) above were disparaging and / or amounted to unprofessional criticism of other health practitioners and had the potential to encourage criticism of other health practitioners; and

12. The statements in Appendix 3, individually or cumulatively, brought, or were likely to bring, discredit to the medical profession; and

The conduct alleged above amounts to professional misconduct in that, either separately or cumulatively, it amounts to malpractice and / or negligence in relation to Dr Canaday's scope of practice pursuant to section 100(1)(a) of the Act, and / or has brought or is likely to bring discredit to the medical profession, pursuant to section 100(1)(b) of the Act.

Dated 10 February 2023

Appendix 1 – Raglan Community Radio statements

#	Statement	Reference
(a)	"As a respiratory physician who treated many of these patients that have very, very severe respiratory failure, they were placed on ventilators, that's the job I did for 12 years. I'm very familiar with the kinds of very severe cases that we are now beginning to see or have seen with the very severe cases of Covid-19"	Disclosure bundle, page 232.
(b)	"[…] there is a very significant number of recorded adverse events or side-effects or things you don't expect following the roll-out of the vaccinations in the United States." "[…] there's a big record of what happens after that is performed, after the vaccines are performed, and there have been a significant number of recorded adverse incidents, including deaths, following the vaccines." "[…] what has happened is that over the last 30 years, there's been a well-established record of a voluntary reporting system for vaccine adverse events in the United States, so for the last 30 years, there has been, for example, between 100 and 200 deaths per year that have been recorded following vaccinations, not saying whether it's caused by them or not, but that's – those are the numbers, voluntarily reported, but, in 2021, there have already been over 6,000 deaths recorded following the COVID vaccines of the various kinds, and anyone that knows those numbers has got to sort of wake up and say, "*Well, that's not normal to have incidents of mortality, of deaths, which is 30 times what the average has been for the last 25 to 30 years*", so that's a concern." (In response to a question about underlying causes): "We don't know that exactly, but what's been observed, which is unusual, is that there have been deaths in people who have been otherwise healthy. There have been deaths in younger people."	Disclosure bundle, page 235.
(c)	"I mean, of course the situation in New Zealand is quite unique insofar as, you know, there being no recent significant numbers regarding COVID-related deaths themselves, in fact, there have been some deaths in New Zealand, I think now it's up to ten or a little bit more recorded after the vaccinations."	Disclosure bundle, page 237.
(d)	(In response to a question about being one of 50 doctors and scientists who signed a petition in New Zealand available online, and whether Dr Canaday was a part of that): "I am, it's called New Zealand Doctors Speaking Out With Science, and it's a very good organisation that has contained people who are of various fields of expertise who have looked at the various facts and statements that have been made about this problem with us – with – with the COVID-19 and with the roll-out of the COVID-19 vaccine or the Pfizer vaccine product, and so they're asking some penetrating questions that I think we all need to ask and we do need to have the answers, and I found them to be a very good source and a support for the actual science behind some of the issues that have been raised."	Disclosure bundle, pages 231-232.
(e)	"I think, you know, a lot of people in New Zealand, they're smart, they're saying, "Look, what's – what's really going on? Am I really being told the truth?" They've done their own investigations. They've gone past the sources which typically have been censored, and actually discovered that there's actually a lot of information out there from people who have been marginalised, and put on to the side-lines, and I think that's the kind of folks that actually showed up in Hamilton last night, and I was hoping that I would be able to give some kind of, I guess, what shall we say? Legitimacy or just say, "Yes, okay, I'm a physician. I've done this for years. I've published in the medical literature. I've presented at international meetings. I've been an academic of a medical school programme. I kind of know the background", and I hoped to provide some legitimacy to the concerns that they had." (In response to a question about the sort of reaction Dr Canaday was getting from his peers - friends and doctors and people you used to know when you were working in the industry):	Disclosure bundle, pages 240 - 241

	"Well, I'd hate – I'd have to say it depends on who's retired and who isn't, and they seem a bit odd -- but, you know, those who don't have their livelihood dependent upon what they say or what they think tend to be a bit freer to – you know, to speak their minds about it. I have several friends in the States, doctor friends, and I've asked them, "You know, have you really considered this and maybe you should, you know, hold off on taking the vaccine", but I – in many cases, I've not been successful, but you see what happens is then they themselves in the active practice of medicine, they've been pressured by the authorities of their hospital or system or their university to take the jab, and once you've taken the jab, you know, you are really pretty well committed –"	
(f)	"We are all gifted with an innate immune system, and we tend to forget that in the age of pharmaceuticals and vaccines, but actually the strength of our native immune system is what we need to concentrate on, and we can build that up by various means, vitamin C, vitamin D have been well demonstrated to be effective in either reducing the likelihood, reducing the symptoms, and even reducing mortality if those levels are sufficient. Vitamin D especially has been relevant there. There are other agents such as zinc, Quercetin, and so on to build the immune system, and so that's the – that's the fundamental things that everybody should be doing."	Disclosure bundle, page 241.
(g)	"The clinical trials will continue until at least January of 2023, but actually what the FDA, which is the Food and Drug Administration, which manages the vaccine approvals in the United States, has approved the use of the Pfizer vaccine from among others only for emergency use authorisation, and that occurs when there is no reliable treatment that is otherwise available, and some of the controversies have arisen over whether that is actually the case, because there's increasing evidence that other treatments are available, they are effective, and so that has raised some questions about why the vaccine has been rolled down especially when it has been only for emergency use. The long-term side-effects are really not known, and so it's raised some questions in a lot of people's minds about, you know, how did we get to this point?"	Disclosure bundle, page 233

