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

BRIEF OF EVIDENCE OF DR CANADAY

Dated 3 April 2023

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A INTRODUCTION

1 The Medical Council and PCC seem to have conflated a majority opinion with scientific consensus. Scientific truths do not follow a democratic process. In other words, having a majority of people support a particular claim does not make that claim true. Instead, it is the weight of the objective data that supports a theory and may establish that theory as an accepted paradigm in science. COVID-19 is a recent disease and the various medicines being used to treat it and vaccines being used to protect against it are all still being studied. It is far, far too early to consider the science settled. To stifle enquiry and debate now would, in my view, be exactly the wrong thing to do.

2 I am an independent thinker who believes it is valuable to discuss all available information about COVID-19, including perspectives and ideas that may not be 'mainstream'. I believe that human knowledge is enhanced when dominant views are critiqued and tested. Nor should such discussions occur only behind closed doors. This is the essence of academic freedom. History is replete with examples of people who have progressed human knowledge by asking questions of accepted wisdom and were prepared to express different ideas. I am always happy for my ideas to be debated, tested and critiqued. I would never say that I am always right.

3 I am not an organiser of the 'Voices for Freedom' group. Voices for Freedom did however invite me to speak to its audiences, which I was happy to do — both in person and online. I did not have any agenda for my talks other than to explore information about COVID-19 and discuss my thinking on the subject. I believe all people have a right to participate in such debates — including to put forward why my own ideas might be wrong. Participating in such discussions and debates is not 'practising medicine' in my view.

4 As I have already said, I am not 'anti-vaccine', and I certainly had no agenda, such as to undermine the government's COVID-19 vaccination programme. I also note that New Zealand is now one of the most comprehensively vaccinated populations in the world against COVID-19.

5 I do however believe the rights articulated in the New Zealand Bill of Rights and Human Rights Acts are important.

6 I cannot understand why my talks are treated as practising medicine and why I am held to some vague but apparently high standard of certainty when government officials, politicians, members of the media and the general public are permitted free expression on COVID-19 (all without being labelled as practising medicine themselves).

7 In this proceeding, the PCC seems to be relying on its position that my views are wrong simply because they vary from official messaging, without giving detailed evidence as to why my views may be wrong, and without acknowledging the countless instances whereby what is considered correct today can be proven to be false tomorrow with the passage of time, and availability of new or confirmatory evidence.

8 A recent example of accepted wisdom changing over time is Molnupiravir, which was funded by Pharmac in 2022 to treat people with COVID-19. The government position recently changed however, and it has decided Molnupiravir has little to no efficacy for treating COVID-19. Indeed, I understand from media reports that international research suggests Molnupiravir could fuel unhelpful and possibly harmful mutations of the COVID-19 virus. If I had raised concerns publicly about Molnupiravir last year, perhaps the Medical Council would have considered it wrong for me to do so.

9 Another example is the previously accepted wisdom that the Pfizer vaccine, Comirnaty, would materially reduce the likelihood of community transmission of COVID-19. Again, time has shown this to be incorrect. As I will discuss later on, had uncertainties around the ability of Comirnaty to reduce community transmission been known, the public may have reached different views about the policy-settings New Zealand chose to adopt in response to the COVID-19 pandemic.

10 I also find it inconsistent that other people, such as medical practitioners employed by the Ministry of Health, can give **individual** health advice (i.e. 'you must get vaccinated') without, for example, framing that advice with the ethically essential necessity of informed consent, acknowledgement of potential risks of a vaccine produced using novel methods, the reality that true medical contraindications to vaccine use exist in some individuals, and

that such decisions have historically remained, and of necessity must remain, within the context of the individual doctor-patient relationship. In other words, those whose actions are perceived to be consistent with government policy are entitled to be pro-vaccine advocates, whereas the Medical Council is opposed to me even discussing the relevant scientific and medical issues involved.

11 Below I respond to particulars 2, 6 and 10 of the charge. In respect of each, I consider the charge of "*potential to mislead*" is perilously close to an arbitrary accusation which may be used to justify censorship, which has no place in a free and democratic society.

B PARTICULARS 2(A) AND 6(D)

12 The relevant particulars allege that statements made by me were inaccurate and/or misleading, or had the potential to mislead, because:

12.1 "*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*" (particular 2(a)); and

12.2 "*Dr Canaday misstated his ability to provide informed advice on the treatment of Covid-19*" (particular 6(d)).

13 In the Raglan interview, I clearly stated:[1]

> *… I have experience as a respiratory specialist and intensive care specialist for 12 years, trained in the United States, and then I changed career to radiology in 1997, and I had been assistant professor of radiology in Creighton University in Nebraska, US, and I moved to New Zealand in 2013, and worked for one of the DHBs here until my retirement just last April [2021].*

14 Further:[2]

> *As a respiratory physician who treated many of these patients that have very, very severe respiratory failure, they were placed on ventilators, and 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 …*

[1] PCC disclosure at 231.
[2] PCC disclosure at 232.

15 And in respect to vaccines generally:[3]

> *… so I'm not anti-vaccine. I recommended it many times for my patients at that time. However, what we're seeing with this particular vaccine, or this particular problem, is quite different to the way that vaccines have been created in the past. …*

16 As part of the *Courageous Convos* presentation, I stated:[4]

> *… 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. I do appreciate the opportunity to really be able to be useful that way.*

My background, training and experience

17 The statements clearly indicate that I had not treated COVID-19 cases. However, COVID-19, certainly in its more severe presentations where intensive care and ventilator management are required, was precisely the kind of work that I did for 12 years in the United States. Had my New Zealand registration and employment been based on my initial specialisation in the United States instead of my third American Board certification — that is, in Diagnostic Radiology — I would have been precisely positioned to be treating severe COVID-19 cases in New Zealand. The Medical Council was well aware of these credentials, as I was required to remove some 15 original certificates and diplomas from their frames to bring them to Wellington on my first assignment in New Zealand in 2009.

18 I note that the PCC's expert is not trained in pulmonary and critical care medicine, but in infectious diseases. Infectious disease specialists typically give advice as to antibiotic or other adjunctive measures to those doctors who manage COVID-19 cases as their primary clinicians. They are not primarily responsible for decision-making and management of such patients.

[3] PCC disclosure at 232.
[4] PCC disclosure at 276.

19 I also could find no papers on PubMed for the period 2020 and 2021 which reviewed and studied critically ill COVID-19 patients in New Zealand by any New Zealand authors; it's possible I may have missed them if they do exist.

Am I capable of providing informed advice?

20 I am confused by the PCC's statement that I "*misstated*" my "*ability to provide informed advice on the treatment of COVID-19*".

21 My medical training was at some of the top medical institutions in the United States: the University of Michigan (where my internal medicine classmate, H Clifford Lane, became Dr Fauci's associate and director of Clinical Research at the National Institute of Allergy and Infectious Disease) and the University of North Carolina (where a colleague and trainee in internal medicine by the name of Francis Collins became the Director of the National Institutes of Health).

22 In my first career in Pulmonary and Critical Care Medicine, I was a practicing clinician for 12 years in a large city hospital, but was considered proficient enough to be chosen as the Chair of the Department of Internal Medicine by my peers. In my second career in Diagnostic Radiology for a period of 8 years, I became tenured as an Assistant Professor of Radiology at a midwestern University Medical School, performed research, published papers, prepared clinical presentations and lectures to radiology registrars, presented original research on a proposed new radiology modality at the European Society of Radiology among others, and worked with statisticians and colleagues in pulmonary medicine whilst I was section head of Thoracic Radiology and Clinical Director of the Radiology Department.

23 My background is somewhat rare in not only crossing specialty boundaries, but also having experience both in front-line critical care medicine, and academic medicine in the field of diagnostic radiology.

24 I am puzzled by the assertion that somehow these credentials can be ignored, as if I have forgotten the essential elements of experience obtained during 12 years of practice in the field of respiratory medicine, or that my academic experience in radiology is somehow not applicable to the analysis of scientific literature relevant to the COVID-19 response. Indeed, much of the foundation of my observations stems from the basic medical education that all physicians undergo.

25 By character, I have always been interested in analysis and research. As an Associate Professor of Radiology for 8 years, I prepared papers for publication and presentation, including an extensive peer-reviewed review article on the Imaging of Asthma. Over the months of writing, I became quite familiar with reviewing original published papers, before the internet age, collating and organising complex data into a readable form. In the teaching of radiology residents (registrars), I learned to use PowerPoint for lecture presentations, which was helpful in my public presentations in New Zealand.

26 In the context of 40 years of medical practice, in both respiratory medicine and the broad scope of clinical radiology, in clinical practice in outpatient, hospital and intensive care settings as well as academic practice, teaching and research, I believe I had a broad skillset necessary to provide my informed opinion, backed up as much as possible by citations of the actual scientific papers.

Why we have to look elsewhere for clinical experience with COVID-19

27 There was no or very limited experience with COVID-19 in New Zealand at the time of its arrival on our shores at the end of February 2020, compared with the much greater experience in the United States. Given this, I had determined, as I presume would be the case with many other front-line New Zealand critical care specialists, that I should consult the published literature elsewhere in the world, and it appeared to me that the greatest experience at the time was from the United States.

28 Experience in reading and publishing scientific papers as an academic as well as experience having been on the front lines of managing critically ill patients in the past gave me what I believe was quite adequate, even a very well-suited, capacity to have an informed, and indeed a considered, opinion on the topic.

C PARTICULAR 10(D)

29 This particular alleges statements made by me were inaccurate and/or misleading, or had the potential to mislead, because:

> *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 …*

30 In the *Fact or Fantasy* presentation, I clearly stated:[5]

> *… 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 [and] proven therapies [are] available for a disease of limited lethality when herd immunity from vaccinations alone cannot be expected. …*

Emergency authorisation / provisional approval

<u>The pandemic and vaccine development</u>

31 The COVID-19 outbreak was declared by the WHO as a global pandemic on 11 March 2020. The causative agent was identified as SARS-CoV-2, a novel coronavirus which had emerged from Wuhan, China.

32 At the time, early reports from Wuhan in 2019 were followed by reports in 2020 from Japan, South Korea, the USA, northern Italy and India. The initial case fatality rate was reported to be as high as 2.1%, thus leading to projections of millions of deaths worldwide. In this context, a rapid vaccine development and deployment program ('Operation Warp Speed') originated in the United States, with Pfizer and Moderna receiving public funding towards its development with similar programs in the United Kingdom (AztraZeneca/Oxford, Johnson & Johnson) and elsewhere in the developed world.

