IN THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL **Med23/575P**

I TE RŌPŪ WHAKATIKA KAIMAHI HAUORA

Under	**the Health Practitioners Competence Assurance Act 2003**
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	**Peter Canaday** of New Plymouth, registered medical practitioner
	Practitioner

SUBMISSIONS FOR DR CANADAY

Dated 21 April 2023

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May it please the Court—

A OVERVIEW

1 Dr Canaday's presentations were made to members of the public, not patients. He was not making 'recommendations' or providing treatment advice. There is no proof any person made a decision they subsequently regretted as a consequence of Dr Canaday's speech. Many likely appreciated his discussions. He was not practising medicine. Thus, only s 100(1)(b) of Health Practitioners Competence Assurance Act 2003 (**HPCAA**) is relevant to the charge — whether the identified statements "*brought or [were] likely to bring discredit to the profession*".

2 As Dr Canaday told the PCC investigating his conduct, "*My intent was to provide my own opinions based solely on information that is publicly available*".[1] These were matters of importance to many people and a wide range of opinions have been expressed. They are not matters to be laughed at, as Dr Thomas did at times. Only yesterday a report joint-authored by a registered medical practitioner with a practising certificate (Emeritus Professor Dr Des Gorman) was released, which included:[2]

> *… the politicisation of the execution of the response to the COVID19 pandemic led to a lack of adaptability and agility and so a response that was more costly than necessary. Managing political risk produced a very natural desire to paint our response as the envy of the world, to claim a monopoly on the truth, to put the best possible "spin" on events, to marginalise criticism and monopolise execution. The facts are made to fit the political narrative in order to maintain public confidence in the chosen response. The use of alarming computer scenarios of widespread hospitalisations and deaths generated a high degree of fear that encourages people to place their faith in authority. …*
>
> *…*
>
> *The Government also became more authoritarian as restrictions on personal freedoms became more burdensome: i.e. it favoured or enforced strict obedience to authority at the expense of these freedoms. The Government claimed a monopoly on the truth, a claim that was increasingly difficult to justify as rules kept changing and claims proved either biased, misleading, or untrue.*
>
> *…*

[1] Notes of evidence at 143, line 30-32.
[2] D Gorman and M Horn "*A critical analysis of the COVID-19 pandemic management in New Zealand*" (April 2023) The New Zealand Initiative < www.nzinitiative.org.nz>.

> *… Critics were discouraged and side-lined and, with a few notable exceptions, the media were largely compliant with this flinty authoritarianism. …*
>
> *…*
>
> *… some academics were happy to provide critical commentary but, in our opinion, most of academia did not get this balance right and were parties to the Government's propaganda. Many of them who rely on significant Government funding also failed to disclose their conflicts of interest. When we decided to comment on the management of the pandemic, the response from our academic colleagues was largely negative. By way of emails, letters to editors, and lobbying, they attempted to have us gagged. In their opinion, we had no right to provide an opinion because we did not belong to their guild and that our duty was to "be helpful" and to support the Government.*

3 The Tribunal's jurisdiction arises out of the particulars of the charge, not any broader assessment of Dr Canaday's presentations. The PCC has not shown that the words used by Dr Canaday bear the meanings alleged in the particulars; that what he said was false; or that his opinions were unreasonable. There is no obligation on Dr Canaday to disprove the charge. Very little or no reliance can be placed on Dr Thomas' evidence for reasons that will be discussed. The Tribunal cannot 'fill in the gaps' with its own knowledge or views.[3] In these circumstances, interpreting the words 'to bring discredit' as applying to Dr Canaday's conduct would be inconsistent with the New Zealand Bill of Rights Act 1990 (**Bill of Rights**).

4 It is submitted the charge is not established.

B INTRODUCTION

5 In mid-2021 Dr Canaday was not employed as a doctor.[4] No health services were being provided by him to any person. He remained a member of our community however, and under the protection of New Zealand's laws, including the Bill of Rights, ss 13 and 14:

> ***13 Freedom of thought, conscience, and religion***
>
> *Everyone has the right to freedom of thought, conscience, religion, and belief, including the right to adopt and to hold opinions without interference.*

[3] *A v Professional Conduct Committee* [2018] NZHC 1623.
[4] At the time of the *Raglan* interview (9 July 2021), *Courageous Convos* presentation (21 July 2021) and *Fact or Fantasy* presentation (19 August 2021).

14 Freedom of expression

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.

6 During 2020 and 2021, the government's response to the COVID-19 pandemic was the most prominent and important political and social issue in the country. Decisions being made by the government were having profound impacts on people's lives. Vaccination using Comirnaty began on 20 February 2021, but it was not made universally available until October 2021. 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.

7 In this context, Dr Canaday expressed himself in public on several occasions. He imparted information and opinions about matters connected with COVID-19.

8 No person is excluded from public discourse and debate merely because of their profession. Indeed, society has benefitted greatly from doctors prepared to challenge the status quo — whether by removing the Broad Street pump handle[5] or lobbying the government to address child poverty in New Zealand.[6] Dr Shane Reti has, for example, been critical of aspects of the government's response to COVID-19, commenting recently "*Covid-19 has affected every New Zealander and changed almost every aspect of our way of life over the last three years. It is imperative that there is a deep and comprehensive review of the health and economic impacts of the Government's response.*"[7] As recently as 12 April 2023, there was political disagreement over continuing to require those testing positive for COVID-19 to isolate for seven days.

9 Health practitioners can, in limited circumstances, be disciplined for speech. However, the imperatives of a free and democratic society require the Tribunal to proceed carefully. It cannot be negligence, malpractice or discreditable merely to hold and express opinions that are minority or unpopular (such as opposition to abortion or birth control; or, in Dr Snow's case, that cholera was caused by germs not miasma). If that is the

[5] Dr John Snow.
[6] See <https://www.cpag.org.nz/what-we-do>.
[7] See <https://www.national.org.nz/national_welcomes_covid_19_royal_commission>.

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. As Dr Thomas observed:[8]

> *What you find in every hospital is that consultants are very idiosyncratic and that they tend not necessarily to follow guidelines at all, that there's a wide-range of treatments recommended, great variation, and so, in general, if I've decided that for my practice this is the regimen or the drugs that I think should be given, then that's what I'll do for the patient, in my belief that that's best for the patient.*

10 It is Dr Canaday's case that, by speaking publicly, he was not practising medicine. Section 100(1)(a) of the HPCAA therefore has no application. This is consistent with Dr Thomas' opinion that giving evidence and presenting lectures is not the practice of medicine. Further, the content of Dr Canaday's speech was not misleading, disparaging or discreditable. The PCC has not and cannot prove that what Dr Canaday said was wrong — or that he spoke in bad faith or to pursue any agenda. What the PCC is really asking this Tribunal to do is discipline Dr Canaday for engaging in reasonable debate about COVID-19 merely because his views might have been, at the time, in the minority. That is the thinnest of ice. 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.

11 Nor can the Medical Council complain that, without the hammer of discipline, it would be powerless. The best response to speech the Medical Council disagrees with is not absolute censorship, but rather for it to have the courage and strength of its convictions. The Medical Council was free to respond in public to Dr Canaday's presentations and explain, from a position of significant resources,[9] mana and influence, what it considered he had got wrong.[10] By suspending and then charging him, the Medical Council has instead created an impression of trying to silence ideas it has

[8] Notes of evidence at 200, line 34 and following.
[9] The Medical Council has likely spent well over $100,000 attempting to silence Dr Canaday. That money could have been spent publicising the Medical Council's own views about COVID-19.
[10] The Medical Council also has extensive powers under Part 3 of the Health Practitioners Competence Assurance Act 2003.

no answer to. This is but one of the harms flowing from a failure to respect the 'fundamental'[11] right to freedom of expression.

C THE PRACTICE OF MEDICINE

12 The charge alleges that Dr Canaday's public speech "*amounts to malpractice and/or negligence in relation to [his] scope of practice pursuant to section 100(1)(a)*" of the HPCAA. Section 100(1)(a) plainly relates to the practice of medicine. It applies only acts or omissions while practising medicine. Private conduct — if it "*has brought or was likely to bring discredit to the profession*" — can in some circumstances be captured by s 100(1)(b).

13 It is therefore necessary for the Tribunal to rule as to whether, by speaking in public about COVID-19, Dr Canaday was practising medicine. If he was not, then s 100(1)(a) will not apply.

14 Dr Canaday's case is that he was not practising medicine. Indeed, the Health and Disability Commissioner (**HDC**) agreed. One of the notifiers to the Medical Council also complained to the office of the HDC. The HDC referred the complaint to the Medical Council, writing:[12]

> *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.*

15 The Medical Council is a responsible authority under the HPCAA. 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. Thus, there must be a way of defining what the practice of each regulated health service entails. The HPCAA achieves this by requiring responsible authorities to publish one or more notices in the *Gazette* that "*describe the contents of the profession in terms of 1 or more scopes of practice*".[13] The relevant definitions in the HPCAA are:[14]

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[11] New Zealand Bill of Rights Act 1990, long title.
[12] PCC bundle at 97.
[13] Health Practitioners Competence Assurance Act 2003, s 11(1) (emphasis added).
[14] Emphasis added.

15.1 To 'practise a profession' or 'practise' means "*to perform services that fall within the description of a health profession*".

15.2 'Scope of practice' means "*any health service that forms part of a health profession and that is for the time being described under section 11*".

15.3 'Health service' means "*a service provided for the purpose of assessing, improving, protecting, or managing the physical or mental health of individuals or groups of individuals*".

16 What these definitions mean is that the Medical Council is only permitted to define the boundaries of the profession it regulates by reference to 'health services', where such services mean 'a service provided for the purpose of assessing, improving, protecting, or managing the physical or mental health of individuals or groups of individuals'.

17 This makes sense. Parliament cannot have intended the HPCAA to allow responsible authorities to self-define spheres of regulation that take over the state's role in deciding (for example) fundamental issues such as the scope of freedom of expression when engaging in public speech.

18 In this context the relevant *Gazette* notice provides:[15]

> ***General scope of practice***
>
> *The "practice of medicine", which 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*

[15] "*Scopes of Practice and Prescribed Qualifications for the Practice of Medicine in New Zealand*" (11 May 2018) *New Zealand Gazette* No 2018-gs2124. Note this will be replaced from 3 May 2023 by "*Scopes of Practice and Prescribed Qualifications for the Practice of Medicine in New Zealand*" (5 April 2023) *New Zealand Gazette* No 2023-gs1359.

> *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.*

19 Paragraph [1] above 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. That would be a nonsense.

20 The only potentially relevant paragraph is [4]. This does not apply, however. Dr Canaday was not "*assessing, diagnosing, treating, reporting or giving advice in a medical capacity*". Nor can the scope of [4] be sufficiently broadened by the subsequent explanatory paragraphs. Not only would doing so make the *Gazette* notice ultra vires s 11 of the HPCAA by seeking to regulate more than the performance of health services, but Dr Canaday was engaged in public discourse on a topic of significant public interest, not "*teaching, research, medical or health management*".

21 Indeed, the limited application of paragraph [4] is exemplified by the PCC's own expert witness, who is no longer a registered medical practitioner but was nevertheless called by a committee of the Medical Council to give evidence about COVID-19. If Dr Thomas is not practising medicine, then neither was Dr Canaday at the relevant time.[16] Other examples include the Medical Council permitting overseas doctors to present at domestic conferences and not insisting that semi-retired doctors hold annual practising certificates to give University lectures.

22 Dr Thomas own view was that "*I don't believe I'm practising medicine … Because there's not a patient here*".[17] Understandably, nor did he consider

[16] Under s 7 of the Health Practitioners Competence Assurance Act 2003, "*No person may … do anything that is calculated to suggest that the person practises or is willing to practise a profession as a health practitioner … unless the person … holds a current practising certificate*".
[17] Notes of evidence at 66, line 27-29.

teaching at a university to be the practice of medicine, despite such teaching (presumably) discussing how to treat diseases.[18]

D NEW ZEALAND BILL OF RIGHTS ACT 1990

Starting point

23 The Bill of Rights is an Act "*to affirm, protect, and promote human rights and fundamental freedoms in New Zealand*".[19] It is important. The Supreme Court has said:[20]

> *The Bill of Rights is therefore a statute of constitutional significance, one which is "intended to be woven into the fabric of New Zealand law". As a statutory bill of rights, even if not supreme law, the Bill of Rights is to be given a generous interpretation — an interpretation suitable to give individuals the full measure of the enacted fundamental rights and freedoms, and one which renders the rights practical and effective, comprehensible beyond the ranks of judges and human rights academics.*

Application to the Tribunal

24 The Bill of Rights applies to acts done by:[21]

> *(a) by the legislative, executive, or judicial branches of the Government of New Zealand; or*
>
> *(b) by any person or body in the performance of any public function, power, or duty conferred or imposed on that person or body by or pursuant to law.*

25 While the scope of (a) is unclear,[22] the Tribunal is undoubtedly captured by (b).[23]

General approach

26 If Dr Canaday was practising medicine (denied), the Tribunal will be required by the charge and s 100(1)(a) of the HPCAA to 'judge' whether his

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[18] Notes of evidence at 66, line 30-34.
[19] New Zealand Bill of Rights Act 1990, long title.
[20] *Fitzgerald v R* [2021] NZSC 131 at [41] per Winkelmann CJ, William Young, Glazebrook, O'Regan and Arnold JJ (footnotes omitted).
[21] New Zealand Bill of Rights Act 1990, s 3.
[22] A Butler and P Butler *The New Zealand Bill of Rights Act: A Commentary* (online looseleaf ed, LexisNexis) at [5.6.1].
[23] A Butler and P Butler *The New Zealand Bill of Rights Act: A Commentary* (online looseleaf ed, LexisNexis) at [5.7.1] and *Moncrief-Spittle v Regional Facilities Auckland Ltd* [2022] NZSC 138.

public speech "*amounts to malpractice or negligence*". It is the words 'malpractice' and 'negligence' that sit at the heart of s 100(1)(a) and create the 'grounds' on which a health practitioner may be disciplined. It is these words, informed by the evidence (including as to any relevant professional standards), that the Tribunal must interpret and apply.