Appendix 2 – Courageous Convos video

#	Statement	Reference
(a)	"So, you know, we all do our parts, and it's not just myself, other physicians are doing their part as well, and it's all part of the necessary way of informing, because really we've been told that of course we're just representing misinformation but I'd like to see the perspective that we're actually providing missing information, and that really is – is a key difference here because we hear lots and lots from the various organs of official government and institutions throughout New Zealand, but we don't actually hear, you know, the full story."	Disclosure bundle, pages 249-250
(b)	"[…] they have to say, "Look, there is ample evidence – ample evidence for the benefit of proven, longstanding many decades use of therapeutics that, you know, we should allow into New Zealand for the purpose of, you know, treatment and prevention because these are well-known – well-known effective agents, you know, they can be – they can be used for this purpose, and I'm talking about, you know, I mean, I'm talking about Ivermectin in particular because the evidence for that is, you know, is overwhelming." "[…] there are over two dozen randomised control studies using Ivermectin which is shown as benefit for prevention before you are exposed to COVID patients, after you have been exposed to COVID patients, for early treatment." "Even for late treatment, even for mortality, and all those studies are out there, and they are peer-reviewed most of them. Some of them are observational, but most of them are very definitive in the benefit of this particular agent, which has been in use for decades, very known highly safe profile, and it's cheap, and it doesn't cost NZ$4,000 like Remdesivir does."	Disclosure bundle, pages 268 - 269
(c)	"I think, you know, you have to make it very obvious, what is sensible, make that obvious to the people at large, because again the only thing that we can count on, we're not going to count on anybody else (several inaudible words) and you have to get to the point where enough people are upset and knowledgeable about how this is not about health, and, you know, and that our very livelihoods and indeed potential future of our country and environment for the next generation is threatened. I mean, we're talking about potential sterility here, and, you know, and we're talking about the elimination of – the potential of having large numbers of deaths from these vaccines […]"	Disclosure bundle, pages 270 - 271.
(d)	"[…] you tend to be lulled into this sense of complacency, and yet things never become obvious until they suddenly change to where they become irreversible, and so it is extremely important that we see the early stages and we intervene early or at least earlier, and say, "You know, we're passed the really, really early stage, we're into the early to mid-stages", and, you know, vigilance and, you know, all the things that you're doing in Voices for Freedom are the essential things to try to stem this before it becomes, you know, another horrific turn in world history." (page 263) (In response to another person saying "*we hear people like Chris Hipkins saying […] "They'll come for you" […] this idea that you're something to be hunted almost*") "You know straight out of the Soviet playbook. I mean that is straight out of the Soviet – make no mistake about that. […] Perverse at a minimum, and intentionally evil on their face. I mean, you have to be concerned in fact whether that's the way it is." […] Meanwhile, it's KGB, you know, kinds of directives. Dob in your neighbour and report anybody that's stepping out of line, and this taking the jab, and of course it's all for your good." (page 263) "It may be – it may be that it's made to appear like incompetence, and I think that's let's pull it out of the – you know, the Soviet playbook too is you make it appear – it's cognitive disinformation, you know, it's like you kind of – you know, you go along to make it look like you're just kind of, well, going along, well, that's not something that's going to get people excited that much, they'll just complain, but they won't do anything, but it's actually intentional (several inaudible words) it's entirely different." (page 274)	Disclosure bundle, pages 263 (first and second quotes) and 274 (third quote).
(e)	"I mean, it's like – you know, this sort of happened at the right time in my particular career, you know, having just recently retired from DHB work, so, you know, it just – it puts together, you know, a lot of the things – I mean, my	Disclosure bundle, page 276.

	clinical background in pulmonary respiratory medicine, because I used to treat these people who have these end-stage, you know, respiratory failure like you've seen with the advanced COVID, and, of course, you know, I was a professor for eight years and teaching residents so I was used to sort of getting up and talking. I presented in international meetings and this and that, so it kind of puts all those things in a way to summarise it all"	