33 The mechanism of action and history of the mRNA vaccine's development is discussed by Dr Thomas,[6] although I disagree with his opinion that the vaccine's rapid development and bypass of typical pathways through to final market approval would allow it to be "*determined to be safe and effective*",[7] as I will discuss below.

34 The pace of development was rapid and used a vaccine development methodology derived from prior work on gene therapy.[8]

35 There had not been widespread, indeed global, deployment of this gene-modification technique in a vaccine product previously. Furthermore,

[5] PCC disclosure at 319.
[6] Brief of evidence of M Thomas (9 March 2023) at [21]-[26].
[7] Brief of evidence of M Thomas (9 March 2023) at [21].
[8] [PCA-101].

classed by the United States Food and Drug Administration (**FDA**) as gene delivery therapies, such vaccines would ordinarily be subject to an extended regulatory cycle which would have required annual visits for safety evaluation over a number of years.[9]

36 The premise of use of this vaccine product, bypassing the usual 5-10 year process of clinical trials prior to full approval (as with most vaccines), was the concern about a very high mortality rate, far exceeding that of the typical seasonal influenza, or even the occasional years of a 'bad flu'. In this setting, a rapid development program was said to be required to save lives in a rapidly spreading, globally prevalent infectious disease.

Relative versus absolute risk reduction

37 It was reported that Comirnaty was '95% effective' in reducing incidence of COVID-19 with symptoms as defined (and as measured by the RT-PCR test) in the group receiving the experimental Pfizer vaccine, and Dr Thomas makes a point of this.[10] In fact, what happened is that the incidence of COVID-19 with symptoms reduced from 0.75% in the placebo group to 0.037% in the vaccinated group,[11] and so there was a 95% reduction in the vaccinated group **relative** to the placebo group.

38 However, what the individual deciding whether to be vaccinated or not is likely to want to know is 'How much will I reduce my chance of contracting COVID-19 if I take up the vaccine?' The answer to that question, from 0.75% to 0.037%, is the **absolute** effectiveness of the Pfizer intervention in the initial clinical data series.

39 I discussed this issue further in response to counterclaims in a NewsHub article about my *Fact or Fantasy* presentation published on 4 September 2021.[12] As part of [PCA-116], I also discussed problems with using endpoints of 'symptoms' which are not specific to infection by SARS-CoV-2.

[9] [PCA-102].
[10] Brief of evidence of M Thomas (9 March 2023) at [27].
[11] Brief of evidence of M Thomas (9 March 2023), annexure 5.
[12] [PCA-116].

Emergency use authorisation in the United States

40 At the time of my presentations, in the United States, Comirnaty was not approved but "*authorised for emergency use*" by the FDA which functions rather like Medsafe in New Zealand. It is relevant to note that emergency use authorisation in the United States is permissible only when other effective drugs for treating the condition are not available. The relevant United States Federal law (21 U.S.C. §360bbb-3) is titled "*Authorization for medical products for use in emergencies*". Subsection (c) of this law provides:[13]

> *The Secretary may issue an authorization under this section with respect to the emergency use of a product only if, after consultation with the Director of the National Institutes of Health and the Director of the Centers for Disease Control and Prevention (to the extent feasible and appropriate given the circumstances of the emergency involved), the Secretary concludes—*
>
> *(1) that an agent specified in a declaration under subsection (b) of this section can cause a serious or life-threatening disease or condition;*
>
> *(2) that, based on the totality of scientific evidence available to the Secretary, including data from adequate and well-controlled clinical trials, if available, it is reasonable to believe that—*
>
> *(A) the product may be effective in diagnosing, treating, or preventing—*
> *(i) such disease or condition; …*
>
> *(B) the known and potential benefits of the product, when used to diagnose, prevent, or treat such disease or condition, outweigh the known and potential risks of the product;*
>
> *(3)* ***that there is no adequate, approved, and available alternative to the product for diagnosing, preventing, or treating such disease or condition*** *…*

41 I further understand that deployment of such a measure, which would not be a product actually approved by the FDA, would not necessarily require in the usual way the product to undergo clinical trials, investigation, or even

[13] Available here: <https://uscode.house.gov/view.xhtml?req=(title:21%20section:360bbb-3%20edition:prelim)> (emphasis added).

data collection as to safety or efficacy. In this regard subsection (k) of the same law provides:

> *Relation to other provisions*
>
> *If a product is the subject of an authorization under this section, the use of such product within the scope of the authorization shall not be considered to constitute a clinical investigation for purposes of section 355(i), 360b(j), or 360j(g) of this title or any other provision of this chapter or section 351 of the Public Health Service Act [42 U.S.C. 262].*

Provisional approval in New Zealand

42 In New Zealand Comirnaty was initially given 'provisional approval' subject to 58 conditions;[14] and the initial subject population was expected to be frontline healthcare and border workers only.[15]

43 The 58 conditions were available in the *New Zealand Gazette* and were to sustain the provisional approval for 9 months, presumably subject to fulfilment of the conditions, with responses due by July 2021.[16] Provisional approval was then renewed on 28 October 2021.[17]

44 Most of these conditions related to manufacturing processes and quality assessment rather than the requirements to provide results of efficacy or any safety signals found in Pfizer's own internal reporting after deployment in New Zealand (or elsewhere).

45 In response to subsequent OIA requests as to whether these 58 conditions had been fulfilled, Medsafe was unhelpful:[18]

> *… the information submitted to Medsafe by Pfizer to address the conditions of the provisional consent for Comirnaty are considered commercially sensitive and is therefore withheld under s9(2)(b)(ii) of the Official Information Act 1981.*

46 This narrative and chronology is part of the overall social context within which my presentations were given.

[14] [PCA-125].
[15] [PCA-126].
[16] [PCA-127].
[17] [PCA-128].
[18] [PCA-129].

47 It is also relevant to note that a High Court case heard on 18 May 2021 resulted in a decision in which the judge questioned how a 'limited use' authorized by section 23(1) of the Medicines Act 1981 could be broadened to the entire New Zealand population over the age of 16, and commented that the Medsafe's provisional consent could be ultra vires s 23 of the Medicines Act (i.e. unlawful).[19]

48 Importantly, the judge proceeded on the basis that "*vaccination is not, and will not be, compulsory for the vast majority of the New Zealand public*" and "*informed consent will otherwise be sought and obtained before any act of vaccination*".[20]

49 The judge's concerns became moot however when the New Zealand Parliament passed an amendment which nullified them. This authorized the Minister of Health to "*give provisional consent to the sale or supply or use of a new medicine if the Minister is of the opinion that it is desirable that the medicine be sold, supplied or used*".[21]

50 I take this amendment to mean that no further review or consultation with Medsafe or any other parties would be required of the Minister, at least not in any formal, accountable, reviewable or transparent way. It therefore appears that by statute, a single individual, without medical training or credentials at all, could legally be given the decision to override any concerns about safety and efficacy which are, by definition, inherent in the term 'provisional approval'.

51 The premise of the judge's opinion that vaccination would not be mandatory was also put in doubt, as subsequent 'mandates' made vaccination all but compulsory for many people to continue living normally and retain their employment.

52 In such a legislative and political environment, freedom of expression becomes all the more important in my view.

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[19] *Nga Kaitiaki Tuku Iho Medical Action Society Inc v Minister of Health* [2021] NZHC 1107 at [66].
[20] *Nga Kaitiaki Tuku Iho Medical Action Society Inc v Minister of Health* [2021] NZHC 1107 at [8].
[21] Medicines Amendment Act 2021, s 5.

53 Subsequent analysis has also revealed that, despite the announcement by the Prime Minister of the provisional approval on 3 February 2021 through Medsafe as being:[22]

> *… informed by the most up-to-date medical and scientific data. We can have confidence in their decision.*

The actual conclusion of Medsafe on its benefit risk assessment was more nuanced:[23]

> *The benefit risk balance of Comirnaty (COVID-19 mRNA Vaccine) for active immunisation to prevent coronavirus disease 2019 (COVID-19) caused by SARS-CoV-2 in individuals 16 years of age and older, is not clear. At this stage, there is* ***evidence only for short-term protection, and longer-term safety data are lacking****. However, experience with the vaccine is accumulating rapidly.*

54 That the Comirnaty vaccine would reduce community transmission of COVID-19 was (in my view) the only viable basis on which to implement coercive measures to encourage a high proportion uptake of the vaccine in the New Zealand population. It was therefore surprising to read Dr Bloomfield's evidence that, in **February and March 2021**, the Ministry did not recommend the mandatory vaccination of border workers:[24]

> *… We were advised that vaccination constitutes medical treatment and therefore engages the right of every person to refuse it if they choose. Requiring vaccination to perform specific high-risk roles at the border would be inconsistent with that right unless it can be demonstrably justified. A demonstrable justification could be impeding community transmission of the virus. But* ***we did not yet have conclusive evidence on the effectiveness of the Pfizer vaccine at preventing or reducing transmission to be confident of the public health value of the vaccination beyond the individual level****. We noted though that might change as more evidence becomes available.*

The intersection between science / medicine, law and politics

55 The primary premise of vaccination that could be (effectively) compelled by government was that becoming vaccinated would reduce the potential for transmitting an infectious agent to others, particularly those members of the

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[22] [PCA-160].
[23] [PCA-161] *Clinical Evaluation, Comirnaty (COVID-19 mRNA Vaccine)* (January 2021) at section VI (emphasis added).
[24] *Four Aviation Security Service Employees v Minister of COVID-19 Response* [2021] NZHC 3012 at [103] (emphasis added).

public who may be vulnerable due to age, underlying medical conditions or immunocompromised status. It was on this basis that public and private facilities were closed to those who were not vaccinated. The usual measures of staying home when sick were considered inadequate, and, for the first time, those without symptoms at all were suspected of being 'carriers' of the virus, capable of spreading it to others.

56 I recall it being reported that Dr Fauci himself indicated that 'Asymptomatic transmission never drives outbreaks'.[25] Canadian viral immunologist Dr Byram Bridle has also discussed how inappropriate use of the RT-PCR test led to the false notion of the 'asymptomatic carrier'.[26] (I further developed this point about pre-symptomatic and asymptomatic carriers in my response to counterclaims in a NewsHub article about my *Fact or Fantasy* presentation on 4 September 2021.[27])

57 The matter of protecting oneself however has historically been a matter of individual choice, since it is the individual who must not only achieve the benefits of lowered risk of illness, hospitalisation or death, but is also the one to bear the risks of vaccination, which, whilst often thought to be minimal with conventional vaccines, are indeterminate in the medium and long term for a novel vaccine product for which there is neither large-scale nor long-term assessment of potential adverse effects.