27 Similarly, under s 100(1)(b) of the HPCAA, the Tribunal must interpret and apply the word 'discredit'.

28 The Bill of Rights applies to the task of interpreting and applying s 100(1)(a) and (b). This means:[24]

> *Wherever an enactment can be given a meaning that is consistent with the rights and freedoms contained in this Bill of Rights, that meaning shall be preferred to any other meaning.*

29 When assessing what meaning is consistent, the rights and freedoms contained in the Bill of Rights may be subject only to "*such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society*".[25]

30 An example of the Bill of Rights working in practice is *Morse v Police*.[26] Ms Morse protested New Zealand's military involvement in Afghanistan by burning a New Zealand flag close to the Wellington Cenotaph on ANZAC day. She was convicted of behaving in an offensive manner in a public place. The Supreme Court held that s 4(1)(a) of the Summary Offences Act 1981 had been improperly interpreted and applied by the District Court and quashed the conviction. The Court's reasons included:

> *[17] … The task for the Court is first to interpret the public order offence created by Parliament in accordance with s 6 of the New Zealand Bill of Rights Act. It requires the meaning least restrictive of the rights in Part 2 to be given to the provision.*[27]
>
> *[105] Burning the national flag in the course of a protest is expressive conduct, which is protected by the right to freedom of expression affirmed by s 14 of the New Zealand Bill of Rights Act 1990. The facts of this case accordingly raise the further question of whether the ordinary meaning of offensive behaviour under s 4(1)(a) of the Summary Offences Act is consistent with the appellant's right to freedom of expression. If it is, the ordinary*

[24] New Zealand Bill of Rights Act 1990, s 6.
[25] New Zealand Bill of Rights Act 1990, s 5.
[26] *Morse v Police* [2011] NZSC 45.
[27] Per Elias CJ.

> *meaning applies. If it is not, under s 6 of the Bill of Rights Act, it will become necessary to consider whether there is an alternative meaning available for the language of s 4(1)(a) which is consistent with the Bill of Rights Act. If such a meaning is available, s 6 requires that it be preferred.*
>
> *[106] It must be borne in mind that under s 5 of the Bill of Rights Act, all rights and freedoms may be made subject to such reasonable limits prescribed by law as can be justified in a free and democratic society. In order to be such a limit on freedom of expression, proscribed offensive behaviour must be confined to sufficiently serious and reprehensible interferences with rights of others. Such conduct is objectively intolerable. The court's analysis must assess the impact of the exercise of the right in the circumstances, as well as the importance of other interests affected. Consideration must also be given to whether there are other methods of addressing the conflict with free speech rights than the offence provision in question or its ordinary meaning.*
>
> *[107] To this end, a balancing of the conflicting interests must be undertaken by the court as a basis for reaching a reasoned conclusion on whether the summary offence of offensive behaviour is a justified limitation on freedom of speech.*[28]

Freedom of expression

31 Sections 12-18 of the Bill of Rights set out "*Democratic and civil rights*". Section 14 provides that:

> ***Freedom of expression***
>
> *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.*

32 Freedom of expression is a central fundamental political right.[29] It is not to be encroached upon lightly. A leading text *The New Zealand Bill of Rights: A Commentary* opines that:[30]

> *Even among fundamental civil and political rights, freedom of expression occupies a special place given the importance it has in a free and democratic society. This should be borne in mind when*

[28] Per McGrath J (footnotes omitted).
[29] *Handyside v United Kingdom* (1976) 1 EHRR 737 (ECtHR) at 754, cited with approval in *Living Word Distributors Ltd v Human Rights Action Group Inc (Wellington)* [2000] 3 NZLR 570 (CA) per Richardson P.
[30] A Butler and P Butler *The New Zealand Bill of Rights Act: A Commentary* (online looseleaf ed, LexisNexis) at [13.6.1].

> *exploring the ambit of the right. In terms of inspiration, four broad and overlapping principles provide a theoretical basis of the right.*

33 The authors go on to identify the four principles as 'human self-fulfilment', 'societal safety-valve', 'the marketplace of ideas' and 'the engine-room of a democratic state'.

34 With respect to the latter two, in the United States it has been said that the marketplace of ideas is the best method of ascertaining the truth, with a multitude of tongues being more likely to produce it than any authoritative selection amongst them.[31] The same Court recognised as a matter of principle that "*debate on public issues should be uninhibited, robust, and wide-open*".[32]

35 As the Broadcasting Standards Authority observed in a recent decision:[33]

> *The openness of our society and its liberal character is recognised in the fundamental concept of freedom of expression, which is enshrined in the New Zealand Bill of Rights Act 1990. This means there should be a freedom to express and impart ideas or information, and a freedom to receive those ideas or information — a freedom which is fundamental in broadcasting. The inclination is therefore towards freedom and away from restrictions, which are only justifiable to avoid actual or potential harm that may be caused by a broadcast.*
>
> *… the free and frank exchange of opinions is an important aspect of the right to freedom of expression, and is fundamental to the operation of our democratic society. There is benefit in the public knowing about the existence and nature of critical views and perspectives. The public interest is not served by having controversial perspectives aired only in online "echo chambers" where they are able to propagate without any effective regulation or challenge.*
>
> *…*
>
> *Another important consideration in this case is academic freedom as a limb of freedom of expression. This is the idea that the encouragement of free and uninhibited research, unrestricted by social conformities and restrictions on subject-matter, facilitates the search for truth in the marketplace of ideas.*

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[31] *New York Times v Sullivan* 376 US 254 at 270 (1964).
[32] *New York Times v Sullivan* 376 US 254 at 270 (1964).
[33] *Adam v Radio New Zealand Ltd* BSA 2022-067, 27 February 2023 at [19]-[24] (footnotes omitted, emphasis added).

…

> *As a regulator, our role is to objectively weigh the right to freedom of expression against the harm that may have potentially been caused by the broadcast, having regard to current community norms and values. In doing so we recognise, as the Supreme Court has recently, that "a function of free speech under our system of government is to invite dispute", indeed, it may "best serve its high purpose … when it stirs people to anger." When determining complaints, we must be careful not to mistake anger that may be caused by a broadcast for a reason to restrict the right to freedom of expression.*

36 There is a difference between speech that is disparaging (such as a racist slur) and debate which might cause a person who disagrees with the ideas being advanced to be offended.

37 Consistent with the importance of the right to freedom of expression, including in healthcare/the medical profession, it is noteworthy that:

37.1 The HPCAA provides that "*No person may be found guilty of a disciplinary offence under this Part merely because that person has adopted and practised any theory of medicine or healing if, in doing so, the person has acted honestly and in good faith*".[34] There is no allegation that Dr Canaday was acting dishonestly or in bad faith. Indeed, this seems to be accepted by the PCC.[35]

37.2 The law protects conscientious objection by medical practitioners.[36]

37.3 The Medical Council accommodates medical practitioners practising 'complementary and alternative' medicine.[37] There are numerous medical practitioners throughout New Zealand who have provided complementary and alternative therapies (such as homeopathy) to patients for years without disciplinary intervention.

37.4 The Medical Council is on record that,[38] where a patient seeks a doctor's view on COVID-19 or vaccination during a consultation, the

[34] Health Practitioners Competence Assurance Act, s 100(4).
[35] Notes of evidence at 277, line 5-7.
[36] Health Practitioners Competence Assurance Act, s 174 and End of Life Choice Act 2019, s 8.
[37] PCC's bundle at 515-519.
[38] Documents relating to the respondent's decision being appealed (14 January 2022) for CIV-2021-085-782 at 10. This document was before the Court as part of the hearing for *Canaday v Medical Council of New Zealand* [2022] NZDC 4436. Dr Shelton has also consented to this document being provided to the Tribunal.

doctor may inform the patient of the nature of the doctor's views on COVID-19, including treatment and vaccination, provided that:

(a) the doctor also informs the patient of the extent to which any views vary from conventional theories of medicine, including "*the Government's position*" and "*the Council's position*"; and

(b) the doctor also provides the patient with the details of another doctor, nearby, who can provide them with further (conventional) advice on COVID-19 and COVID-19 vaccination.

37.5 It is impossible to reconcile allowing a diversity of ideas within the doctor-patient relationship, but not during public discourse.

37.6 The Health and Disability Commissioner is on record that health care providers:[39]

> *… are entitled to provide information from the perspective of their own practice and beliefs. It is crucial, however, that if the position being put forward to the consumer is at odds with the current scientific consensus, that must be made explicitly clear. …*
>
> *… While it is not necessary for providers to agree with the consensus view, they must not withhold that information from consumers. They must make it clear when their position diverges from the scientific consensus.*
>
> *The Code gives rights to all consumers – those who subscribe to conventional medicine and those who do not; those who wish to vaccinate and those who don't. …*

37.7 The position articulated by the Health and Disability Commissioner implicitly recognises the other side of the coin — that the right to freedom of expression includes the freedom to "*seek*" and "*receive*" "*information and opinions of any kind in any form*". The focus cannot be on Dr Canaday alone. It must include considering whether limiting the rights of others to receive information of the type included in Dr Canaday's presentations can be justified.

[39] Meenal Duggal "*The measles outbreak and your right to information*" (11 September 2019) Health and Disability Commissioner <www.hdc.org.nz>.

Justified limitation

38 As already noted, the right to freedom of expression is not absolute. It may be subject "*to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society*". There has been considerable academic and judicial debate about the methodology for conducting that exercise.

39 In *Hansen v R*, Tipping J analysed the 'demonstrably justified' threshold by asking:[40]

> *(a) does the limiting measure serve a purpose sufficiently important to justify curtailment of the right or freedom?*
>
> *(b) :*
>
> *(i) is the limiting measure rationally connected with its purpose?*
>
> *(ii) does the limiting measure impair the right or freedom no more than is reasonably necessary for sufficient achievement of its purpose?*
>
> *(iii) is the limit in due proportion to the importance of the objective?*

40 The Tribunal must therefore consider whether treating Dr Canaday's public speech as falling foul of s 100(1)(a) and/or (b) of the HPCAA is a proportionate response to any potential harm that is established by the PCC's evidence, while having regard to the intrusion on Dr Canaday's rights that such a conclusion will involve.

41 In *Yardley v Minister for Workplace Relations and Safety* (***Yardley***)[41] the Court had to determine whether the COVID-19 Public Health Response (Specified Work Vaccinations) Order 2021 was unlawful for implementing unjustified limits on fundamental rights protected by the Bill of Rights.[42]

42 The Court accepted that, notwithstanding the views of the Minister and officials involved in making the Order, the Court had a constitutional responsibility to ensure that decisions are made lawfully, and "*the Crown has the burden to demonstrate that a limitation of a fundamental right is*

[40] *Hansen v R* [2007] NZSC 7, [2007] 3 NZLR 1 at [104].
[41] *Yardley v Minister for Workplace Relations and Safety* [2022] NZHC 291.
[42] *Yardley* at [41].

demonstrably justified".[43] It observed with reference to *Make It 16 Inc v Attorney-General*[44] that this task requires a 'rigorous' approach.

43 It is submitted that the rigor this Tribunal must require of the PCC includes being able to explain and establish through evidence what was wrong with Dr Canaday's public speech and why those 'wrong' elements presented a material risk to the health and safety of members of the public.[45] As the Court in *Yardley* observed, these types of questions are practical, not rhetorical.[46]

44 It is also submitted that the concept of 'risk' is not simplistic. The PCC may speculate that a person hearing Dr Canaday's speech might be more likely to decide not to be vaccinated with Comirnaty. Whether or not the Tribunal is prepared to draw such an inference (which is opposed, given the lack of evidence), it ought not to ignore the issues of informed consent; the agency of those who listened to Dr Canaday; and the protected freedoms to seek, and receive information and opinions of any kind. If a hypothetical person received information that was true, and in-part because of that true information made an autonomous decision not to be vaccinated with Comirnaty, then that is a valid personal decision, not a risk to health and safety. To consider otherwise would be fatally paternalistic.

45 Practical questions must be answered by evidence. In *Yardley* the Crown's case failed in-part for a lack of evidence,[47] and in-part for a failure to engage with the applicants' evidence.[48] Dr Canaday's case has followed a similar pattern.