Appendix 3 – Fact or Fantasy

#	Statement	Reference
(a)	"[…] the emergency use authorisation requires that there is no suitable treatment for COVID-19 available, but in fact we did have these early reports of reduction in morbidity and mortality from Hydroxyquinoline zinc and azithromycin were suppressed." "Dozens of studies have shown Hydroxyquinoline and Ivermectin work. Both have been in use in decades for other reasons. Their benefits are greatest when given for prevention for prophylaxis and also post-exposure prophylaxis when you know somebody's had COVID and you've been around them, also for early treatment."	Disclosure bundle, pages 312 and 313
(b)	"Now, why hasn't Ivermectin been approved? Well, throughout, there's been some leaked and unredacted copies of the actual Pfizer contract with various nations, and this became available recently. Some countries actually were able to provide this data, but America's frontline doctors, chief scientific experts, Michael Eden, former Pfizer vice-president, chief scientists for allergy and respiratory product development, has looked at it and said, "Yes, these contracts look very real because that's the kind of thing that I dealt with for the last 30 years while I was working at Pfizer"." "Conclusion then is that if you're wondering why Ivermectin was suppressed, it's because the agreement countries had with Pfizer does not allow them to escape their contract which states that even if a drug will be found to treat COVID-19, the contract cannot be voided, and so tens of millions of dollars later, there's a reluctance to actually change that situation."	Disclosure bundle, page 314
(c)	"So, in short, we are being asked to inject into our bodies an experimental biological agent which uses previously unproven techniques. It shows recent numbers of post-vaccination deaths and has no studies to assess potentially significant long-term effects, and for which highly effective in proven therapies all available for a disease of limited lethality when herd immunity from vaccinations alone cannot be expected."	Disclosure bundle, page 319
(d)	(Immediately following the quote above): "We have to keep this mind when we discuss, and we look at those who provide us these guidelines. It is impossible to get a man to understand something if his salary depends upon his not understanding"	Disclosure bundle, page 319
(e)	(In response to comments that "*The Medical Council have asked the doctors, instructed the doctors, just to tell them the benefits of the vaccine and not tell them the risks or the uncertainties, so, in my view, the Medical Council is actually breaching the law. They are inciting doctors to breach the law, and they're punishing the doctors who try to give informed – ensure their patients can give informed consent. It's absolutely remarkable what's happening. The difference between what they say and what they do, there's no correlation. They just have no respect*.") "You know, there's been a lot of bullying, and, you know, I guess it's less effective for me now because I'm retired, but I guess I'm now going to be permanently retired because I can't even work part-time, I suspect, with these kinds of bullying going on. And that's where of course is many doctors are afraid and they know some of these things. To be honest, I think many of them do not know, you know, what's really behind this particular inoculation product. But there's – you know, who do, however, even suspect it, are, you know, just are being cowered into silence and passiveness unfortunately."	Disclosure bundle, pages 322 – 323.

(f)	"Some reports may exist in regard to whether miscarriages are unusually elevated. There is a paper that I will include that (inaudible) there's been some questions about whether the report is accurate or not, so I'm not going to say that we know that for sure, but we ought to know it for sure, definitely before we really proceed further."	Disclosure bundle, page 312.
(g)	"Graphene oxide is a […] very high-tech component made out of carbon atoms which are arranged in a certain very, very thin so-called nano thickness, which is basically one atom thick, and that can be used in many different technical and industrial processes. It's also use for helping and supposedly in drug deliveries, and this and that. " "It's been found according to this report from (inaudible) out of Spain that graphene oxide components are present in almost of all the submitted phials of the Pfizer product in the – that were submitted for assessment by a spectroscopy and by – by transmission of electron microscopy. What they found is that contained within those phials was this – the actual physical characteristics that are the same under the microscope in this – these samples as is known in reference samples, so they're looking exactly the way graphene oxide looks like, so it is a – it's a very real concern – I'm wondering if indeed those are the cause of many of these symptoms that we are seeing in the post-vaccinated patients." "We do know that many times the actual package insert for these so-called vaccine products are blank, and they don't list all of the products. They may not even in fact list any of the products, but the likelihood is that graphene oxide if it is indeed present in these – in these products – in these Pfizer vaccine products, that it could be excluded simply by being proprietary and you don't have to say anything about that, if it's an experimental product used for emergency authorisation. You have to have it once the drug is released, you have to have it – the vaccine or anything else, it has to be very complete, and you've probably seen these very long, you know, packaged inserts that come with medicines for properly released drugs. We don't have that here. So is that the case, is that the cause of some of these magnetic effects that are being observed. It very well could be. I can't say that I know enough about it. We'd need to see this kind of work that's been done by (inaudible). We need to see that confirmed. Yes, it's a very interesting proposal, and it may explain some of these phenomena because the spike protein is not going to explain any of these magnetic phenomena, but the graphene oxide could very well do so. Yeah."	Disclosure bundle, pages 326 - 327