58 The alternative to seeking 'full' vaccination of the entire population would have been to use classical measures which had been employed to mitigate pandemics of influenza in the past — isolating the ill and frail, having people stay home when sick, recognising the value of intrinsic herd immunity among the bulk of the population, especially the children, young and middle-aged adults in whom there was evidence of significantly less morbidity and mortality than among the usual victims, the elderly and infirm. As I said in my *Fact or Fantasy* presentation, "*herd immunity from vaccinations alone cannot be expected*".[28]

59 Targeting vaccination programs to the most vulnerable would have preserved precious national resources and allowed an economy not to be crippled and, for some, their livelihood, life savings and businesses not to

[25] Available here: <https://www.youtube.com/watch?v=nTGX4crz2C0>.
[26] [PCA-135].
[27] [PCA-134].
[28] PCC disclosure at 319.

be permanently destroyed. This was essentially an influenza-like illness, although of perhaps greater severity and its involvement as a vasculopathic disease process (i.e. also injurious to blood vessels) did become evident before long.

Comirnaty does not prevent transmission after all

60 Surprisingly, and somewhat late (October 2022), it came to light that Pfizer had not assessed whether Comirnaty would actually reduce transmission of the virus from infected individuals who had received the vaccine. This came directly from a Pfizer top executive in response to a question from an MP from the European Parliament.[29]

61 The clinical trials had been aimed at reducing infection in the first place (at least as could be assessed by a positive RT-PCR test) and reducing the incidence of relevant symptoms.[30]

62 It had been reasoned that if the vaccine had been successful at reducing infection, that it would naturally follow that reduction in transmissibility could be assumed. In fact, a statement from the UK Health Security Agency stated this definitively in its **January 2022** vaccine surveillance report:[31]

> *Uninfected individuals cannot transmit; therefore, the vaccines are also effective at preventing transmission.*

63 And this was perhaps close to true in the early stages of the pandemic. However, as the Delta variant became dominant, and especially with the ascendancy of Omicron, the initial 89% reduced transmissibility became 34% with Delta by **June 2021** in Israel, where Comirnaty was the sole product in use.[32]

64 In the Omicron era, it was already known that the vaccine effectiveness against a person becoming infected had fallen to only **35%** in a Danish study[33] — not surprising given the extent of antigenic departure from the original alpha (Wuhan) strain. The study showed that the unvaccinated were only **9%** more susceptible to contracting COVID-19 in an Omicron

[29] [PCA-168].
[30] Brief of evidence of M Thomas (9 March 2023), annexure 5.
[31] [PCA-139].
[32] [PCA-140].
[33] [PCA-141].

household by transmission from a positive case compared to 'fully vaccinated' individuals.[34]

65 There was some protection from transmission however in the 'boosted' group of recipients. The authors confirmed the prevailing recognition that Omicron was about 3 times more transmissible than Delta by the **end of 2021**.

66 A key report from the *Lancet* showing that vaccinated UK household contacts with breakthrough infections had (Delta) peak viral load and viral transmission rates similar to the unvaccinated members of the household (25% versus 23% respectively), although successful transmission was about 50% more likely to the unvaccinated members. These findings were from a study ending in **September 2021**.[35]

67 So, this paper showed that:

67.1 Comirnaty, designed for the first wave before the many SARS-CoV2 variants, was not very effective in preventing COVID-19 in the community among household contacts in the Delta era.

67.2 Protection against infection waned after 2 to 3 months.

67.3 If a person was vaccinated, they were just as likely to transmit the virus to others in the household as was an unvaccinated person.

67.4 There was modest protection against developing COVID-19 from an infected household member compared to an unvaccinated household member (35% improvement).

68 Two months before this, in **July 2021**, an outbreak of SARS-CoV-2 infections (Delta variant) was documented in the MMWR, official organ of the US Centers for Disease Control and Prevention. In large public gatherings in Massachusetts, 74% of COVID cases occurred in a 2-dose vaccinated cohort, whereas the proportion of subjects vaccinated was similar at 69%, and the cycle threshold values in the RT-PCR swab specimens were similar (being a rough proxy for viral load).

[34] Although the results are arguably skewed by including 'partially vaccinated' individuals in the 'unvaccinated' camp, and individuals previously infected with Omicron in the 'vaccinated' camp.
[35] [PCA-142].

69 Thus, shortly after the date of my presentation, it was known and knowable that the Comirnaty vaccine did not reliably reduce transmissibility of the Delta variant, and especially after that, the Omicron variant. Yet, the New Zealand government's response in regard to applying different rules to vaccinated and unvaccinated groups (e.g. the implementation of vaccine (internal) passports, entry requirements to public places, and the strong recommendations from government authorities and agencies to private businesses) by the end of 2021 is well documented.

70 The very basis for these policies (reduced community transmission) was arguably moot from late 2021 and became especially so by the time that Omicron became the prevalent variant in New Zealand by **March 2022**.

71 In New Zealand, the COVID-19 vaccination pass system came into effect on 16 November 2021 and lasted until mid-October 2022.

Conclusion

72 A fundamental human right is the ability to refuse medical treatment. Society usually permits such refusal, even where the consequences of doing so might be to increase risks to self and the likely cost of any future medical care that may be required.

73 An argument can be made for departing from this principle where universal vaccination will prevent harms to other people. An example might be measles. There is a vaccine for measles that has been proved over a long time to be relatively safe. Measles is a potentially harmful illness that is difficult to treat. Compulsory measles vaccination could be a method adopted to optimise herd immunity and would be intended to reduce the risk of measles transmission within the community, particularly to vulnerable people such as new-born infants. In other words, vaccination has a clear benefit to the community. Some would argue that such a benefit is sufficiently weighty to justify compulsory vaccination with few exceptions.

74 The situation with COVID-19 was quite different. The vaccine was new and so no long-term safety data were available. Further, it did little to prevent transmission and certainly did not achieve herd immunity (and this is now a generally accepted fact). Thus, the key benefits of vaccination were personal — i.e. the possibility that any COVID-19 infection would be less severe in a vaccinated person. In my view there is no justification for

(effectively) forcing people to make that individual choice — particularly where potential harms, even serious adverse effects may not yet be known. If there were such a justification, then why do we not outlaw smoking tobacco and fattening foods, and mandate exercise for the population? This would be a moral equivalent in my view.

75 This is one of the reasons why permitting freedom of expression is so important. If things like the efficacy and safety profile of a new vaccine cannot be discussed by medical practitioners and others, then debate is stifled and it becomes impossible to effectively participate in political decisions. Such political decisions were undoubtedly life-changing for those who lost jobs during the pandemic. If it had been known that Comirnaty did little to prevent community transmission at the relevant times, then the New Zealand community might have persuaded its elected representatives to reach different views about the government's policy settings and what it was asking of those who, for their own reasons, did not wish to be vaccinated with Comirnaty. This is especially so as new data actually did come to light, and where modification of the initial hard lockdown measures could have been reassessed.

76 I also note Dr Thomas' statement that:[36]

> *… health professionals such as doctors, nurses, and others who come in contact with patients, may be required to be vaccinated against many diseases. For example, health professionals may be required to be vaccinated against measles, poliomyelitis and other childhood illnesses to reduce their risk of transmitting these infections to their patients.*
>
> *… once the COVID-19 vaccine became available in New Zealand, health professionals had a responsibility to do all that was feasible to reduce the risk that they might transmit the infection to their patients, particularly if they were caring for patients with weak immune systems, or other conditions that increased their risk of suffering severe COVID-19 disease. I am very dubious of the claim that doctors in New Zealand had been paid not to tell the truth about any matters relating to COVID-19.*

77 There are several deficiencies with this statement in my view. First, the impact on transmissibility has proved to be negligible. Second, it is a false equivalence to compare the new mRNA vaccine to, for example, the MMR vaccine. Comirnaty, known to use a novel technique which differs from all

[36] Brief of evidence of M Thomas (9 March 2023) at [68] and [69].

prior human vaccine products implemented for widespread use, is assumed to have a similar or acceptable safety and efficacy profile to vaccines developed using long-standing and time-tested techniques. This was indeterminate at the time of my presentations, as there were no long-term results from the remainder of the clinical trials. I am not aware of any prior example of health professionals being 'required' to be inoculated with a novel vaccination.

78 It is also wrong to suggest that I claimed doctors in New Zealand had been paid not to tell the truth about any matters relating to COVID-19. What I did say was that doctors' livelihoods depended on toeing the party line. This very proceeding is a case in point, where, as a direct result of me discussing COVID-19 in public, my practising certificate was suspended. Indeed, it was not necessary to make such a claim, because a strongly worded directive to doctors, and a public announcement by the Chair of the Medical Council were certainly powerful enough incentives for many to remain silent.

79 Furthermore, the Prime Minister, the Director General of Health and the Medical Council all issued authoritative expectations that the government and its Ministry of Health website will be the 'single source of truth' about COVID-19 and the vaccine programme. It is therefore hardly to be expected that most doctors would be looking elsewhere to find information.

Experimental biological agent

80 I do not resile from choosing these words to describe the Pfizer mRNA vaccine. Of course it was experimental — it had bypassed the normal approval process and never before had there been a mass-rollout of an mRNA vaccine. It also differed fundamentally from the vaccines people were accustomed to. Rather than introduce something for the immune system to respond and build immunity to, the mRNA vaccine introduced a set of instructions to cause the recipient's cells to start producing the SARS-CoV-2 spike protein, and the body was then expected to build predominantly an antibody response to it.

81 But one example of the experimental nature of this biological agent is the issue of reverse transcription (there are other issues I could discuss).

82 Initially it was thought that once the mRNA payload had gained entry into human cells via the ACE-2 receptor binding, enhanced by the furin cleavage

site on the S1-S1 synthetic spike protein, there was no chance of entry to the nucleus or reverse transcription into cytoplasmic- or nuclear-resident DNA. This turned out to be questionable, as in a paper showing just that, where mRNA from the vaccine was reverse transcribed into DNA in the nuclei of hepatic (liver) cells.[37]

83 Another paper has concluded that:[38]

> *Current engineering strategies and declared future directions for the improvement of mRNA vaccines do not consider the possibility of vaccine mRNA genome integration via L1 retroelements native to human cells. …*
>
> *… Why this risk is overlooked is even more obscure given that mRNA retroposition is a biomedically recognized phenomenon outside vaccinology. …*
>
> *Every technology is a double-edged sword and mRNA therapeutics are not an exception. In this complex COVID-19 crisis, it is essential that all pros and cons of control measures, procedures, treatments, prophylaxis and vaccine technologies are continually openly discussed and cautiously evaluated from many angles. …*
>
> *Whether the current vaccine mRNAs could integrate into the genome, and by which frequency, has to be ultimately demonstrated using experiments. However, it remains puzzling why and how the mRNA vaccinology field neglected the retroposition biology of L1 retroelements and its theoretical links to possible vaccine mRNA retroposition, especially when one considers the volume, visibility and significance of the L1 and retroposition research. …*
>
> *I conclude that* ***the broadly reiterated statement that mRNA-based therapeutics could not impact genomes is an unfounded assumption of unclear origin****. This implies that the current mRNA vaccine evaluations, which lack studies that specifically address genome integration, are insufficient to declare their genome integration safety. … It is, therefore, important that the exact nucleotide sequences of mRNA vaccines are disclosed and easily publicly accessible, including product information documents, to allow for unambiguous and independent tracking of possible vaccine mRNA integration in the somatic and germinative genomes of already vaccinated people and their progeny.*

[37] [PCA-163].
[38] [PCA-164] (footnotes omitted, emphasis added).