46 *Yardley* is a powerful precedent for not falling into the trap of devaluing a perspective because it is not in the majority. It is minority opinions that the Bill of Rights must most importantly protect. The PCC's criticisms of Dr Canaday's public speaking are not, with respect, matters of which judicial notice can be taken — particularly in a Bill of Rights case. Dr Canaday's public speech is prima facie protected, and it is for the PCC to provide an evidential basis for its argument that treating his public speech as

[43] *Yardley* at [63].
[44] *Make It 16 Inc v Attorney-General* [2021] NZCA 681 at [51]-[53].
[45] Refer to the Health Practitioners Competence Assurance Act 2003, s 3.
[46] *Yardley* at [69].
[47] For example, see, *Yardley* at [74]-[76].
[48] *Yardley* at [89].

malpractice, negligence and/or discrediting is a justified limitation. It has not done so.

47 Nor can the PCC's evidential problems be surmounted by an heroic application of the precautionary principle referred to in *Yardley*. There is a significant and legally relevant difference between an order made under primary legislation intended to "*support a public health response to COVID-19*"[49] and a consistent and fair application of the HPCAA — s 100 of which has not been amended in response to the pandemic. As the Office of the United National High Commissioner for Human Rights has reminded member countries, emergency measures restricting human rights must, amongst other things, be 'provided by law'.[50] The Tribunal has no legitimate discretion to take an 'emergency measures' approach to s 100. The Human Rights Committee which monitors implementation of the International Covenant on Civil and Political Rights has also observed:[51]

> *Freedom of expression and access to information and a civic space where a public debate can be held constitute important safeguards for ensuring that States parties resorting to emergency powers in connection with the COVID-19 pandemic comply with their obligations under the Covenant.*

Conclusion

48 The Tribunal must interpret and apply the words 'malpractice', 'negligence' and 'discredit' — as well as any professional standards or guidelines relied on by the PCC — in a way that is consistent with Dr Canaday's right to freedom of expression. As the Supreme Court held in *Morse v Police*, it is first necessary to interpret the "*offence created by Parliament in accordance with s 6 of the New Zealand Bill of Rights Act. It requires the meaning least restrictive of the rights in Part 2 to be given to the provision*".[52]

49 Treating public speech as a ground on which a health practitioner may be disciplined is obviously inconsistent with free expression. Thus, to the extent s 100(1) of the HPCAA has any application at all, the Tribunal must decide whether disciplining public speech can be demonstrably justified in a free and democratic society. The PCC has the onus of demonstrating —

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[49] COVID-19 Public Health Response Act 2020, s 4.
[50] See <https://www.ohchr.org/Documents/Events/EmergencyMeasures_Covid19.pdf>.
[51] See <https://www.ohchr.org/Documents/HRBodies/CCPR/COVIDstatementEN.pdf>.
[52] *Morse v Police* [2011] NZSC 45 at [17] per Elias CJ.

through evidence — that Dr Canaday's speech was not only wrong, but also sufficiently harmful to justify censorship by treating it as professional misconduct deserving of penalty. It is submitted that if the PCC has not established the information was wrong, the issue of harmfulness does not arise.

E DISTRICT COURT DECISION

50 As referred to in Dr Lum's evidence,[53] the Medical Council made a decision under s 69 of the HPCAA to suspend Dr Canaday's practising certificate. That decision was successfully appealed to the District Court.[54]

51 The District Court decision is only tangentially relevant to this proceeding. It was based on affidavit evidence alone and involved a different section of the HPCAA and different legal tests. Further, section 50(1) of the Evidence Act 2006 provides:

> *Evidence of a judgment or a finding of fact in a civil proceeding is not admissible in a criminal proceeding or another civil proceeding to prove the existence of a fact that was in issue in the proceeding in which the judgment was given.*

F GENERAL LEGAL CONTEXT

Components of a disciplinary finding

52 Before an adverse disciplinary finding can be made against Dr Canaday under s 100 of the Act, the PCC must prove and establish the following steps:

First stage

52.1 First: the factual allegations made in each of the particulars. (This requires more than merely proving the words Dr Canaday said. For particulars 2, 6 and 10, the PCC must prove the specific allegations it has made about the meaning of Dr Canaday's speech.)

52.2 Second: did any conduct that is proved fall short of that expected of a reasonably competent health practitioner operating in the same vocational area? This requires an objective analysis of whether the

[53] Brief of evidence of Dr Lum (9 March 2023) at [12].
[54] *Canaday v Medical Council of New Zealand* [2022] NZDC 4436.

practitioner's acts or omissions can reasonably be regarded by the Tribunal as constituting malpractice, negligence or otherwise bringing, or likely to bring, discredit on the profession.

Second stage

52.3 Third: if so, whether the departure from acceptable standards has been significant enough to warrant a disciplinary sanction for the purposes of protection of the public or maintaining professional standards? This is the issue of threshold.

53 The Tribunal must consider the evidence relating to each of the PCC's particulars and make a separate finding on each one. In doing so, the Tribunal must be uninfluenced by the evidence submitted to advance the other particulars. The Tribunal should then arrive at a conclusion as to the overall gravity of the conduct, but only with respect to those particulars which the Tribunal has found to be established.[55]

Onus of proof

54 The onus of proof lies with the charging authority. In *Cole v PCC* the High Court clearly articulated this as follows:[56]

> *As the charging body before the Tribunal, the PCC had the burden of proving, on the balance of probabilities, what conduct of [the practitioner] did amount to professional misconduct. This meant that the PCC had the task of putting sufficient evidence before the Tribunal to satisfy it that the facts of the charge were proven and that, on balance, these facts were significant enough to amount to professional misconduct.*

55 To uphold the Tribunal's public protection function,[57] there is an expectation that "*in disciplinary cases … the practitioner must be prepared to answer the charge once a prima facie case has been made out*".[58] A practitioner cannot simply rely on silence or a submission that the charges have not been proved.[59]

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[55] *Duncan v Medical Disciplinary Committee* [1986] 1 NZLR 513 at 547 (CA).
[56] *Cole v PCC* [2017] NZHC 1178 at [36].
[57] See *Z v Dental Complaints Committee* [2008] NZSC 55 at [113], [115], [128] and [145].
[58] *Cole v PCC* [2017] NZHC 1178 at [36].
[59] *Re C (A Solicitor)* [1963] NZLR 259; *Re Vernon, ex p Law Society of New South Wales* [1966] 1 NSWLR 511 at 515.

56 However, this 'expectation' must not be taken so far as to reverse the onus of proof, whether by explicit words or in substance. In *Geary v The Psychologists Board*,[60] the High Court found that the Board had erroneously reversed the onus of proof by tasking Mr Geary with establishing his position in respect to one of its particulars, rather than it being for the Board to establish the facts of its charge. The High Court described the Board's misapprehension of its function as a "*fatal error*".[61]

57 Accordingly, Dr Canaday does not have to disprove any of the facts of the PCC's charge against him. That is so even though he has given evidence.

58 Further, the Tribunal must limit itself to deciding the case based on the evidence presented by the parties. "*It is a fundamental requirement of natural justice that this be done*."[62] The High Court has endorsed the following approach as being correct:[63]

> *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.*

59 The PCC's case relied wholly on Dr Thomas. However, because of the way he approached his evidence, he cannot be relied upon. He plainly did not read or consider Dr Canaday's evidence and did not express any meaningful view about the validity of that material. Because of this, the PCC cannot establish Dr Canaday's information was wrong or provided an unreasonable basis from which to form opinions. It is no answer to argue that if a search of PubMed did not return Dr Canaday's sources, there was no need to read them. Dr Thomas conceded there was some role for unpublished material and Dr Canaday gave evidence that:[64]

> *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,*

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[60] *Geary v The Psychologists Board* HC Wellington CIV-2005-485-1562, 28 May 2007.
[61] *Geary v The Psychologists Board* HC Wellington CIV-2005-485-1562, 28 May 2007 at [27].
[62] *A v Professional Conduct Committee* [2018] NZHC 1623 at [26].
[63] *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).
[64] Notes of evidence at 395, line 22-26.

> *has not yet been published and needs confirmation, like I have explained.*

60 The expert witness engaged by the PCC 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.

Standard of proof

61 It is well established that the PCC must prove the components of the charge on the balance of probabilities.

62 Application of the civil standard of proof is flexible. In *Cole v PCC* Gendall J held that how the standard is applied "*… is dependent on the seriousness of the matters to be proved and the consequences of proof*".[65] In *Singh v Director of Proceedings*, Ellis J held "*the more serious the allegation, the stronger the evidence must be in order to establish it ... because of the relative improbability that such an allegation is true*".[66]

Malpractice and negligence

63 In *Collie v Nursing Council of New Zealand*, Gendall J described negligence and malpractice as follows:[67]

> *Negligence or malpractice may or may not be sufficient to constitute professional misconduct and the guide must be standards applicable by competent, ethical and responsible practitioners and there must be behaviour which falls seriously short of that which is to be considered acceptable and not mere inadvertent error, oversight or for that matter carelessness.*

64 Malpractice, as distinct from negligence, is "*generally reserved for cases in which there is some element of immoral or unethical conduct or culpable negligence by the practitioner*".[68] (In this context, 'culpable negligence' is a reference to the high criminal standard of recklessness.)

[65] *Cole v PCC* [2017] NZHC 1178 at [36].
[66] *Singh v Director of Proceedings* [2014] NZHC 2848 at [25].
[67] *Collie v Nursing Council of New Zealand* [2001] NZAR 74 at [21] (emphasis added).
[68] *PCC v A* [2021] NZHC 949 at [23], citing a Tribunal decision.

Bringing discredit

65 With respect to the ground of conduct bringing discredit to the profession, in *Collie v Nursing Council of New Zealand*, Gendall J stated:[69]

> *To discredit is to bring harm to the repute or reputation of the profession. The standard must be an objective standard with the question to be asked by the Council being 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 nursing profession was lowered by the behaviour of the nurse concerned.*

66 At face-value this test is somewhat vague and, because of this, must be applied carefully. It focusses not on the opinions of other doctors, but of members of the public. The public may however hold a range of opinions. What might annoy one person, another may value as an expression of free speech.

67 Should the Tribunal find that some of Dr Canaday's conduct as proved by the evidence constituted negligence, it is submitted a finding of bringing discredit need not go hand-in-hand. The concepts of negligence, malpractice and bringing discredit are distinct, and merely because they are conjoined in the charge does not mean the Tribunal cannot separate them out.[70] Indeed, the differing definitions and standards applying to each mean they must be considered distinctly.

Threshold for discipline

68 As a separate step, the Tribunal must be satisfied that disciplinary sanction is required for the purposes of discipline. This is not true of every departure from acceptable standards. Even if a breach of professional standards amounting to malpractice, negligence or discredit is established, something more is required before a finding of "*professional misconduct*" may be found established. This is the 'disciplinary threshold'.

69 In *Cole v PCC*, Gendall J said:[71]

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[69] *Collie v Nursing Council of New Zealand* [2001] NZAR 74 (HC) at [28].
[70] See for example *PCC v Dr Y* HPDT 1062/Med18/430P, 4 February 2020.
[71] *Cole v PCC* [2017] NZHC 1178 at [45] (evidence added).

> *It is clear that a finding of professional misconduct is a significant matter indeed. It should be reserved for only the most serious misconduct.*

70 In *Vatsyayann v PCC*, Simon France J said:[72]

> *… it is plain that something more than a breach of acceptable standards is required, because otherwise there would be no need for step two. It is also plain that the breach must be of sufficient significance to merit recording a finding of professional misconduct against the practitioner. It is important to bear in mind that it is a finding that carries stigma, and represents a message about the person's conduct of their professional responsibilities that will be keenly felt by the person, and noted by his or her peers.*

71 In *O v PCC*,[73] Allan J followed the Court of Appeal in *F v Medical Practitioners Disciplinary Tribunal*, where the Court observed:[74]

> *… the Tribunal or Court needs to satisfy itself that the conduct adversely affects the practitioner's fitness to practise in order to determine that the conduct warrants a disciplinary sanction.*

72 This is in harmony with the principal purpose of the Act — protecting the public and ensuring practitioners are competent and fit to practise.

73 As Baragwanath J in *J v Director of Proceedings* further observed:[75]

> *Professional misconduct expresses a high threshold of breach of duty.*

74 In *Johns v Director of Proceedings*,[76] Moore J confirmed that the threshold question is one which ought to be considered with care, having regard to the purposes of the Act. It is common for the charging authority to cite *Martin v Director of Proceedings*[77] and the High Court's determination that threshold should not be regarded as "*unduly high*". Indeed, whilst not "*unduly high*", it is still a "*high*" bar.

75 Threshold is therefore a significant and separate consideration to the first stage of the test. Even where the Tribunal makes a finding of misconduct, it does not follow that the breach must require an adverse disciplinary

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[72] *Vatsyayann v PCC* HC Wellington CIV-2009-482-259, 14 August 2009 at [8].
[73] *O v PCC* [2011] NZAR 565 at [39].
[74] *F v Medical Practitioners Disciplinary Tribunal* [2005] 3 NZLR 774 at [80].
[75] *J v Director of Proceedings* HC Auckland CIV-2006-404-2188, 17 October 2006, at [35].
[76] *Johns v Director of Proceedings* [2017] NZHC 2843.
[77] *Martin v Director of Proceedings* [2010] NZAR 333.

finding. The PCC must satisfy the Tribunal that the conduct adversely affects the practitioner's fitness to practise to determine that the conduct warrants a disciplinary sanction.