84 Thus, there is some legitimate concern that DNA coding for production of the spike protein by our cells' own machinery may be a genetic component that could be passed on to future generations.

D PARTICULAR 2(B)

85 This particular alleges statements made by me were inaccurate and/or misleading, or had the potential to mislead, because:

> *Dr Canaday's use of information from the United States was not balanced with data from New Zealand and did not provide sufficient information about the vaccination mortality rate, and was therefore likely to imply that deaths after vaccination were caused by the vaccine …*

86 In the Raglan interview, I clearly stated:[39]

> *Well, one of the concerns has been that there is a very significant number of recorded adverse events or side-effects or things you don't expect following the roll-out of the vaccinations in the United States. Again, I use that as a reference point because that's where the most experience is. They've had over 150 million people who have received vaccinations in the United States, and so 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. Now, of course, there's always this question of whether people have their underlying diseases as a cause of death … as opposed to the vaccinations, and sometimes we're just not going to be able to tell …*

What I did not say

87 In my view the PCC charge mischaracterises what I said. I did not say that I believed the vaccinations were the cause of death. I did go on to state that the available data would normally indicate that an investigation should be done to find out why the much higher deaths might be occurring after the COVID-19 vaccines compared to all others before it.

Post-vaccination mortality rates

88 Calculating a mortality rate after vaccination would have been a highly complex and error-prone, statistically unreliable venture at the time. What I said was true and correct at the time: the fact of a much larger reported

[39] PCC disclosure at 235.

number of deaths in the VAERS reporting system in the United States when compared to prior years is not a matter for dispute, and I fail to comprehend the charge that what I said was inaccurate or misleading.

89 There is a clear difference in the annual reported deaths following all other vaccines up to the year of rollout of the mRNA and DNA adenovirus vector vaccines in 2021. The link to the original dataset contemporaneous with my *Raglan* presentation is listed in slide 66.[40]

90 Whilst it was not the primary topic of my discussion of this point in the public presentation (in July 2021) to comment about causality, it is notable that of the 35,000+ deaths in recent data, reported to VAERS as following a COVID-19 vaccination, nearly 25% of these were reported within 2 days of the injection, and over a third within the first week.[41]

The question of causality

91 I have addressed the question of post-vaccination deaths and the analytics necessary to determine if a causal link can be inferred in my response to counterclaims in a NewsHub article about my *Fact or Fantasy* presentation, published on 4 September 2021.[42]

92 A number of factors classically used to determine causality are evident in the present case — the question is whether there may be a causal link between vaccination and deaths. At a minimum, these reported figures in the VAERS database in the United States represent a signal, which requires a deeper, broad-based and transparent programme of investigation.

93 I also fail to comprehend the point about "*balanced with data from New Zealand*" when there was little reliable NZ data available for public assessment at the time. I am puzzled by the implication that somehow New Zealanders would be so uniquely different in their susceptibility to COVID-19 morbidity and mortality to persons in the United States that we should not use the data available there when there is not enough in New Zealand.

[40] [PCA-1]. (The current dataset to 3 March 2023 is [PCA-2].)
[41] [PCA-173].
[42] [PCA-3].

E PARTICULAR 2(C)

94 This particular alleges statements made by me were inaccurate and/or misleading, or had the potential to mislead, because:

> *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 …*

95 In the Raglan interview, I clearly stated:[43]

> *… 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. Again, many of the times, with individuals who have underlying disease, that's where the roll-out occurred in the first place so we don't know, you know, just what's going to happen in New Zealand, but there's been, you know, zero to one death due to COVID during this this year … and, you know, some eight to 10 deaths or so following vaccinations, so I think it's too early to tell what will happen in New Zealand …*

COVID-19 deaths in New Zealand

96 The contemporaneous report from the New Zealand Ministry of Health as at 9 July 2021 indicated that there were a cumulative 1,602 deaths since the first NZ case.[44]

97 However, the assignment of a death designated as in a 'case' of COVID-19 has often been viewed as problematic:

97.1 Firstly, there is the problem of assigning a disease designation to persons without symptoms, i.e. the 'asymptomatic' case. This represents a substantial departure from the classical definition of a case. Physicians until 2020 understood a case, where defined in the setting of an infectious disease, to be an individual with symptoms and signs discoverable through soliciting a patient history, results of a physical exam and correlation with laboratory and imaging findings.

97.2 Secondly, the RT-PCR test, originated by Kary Mullis (for which he received a Nobel Prize), was never intended for clinical diagnosis,

[43] PCC disclosure at 237-238.
[44] [PCA-4].

and thus cannot alone be used as a prima facie definition of a COVID-19 case.

98 I explore this further in my researched responses to the asserted 'debunking' of claims I made in my *Fact or Fantasy* presentation. An article purporting to debunk some 24 'claims' was published by NewsHub on 4 September 2021, and my responses to two relevant counterclaims are cited here:

98.1 Regarding RT-PCR tests not designed for diagnosis, I posted this response: [PCA-5].

98.2 Regarding RT-PCR tests subject to a significant proportion of false positives, I posted this response: [PCA-6].

99 These topics were further discussed in a column at New Zealand Doctors Speaking Out with Science (**NZDSOS**) by Susan Pockett, MSc, PhD. Although she is a science researcher and not a physician or healthcare practitioner, I concur with her conclusions and comprehensive explanation.[45]

100 In conclusion, it is difficult to know how many deaths were directly attributable to being a COVID-19 case in statistics provided by the New Zealand Ministry of Health. As at 9 July 2021, the proportion of the New Zealand population that had died and was officially listed as due to COVID-19 represented approximately 0.03% of the total population (= 1,602 / 5,111,300), compared to 626,663 cumulative deaths in the United States on the same date in a population of 332,070,790, or 0.2% of the US population.[46]

101 At the time of my presentation, the number of deaths in the United States was nearly 400 times the number of deaths in New Zealand.

Post-vaccination deaths in New Zealand

102 According to the Centre for Adverse Reactions Monitoring (**CARM**), data on Medsafe (the New Zealand Medicines and Medical Devices Safety Authority), as at 10 July 2021, there were 19 deaths reported after administration of the Comirnaty vaccine. Medsafe reported that 14 were

[45] [PCA-7].
[46] [PCA-8].

determined to be unrelated, 2 were not accompanied by sufficient information, and 3 were yet to be determined as of that date.[47]

103 None of these decedents underwent autopsy (post-mortem examination). However, it has been shown by Arne Burkhardt, a distinguished pathologist and professor with over 150 publications, in a small series of post-vaccination deaths in Germany (15), that 80% of post-mortem exams demonstrated either 'very probable' (33%) or 'probable' (47%) histological evidence of a causal link to the vaccination.[48]

104 In addition to imprecise (and unspecified) methods of determining cause of death, the Medsafe reporting mechanism is recognised to significantly underestimate the true prevalence of adverse effects and deaths, and only 5% of actual cases may be reported.[49]

105 This mirrors what has been found in other nations' reporting systems, such as the USA, where the Lazarus study of a voluntary reporting system in a regional healthcare system (2011) found that "*fewer than 1% of vaccine adverse events are reported*".[50]

106 Similar conclusions were made in a prior published review of 37 published studies from 12 countries on this topic as of 2006, and again, significant underreporting was confirmed, with a median underreporting rate of 94%, meaning only 6% of adverse events were reported.[51]

107 This 6% figure is close to that estimated for underreporting to Medsafe in New Zealand, as stated above.

108 A citizen-based roster of reported deaths following vaccination in NZ was evaluated by volunteers — being cross-checked with other sources, such as public death notices, and enquiry from businesses where available. Whilst unofficial, the number of deaths post-vaccine as of 9 July 2021 was approximately 94, thereby exceeding those reported to the CARM by a substantial margin (although there would be differences related to the time of reporting). This was at a time when CARM was reporting 19 deaths, and not attributing any to possible post-vaccine adverse effects.

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[47] [PCA-9].
[48] [PCA-169].
[49] [PCA-11].
[50] [PCA-12].
[51] [PCA-13].

109 Citizen reporting of adverse events and deaths have been collated through a website.[52]

110 The following is a table of deaths reported in this manner as of 9 July 2021: [PCA-16].

111 The matter of causality, that is, determining whether vaccination was causally related to deaths, is a matter of great controversy, beyond the scope of the PCC's charges, and beyond the scope of this discussion. I had never stated an opinion during the relevant presentations that the vaccines caused deaths of New Zealanders.

F PARTICULAR 2(D)

112 This particular alleges statements made by me were inaccurate and/or misleading, or had the potential to mislead, because:

> *New Zealand Doctors Speaking Out with Science is not generally accepted by the profession as a reliable source of balanced information on the Covid-19 vaccine …*

113 In the Raglan interview, I clearly stated:[53]

> *… New Zealand Doctors Speaking Out With Science, and it's a very good organisation that has contained people who are of various fields of expertise who have looked at the various facts and statements that have been made about this problem with us … 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.*

114 The following is taken from the NZDSOS website as to its origin, in 2021. I agree with these objectives, and believe that these principles had, until recently, been foundational and universally accepted as doctors' ethical obligations:[54]

> ***Founding Objectives in 2021***
>
> ***Our Message***

[52] Available here: <https://thehealthforumnz.co.nz/>.
[53] PCC disclosure at 231-232.
[54] Available here: <https://nzdsos.com/message-objectives/>.