Professional standards

76 Guiding statements and professional standards are not black letter law. They have not been subject to the same degree of scrutiny as statute and care must be taken when relying on them as rules. In *Collie v Nursing Council of New Zealand*, Gendall J held:[78]

> *[A] breach of a standard in a code may or may not be professional misconduct, or other conduct deserving of disciplinary sanction. It all depends and is a question of degree. So too misconduct can be conduct outside that specifically referred to in the code because the ambit of human behaviour, whether by a professional person or otherwise, is unlimited.*

77 It is well established that guidelines and statements are not determinative, either in terms of setting standards relevant to professional disciplinary proceedings or for establishing professional misconduct. In *O v PCC* Allan J noted:[79]

> *It is to be borne in mind that a breach of a professional ethics code does not automatically amount to professional misconduct for the purposes of the 2003 Act. In* Re A (Barrister and Solicitor of Auckland)*, this Court reversed a finding of guilt by the Law Practitioners Disciplinary Tribunal on the basis that the Tribunal had equated a breach of the lawyers conduct and client care rules with professional misconduct. The breach of the Code was simply the first step in the necessary analysis.*

78 A similar warning was given by Young J in *Staite v Psychologists Board*:[80]

> *The code of ethics of the New Zealand Psychological Society should not be treated as a straight-jacket to be applied irrespective of the circumstances and context in which the psychologist is acting.*

79 In the light of this, careful consideration of any guidelines or statements relied on as substantiating the charge is needed. The PCC has included in its bundle:

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[78] *Collie v Nursing Council of New Zealand* [2001] NZAR 74 (HC) at [30].
[79] *O v PCC* [2011] NZAR 565 at [84] (footnotes omitted).
[80] *Staite v Psychologists Board* HC Christchurch AP 52/98, 18 December 1998.

79.1 *Good Medical Practice* (December 2016);

79.2 *Unprofessional behaviour* (August 2020);

79.3 *NZMA Code of Ethics* (August 2020);

79.4 *Statement on advertising* (November 2016);

79.5 *Doctors and CAM (complementary and alternative medicine)* (November 2017); and

79.6 *Guidance statement — COVID-19 vaccine and your professional responsibility* (undated).

80 The statements on *Good Medical Practice* and *Unprofessional behaviour* are potentially relevant.

81 The *NZMA Code of Ethics* is irrelevant. Dr Canaday was not a member of that private organisation, which no longer exists. Dr Thomas was not a member of the NZMA either, and he did not seem to look to it for any guidance.[81]

82 The *Statement on advertising* is also irrelevant, as Dr Canaday was not 'advertising' as the term is defined in the document itself.

83 Despite the PCC pressing Dr Canaday to accept the relevance of the statement *Doctors and CAM (complementary and alternative medicine)*, which he said he was not familiar with, it is not relevant either. A fair reading of the statement is that it is clearly directed at "*doctors who practise complementary and alternative medicine*" with respect to patients.[82]

84 The *Guidance statement* must be treated with real caution. Under the HPCAA, the Medical Council's functions include setting "*standards*".[83] Issuing 'guidance' sits outside the Medical Council's statutory powers. The status of the *Guidance statement* is therefore entirely unclear. There are no other 'guidance statements' issued by the Medical Council. It was not consulted on or developed in the same way as a professional standard.[84]

[81] Notes of evidence at 33, line 19-31.
[82] Medical Council of New Zealand *Doctors and CAM (complementary and alternative medicine)* (November 2017) at [4].
[83] Health Practitioners Competence Assurance Act, s 118(1)(i).
[84] Through its cross-examination of Dr Canaday, the PCC seemed to accept that consultation is a normal prelude to adopting a professional standard.

Nor does it appear in the section of the Medical Council's website headed 'Current standards':[85]

> *The principal function of the Medical Council of New Zealand is to protect the health and safety of the public by ensuring that doctors are competent and fit to practise. We do this by setting standards of clinical and cultural competence and ethical conduct for doctors.*
>
> *Our current standards set out the principles and values that define good medical practice, and outline what we expect from doctors in all aspects of their professional behaviour.*
>
> *Our current standards are used by the Health Practitioners Disciplinary Tribunal, the Council and the Health and Disability Commissioner as benchmarks against which doctors are measured.*

85 All this was perhaps to insulate the *Guidance statement* from being challenged as proposed professional standards have been in the past.[86] Certainly the *Guidance statement* is inconsistent with the Bill of Rights and other Medical Council professional standards.[87]

86 In this context, the Medical Council cannot now claim the *Guidance statement* is 'what we expect from doctors' as would be the case for a professional standard.

87 Consistent with this, Dr Thomas did not know that the Medical Council had issued a statement relating to COVID-19.[88] He had never seen the *Guidance statement* before.[89]

Expert evidence

88 The correct approach to the consideration of expert evidence was discussed by the Tribunal in *Re Vatsyayann*.[90] This included:

88.1 "*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*

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[85] See <https://www.mcnz.org.nz/our-standards/current-standards/>.
[86] *Hallaghan v Medical Council of New Zealand* HC Wellington CIV-2010-485-222, 2 December 2010.
[87] It was Dr Canaday's view that the Guidance statement "*conflicts precisely with other statements from the Medical Council*" (Notes of evidence at 310, line 22-23).
[88] Notes of evidence at 28, line 30-31.
[89] Notes of evidence at 44, line 30.
[90] *Re Vatsyayann* HPDT 355/Med10/152P, 16 March 2011 at [20]-[22].

the professional opinion is capable of withstanding logical analysis; if it does not, the Tribunal may conclude the opinion is not reasonable or responsible."[91]

88.2 "*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.*"[92]

89 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:[93]

> *… [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.*

90 As discussed below, the same could be said of Dr Thomas' evidence.

G INTERNATIONAL AND ACADEMIC PERSPECTIVES

Academic perspective from the United States of America

91 Prof C H Coleman[94] recently published a paper in an academic journal arguing that, in most cases, imposing disciplinary penalties on physicians for speech that takes place outside a physician-patient relationship would have dangerous policy implications and would almost certainly be unconstitutional.[95] He considers discipline would only be appropriate where it can be established that a physician has disseminated information they

[91] *Re Vatsyayann* HPDT 355/Med10/152P, 16 March 2011 at [21.3] (footnotes omitted).
[92] *Re Vatsyayann* HPDT 355/Med10/152P, 16 March 2011 at [22.2].
[93] *Air Chathams Ltd v Civil Aviation Authority of New Zealand* HC Wellington CP146/98, 27 May 2003 at [47].
[94] Formerly Bioethics and Law Adviser at the World Health Organization (WHO) in Geneva, Switzerland.
[95] C Coleman "*Physicians who disseminate medical misinformation: testing the constitutional limits on professional disciplinary action*" (2022) 20 First Amendment Law Review 113.

know to be false, or with reckless disregard as to whether it is true. The paper includes:[96]

> *Characterizing physicians' public speech about medical matters as an aspect of professional practice would also have troubling policy implications. If disciplinary actions based on physicians' public statements were subject to the more deferential standards applicable to the regulation of professional practice, licensing boards would be free to penalize physicians whenever they express opinions that conflict with prevailing professional norms, even if those opinions cannot be shown to be objectively false. Physicians who believe that the existing standard of care is misguided would therefore have no way to express their views publicly without exposing themselves to potential disciplinary action.*
>
> *If physicians could not question prevailing standards without risking professional discipline, the result would be a substantial chilling effect on potentially valuable speech. The history of medicine contains numerous examples of once-accepted medical standards that were ultimately shown to be ineffective or harmful. …*
>
> *…*
>
> *… 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.*

Hoeg v Newsom

92 This case challenged a Californian statue providing that "*[i]t shall constitute unprofessional conduct for a physician and surgeon to disseminate misinformation or disinformation related to COVID-19, including false or misleading information regarding the nature and risks of the virus, its prevention and treatment; and the development, safety, and effectiveness*

[96] C Coleman "*Physicians who disseminate medical misinformation: testing the constitutional limits on professional disciplinary action*" (2022) 20 First Amendment Law Review 113 at 139 and 141 (footnotes omitted).

of COVID-19 vaccines."[97] The statue defines 'misinformation' as "*false information that is contradicted by contemporary scientific consensus contrary to the standard of care*".[98]

93 A preliminary injunction was granted. The Court observed:[99]

> *A statute is unconstitutionally vague when it either "fails to provide a person of ordinary intelligence fair notice of what is prohibited, or is so standardless that it authorizes or encourages seriously discriminatory enforcement."*
>
> *…*
>
> *Vague statutes are particularly objectionable when they "involve sensitive areas of First Amendment freedoms" because "they operate to inhibit the exercise of those freedoms." … The Supreme Court has said that "when a statute interferes with the right of free speech or of association, a more stringent vagueness test should apply."*
>
> *…*
>
> *… "contemporary scientific consensus" lacks an established meaning within the medical community, and defendants do not propose one. The statute provides no clarity on the term's meaning, leaving open multiple important questions. For instance, who determines whether a consensus exists to begin with? If a consensus does exist, among whom must the consensus exist (for example practicing physicians, or professional organizations, or medical researchers, or public health officials, or perhaps a combination)? In which geographic area must the consensus exist (California, or the United States, or the world)? What level of agreement constitutes a consensus (perhaps a plurality, or a majority, or a supermajority)? How recently in time must the consensus have been established to be considered "contemporary"? And what source or sources should physicians consult to determine what the consensus is at any given time (perhaps peer-reviewed scientific articles, or clinical guidelines from professional organizations, or public health recommendations)? The statute provides no means of understanding to what "scientific consensus" refers.*

[97] *Hoeg v Newsom* US District Court 2:22-cv-01980 WBs AC, 25 January 2023 at 4.
[98] *Hoeg v Newsom* US District Court 2:22-cv-01980 WBs AC, 25 January 2023 at 4 (emphasis added).
[99] *Hoeg v Newsom* US District Court 2:22-cv-01980 WBs AC, 25 January 2023 at 15, 16, 19, 20, 22 and 23 (references omitted).

> *Judicial references to the concept of scientific consensus — in the context of COVID-19 as well as other disputed scientific topics — confirm that the term lacks an established meaning. …*
>
> *Because the term "scientific consensus" is so ill-defined, physician plaintiffs are unable to determine if their intended conduct contradicts the scientific consensus, and accordingly "what is prohibited by the law." …*
>
> *…*
>
> *… COVID19 — a disease that scientists have only been studying for a few years, and about which scientific conclusions have been hotly contested. COVID-19 is a quickly evolving area of science that in many aspects eludes consensus.*

94 Similar issues arise in Dr Canaday's case. The PCC alleges he is guilty of negligence and/or malpractice for expressing views that were 'not supported by generally accepted scientific evidence'.[100]

Thiab v Western Sydney University

95 Ms Thiab was a nursing student who discussed COVID-19 matters. The University disagreed with her views and imposed sanctions. She claimed the University had breached its obligation under s 35 of the Western Sydney University Act 1997 not to discriminate against her on the ground of religious or political beliefs. The Court observed:[101]

> *Historical events also provided context for the enactment of the provisions reflected in s 35. Galileo's persecution by the Inquisition was a famous example. More recently, and more immediately relevantly for present purposes, were Stalinist and Maoist enforcement of academic conformity with the party line (including in particular forced recantation of "incorrect" beliefs, and forced self-criticism for having professed those beliefs in the first place): see Priestland, D, The Red Flag: A History of Communism (Grove Press, 2009), 144.*
>
> *It is hard to overstate the importance of this subject. Freedom of thought and freedom of speech have been bracketed together as indispensable conditions of a free society …*

96 A similar theme of the perils of autocracy was discussed in Dr Canaday's *Courageous Convos* presentation.

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[100] Disciplinary charge at [6(b)], [6(c)] and [10(a)].
[101] *Thiab v Western Sydney University* [2022] NSWSC 760 at [145]-[146] (footnotes omitted).

H PARTICULARS OF THE CHARGE

97 Counsel for the PCC described the charge as a "*Russian doll*".[102] It is somewhat complex and will need to be considered carefully.

98 Particulars 2, 6 and 10 allege certain statements were "*inaccurate and/or misleading, or had the potential to mislead, in that …*".[103] The words 'in that' are critical, and link to various sub-particulars which describe each of the alleged inaccuracies. It is therefore the sub-particulars which must be proved. To take an example — particular 2(c) — the PCC has the onus of establishing that:

98.1 'Dr Canaday overstated the number of confirmed deaths linked to the Pfizer vaccine in New Zealand'; and

98.2 That this overstatement, if proved, 'suggested that the vaccine was more dangerous than COVID-19 itself'.

99 Particulars 3, 7 and 11 allege that certain specified statements were "*disparaging and/or amounted to unprofessional criticism of other health practitioners and had the potential to encourage criticism of other health practitioners*".[104]

100 Particulars 4, 8 and 12 are a catch-all, alleging that the statements in the Appendices to the charge "*individually or cumulatively, brought, or were likely to bring, discredit to the medical profession*".

101 The charge concludes with the usual boilerplate statement that "*The conduct alleged above*" (to the extent it is established), "*either separately or cumulatively*", "*amounts to malpractice and/or negligence pursuant to s 100(1)(a)*" (which it cannot, if it was not the practice of medicine), "*and/or has brought or is likely to bring discredit to the medical profession pursuant to s 100(1)(b)*".

102 As noted, particulars 2, 6 and 10 of the charge require the PCC to establish that certain words spoken by Dr Canaday were "*inaccurate and/or misleading*" for the reasons identified in the sub-particulars. This means the PCC must prove, through evidence and to the required standard, every

[102] Notes of evidence at 14, line 4.
[103] Emphasis added.
[104] Emphasis added.

allegation made in the charge. For example, particular 6(b) asserts that 'generally accepted science' does not support certain treatments for COVID-19. Proving this is a very different task from, for example, establishing whether an alleged act was in fact carried out. Indeed, a question like 'what is the generally accepted "*science*" on COVID-19 treatments' is arguably meaningless. 'Science' is presumably a shorthand for scientific knowledge — but of course the very point of scientific method is to always observe, question and hypothesise. This is what distinguishes it from mere belief or doctrine. As the decision in *Hoeg v Newsom* (referred to above) held, "*'scientific consensus' concerning COVID-19 is an illusory concept, given how rapidly the scientific understanding and accepted conclusions about the virus have changed. … the so-called 'consensus' has developed and shifted, often within mere months, throughout the COVID-19 pandemic.*"[105] Examples of the changing state of knowledge in New Zealand include the initial belief that vaccination would inhibit community spread of COVID-19 and the adoption and subsequent rejection of Molnupiravir as a treatment for COVID-19.[106] Many more examples exist.

103 It is at issue whether the Tribunal would ever be able to make findings about 'generally accepted science', restricted as it is to the evidence presented by the parties. The PCC's evidence certainly provides no basis for drawing conclusions about the state of scientific knowledge. It relies on a single brief of evidence from a witness whose evidence failed to comply with Practice Note No 3.

I THE PCC'S WITNESSES

Dr Lum

104 Dr Lum was not an important witness, however she did watch the videos of Dr Canaday's presentations and agreed "*it was important to do that because the transcript doesn't obviously tell us what was in the slides that were presented, so the visual part of it couldn't be included in the transcript*".[107]

[105] *Hoeg v Newsom* US District Court 2:22-cv-01980 WBs AC, 25 January 2023 at 24.
[106] Brief of evidence of Dr Canaday (3 April 2023) at [8].
[107] Notes of evidence at 146, line 7-10.

Dr Thomas

Overview

105 Little (if any) weight can be placed on Dr Thomas' evidence. His duties under Practice Note No 3 included:[108]

> *[1] An expert witness has an overriding duty to assist the Tribunal impartially on relevant matters within the expert's area of expertise.*
>
> *[2] An expert witness is not an advocate for the party who engages the witness.*

106 Dr Thomas was plainly not impartial. His evidence was at times condescending. His demeanour raises concerns of bias. On several occasions Dr Thomas laughed as propositions were put to him, which underscores this point.[109] He was an established (and proud) advocate for the 'government position' on COVID-19 matters and treated contrary views with distain. He seemed to consider the views of those at odds with the 'government position' as unworthy of scrutiny or consideration. That is why he decided:

106.1 not to watch the videos, as doing so was not worth his time;[110]

106.2 not to review Dr Canaday's slides;[111] and

106.3 not to check Dr Canaday's references, assuming them to be 'ridiculous stuff'.[112]

107 It was even unclear whether Dr Thomas had read Dr Canaday's brief of evidence with any care, if at all. He received Dr Canaday's brief approximately two weeks prior to the hearing (if not more recently), yet had no memory of important parts of that evidence, including Dr Canaday's clear denial that he had mis-referred to hydroxychloroquine (**HCQ**).[113] Nor could

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[108] Emphasis added.
[109] For example, see Notes of evidence at 34, line 7; at 80, line 15; at 111, line 27; and at 117, line 18.
[110] Notes of evidence at 62, line 4; and at 62, line 9.
[111] Notes of evidence at 63, line 3.
[112] Notes of evidence at 63, line 7-10; and at 155, line 2-12.
[113] For example, not recalling that Dr Canaday had identified transcription errors with the word hydroxychloroquine (Notes of evidence at 178, line14-19).

Dr Thomas recall details such as the references to Dr Zelenko[114] or initially even whether he had seen the brief.[115] His opinions were pre-judged.

108 Dr Thomas said that he considered Voices for Freedom to be "*the exact antithesis of what I believe in; that medical treatment, or that treatment for serious conditions is best done by people who know what they're talking about rather than people who live based on a web of Trump-influenced lies and fantasy.*"[116] These are hardly the words of an impartial expert.

109 He was also a party to several articles, including "*Politicians: please work together to minimise the spread of COVID-19*" published in the New Zealand Medical Journal.[117]

110 Dr Thomas agreed he was "*very supportive of the government approach to the pandemic*",[118] as well as being "*very supportive of the Ministry of Health and the Medical Council*".[119] He believed the "*management of COVID-19 in New Zealand was exemplary*".[120] He did not reject that this influenced how he viewed what Dr Canaday said.[121]

111 An example of Dr Thomas' bias was his admission that he did not review the graph Dr Canaday had referred to regarding the use of Ivermectin in India, because "*I made a pre-judgement that it was unlikely to be as helpful for me as other information that I was looking at.*"[122]

112 When putting forward references, he "*selected those that I thought were likely to be the closest to the accepted truth*",[123] but failed to comply with the obligation to be transparent about how he had searched, what information he had found, and what methods he had used to prefer some references while rejecting others.

113 When asked about a study Dr Canaday had referenced, Dr Thomas commented:[124]

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[114] Notes of evidence at 182, line 17.
[115]
[116] Notes of evidence at 34, line 18-22.
[117] Notes of evidence at 37, line 12.
[118] Notes of evidence at 41, line 22-25.
[119] Notes of evidence at 42, line 29-32.
[120] Notes of evidence at 91, line 3-4.
[121] Notes of evidence at 43, line 3-5.
[122] Notes of evidence at 168, line 1-15.
[123] Notes of evidence at 66, line 8-10.
[124] Notes of evidence at 183, line 8-16.

> *A. But I guess I would state that it sounds 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. And so, I would be wanting to read this very carefully before I decided that one should necessarily agree with the conclusions of the authors.*
>
> *Q. Absolutely, and that's precisely what you should have done, isn't it?*
>
> *A. No.*

114 Dr Thomas only looked at the first page of the NZDSOS website.[125] He 'didn't have any time' for the organisation.

115 Dr Thomas' attitude is perhaps summed up by his view that "*I think the profession … relies, sometimes like a church or a military organisation, on a cohesive force being applied …*".[126] An expert witness ought not to see themselves as part of that cohesive force. As referred to above,[127] the Tribunal is entitled to set aside expert evidence that was "*opinionated, argumentative and certainly not unbiased.*"

The role of non-specialists

116 Relevant to particulars 2(a) and 6(d) of the charge, nor had Dr Thomas treated COVID-19 patients or administered vaccinations against COVID-19.[128] Further, he did not criticise other doctors without any "*particular special expertise*" commenting publicly on COVID-19.[129]

Dr Thomas' views on consensus

117 Dr Thomas accepted "*discussion and debate*" is a natural part of addressing important questions in medicine.[130] He agreed that journal articles only reflect the 'consensus' of a small editorial/review group and it is normal to then test those opinions further.[131] Contrary views can be expressed:[132]

> *Q. And that's important, isn't it, to be able to discuss what the so-called consensus is?*

[125] Notes of evidence from 107, line 18.
[126] Notes of evidence at 214, line 12-15.
[127] *Air Chathams Ltd v Civil Aviation Authority of New Zealand* HC Wellington CP146/98, 27 May 2003 at [47].
[128] Notes of evidence at 35, line 16-23.
[129] Notes of evidence at 41, line 10-12.
[130] Notes of evidence at 25, line 28.
[131] Notes of evidence at 26, line 27-28.
[132] Notes of evidence at 27, line 1-20.

A. Yes.

Q. Because it will be inevitable there will be some people who don't agree with the consensus?

A. It will be.

Q. And it's important those people are entitled to express the contrary view, isn't it?

A. That's not for me to decide. That's an opinion that the Medical Council might have an opinion on. I'm merely giving scientific expertise, not a decision about whether people can express their opinion on not.

118 Dr Thomas also conceded:

118.1 "*there's always various sources contributing to what may be considered to be the truth*";[133]

118.2 doctors were entitled to do their own research;[134] and

118.3 it was a "*rapidly changing situation*".[135]

119 On reflection, Dr Thomas thought a position of 'no tolerance whatsoever' for other ideas was unwise,[136] and he agreed the Medical Council had 'made an example of' Dr Canaday[137] — which would possibly have a 'chilling effect' on people expressing their views.[138]

120 His evidence included:[139]

Q. … Right throughout 2020 and 2021 things were developing, and what was thought to be correct at one stage subsequently proved not to be correct. Can you think of any examples of that?

A. Yes, I can. …

121 And:[140]

[133] Notes of evidence at 30, line 8-10.
[134] Notes of evidence at 31, line 11-15 and 26-29.
[135] Notes of evidence at 38, line 20-22.
[136] Notes of evidence at 49, line 26-27.
[137] Notes of evidence at 50, line 18-25.
[138] Notes of evidence at 50, line 31-34.
[139] Notes of evidence at 30, line 23-27.
[140] Notes of evidence at 48, line 15-24 (emphasis added).

> *A. I think it's appropriate for a doctor, if they have questions about the safety of vaccination, to try and answer those questions for themselves with the best possible research that they can do.*
>
> *Q. And having done that, and that's a very fair answer; having done that, is it permissible then for them to talk publicly about what they have found and what views they've formed as basis of that research?*
>
> *A. I think as long as they speak very honestly about what they have found, that's probably acceptable.*

122 Dr Thomas agreed there was substantial uncertainty associated with the Comirnaty vaccine. For example:[141]

> *A. It's very difficult to predict the future, isn't it? So, the consequences of vaccination given in 2021 that might have occurred in 2025 would not have been known at the end of 2021, that's correct.*
>
> *Q. But normally with these vaccines they have 5 to 10 years of study, don't they? They go through clinical trials and that's then handed to the FDA or MedSafe who then make a decision as to whether to approve it or not?*
>
> *A. … that's right.*

123 He opined, "*Nothing is a hundred percent, in medicine at least.*"[142]

124 Dr Thomas acknowledged that information about potential risks might be important to people, but in the 'real world' there simply wasn't time to have such detailed discussions.[143] From Dr Canaday's perspective, this is all the more reason to encourage freedom of expression so that those people who want more information can access it.

J DR CANADAY'S EVIDENCE

125 Dr Canaday gave evidence as an intelligent person who is a deep and independent thinker. He had undertaken extensive research and held considerable knowledge at his fingertips. He made concessions appropriately and admitted that, with the benefit of hindsight, there were some aspects of his presentations that could have been improved. His unshakable belief in the importance of freedom of expression was there for

[141] Notes of evidence at 68, line 3-11.
[142] Notes of evidence at 73, line 1.
[143] Notes of evidence at 90, line 24-27; and at 105, line 23-28.

all to see. Dr Canaday presented as a man of principle. He was polite and respectful — a far cry from someone who might flippantly disparage a colleague.

126 At the beginning of each presentation Dr Canaday informed his audience that the "*assumptions, research and conclusions are my own and do not represent the views or conclusions of … the NZ Ministry of Health*" and "*Nothing in this presentation is intended to … advise how to … treat or cure COVID-19*".[144] He was then assiduous in not offering advice, with the only exception perhaps being with respect to vitamins to build up the immune system. That is common advice. In all other respects (for example to access Ivermectin), the audience would need to consult a prescribing doctor. Nowhere in the many pages of transcripts does Dr Canaday tell his audience not to be vaccinated. He said:[145]

> *They cannot rely on my advice. I specifically said I am not giving medical advice. All such decisions as you are describing must take place in the context of an individual consultation between a patient and his doctor. I never entered such a consultative relationship.*

127 Dr Canaday was also clear that his concerns were not directed at fellow-medical practitioners:[146]

> *… nowhere in my presentations was I talking about other doctors. I may have been talking about Government officials.*

128 And:[147]

> *… that is not the intention for me to say that other "doctors" may have not been telling the truth.*

129 Dr Canaday's earnest and authentic position was demonstrated by the following answer given under cross-examination:[148]

> *Some rules may overrule or may contradict more essential rules. For example, the Hippocratic Oath is the first; do no harm. That is more important than any subsequent statutory rules or obligations which may be imposed. And if those statutory rules and obligations violate our intention to maintain our Hippocratic Oath, there will be a conflict.*

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[144] PCC bundle at 354. See also Notes of evidence at 277, line 17-21.
[145] Notes of evidence at 304, line 6-10.
[146] Notes of evidence at 280, line 16-18.
[147] Notes of evidence at 281, line 12-13.
[148] Notes of evidence at 287, line 26-32.

K PARTICULARS 2, 6 AND 10 (INACCURATE/MISLEADING) NOT ESTABLISHED

Relevant professional standards

130 While Dr Thomas made some high-level 'concluding remarks' at [71] of his brief of evidence, he expressed no reasoned opinion as to what the relevant professional standard was (if any) that applied to Dr Canaday's public speech. The Tribunal is left with the documents included in the PCC's bundle.