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

Our Objectives

Ensuring the ability of Medical Practitioners to speak without censure

- *Up-holding the sanctity of patient-practitioner relationships and communications*
- *Legally supporting practitioners who are censured*
- *Building alternative health structures and platforms*

Promoting medical freedom

- *Affirming the Hippocratic Oath: First do no harm*
- *Empowering individuals to say NO to vaccine passports*
- *Opposing vaccine mandate orders*
- *Promoting freedom of choice around mask wearing and social contact*
- *Encouraging all effective medicines and treatments, including proven alternative and traditional therapies*
- *Supporting appropriate legal undertakings*

Supporting the public with unbiased information and care

- *Providing fully informed consent including information on:*
  - *Natural immunity*
  - *Early treatment of C-19*
  - *Harms and efficacy of the C-19 injections*
- *Acting in accordance with:*
  - *Basic Concepts and Universal Laws of the Wakaminenga Kauniera Hauora Health Council*
  - *The New Zealand Bill of Rights 1990*
  - *The Nuremburg Codes*
  - *The UNESCO Universal Declaration of Bioethics and Human Rights (this does not imply blanket support of the UN)*
- *Building an alternative narrative to the mainstream media*
- *Setting up alternative health care structures and supporting individuals in need of care*
- *Promoting robust public debate*

115 The statement that "*[NZDSOS] is not generally accepted by the profession as a reliable source of balanced information*" is not supported by any evidence provided. I'm confused as to how the PCC could make that determination, other than that the views expressed at NZDSOS often run counter to the narratives put forth by government officials and designated spokespersons whose potential conflicts of interest remain unexplored.

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

117 While I am not one of the organisers of NZDSOS, my understanding is that many members share my views about freedom of expression and that the website provides a way for people in medical, scientific and related professions to express themselves freely. That does not mean I agree with everything published on the website.

118 NZDSOS has been supportive of me, as by publishing material from me through which I have been engaging in a detailed way in response to a NewsHub article that listed various issues NewsHub believes I have got wrong during my 19 August 2021 *Fact or Fantasy* presentation hosted by Voices for Freedom. I think it is appropriate that NewsHub have the freedom of expression to attempt to convince their readers that some of what I have said may be wrong. It is only fair that I should be permitted the same freedom.

What does 'generally accepted by the profession' actually mean?

119 Implicit in this charge is the assumption that what is "*generally accepted by the profession*" is truthful, 'settled science', or definitive enough to discard a fundamental principle of scientific inquiry, where precepts are subject to open, and often vigorous debate. This is especially necessary for a product using novel methods of design, uncertain provenance, very limited clinical trials and worrisome signals of possibly excessive adverse effects.

120 All of these proposed reference standards eliminate the possibility that the conventionally accepted narrative, guidance statements and directives may simply be wrong. Moreover, they directly oppose bedrock principles of scientific enquiry, which requires the freedom to challenge accepted doctrine.

121 The current charges appear to rest upon assertions of ‘claims without evidence’ (which may mean ‘without evidence we know of’), or departure from ‘consensus of opinion’ or ‘best available evidence’.

What do eminent scientists say about consensus?

122 One of the universally recognized and most eminent physicists of the 20th century, Albert Einstein, was faced with a treatise *One Hundred Authors against Einstein* in response to his at-the-time radical theory of special relativity. His reported answer? ‘Why one hundred? If I were wrong, one would have been enough’.

123 Another of the most prominent physicists in the 20th century, a central figure in the Manhattan Project, described as ‘the best mind since Einstein’, was Richard P Feynman, whose collected physics lectures were seminal to my undergraduate education.

124 His opinions about science versus consensus follow:[55]

> *No government has the right to decide on the truth of scientific principles, nor to prescribe in any way the character of the questions investigated … Instead, it has a duty to its citizens to maintain the freedom, to let those citizens contribute to the further adventure and the development of the human race.*
>
> *I would rather have questions that can't be answered than answers that can't be questioned.*
>
> *Learn from science that you must doubt the experts. As a matter of fact, I can also define science another way: Science is the belief in the ignorance of experts.*

125 From the world of medicine, we see the same sentiment from David Sackett, the founder of Evidence-Based Medicine, in the prestigious British Medical Journal in the year 2000:[56]

> *… experts like me commit two sins that retard the advance of science and harm the young. Firstly, adding our prestige to our opinions gives the latter far greater persuasive power than they deserve on scientific grounds alone. Whether through deference, fear, or respect, others tend not to challenge them, and progress towards the truth is impaired in the presence of an expert.*

[55] Available here: <https://www.azquotes.com/author/4774-Richard_P_Feynman>. See also more generally: <http://www.feynman.com/science/what-is-science/>.
[56] [PCA-23].

126 Implicit in the claim that NZDSOS "*is not generally accepted by the profession as a reliable source of balanced information on the COVID-19 vaccine*" is that there is no place for alternative views, debate or revision of current dogma, but in so doing, those making the claim suggest that there is no place for bedrock principles of science either.

G PARTICULAR 2(E)

127 This particular alleges statements made by me were inaccurate and/or misleading, or had the potential to mislead, because:

> *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 …*

128 In the Raglan interview, I clearly stated:[57]

> *… 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. …*
>
> *… I think the main thing to concentrate on is health, getting the usual things that you would expect to see, exercise, lots of sunlight, you know, trying to maintain an optimal weight, treating your underlying heart conditions, underlying respiratory conditions, being active, all of those things will benefit.*

The role of natural immunity

129 I have prepared a detailed explanation of the role of natural immunity in my response to the allegedly 'debunked' claims I have made on this topic, published in an article in NewsHub on 4 September 2021.[58] This reflects my assessment of what was known **and knowable** at the time of publication, on or about September 2021. I also discuss the waning immunity achieved after vaccination, as well as issues with how vaccination status is calculated. In the same response I also provided 30 references to the medical literature.

[57] PCC disclosure at 241.
[58] [PCA-24].

130 The reference to non-pharmaceutical measures was related primarily to prophylaxis or prevention of COVID-19 rather than treatment, although for some who employ them, attention from the healthcare system may not even be needed. These measures for treatment are discussed elsewhere, but clearly, if prevention had been emphasised, and had it been shown to be effective, the need for vaccination would have been reduced, and could have been targeted at potentially vulnerable individuals, as had been the customary approach for selective vaccination against respiratory infectious diseases until 2020.

On the efficacy of non-pharmaceutical measures

131 I have provided a list of 33 references from the medical literature available for independent confirmation, many from peer-reviewed papers regarding the role of vitamin D in COVID-19.[59]

132 Dr Thomas provides a single meta-analysis on the role of vitamin D supplementation for treatment of COVID-19,[60] whereas its use is most typically discussed in the context of prophylaxis, and then optimisation of blood vitamin D levels in those hospitalised and treated with other therapeutic measures.

133 There is a very detailed analysis available of the studies with assessment of the role of vitamin D in immune response, separate assessment by type of vitamin D administered, methodologies of the investigations and the statistical power of their results. This study includes an independent meta-analysis of 107 treatment studies and 153 sufficiency studies. The outcomes for mortality, need for mechanical ventilation, admission to ICU, hospitalisation, and case numbers are separately assessed, and showed an overall improvement of 37%.[61] The authors of this study group are anonymous and have presumably been countering the expected narrative at their institutions, but in my opinion, they provide a very comprehensive review of multiple topics related to COVID-19 interventions. From the context, it is evident that those participating in this group are accustomed to methods of analysis and published research.

[59] [PCA-170].
[60] Brief of evidence of M Thomas (9 March 2023) at [61(b)].
[61] [PCA-26].

134 The collation and analysis of published studies which also relate to the beneficial effects of vitamin C, N-acetyl cysteine, zinc, quercetin and other interventions on prevention, early treatment and other measurable endpoints are also given at this site, in addition to the effect of vitamin D.[62]

135 References to support the use of prophylactic measures were provided at the time of the public presentation at Raglan, which were the same as given during the *Fact or Fantasy* presentation.

136 Even in New Zealand, the *Best Practice Bulletin* (No. 19) from February 2021 advised that vitamin D supplementation may have a role for New Zealanders, particularly in the winter months.[63]

137 The vitamin C paper to which Dr Thomas refers[64] is from a single journal article, whereas 57 studies are reviewed in a meta-analysis from the C19 study group,[65] with assessment of endpoints of mortality, ICU admission, hospitalisation and recovery, showing benefit of 22% on average.[66]

138 The zinc paper to which Dr Thomas refers[67] is a single meta-analysis referencing mortality, whereas 39 studies are reviewed in a meta-analysis by the C19 study group, with assessment of endpoints of mortality, ventilation, hospitalisation, viral clearance and recovery, showing benefit of 28% on average. Even when 15 of 39 studies were eliminated, statistically significant efficacy in a pooled analysis was still preserved.[68]

139 There can always be criticisms of the results of pooled studies, but the above referenced resource is very transparent in how the reviewers have analysed the available studies, even posting a request to point out any errors critics may find, and a request to post additional studies, so as to keep the website resource as current as possible by continuing to analyse and re-analyse the datasets available.

140 In conclusion, there is abundant evidence of the value of a number of non-pharmaceutical interventions, only a few of which are touched upon here.

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[62] [PCA-27].
[63] [PCA-28].
[64] Brief of evidence of M Thomas (9 March 2023) at [61(a)].
[65] I refer to the independent COVID-19 countermeasures analysis group as the 'C19 study group'.
[66] [PCA-29].
[67] Brief of evidence of M Thomas (9 March 2023) at [61(c)].
[68] [PCA-30].

This type of evidence was also available at the time that I gave my *Raglan* and *Courageous Convos* presentations.

Clinical guidance is available from non-government sources

141 In my opinion, the Frontline Critical Care Coalition (**FLCCC**) has very extensive experience as treating as well as research physicians, and has refined their protocols and recommendations for treatment, prevention and management of patients with or at risk of developing COVID-19 in the United States, as I stated in my *Raglan* presentation.[69]

142 I am confused as to how discussing COVID-19 preventive measures with essentially no downside could be considered to "*mislead the public as to the efficacy of the Pfizer vaccine*", since I made no mention of the Pfizer vaccine in this context.

143 Is the PCC concerned that, instead, I should suggest that a person should not take measures to optimise one's natural immune system prior to uptake of the vaccine? Or deciding not to do so? Since the purpose of the vaccine is to stimulate the immune system, wouldn't one want a robust and optimally competent underlying immune system to start with?

H PARTICULAR 6(A)

144 This particular alleges that statements made by me were inaccurate and/or misleading, or had the potential to mislead, because:

> *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. …*

145 In the *Courageous Convos* presentation, I clearly stated:[70]

> *… 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 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.*

[69] [PCA-1]. See also: <https://covid19criticalcare.com/>.
[70] PCC disclosure at 249-250.

Whose 'full story'?

146 It is false to claim that I was suggesting that I was 'providing the full story', but only that we had not **heard** the 'full story' from official sources. The entire contents of this brief of evidence is intended to prove the point. As but one example, I have detailed above at [53] and [54] the risk/benefit uncertainty being expressed privately by officials at a time that public messaging was advocating unequivocally for universal vaccination.