131 As explained above, the COVID-19 specific *Guidance statement* should be set aside. The Medical Council cannot have it both ways: it cannot shy away from adopting the *Guidance statement* as a professional standard while simultaneously asking the Tribunal to treat it as such.

132 The only potentially relevant standards are *Good Medical Practice* and *Unprofessional behaviour*. However, neither prohibits participating in public discourse or purports to limit doctors from disagreeing with "*local panels of experts*".[149] A fair reading of the statement on *Unprofessional behaviour* (in particular paragraph [3]) is that it is targeted at inappropriate interactions or communication between a practitioner and their patients/colleagues. Or, outside the healthcare setting, personal conduct (such as criminal offending) that might bring discredit. Any broader reading would make the standard's scope so indeterminate as to be meaningless.

133 No Tribunal decisions could be found which discuss the concept of 'misleading' or 'inaccurate' statements in circumstances similar to this charge. Practitioners have been charged for misleading patients and inaccurate advertisements, but not public discourse.

When could an 'inaccurate' and/or 'misleading' statement be negligence, malpractice or bring discredit?

134 The Tribunal's first task is to interpret the disciplinary 'offence' created by Parliament in accordance with s 6 of the Bill of Rights Act by giving s 100(1)(a) and (b) of the HPCAA the meaning least restrictive of the protected rights.[150]

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[149] Brief of evidence of Dr Thomas (9 March 2023) at [71].
[150] *Morse v Police* [2011] NZSC 45 at [17] per Elias CJ.

135 It is submitted this must mean:

135.1 Restricting the concepts of 'negligence' and 'malpractice' to acts and omissions occurring in the context of providing health services[151] — not public discourse.

135.2 Declining to treat public speaking as "*behaviour which falls seriously short of that which is to be considered acceptable*",[152] particularly given the absence of any clear professional standard directed at stopping doctors from debating scientific knowledge or expressing opinions that are not welcomed by the government and/or Medical Council.

135.3 Accepting that good faith public discourse is incapable of lowering the reputation and good standing of the profession in the minds of reasonable members of the public informed with knowledge of all factual circumstances.[153] A circumstance any reasonable member of the public would take into account is the legislation enacted 13 years before the HPCAA to "*promote human rights and fundamental freedoms in New Zealand*".

135.4 Adopting the test advocated by Prof Coleman[154] — which would limit discipline to cases where a practitioner has disseminated information they knew to be false or with reckless disregard as to whether it was true. This would also align with Dr Thomas' thinking that "*as long as they speak very honestly about what they have found, that's probably acceptable.*"[155]

136 Anything less than this would render the protection afforded by the Bill of Rights illusory. It would be impossible for practitioners to know, in advance, what type of involvement in public life might draw disapproval by the Medical Council and risk allegations of professional misconduct. This is particularly so where both the Medical Council and Health and Disability Commissioner

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[151] Meaning a service for the "*purpose of assessing, improving, protecting, or managing the physical or mental health of individuals or groups of individuals*", see Health Practitioners Competence Assurance Act 2003, s 5.
[152] *Collie v Nursing Council of New Zealand* [2001] NZAR 74 at [21].
[153] *Collie v Nursing Council of New Zealand* [2001] NZAR 74 (HC) at [28].
[154] C Coleman "*Physicians who disseminate medical misinformation: testing the constitutional limits on professional disciplinary action*" (2022) 20 First Amendment Law Review 113.
[155] Notes of evidence at 48, line 15-24.

seem to be mindful of patients' rights and countenance the discussion of views about vaccines that may be 'minority' in the context of individual doctor-patient interactions.

Analysis of the particulars and the evidence

Particulars 2(a) and 6(d)

Particular	Relevant quote(s)
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	"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"
The key word is "*misstated*". It is for the PCC to identify something in the relevant quote that was inaccurate. The PCC also has not established that Dr Canaday was purporting to 'provide informed advice' (as opposed to information).	
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	"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"
The key word is "*misrepresented*". Again, it is for the PCC to identify something in the relevant quote that was inaccurate. The PCC also has not established that Dr Canaday was purporting to 'provide informed advice' (as opposed to information).	

137 The Medical Council demanded no special qualifications before medical practitioners could comment on COVID-19 matters. The real issue in these particulars is whether Dr Canaday was honest, which he was.

138 Dr Canaday's description of his experience and background was accurate. His education and experience is extensive.[156] His presentation slides described him as a "*former*" respiratory and critical care physician.[157] He advised his audience:[158]

> *Topics, references, assumptions, research and conclusions are my own and do not represent the views or conclusions of … the NZ Ministry of Health.*
>
> *Nothing in this presentation is intended to diagnose, advise how to diagnose, treat or cure COVID-19 or any other disease entity discussed herein.*

139 Dr Canaday was not giving "*advice on the treatment of COVID-19*". He explained this forthrightly under cross-examination.[159]

140 The PCC has not established that Dr Canaday was somehow unable to comprehend and discuss information about COVID-19.

141 It is a nonsense to suggest only doctors of specific specialties may discuss COVID-19. The Medical Council adopted no professional standard to that effect and plainly doctors of all types were permitted speech that agreed with the government position (for example, Dr Betty and Dr Murton, who Dr Thomas agreed had no special expertise).

142 Dr Thomas' only evidence in chief was oblique: "*[71] … 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.*"

143 However, Dr Thomas has not "*provided medical care of a respiratory nature to any Covid-19 patients*" but has been called as an expert on COVID-19. He offered no criticism of other doctors who spoke publicly.

Particular 2(b)

Particular	Relevant quote(s)
Dr Canaday's use of information from the United States was not balanced	"[…] there is a very significant number of recorded adverse events or side-effects or things you don't expect

[156] Brief of evidence of Dr Canaday (3 April 2023) at [20]-[26] and Document 13.
[157] Evidence for the practitioner at 59.
[158] Evidence for the practitioner at 60.
[159] Notes of evidence at 304, line 6-10.

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	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." … "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."
There is no explicit obligation in a professional standard to 'balance with data from New Zealand'. The key allegations are that Dr Canaday (a) did not provide sufficient information about the vaccination mortality rate (Dr Thomas gave no evidence about what might be 'sufficient'); and (b) was <u>therefore</u> likely to imply that deaths after vaccination were caused by the vaccine (without being able to prove (a), the PCC cannot prove (b)).	

144 Dr Canaday never gave a "*vaccination mortality rate*" (so called by the charge). He discussed the number of deaths that occurred after vaccination in several pharmacovigilance data sets. He was careful to state that he did not imply a direct causal effect.

145 Dr Canaday said during the Raglan interview:[160]

> *I use [the USA] as a reference point because that's where the most experience is.*

146 He was clear that the number of recorded adverse events was not necessarily caused by the vaccine, saying "*there's always this question of*

[160] PCC bundle at 257.

whether people have their underlying diseases as a cause of death … as opposed to vaccinations". He also said:

146.1 "*I think it's too early to tell what will happen in New Zealand*"; and[161]

146.2 "*It's … not confirmed as to whether the vaccines have caused the deaths*".[162]

147 Dr Canaday's views are further well-explained at [85]-[111] of his brief of evidence.

148 In oral evidence he explained why, for principled reasons, the New Zealand data were not referred to.[163] When pressed in cross-examination he answered:[164]

> *A. … The situation here is there was insufficient data here in New Zealand to make such conclusions in New Zealand. The greatest experience with this disease happened to be in the United States, which is my home country, therefore I was very familiar with the CDC and the FDA, the process of vaccine approvals, the way that things were supposed to be evaluated, what the past history was in regard to prior vaccinations that had been giving signals* [of possible vaccine-related adverse effects that suggested the need for formal and transparent investigation].

149 Dr Thomas does not comment on any need to 'balance' with data from New Zealand, or what other information "*about the vaccination mortality rate*" it was imperative that Dr Canaday provide.

150 Nor did Dr Thomas' evidence in chief comment on what, if anything, Dr Canaday was 'implying'.

151 In oral evidence he agreed the United States of America was a valid source of information.[165]

152 Everything Dr Canaday said was true, and he explained why it was difficult to interpret the data. The alleged implication cannot be established. Dr Canaday's views have always been upfront, not implied: he considered that the VAERS data deserved to be taken seriously and investigated further.

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[161] PCC bundle at 260.
[162] PCC bundle at 258.
[163] Notes of evidence at 322, line 33 and following.
[164] Notes of evidence at 321, line 30 and following.
[165] Notes of evidence at 95, line 17-29.

153 While Dr Canaday was not giving advice to patients, it is noteworthy that doctors are required to be honest and open about risks and uncertainties.[166]

Particular 2(c)

Particular	Relevant quote(s)
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	"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."
The PCC will need to prove both an overstatement (denied) and how this "*suggested that the vaccine was more dangerous than COVID-19*".	

154 What Dr Canaday said was "*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"*.[167] If anything, the number was understated.

155 See also Dr Canaday's brief of evidence at [85]-[111].

156 Dr Thomas gave evidence at [38]-[39] that "*The safety report that was published closest in time to Dr Canaday's interview on 9 July 2021 … noted that there had been two reported deaths*". In fact, the report states "*Up to and including 3 July 2021, a total of 18 deaths were reported to CARM after the administration of the Comirnaty vaccine.*"[168] Dr Thomas agreed this was the case.[169]

157 Dr Canaday did not say that the reported post-vaccination deaths had been caused by the vaccination — he advocated for "*investigation*".[170]

Particular 2(d)

Particular	Relevant quote(s)
New Zealand Doctors Speaking Out with Science is not generally accepted	"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

[166] Medical Council of New Zealand *Informed Consent: Helping patients make informed decisions about their care* (June 2021).
[167] PCC bundles at 259.
[168] PCC bundle at 740.
[169] Notes of evidence at 101, line 28-30.
[170] PCC bundle at 259.

by the profession as a reliable source of balanced information on the COVID-19 vaccine	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."
This particular is confused. 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. The charge can only relate to the time of the interview in mid-2021. There is no evidence of what the profession thought, nor any evidence of what information was displayed on the NZDSOS website, at that time.	

158 Dr Canaday has never endorsed everything published by NZDSOS. He said, in essence, that it was important to have people prepared to ask questions and not have normal scepticism and inquiry shut down by an insistence that only the government summary of scientific knowledge could be 'correct'. He discusses this at [112]-[126] of his brief of evidence.

159 In oral evidence Dr Canaday explained further "*I appreciate their ability and willingness to have given me a platform whereby these answers to the Newshub articles had been posted*".[171]

160 Dr Thomas' views are at [66]-[67]. He refers to only having "*looked at the first page of the [NZDSOS] website*", 1.5 years after Dr Canaday's presentation.

161 The scope of his subsequent opinion is therefore puzzling. His refusal to look beyond the first page highlights a fatal bias and his likely view that there is, indeed, 'one source of truth' (his).

162 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'.

[171] Notes of evidence at 245, line 5-8.

163 The PCC has not produced any evidence of something on the NZDSOS website in mid-2021 that it considers was wrong. It could have, for example, used the 'Way-back Machine'.[172]

164 Nor was Dr Canaday advertising NZDSOS, he was responding to a question put to him during an interview. It was also widely publicised in media at the time that the government disagreed with NZDSOS.

165 Whatever Dr Thomas' view of NZDSOS is now (when he prepared his evidence in March 2023, having perused the first page of a website), it is not relevant to what the position was in July 2021 when Dr Canaday gave the presentation.

Particular 2(e)

Particular	Relevant quote(s)
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	"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."
The PCC must prove Dr Canaday's words would "*likely*" have been received as saying something about the Comirnaty vaccine's efficacy that was inaccurate. (As a potential unfairness, it is noted the PCC does not specify what the alleged inaccuracy was.)	

166 During the *Raglan* interview Dr Canaday suggested a healthy immune system would help protect against COVID-19. Dr Thomas did not disagree with this. Dr Canaday then discussed some things that, in his opinion, can contribute to a healthy immune system. His brief of evidence sets out in detail the bases for his opinion (at [127]-[143]). While Dr Canaday was not offering treatment advice, his views clearly accord with a substantial body of opinion, including that of Dr Fauci.[173] Dr Canaday attached, in full, the research of the 'C19 study group', yet this was not reviewed by Dr Thomas nor cross-examined by the PCC. The Tribunal's Chair did ask about the

[172] Notes of evidence at 474, from line 23.
[173] Document 10.

group and Dr Canaday's explanation is at page 419 of the Notes of evidence. While the material attached to his brief is contemporary, this was a resource also available at the time of his presentations.

167 Dr Thomas did not give evidence in chief as to how or why commenting on the efficacy of other preventative measures would be interpreted as relevant to Comirnaty.

168 At [64] of his brief of evidence, he commented "*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.*" This judgemental attitude, which is surprising to see in an expert brief of evidence, reflects Dr Thomas' lack of impartiality.

169 It could always be expected that a portion of the New Zealand population would not wish to be vaccinated. Should this group be isolated from discussion of other preventative measures?

170 Simply being healthy is correlated with low morbidity and mortality from diseases such as COVID-19. Discussing the benefits of a 'healthy lifestyle'/maintaining a strong immune system cannot be wrong. Dr Canaday's views about the benefits of vitamin D etc were all based on information he had researched in good faith, and none of this was effectively challenged by the PCC.