147 I fail to comprehend how my attempt to provide "*missing information*" is likely to "*misrepresent the efficacy of New Zealand's pandemic response*". The efficacy of the response is what it was and is now, and I did not represent, intend to represent or misrepresent anything. I provided what I believed to be relevant findings from the scientific literature at the time that would support people becoming as informed as possible prior to making the sacred, personal and consequential decision to take up the vaccine or not.

The Medical Council and informed consent

148 The Medical Council has published an 8-page statement on informed consent, and registered doctors are expected to comply with it, and assist the patient to become aware of certain expectations, rights and outcomes in the context of consenting to any medical procedure.[71]

149 This document lays out the expectations for all doctors, and specifically states that "*without informed consent, the treatment **may be unlawful**. To help the patient decide whether they want a treatment, they first need to be given information, such as the risks and benefits of their treatment options*".[72]

150 Further, in paragraph 3 the document states, "*You must give your patient the information they need to help them make a fully informed decision. Share information that is relevant to them, in a way they understand, and allow reasonable time for the patient to make their decision*".

[71] [PCA-32].
[72] Emphasis added.

The Medical Council's Guidance Statement to doctors

151 The Medical Council also published a document titled *Guidance Statement: COVID-19 vaccine and your professional responsibility* (28 April 2021).[73] This refers to Right 6 of the Code of Health and Disability Services Consumers' Rights,[74] which is the right to be **fully** informed.

What the Guidance Statement implies

152 The *Guidance Statement* is remarkable for several things:

152.1 Doctors are expected to take up vaccination regardless of any research they may have done themselves, or that of others to which they may have access. Personal or philosophical objections are not permitted. Medical exemptions on the basis of contraindications were almost universally denied by the Ministry of Health at the time.

152.2 There is **no** mention of the necessity to discuss possible **risks** of vaccination but only benefits, despite the clear guidance of the same Medical Council's prior statement that risks must be discussed prior to any patient making an informed decision.

152.3 There is a call for doctors to provide evidence-based advice or information, but in the same statement, any advice or independently obtained evidence deemed to be 'anti-vaccination' (a term which remains undefined) is not permitted.

152.4 The referral to the Ministry of Health website as the sole source of information is, by definition, a government determination to replace the individualised context of the doctor-patient relationship with, in effect, the corporate/government practice of medicine.

153 Thus, there is clear evidence that the usual forum for scientific debate had been suppressed, and that any medical literature which challenged the government position would be rejected.

[73] [PCA-33].
[74] [PCA-165].

I PARTICULARS 6(B) AND 10(A)

154 These particulars allege statements made by me were inaccurate and/or misleading, or had the potential to mislead, because:

154.1 "*Dr Canaday's recommendation of other 'effective' Covid-19 treatments is not supported by generally accepted scientific evidence*"; and

154.2 "*Dr Canaday's support of other Covid-19 treatments including hydroxyquinoline and ivermectin is not supported by generally accepted scientific evidence*".

155 Again, we have the claim that my comments were 'not supported by generally accepted scientific evidence'. I have already spoken about from [119] above the problems with this type of challenge, wherever scientific principles are supposed to underlie the practice of medicine.

156 In the *Courageous Convos* presentation, I clearly stated, in relevant part:[75]

> *… there is ample evidence … for the benefit of proven, longstanding many decades use of therapeutics that … we should allow into New Zealand for the purpose of … treatment and prevention because these are … effective agents, … they can be … used for this purpose, and I'm talking about … Ivermectin in particular because the evidence for that is … overwhelming.*

157 In the *Fact or Fantasy* presentation, I stated:[76]

> *Dozens of studies have shown [Hydroxychloroquine] and Ivermectin work. …*

158 Neither Hydroxyquinoline nor Hydroxyquinone was mentioned by me as a possible therapeutic product for use in treating COVID-19. These names appear to have been mis-transcribed.

159 In the sections below I explain the background to my thinking at the time I gave the relevant presentations in July and August 2021.

[75] PCC disclosure at 268.
[76] PCC disclosure at 313.

Hydroxychloroquine — the first repurposed drug

160 The 'Zelenko protocol' is a treatment regimen for COVID-19 that was the result of observations by a primary care physician in a Jewish community north of New York City in the early days of the COVID-19 pandemic, in **March 2020**.

161 Dr Zelenko was faced with patients in his practice who were sick with COVID-19, and a significant number of them or others he knew about ended up in hospital, some dying.

162 He noted the paper by Didier Raoult, referenced below and by Dr Thomas,[77] that showed significant efficacy of Hydroxychloroquine (**HCQ**) with or without Azithromycin (**AZM**) in early observations. Dr Zelenko modified this regimen to include a combination of HCQ, AZM, and zinc (because zinc was known to inhibit replication of intracellular coronavirus RNA from a paper in 2010[78] and HCQ was known to be a zinc ionophore, meaning it assisted with transfer of zinc across human cell membranes[79]).

163 This combination had also shown efficacy in improving outcomes in hospitalised COVD-19 patients.[80] It was formalised in what came to be known as the 'Zelenko protocol'.[81]

164 Dr Zelenko's protocol gained attention after he reported success in treating 669 COVID-19 patients in his community with this combination of drugs. Here is the original published report of these results: [PCA-40].

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

166 Dr Peter McCullough's work on COVID-19 has been extensive. He had published some 47 papers related to this topic at the time, and he was very

[77] Brief of evidence of M Thomas (9 March 2023) at [57].
[78] [PCA-36].
[79] [PCA-37].
[80] [PCA-38].
[81] [PCA-166].

familiar with the subject from first-line treatment experience. As a distinguished academic cardiologist, editor and reviewer of prominent scientific journals, he published what was stated to be the most cited paper in the early stages of the pandemic, in August 2020. His study on the pathophysiological basis and rationale for early outpatient treatment was presented in one of the most high-profile internal medicine journals, the American Journal of Medicine.[82]

167 Dr McCullough has also published:

167.1 a comprehensive review of HCQ and its controversial role in COVID-19 disease in January 2021;[83] and

167.2 the results of an early ambulatory multidrug regimen for use in high-risk patients with SARS-CoV-2 infection (COVID-19) in March 2021.[84]

The Raoult Study

168 Regarding the Raoult study which Dr Thomas references,[85] the reduction in RT-PCR positive nasal swabs in hospitalised patients with the use of HCQ and AZM was clearly statistically significant despite the small sample size of 42 patients (even without the use of zinc as was shown to be beneficial in the subsequent Zelenko paper). Only 6 of 20 HCQ patients received AZM, and in a small sample showed possible improvement even over the HCQ alone. It became the most cited paper on treatment of COVID-19 at the time, early in the pandemic.

169 A second follow-up study with 1,061 patients which was published as a preprint only showed a virological cure in 92% of patients and a mortality rate of 0.75% (all respiratory failure) at a time when typical case fatality rate for COVID-19 in France was 19% in May 2020.[86]

170 Didier Raoult published a response to criticism of his initial paper in which he also performed his own meta-analysis of 20 studies done to date, in 18,211 patients with endpoints of mortality. Separately, papers involving 4,540 patients were reviewed for viral persistence with the risk of shedding.

[82] [PCA-41].
[83] [PCA-42].
[84] [PCA-43].
[85] Brief of evidence of M Thomas (9 March 2023) at [57].
[86] [PCA-44] and [PCA-45].

Studies with HCQ showed at least an 18% reduction in mortality overall, even when excluding his own studies, sometimes as much as 47% when only clinical studies were reviewed, as opposed to those referred to as 'big data' (which involve very high volumes, need for sophisticated data processing assets, and high intake velocity of cases with their associated data). There was also a 53% reduction in nasal virus persistence in the relevant studies.[87]

171 He also pointed to problems whereby some study authors had conflicts of interest with Gilead, the manufacturer of the competing drug Remdesivir, a repurposed and failed Ebola drug whose studies tended to show little benefit. This drug was initially approved for use in hospitalised COVID-19 patients, but then was 'un-recommended' by the WHO, perhaps when reports of significant renal and urinary adverse reactions surfaced.[88]

An independent research base

172 A breakdown of the types of studies and the results of 36 existing studies available as of 2 March 2023 shows especially high efficacy when HCQ is given for prophylaxis, and early in the disease; see: [PCA-48].

173 The meta-analysis to which Dr Thomas refers[89] involves mostly hospitalised patients in only one randomised control study, and 12 cohort studies, with a study end-point of mortality. HCQ has been shown to be least effective when used late in the course of the disease, as compared to earlier on. In contrast, a comprehensive and highly annotated real-time meta-analysis of 385 studies is now available, with breakdown by pre-exposure prophylaxis, post-exposure prophylaxis, early treatment and late treatment, with improvement in 34%, 30%, 62% and 19% respectively of clinical trials overall.

174 Also, analysis of the results of randomised controlled trials inclusive or exclusive of late treatment is made. Endpoints of mortality, hospitalisation, recovery, and viral loading are separately assessed. The meta-analysis also references results of in silico (computer modelled), in vitro (laboratory research) and in vivo (animal) studies which are supportive of HCQ efficacy,

[87] [PCA-46].
[88] [PCA-47].
[89] Brief of evidence of M Thomas (9 March 2023) at [58].

primarily in prophylaxis and early treatment. Recapitulation of each study is provided in tabular and forest plot form.[90]

175 As noted above, the anonymous authors (who have presumably been countering the expected narrative at their institutions) also discuss the likely inherent methodological errors leading to published studies which show no benefit, and the choice of small subsets of trials focussing on late treatment with sometimes excessive doses. From the context, I am convinced that those participating in this group are accustomed to methods of analysis and published research.

Ivermectin

176 Dr Thomas states that he believes that "*in mid-2021, there was some uncertainty about the potential effect of ivermectin and hydroxychloroquine in patients with COVID-19*".[91]

177 Dr Thomas references the BIRD group (British Ivermectin Recommendation Development Group)[92] which published a meta-analysis in the American Journal of Therapeutics in 2021 from 15 trials available through 25 April 2021 on 27 August 2021.[93] This review found statistically significant 62% reduction in mortality where Ivermectin was used compared to no Ivermectin. Significant but low certainty evidence also showed an 86% reduction in infection with Ivermectin prophylaxis. Severe adverse effects were rare. The "*expression of concern*" by the Journal editor is referenced[94] from six months later, on 17 February 2022.

178 This 'expression of concern' was based on allegations, unproven at the time, that there may have been inaccurate data collection which may have changed the conclusions of efficacy. The authors responded subsequently, indicating that the "*Editorial 'Erratum' now posted with our original article contains hyperlinks not corresponding with the citations in the PDF version; these point in error to irrelevant citations*".[95] They also showed that, even when excluding the disputed trials, meta-analysis continued to show efficacy.

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[90] [PCA-48].
[91] Brief of evidence of M Thomas (9 March 2023) at [49].
[92] Brief of evidence of M Thomas (9 March 2023) at [50].
[93] Brief of evidence of M Thomas (9 March 2023), annexure 19.
[94] Brief of evidence of M Thomas (9 March 2023) at [51].
[95] [PCA-167].

179 Dr Thomas goes on to reference a meta-analysis published on June 2022 on the Cochrane Library Database website,[96] which I discuss in the paragraphs below.

180 PowerPoint slides in my presentation mostly closely associated with that time period provided the source for my statement in the *Courageous Convos* presentation that Ivermectin may well be an effective alternative agent in prevention and treatment of COVID-19. I noted that at the referenced website (on slide 80), that there was a collation of 58 studies involving Ivermectin, including 29 randomised controlled trials. The collected data suggested a 70% improvement in mortality in 22 trials overall. More marked improvement was noted when Ivermectin was used in prophylaxis (85%) and early treatment (78%).[97]

181 I had also shown daily case counts from India after rollout of Ivermectin in the national COVID-19 treatment protocol, showing a peak in cases 14 days later, a peak in mortality 10 days after that, and then marked declines in both (on slide 97).[98] Similarly, I showed a graph of cumulative COVID-19 deaths in Mexico, whereby those in the one state (Chiapas) that used Ivermectin in its treatment protocol showed a markedly lower cumulative mortality compared to the other 30 states (on slide 98).[99]

<u>What does Medsafe say about the use of Ivermectin?</u>

182 That said, even in New Zealand, where guidance from Medsafe was confusing and contradictory, it was not prohibitive — at least as well as one might conclude from correspondence with Medsafe regarding the use of Ivermectin for prevention or treatment of COVID-19.[100]

183 In summary, a suitable oral pharmaceutical containing therapeutic doses of Ivermectin has undergone safety testing sufficient to be approved for use in New Zealand and its use where prescribed by a New Zealand doctor for an 'off-label' use (in this case, for COVID-19) is in fact permitted by Medsafe under section 25 of the Medicines Act 1981.

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[96] Brief of evidence of M Thomas (9 March 2023) at [52].
[97] [PCA-50].
[98] [PCA-96].
[99] [PCA-96].
[100] [PCA-51].

184 Nevertheless, in the real world, multiple doctors in New Zealand have come under scrutiny, even with threat of losing their right to practise, for prescribing Ivermectin or attempting to import it as a licensed health practitioner where it has been unavailable. So doctors who have made themselves aware of world literature which, in their considered opinion, supports the use of Ivermectin in management of COVID-19 have often not been able to treat their patients as they see fit.

Independent analysis of COVID-19 measures

185 We now have 18 months of additional studies in the C19 study group review of Ivermectin. As of 22 March 2023, there are 197 studies included in the C19 study group meta-analysis of Ivermectin, of which 149 are peer-reviewed and 95 compare treatment and control groups.[101] Of these, 45 were randomised control trials, showing 57% improvement for early treatment, 32% improvement when treatment was started late, and 79% improvement in prophylaxis. The discussion of bias in randomised controlled trials is an important one, as are the arguments for the reliability of non-RCT studies. Endpoints of mortality, hospitalisation, need for ventilation, ICU admission, recovery, case numbers, and viral clearance are separately assessed. Studies considered to have critical methodological bias were excluded.

186 The meta-analysis also references results of in silico (computer modelled), in vitro (laboratory research) and in vivo (animal) studies which are supportive of HCQ efficacy, primarily in prophylaxis and early treatment. Recapitulation of each study is provided in tabular and forest plot form, along with appendices and explanation of statistical analysis.

187 The study of Elgazzar, for example, which was criticised for its methodology and was originally included in the meta-analysis at this website, was excluded along with a number of others, but the remainder of studies when collated still showed efficacy. Very detailed explanations were given for the studies that needed to be eliminated on various methodological grounds.

Analysis of why some studies showing no benefit are flawed

188 What is interesting is that there is a voluminous dissertation on those studies and meta-analyses which 'competed' with studies showing efficacy,

[101] [PCA-52]. See also: <https://c19ivm.org/>.

and purported to show no or even negative efficacy (i.e. harm). One of these critical reviews was of the very study of Popp[102] referred to by Dr Thomas.[103]

189 Here listed are some of the criticisms of the Cochrane Library study of Popp et al:

189.1 Unsupported assertions of adverse reactions to Ivermectin, and the outdated claim that unsafe dosing would be needed to be effective.

189.2 A demand for RT-PCR or antigen testing, without analysis of reliability and not universally available even in developed countries at the start of the pandemic.

189.3 Contradictions in the exclusion criteria, including placebo and approved standard of care comparators, but rejecting HCQ, though held to be ineffective (and an approved standard of care in some jurisdictions).

189.4 Inclusion of 'deemed active' comparators whilst excluding 'potentially active' ones.

189.5 Exclusion of combination therapies, though the norm among practising clinicians.

189.6 The rejection of other than randomised control trials when the objective is a 'complete evidence profile'.

189.7 Arbitrary time-points for outcome measures, excluding non-compliant trials.

189.8 Fragmentation of data by location of care under varying hospitalisation criteria.

189.9 The resulting focus on a small fraction of the available clinical evidence, with most comparisons based on single studies with no meta-analysis possible.

[102] [PCA-53].
[103] Brief of evidence of M Thomas (9 March 2023) at [52].

189.10 A resulting inpatient mortality comparison with fewer patients than a June 2020 confounder-matched study.

189.11 No conclusion on the headline mortality outcome, when multiple lines of evidence from elsewhere (including the WHO) point to significant mortality advantage.

190 These criticisms were enlarged after the updated Popp study was published as a preprint in June 2022.[104]

191 Criticisms of the updated Cochrane Library study by the C19 study group can be seen here: [PCA-55].

192 In reviewing any studies in scientific literature, one must be cognisant of bias when selecting, reading and relying upon what studies are available. Increasingly, it has become evident that undisclosed conflicts of interest can place a 'finger on the scales', but in any case, it is a tenet of scientific integrity that one should never rely upon a single study, even one by a reputable organisation like the Cochrane Library. The matter of commercially driven bias in peer-reviewed published medical literature is discussed further below at [204]-[208].

J PARTICULAR 10(B)

193 This particular alleges statements made by me were inaccurate and/or misleading, or had the potential to mislead, because:

> *Dr Canaday's inference that other Covid-19 treatments were suppressed in favour of the Pfizer vaccine:*
> *i. was not supported by evidence; and/or*
> *ii. lacked balance and was likely to undermine public confidence in the Pfizer vaccine; and*

194 I will turn next to the background of why it was reasonable for me to be concerned about the potential for other preventative and therapeutic countermeasures against COVID-19 to be supressed.

Corporate interests and suppression

195 There are published studies of bias related to corporate interests.[105]

[104] [PCA-54].
[105] [PCA-60].

196 I have also read blogposts related to personal experiences with such bias by a leading pulmonologist who has testified before the US Department of Homeland Security on 8 Dec 2020, titled "*Focus on Early Treatment of COVID-19*".[106] Dr Pierre Kory and his associates are behind the FLCCC. In Dr Kory's Substack posts, he describes the challenges in successfully publishing studies showing efficacy of Ivermectin in high-profile medical journals.

Why would information about these drugs be suppressed?

197 The matter of why repurposed, cheap and off-patent drugs seemed to be universally suppressed in so many jurisdictions around the world was thus suspected to be related to the incentives that the huge and global pharmaceutical corporate complex had to engineer the suppressing of safe and cheap alternatives to their own offerings. A number of new, patentable and expensive drugs were in development to treat individuals for active COVID-19 in the event that vaccination was not completely effective as a preventive measure. This pathway could only be possible if cheap and effective but repurposed drugs for treatment were not available.

198 Among these are Remdesivir (Gilead), Molnupiravir (Merck), Paxlovid (Pfizer), and anti-SARS-CoV-2 monoclonal antibodies (Lilly). It came to light that not only was there a pecuniary incentive to suppress, but actual evidence of a contractual/political incentive on the part of governments to do so. This is because of the terms of the contracts signed between Pfizer and respective governments. While I have not seen Pfizer's contract with the New Zealand government, contracts with other countries are available on the internet and it can be inferred our version would be similar. I understand the publicly available contracts to require the purchase of vaccines to be followed through, even if other (cheaper) ways of managing COVID-19 are discovered, such as repurposed drugs.

Censorship of doctors who speak out

199 Doctors worldwide have also been censored or have feared regulatory action against their practice certificates if they speak up, although through independent forums, doctor groups have been able to raise their concerns:

[106] [PCA-61].

199.1 In New Zealand: [PCA-71].

199.2 In Australia: [PCA-72].

199.3 In Canada: [PCA-73].

199.4 In the United States: [PCA-74].

199.5 Rome declaration: [PCA-75].

200 Recently, a peer-reviewed publication detailed how censorship of the views of dissenting doctors, often highly accomplished in their fields, has been carried out over the last 3 years.[107]

201 The abstract of that paper states:

> ***Censorship and Suppression of Covid-19 Heterodoxy: Tactics and Counter-Tactics***
>
> ***Abstract***
> *The emergence of COVID-19 has led to numerous controversies over COVID-related knowledge and policy. To counter the perceived threat from doctors and scientists who challenge the official position of governmental and intergovernmental health authorities, some supporters of this orthodoxy have moved to censor those who promote dissenting views. The aim of the present study is to explore the experiences and responses of highly accomplished doctors and research scientists from different countries who have been targets of suppression and/or censorship following their publications and statements in relation to COVID-19 that challenge official views. Our findings point to the central role played by media organizations, and especially by information technology companies, in attempting to stifle debate over COVID-19 policy and measures. In the effort to silence alternative voices, widespread use was made not only of censorship, but of tactics of suppression that damaged the reputations and careers of dissenting doctors and scientists, regardless of their academic or medical status and regardless of their stature prior to expressing a contrary position. In place of open and fair discussion, censorship and suppression of scientific dissent has deleterious and far-reaching implications for medicine, science, and public health.*

[107] [PCA-76].

Suppression of alternative views by doctors (and others) in New Zealand

202 Turning to New Zealand, the Chair of the Medical Council, Dr Curtis Walker, announced in the public media on 12 June 2021 that, in effect, "*doctors spreading 'misinformation' about COVID-19 may lose their job*".[108]

203 Given this and the *Guidance Statement*,[109] it is evident that the Medical Council, through its regulatory powers inherent in the Health Practitioners Competence Assurance Act 2003, has issued was I perceive to be threats against any practitioner whose views, however expressed, depart from or even question any aspect of the vaccine program.