171 The leap that cannot be made (particularly in a disciplinary context) to simply ask the Tribunal to simply infer that Dr Canaday's discussion of vitamin D etc "*was likely to mislead the public as the efficacy of the Pfizer vaccine*".

172 With respect to the issue of 'balance' raised by the PCC when cross-examining, Dr Canaday said:[174]

> *A. … I did not provide the Government's view because my assumption was everyone already knew what the Government's views were.*
>
> *Q. So, you didn't provide that balance, you just provided your words?*

[174] Notes of evidence at 309, line 18-24.

> *A. Just as the Government provided only their side of the picture, that's correct.*

173 He also noted:[175]

> *… On the other hand, the same radio station did interview a pro vaccine person after my interview.*

174 Echoing this double-standard of demanding balance from only some people, Dr Curtis Walker commented publicly (but without references) that "*There's a mountain of evidence out there of how effective and safe the Covid vaccine is. And we've already seen the alternative of unvaccinated populations where millions have died.*"[176]

Particular 6(a)

Particular	Relevant quote(s)
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	"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."
The PCC must establish both elements: (a) that it is "*incorrect*" there is missing information; and (b) the suggestion of missing information is likely to misrepresent the efficacy of New Zealand's pandemic response. The PCC's case falls down on both counts.	

175 See [144]-[153] of Dr Canaday's brief of evidence. He was not commenting on the "*efficacy of New Zealand's pandemic response*", but rather protesting the shutting down of the marketplace of ideas the Bill of Rights is intended to protect. He also never claimed to be providing the 'full story'. Dr Canaday said people were not <u>hearing</u> the full story and his intention was to provide 'missing information'.

[175] Notes of evidence at 313, line 18-20.
[176] Evidence for the practitioner at 1216-1217.

176 Dr Thomas provided no evidence in chief about this. In oral evidence he agreed that around the time of Dr Canaday's presentations there was indeed 'missing information'.[177]

177 It is clear from Dr Canaday's evidence, and Dr Thomas', that the prevailing public messaging was 'missing' much of the more nuanced and detailed information arising from the rapidly growing state of scientific knowledge about COVID-19 and the mRNA vaccines (including their efficacy at preventing community transmission; impact on pregnancy; and efficacy in Asian and Polynesian populations etc). This is also clear from the Ministry of Health/Medsafe information from the relevant time, much of which was not disclosed to the public.

Particular 6(b)

Particular	Relevant quote(s)
Dr Canaday's recommendation of other "effective" COVID-19 treatments is not supported by generally accepted scientific evidence	"[…] 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."
By 'other' treatments the charge must be referring to Ivermectin, as that is the only treatment mentioned in the relevant quote. The charge puts what "*is*" generally accepted at issue. This must be read as what 'was' that state of play in mid-2021. The PCC must establish there was no 'generally accepted scientific evidence' supporting the effectiveness of Ivermectin.	

[177] For example, see Notes of evidence at 90, line 6-9.

178 Dr Canaday discusses Ivermectin at [176]-[192] of his brief of evidence.

179 He 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]*".

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

181 Dr Canaday was clear that anyone wanting to explore Ivermectin further (such as seeking a prescription) would need to seek advance from their doctor.[178]

182 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.

183 At [49] of his brief of evidence Dr Thomas states "*In my opinion, in mid-2021 there was some uncertainty about the potential effect of ivermectin and hydroxychloroquine in patients with COVID-19.*"

184 In oral evidence he agreed 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*".[179]

185 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.

186 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'.

[178] For example, see Notes of evidence at 351, line 4-6.
[179] Notes of evidence at 202, line 19-26.

Particulars 6(c) and 10(c)

Particular	Relevant quote(s)
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	"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 … 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 […]"
The PCC must establish that the words spoken (a) inferred a link between the Pfizer vaccine and sterility and/or deaths; (b) that the nature of the inference was unprofessional; and (c) the inference was not supported by 'generally accepted scientific evidence'. 'Is not supported …' must be read as 'was'.	
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	"Some reports may exist in regard to whether miscarriages are unusually elevated. There is a paper that I will include that … 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."
The PCC must establish that the words spoken (a) suggested a link between the Pfizer vaccine and miscarriage; (b) that the nature of the suggestion was unprofessional; and (c) the suggestion was 'likely to undermine public confidence in the Pfizer vaccine.	

187 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*".[180]

188 Describing something as 'potential' is not the same as 'inferring a link'.

189 See [209]-[227] and [231]-[234] of Dr Canaday's brief of evidence. His views were held in good faith, well-researched and expressed tentatively. There was nothing 'emotive' about them. They were based on evidence,

[180] Emphasis added.

which Dr Thomas failed to show it was unreasonable for Dr Canaday to take into account.

190 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.

191 Dr Thomas' own evidence is at [40]-[45] of his brief. It 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 …*".[181] These caveats in the evidence Dr Thomas relied on mean it must fall short of establishing a 'generally accepted' position.

192 Dr Thomas' 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[182]). This is the sort of information that ought to form part of informed consent. The PCC seems to be implicitly advocating for making only limited information available to those being asked to take up the Comirnaty vaccine.

Particular 6(d)

193 See 2(a) above.

Particular 10(a)

Particular	Relevant quote(s)
Dr Canaday's support of other COVID-19 treatments including [hydroxychloroquine] and ivermectin is not supported	"[…] 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."

[181] Emphasis added.
[182] Evidence for the practitioner at 1697-1858.

by generally accepted scientific evidence	"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."
Again, "*is*" should be 'was'. The PCC must show there was no 'generally accepted scientific evidence' supportive of HCQ in mid-2021.	

194 Dr Canaday discusses HCQ at [160]-[175] of his brief of evidence. (For Ivermectin, see 6(b) above.)

195 Again, Dr Canaday's reliance on the extensive 'C19 study group' material went unchallenged and uninterrogated. This shows there was more than sufficient evidence as at mid-2021 for Dr Canady to form a position view about HCQ.

196 In relation to HCQ, Dr Thomas' evidence in chief is at [57]-[59]. He acknowledges the efficacy of HCQ to treat COVID-19 was a subject of genuine scientific inquiry and controversy. While he judges (without referring to the details of any comprehensive literature review) that "*by early 2021 it was clear that most dispassionate clinicians would have discounted any benefit*" from HCQ, Dr Canaday gave unchallenged evidence of a substantial body of opinion which disagrees with Dr Thomas' view.

197 Dr Thomas' evidence does not go so far as the alleged particular — e.g. 'not supported by generally accepted science'.

198 Dr Canaday's discussion of HCQ 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.

199 The PCC's evidence falls far short of enabling the Tribunal to make a finding as to what was 'generally accepted scientific evidence' in mid-2021.

200 Indeed, Dr Thomas chose not to watch the videos or look at Dr Canaday's slides because he assumed doing so would not assist him.[183]

[183] Notes of evidence at 62, line 4; and at 62, line 9.

Particular 10(b)

Particular	Relevant quote(s)
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	"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."
The PCC must show (a) there was no evidence of suppression; (b) Dr Canaday's comments 'lacked balance'; and (c) Dr Canaday's comments were 'likely to undermine public confidence in the Pfizer vaccine'.	

201 Dr Canaday addresses this particular at [193]-[208] of his brief of evidence. In short, there was some 'evidence' of suppression, so the charge cannot be established. This includes Dr Canaday's discussion of the Pfizer contract and the attitude towards the off-label prescribing of Ivermectin in New Zealand.

202 Dr Thomas mentioned but provided no substantive evidence on this issue.[184]

203 Dr Thomas has not seen any of the Pfizer contracts.[185]

204 Canaday referred to the reasons for his views as part of his presentation. He never suggested that the suppression of Ivermectin was related to the efficacy of Comirnaty.

205 That Ivermectin was suppressed in New Zealand is objectively true. Importation was restricted and the Medical Council has treated off-label prescribing as a matter for disciplinary investigation. This treats Ivermectin

[184] Brief of evidence of Dr Thomas (9 March 2023) at [49].
[185] Notes of evidence at 93, line 21.

in a markedly different way from every other medicine with a similar safety profile.[186]

206 It cannot be wrong for Dr Canaday to wonder as part of public discourse about the reason for such suppression.

Particular 10(c)

207 See 6(c) above.

Particular 10(d)

Particular	Relevant quote(s)
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	"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."

208 See Dr Canaday's brief of evidence at [80]-[84].

209 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.

210 Dr Thomas did not comment on this issue.

211 In oral evidence he agreed that "*the vaccine that we ended up using as a nation uses the novel technology*",[187] and that Comirnaty was "*developed rapidly*"[188] (albeit built upon a background of prior research).

[186] Dr Thomas did not disagree with the proposition that New Zealand doctors had been discouraged from prescribing Ivermectin 'off-label' for COVID-19 (Notes of evidence at 176, from line 30).
[187] Notes of evidence at 82, line 1-3.
[188] Notes of evidence at 84, line 10.

212 This is also confirmed by references in the Medsafe and Pfizer documents. Pfizer's application to Medsafe commenced with "*This application seeks provisional registration of a new biological entity, BNT162b2 [mRNA]*".[189]

213 It ought not to be a matter of professional misconduct to police the use of language in this way. The Comirnaty vaccine can fairly be described as a 'biological agent'. As Dr Thomas describes in his evidence, it is designed to introduce mRNA to the recipient's cells, thereby causing those cells to manufacture a protein similar to part of the SARS-CoV-2 spike protein.

214 It is also reasonable to regard Comirnaty as 'experimental' given the speed of its development, its use of mRNA technology and its lack of medium- and long-term safety data.

Particular 10(e)

Particular	Relevant quote(s)
The statements concerning graphene oxide lacked evidential foundation and were presented uncritically	"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 … 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 …"

[189] Evidence for the practitioner at 1727.

The PCC needs to establish both elements — that there was no evidential foundation, and that the information was presented uncritically.

215 See Dr Canaday's brief of evidence at [228]-[230]. Dr Canaday attached the relevant paper (in Spanish and English), yet Dr Thomas did not read it and the PCC did not refer him to it in cross-examination.

216 Dr Thomas' evidence is at [46] and [47] of his brief.

217 A Reuter's 'fact check' relied on by Dr Thomas falls far short of the standard of scientific literature he, by inference, demands of Dr Canaday.[190]

218 Dr Canaday simply referred to the source of the suggestion that Comirnaty contained graphene oxide. He did not accept the source uncritically and clearly referred to the presence of graphene oxide as only a possibility, not a certainty — e.g. "*if it is indeed present in*" Comirnaty.

219 In other words, there was an 'evidential foundation' for Dr Canaday's comments, but he questioned its reliability.

Conclusion on particulars 2, 6 and 10

220 As explained in the tables above, none of the sub-particulars comprising particulars 2, 6 and 10 have been established. Even were the Tribunal to disagree with how Dr Canaday expressed himself in some respects, nothing he said can be characterised as negligence, malpractice or having brought discredit when those terms are interpreted and applied in a manner consistent with the Bill of Rights Act.

221 Nor is there evidence of any person being misled. This is unsurprising, as the PCC has not established that anything Dr Canaday said was untrue. At best, Dr Canaday drew and expressed conclusions from information that other doctors might not have. That is the essence of freedom of expression and the scientific method.

222 As is apparent from Dr Canaday's presentations, his PowerPoint slides, and his evidence before the Tribunal, there was nothing reckless about his speech and he was not speaking in bad faith. This is simply a case of people reaching different conclusions about the facts. The Medical Council

[190] Notes of evidence at 196, line 15.

is entitled to contest and oppose Dr Canaday's ideas — but this is not a case for censorship through discipline.

L PARTICULARS 3, 7 AND 11 (DISPARAGING) NOT ESTABLISHED

Relevant professional standards

223 The most relevant professional standard is the Medical Council's statement on *Unprofessional behaviour*. This is framed in very broad and uncertain terms. What can be regarded as unprofessional behaviour deserving of discipline is informed by the Tribunal decision *PCC v Mendel*.[191] In that case the particulars of the charges against the doctor included:

223.1 An allegation that he breached accepted professional and ethical standards by engaging in unprofessional behaviour towards his colleagues on 14 specific occasions (particular 1(a)–(n)). While ten of the particulars were found proved, none were held to warrant disciplinary sanction on their own. That included Dr Mendel making a 'throat-slitting' gesture in front of junior registrars (1(j)) and telling junior registrars that former colleagues who had complained about him were 'sorry in the end' and had 'got what they deserved' (1(i)).

223.2 A separate allegation that he breached accepted professional and ethical standards by engaging in unprofessional behaviour towards his colleagues on three other specific occasions (particular 2(a)–(c)). Only particular 2(b) was found proved on the facts, but it is relevant. Dr Mendel had disagreed with a colleague about the management of a patient and the two had argued during a telephone conversation. Dr Mendel was found to have used the words 'I'm going to get you', which his colleague found threatening. However, in the context of the disagreement between colleagues, it was held "*The Tribunal accepts that the words referred to in the sub-particular were used by Dr Mendel and finds that these words were less appropriate than may have been the case. They are not, however, misconduct as defined by [the Act]*".[192]

[191] *PCC v Mendel* HPDT 977/Med17/394P, 25 July 2018.
[192] *Re Mendel* HPDT Med17/394P, 25 July 2018 at [173].

224 It can be seen from *PCC v Mendel* that the threshold is high, as it should be. It is not uncommon for people to take offence at each other. Discipline is reserved for conduct falling 'seriously short' of acceptable standards.[193]

225 In this case there is no victim complaining about what Dr Canaday said. That is a far cry from a case such as *PCC v Hugill*,[194] where the Tribunal heard evidence from a colleague who had read Ms Hugill's comments and been offended by them. Ms Hugill also admitted her comments were inappropriate. The comments were also plainly offensive and racist, including statements such as "*Māori nurses sit on their fat arses eat and have meetings all day*", "*Māori are by far the laziest and cunning underhanded I have worked with*" and "*It's the Māori nurses who steal*".

226 It is accepted that the censorship of hate speech is not an unjustified limit on free expression.[195] Hate speech is entirely different from expressing opinions that another person might disagree with or be annoyed by.

When could a 'disparaging' or 'critical' statement be negligence, malpractice or bring discredit?

227 The Bill of Rights is less relevant to interpersonal conduct. Here, however, the alleged criticism/disparagement occurred in the context of public discourse, so the Bill of Rights must be considered. In a case like *PCC v Hugill* there can be no Bill of Rights defence to statements that were themselves discriminatory. For Dr Canaday's case, the Tribunal will however need to keep in mind whether, by characterising his words as disparaging, the PCC is seeking to unfairly limit the way in which he was entitled to express his ideas. As the Broadcasting Standards Authority said:[196]

> *… as the Supreme Court has [recognised] recently, that "a function of free speech under our system of government is to invite dispute", indeed, it may "best serve its high purpose … when it stirs people to anger." When determining complaints, we must be careful not to mistake anger that may be caused by a broadcast for a reason to restrict the right to freedom of expression.*

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193 *Collie v Nursing Council of New Zealand* [2001] NZAR 74 at [21] (emphasis added).
194 *PCC v Hugill* HPDT 1114/Nur20/468P, 28 September 2020.
195 A Butler and P Butler *The New Zealand Bill of Rights Act: A Commentary* (online looseleaf ed, LexisNexis) at [13.20].
196 *Adam v Radio New Zealand Ltd* BSA 2022-067, 27 February 2023 at [24] (footnotes omitted).

228 The Medical Council (and others) did not refrain from describing practitioners such as Dr Canaday as 'anti-vax', purveyors of 'misinformation'[197] and 'peddling conspiracy theories'.[198] Dr Canaday disagrees with those labels, but has not complained about Dr Curtis Walker for speaking publicly in that way. Nor has he complained about:

228.1 Dr Nikora's colourful language, which included describing him as a liar;[199]

228.2 Dr Jim Vause referring to 'porkies' and 'pathological personality traits'; or

228.3 Professor Gorman's full-throated attack on the government's response to COVID-19.[200]

Analysis of the particulars and the evidence

Appendix 1(e)

229 The relevant passage does not refer to other health practitioners (other than some friends in the United States of America). It is far more likely to have been received as a comment about government communications. That was certainly Dr Canaday's intention.[201]

230 In the first part of the quote Dr Canaday was acknowledging that some people were wanting to know more than the simple message 'get vaccinated', as was their right to informed consent. It was true that those expressing concerns about the efficacy of Comirnaty or its lack of long-term safety data were being marginalised. It cannot be wrong in the setting of public discourse for a person — Dr Canaday — to say, 'I share some of your concerns and I'm happy to discuss the reasons why that is so'.

231 In the second part, Dr Canaday related the experiences of some acquaintances from overseas. This cannot reasonably be interpreted as a slight on New Zealand's 'medical profession', which is the purview of the HPCAA. It is also noted that while the PCC seemed to suggest the word

[197] Evidence for the practitioner at 1939.
[198] Evidence for the practitioner at 1215.
[199] PCC bundle at 47.
[200] D Gorman and M Horn "*A critical analysis of the COVID-19 pandemic management in New Zealand*" (April 2023) The New Zealand Initiative < www.nzinitiative.org.nz>.
[201] Notes of evidence at 304, line 26-30.

'jab' was pejorative, its own evidence shows the term was in common usage.[202]

Appendix 2(a)

232 It is submitted Dr Canaday's evidence has demonstrated there was a great deal of information 'missing' from the very simple government messaging about Comirnaty — for example, uncertainty about whether vaccination would materially reduce community transmission.[203]

233 Again, there is nothing in the relevant comment directed to other health practitioners. Given the high stakes public policy decisions being made at the time, it cannot be consistent with freedom of expression to rule that minority contributions to the debate must be treated as professional misconduct. In the relevant quote Dr Canaday refers to "*the various organs of official government*", not colleagues. This is a criticism echoed recently by Professor Gorman. In cross-examination, Dr Canaday confirmed:[204]

> *My reference to the "full story" was not with respect to other practitioners. Once again I have tried to make that very clear, Sir. What I have said is that the Government officials and the Government line was not giving the full story.*

Appendix 2(d)

234 These passages are clearly political speech deserving of protection (whether or not you agree with them). They have nothing to do with medicine or other health practitioners. Dr Canaday and the interviewer discussed the government messaging that was prevalent in connection with New Zealand's COVID-19 response. There were a wide range of views in society about things like 'lockdown' rules and their enforcement. Many thought that being encouraged to 'dob-in' neighbours was inconsistent with New Zealand's democratic values. Dr Canaday discussed his wife's experience as a Ukrainian growing up in the Soviet Union where conformity of thought and behaviour was demanded. He and the interviewer expressed the inherently political views that the conformity being demanded in New Zealand could be compared to the early stages of totalitarian

[202] For example, see PCC bundle at 47 and 726.
[203] See for example Dr Thomas' agreement that it was unknown, for example, what the efficacy of Comirnaty was in respect of Polynesian and Asian people (Notes of evidence at 71, line 20).
[204] Notes of evidence at 304, line 26-30.

regimes, and it was important to have people and organisations prepared to question the status-quo.

235 Comparisons of this sort are sometimes made during public discourse. In *Thiab v Western Sydney University* the judge indirectly compared disciplining a student for holding minority views about COVID-19 with "*Stalinist and Maoist enforcement of academic conformity with the party line*".[205]

Appendix 3(d)

236 The words complained about are a quote attributed to Mr Upton Sinclair, an American journalist and political activist who was active in the United States of America during the great depression. He used these words to admonish California newspaper publishers who opposed the progressive reforms he was championing.

237 In the context of Dr Canaday's speech, he was observing that people paid by institutions, where a particular view or outcome is expected, are often not free to dissent for fear of losing their employment or may even be subconsciously closed-off to non-confirming ideas.

238 The fear of losing one's livelihood is exemplified by the Medical Council's decision to suspend Dr Canaday's practising certificate, which was overturned on appeal.

239 Merely saying words that might annoy some practitioners (although the PCC has called no evidence of such annoyance) is not the same as criticism or disparagement that meets the test for professional misconduct.

Appendix 3(e)

240 Can it really be professional misconduct for a practitioner who the Medical Council had wrongfully suspended for public discourse to make such comments? It is hardly surprising Dr Canaday would have experienced the Medical Council position of 'zero tolerance' as an attempt to silence views it disagreed with. That was, presumably, the intention of Dr Curtis Walker's media comments.

[205] *Thiab v Western Sydney University* [2022] NSWSC 760 at [145].

241 Dr Canaday's words comments are not disparaging of other health practitioners, but rather an expression of opposition to the limiting of public debate. By this particular the PCC is saying, in effect, not only was it wrong for Dr Canaday to discuss COVID-19 in a way we disapproved of, it was also wrong for him to discuss the fact that public discourse was being restricted.

Conclusion on particulars 3, 7 and 11

242 None of the specific words identified by the Medical Council come close to the sort of conduct targeted by the statement on *Unprofessional behaviour* or the precedent of *PCC v Mendel*.

243 The PCC may point to the example of *Re Tiller*,[206] where a pharmacist was disciplined for a press-release that was critical of other pharmacies' pricing practises. In that case however, Ms Tiller agreed her conduct amounted to professional conduct and did not suggest it was protected by the Bill of Rights. Her press-release was intended to attract customers; it directly accused colleagues of unethical behaviour; and clearly breached the relevant Code of Conduct, 'obligation 8.1' of which provided "*the pharmacist must not disparage the professional services of other pharmacies or pharmacists*".

244 The words focussed on by the PCC do not accuse colleagues of unethical behaviour. Dr Canaday was, outside of any professional setting, expressing his opposition to government policies and his fear that the positions being adopted by the government and Medical Council would make it practically impossible for colleagues to exercise their rights to freedom of expression.

M PARTICULARS 4, 8 AND 12 (DISCREDITING) NOT ESTABLISHED

245 Where not an adjunct to findings of negligence/malpractice, discredit is usually reserved for conduct that has some element of moral transgression. That cannot be said of Dr Canaday. The Tribunal has seen the care with which he communicates and the genuine conviction of his views. 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 s 100(1)(b) a meaning that is consistent with the rights and freedoms

[206] *Re Tiller* HPDT 425/Phar11/195P, 9 December 2011.

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.

246 The quotes also 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.

247 It would also be hard to reconcile a finding of discredit if particulars 2, 3, 6, 7, 10 and 11 are not established.

N CONCLUSION

248 Even if one of more particulars are established, the Tribunal will still need to consider the 'high' threshold and whether this is an instance of 'the most serious misconduct' deserving of penalty. Dr Canaday has already successfully appealed a suspension and given a voluntary undertaking acceptable to the Medical Council.

249 It is submitted discipline is a problematic response to ideas the PCC disagrees with. This case is unlike the example of Andrew Wakefield. He was struck off the register not for publishing his hypothesis, but for failing to disclose financial conflicts of interest and enrolling children in his observational study without proper informed consent.

250 In any event, the evidence does not establish the particulars alleged against Dr Canaday. The Tribunal's sole task is, of course, to focus on those particulars. The Tribunal's questions for Dr Canaday went beyond the four-corners of the charge that he is required to answer. This is not a criticism: it is clear the Tribunal has been following the evidence closely. However, whether or not the Tribunal disagrees with other parts of Dr Canaday's presentations and wishes to counsel him, this cannot be determinative of disciplinary liability which may arise only from the allegations in the charge itself.

Dated this 21st day of April 2023

……

M McClelland KC and A L Holloway

Counsel for Dr Canaday

ADDENDUM

251 The PCC has provided two overseas authorities not discussed above. A brief response to each follows:

Adil v General Medical Council [2023] EWHC 797

252 The practitioner's conduct was very different. For example, he published a video claiming that Bill Gates had infected the entire world with COVID-19 and COVID-19 vaccines could contain microchips to 'further the 5G mobile phone technology agenda'. His views were described as 'outlandish'. The GMC Tribunal determined that Dr Adil's current fitness to practise was impaired.

253 While the Court on appeal accepted the Tribunal's decision was not an unjustified interference with Dr Adil's article 10 rights (freedom of expression), it commented at [32] and [33]:

> *… Neither holding nor expressing an outlying opinion on a matter of professional practice ought to give rise to punishment, absent clear justification, for example where there is evidence of harm to patients or public health.*
>
> *… Any general practice on the part of the GMC of applying disciplinary sanctions to medical practitioner simply because they held or expressed views that were "not part of widely accepted medical opinion" … would engage the operation of article 10 rights. …*

Strom v Saskatchewan Registered Nurses' Association, 2020 SKCA 112

254 Ms Storm was a nurse who used social media to criticise the palliative care provided to her grandfather. Her appeal against disciplinary findings was successful. The Court held:

> *[160] The freedom to criticize services extends equally to public services. Indeed, the right to criticize public services is an essential aspect of the "linchpin" connection between freedom of expression and democracy. … Criticism of the healthcare system is manifestly in the public interest. Such criticism, even by those delivering those services, does not necessarily undermine public confidence in healthcare workers or the healthcare system. Indeed, it can enhance confidence by demonstrating that those with the greatest knowledge of this massive and opaque system, and who have the ability to effect change, are both prepared and permitted to speak and pursue positive change. In any event, the fact that public*

confidence in aspects of the healthcare system may suffer as a result of fair criticism can itself result in positive change. Such is the messy business of democracy.

…

[162] … Having focused solely on the personally critical portions of Ms. Strom's post identified in the Charge, it failed to recognize that her comments were not only both critical and laudatory but were self-evidently intended to contribute to public awareness and public discourse. …

…

[167] … Although she identified as a nurse and an advocate, she was not and did not purport to be carrying out her duties as a nurse. She was on maternity leave and spoke to the quality of care provided by a distant facility with which she had no professional relationship. The private aspect of the posts was made clear and was significant. Further, and as has been noted, the posts have not been shown to be false or exaggerated and, on the face of it, would appear to be balanced.

[168] The denial of the right to speak in these circumstances is important. Proportionality, of course, is not concerned solely with the severity of the impact on Charter rights. It is concerned with the balance between rights and objectives. … It bears repeating that speech cannot be unduly constrained to avoid offending others. …

[169] For all of these reasons, the Discipline Committee was incorrect in finding that the infringement of Ms. Strom's Charter right to freedom of expression was justified. …