Pharmaceutical companies control medical journals

204 The influence of pharmaceutical companies on publishing decisions is a matter of discussion internationally.[110]

205 A former editor of the New England Journal of Medicine, one of the most prestigious medical journals in the world, Arnold Relman, said in an editorial in 1990:[111]

> *… readers of review articles and editorials … must rely on the objectivity of the author. When authors have a financial as well as a scientific interest in their subjects, questions inevitably arise that cast doubt on this presumption of objectivity. It is a problem that can and should be avoided by selecting authors who have no financial stake in the subjects they write about.*

206 Unfortunately, as the following news report points out, this issue has not been adequately addressed, and many believe that things have indeed become much worse. An interview with a later editor-in-chief of the same New England Journal of Medicine in 2016, Marcia Angell, suggested so:[112]

> *… a lot of the criticisms that both Bud (Arnold's nickname) and I had was the weakening the conflict-of-interest policy that Bud put into effect. After Bud retired, his successor, Jerome Kassirer continued his strong conflict-of-interest policies for the eight years that he was there, and I then continued for the one year I was editor-in-chief. All three of us continued the most stringent conflict-of-interest policies of any medical journal. When Drazen [subsequent editor of the*

[108] [PCA-77]. See also [PCA-171].
[109] [PCA-33].
[110] See for example [PCA-79].
[111] [PCA-80].
[112] [PCA-81].

> *NEJM] came in, one of the first things he did was to weaken them. In recent years, he has been arguing essentially in favor of conflicts of interest as though the pharmaceutical industry and academic medicine were in the same business somehow, and we ought to support each other. So this created controversy about Drazen's policies — policies that neither Bud, nor I, nor Jerry Kassirer approved of.*

207 These citations may be truly eye-opening to those outside of the academic medical community, but what goes on 'in the kitchen' affects us all.

208 This is also why it must remain permissible to question conventional opinion based on published literature and "*generally accepted by the profession*", and why it is inappropriate to cast judgment on those who may wish to read the published literature more carefully.

K PARTICULAR 10(C)

209 This particular alleges statements made by me were inaccurate and/or misleading, or had the potential to mislead, because:

> *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 …*

210 The relevant passage from Appendix 3 to the charge reads:

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

211 In my *Fact or Fantasy* presentation, I described the similarity of the spike protein, which is manufactured by the cells of the body with instructions from the vaccine's mRNA payload to the placental syncytin-1 protein. This claim was discussed initially in a medical news report and formalised in a petition by Dr Michael Yeadon and Dr Wolfgang Wodarg (a German respiratory physician and former member of the German Bundestag) to the European Parliament, filed in November 2020 for a stay of action by the European Medicines Agency in regard to deployment of the COVID-19 vaccines.[113]

[113] [PCA-94].

212 In section C(XI) (page 5), the authors state:

> *Several vaccine candidates are expected to induce the formation of humoral antibodies against spike proteins of SARS-CoV-2. Syncytin-1 … which is derived from human endogenous retroviruses (HERV) and is responsible for the development of a placenta in mammals and humans and is therefore an essential prerequisite for a successful pregnancy, is also found in homologous form in the spike proteins of SARS viruses. There is no indication whether antibodies against spike proteins of SARS viruses would also act like anti-Syncytin-1 antibodies. However, if this were to be the case this would then also prevent the formation of a placenta which would result in vaccinated women essentially becoming infertile. To my knowledge, Pfizer/BioNTech has yet to release any samples of written materials provided to patients, so it is unclear what, if any, information regarding (potential) fertility-specific risks caused by antibodies is included.*
>
> *According to section 10.4.2 of the Pfizer/BioNTech trial protocol, a woman of childbearing potential (WOCBP) is eligible to participate if she is not pregnant or breastfeeding, and is using an acceptable contraceptive method as described in the trial protocol during the intervention period (for a minimum of 28 days after the last dose of study intervention).*
>
> *This means that it could take a relatively long time before a noticeable number of cases of post-vaccination infertility could be observed.*

213 At the time of my presentation, there was a plausible basis for concern but no proof. My slide presentation raised a very legitimate question, and what I felt was the need to be much more certain that this does not happen before recommending the vaccine to pregnant women. This is entirely consistent with the 'precautionary principle' whereby new and untested interventions are not broadly applied, especially in the vulnerable population of pregnant women.

214 On slide 77 of the *Fact or Fantasy* presentation, I stated that "*Possible cross-reactive antibody may threaten placental integrity*" and "*Not enough information is currently available to determine if rate of miscarriages is unusually elevated*".[114]

[114] [PCA-96].

The Shimabukuro study

215 In subsequent presentations I have also discussed the famous Shimabukuro paper published in the New England Journal of Medicine in June 2021, that had been used to justify the purported safety of using the Pfizer/BioNTech and Moderna mRNA formulations during pregnancy.[115]

216 At the time there was some controversy as to whether miscarriages were increased after vaccination, as a result of a letter to the editors on 8 September 2021, not available at the time of the presentation.[116]

217 The letter authors correctly pointed out that only those pregnant women vaccinated in the first and second trimesters should be represented in the denominator in the percentage calculation when miscarriages are the endpoint to be measured.

218 The authors of the original paper may have reached a misleading conclusion in that they included <u>all</u> vaccinated pregnant women in all stages of pregnancy in the denominator, whereas the number of spontaneous abortions (miscarriages) stopped at week 20, which is also when they should have stopped including any more women who were vaccinated after this in the denominator.

219 This altered the spontaneous abortion rate from the published results of 12.6% (= 124/827) to the writers' recalculated rate of 82% (= 104/127) when one correctly includes only the group with both vaccinations and spontaneous abortions up to 20 weeks. This rate would be extraordinarily high if confirmed.

220 Whilst the letter to the editors had not appeared until 8 September 2021, one of my sources had already recognised this error in calculation and noted it in a news report. I concurred that there could be an issue with increased risk after all, but I did not actually show slide 78 (with these alarming figures) at the time of the presentation in a cautionary move.

221 As it turns out, the calculation of true miscarriage rate is even more complicated when data are presented in a confusing way, and the study did

[115] [PCA-97].
[116] [PCA-98].

not have a long-enough follow-up period to assess all relevant pregnancy outcomes.

A deep dive into the Shimabukuro paper

222 A post from 14 September 2021 discusses the Shimabukuro paper and the letter to the editors in great detail.[117]

223 Just this current March 2023, Dr Syed updated his blog on the miscalculation of miscarriage rates, based on internal data that Pfizer had accumulated after rollout of the Comirnaty vaccine. He goes into exhaustive detail as to the limitations of prior studies, how statistics can be skewed and how even prominent obstetrician-gynecologists can be misled, but still concludes that:[118]

> *There is an undeniable safety signal for around a doubling of miscarriage rates following administration of mRNA vaccines in pregnancy. The regulators had this information at the time they approved the drugs.*

224 So, in the end, assessing true miscarriage rates is difficult, but we cannot assess this vaccine using novel development techniques as being truly safe in pregnancy with, in my opinion, the required degree of certainty. After the thalidomide experience (where an anti-emetic drug used during pregnancy resulted in phocomelia/'flipper arms'), it has been customary **not** to deploy new medical interventions of this nature during pregnancy in its initial deployment, especially for widespread and indeed global, general use.

How to assess 'sterility'

225 The matter of 'sterility' or really 'infertility' is difficult to parse from what I could find in the scientific literature. Collecting data in humans can be fraught with confusing issues: decisions to bear children are highly personal, and factor in many factors of lifestyle, work commitments, age, family traditions, ethnicity, health status, gender preferences and diet are just a few. And yet, 'fertility' is a term which collects all of these elements into a single number of '1.9 children', for example, from which changes compared to historical references are assessed and interpretations made. In my view, it may be difficult to discern a reliable conclusion.

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[117] [PCA-99].
[118] [PCA-100].

226 Things can be quite different in experimental animals where conditions are controlled and the longer-term effects on first, second and third generation fertility can, in theory, be assessed. How that translates to infertility in humans may be problematic.

227 This is not an area in which I feel capable to assert a considered opinion, nor, I believe should it be a primary focus of this response.

L PARTICULAR 10(E)

228 This particular alleges statements I made were inaccurate and/or misleading, or had the potential to mislead, because:

> *The statements concerning graphene oxide lacked evidential foundation and were presented uncritically.*

229 In July 2021, a research group named 'LaQuinta Columna' based in Spain reported that they had discovered through mass spectroscopy and electron microscopy the presence of materials that appeared similar to known reference sources of graphene oxide within sealed phials of Conirnaty. This source was available to me at the time that I answered a question from the online audience during the webinar aired on 19 August 2021. The discovery is described in the following link: [PCA-155].

230 Early reports from LaQuinta Columna were available to me at the time that I made mention in my public presentations of the possibility, but not certainty, that graphene oxide may be an undisclosed ingredient of Comirnaty in New Zealand and may be a contributor to the widely reported paramagnetic effects in inoculated subjects.[119] The implications of this finding are beyond the scope of this discussion.

M PARTICULAR 6(C)

231 This particular alleges statements made by me were inaccurate and/or misleading, or had the potential to mislead, because:

> *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 …*

[119] PCC disclosure at 327. See also [PCA-172].

232 In the *Courageous Convos* presentation, I clearly stated:[120]

> *… we're talking about potential sterility here … and … about … the potential of having large numbers of deaths from these vaccines …*

233 I have already addressed these issues in response to particulars 2(b) and 10(c). I do not think it is unprofessional to be worried about **potential** deaths and **potential** sterility. New Zealand was proposing to use a vaccine that had been developed very quickly and had not undergone the usual regime of testing. No data of medium or long-term safety were available, because the vaccine had only existed for a short time. In such circumstances it was essential that scientists and doctors be acutely alert to signals about potential adverse effects of the product. New Zealanders should expect nothing less of us. Nor is there any basis in a free and democratic society to keep secret or censored information about product safety and discussion of it. My presentations were given in the utmost good faith and with no agenda whatsoever. I cannot understand why people needed to be 'protected' from the information I was discussing through censorship. Implicit in such a view is, in my view, an incredible disregard for the agency and rights of ordinary people who interact with the medical profession, and also unfortunately suggests that authorities may actually have something to hide

234 Slides 61-70 in my *Fact or Fantasy* presentation on 15 July 19 at Thames, contemporaneous with the presentation relevant to particular 6, discussed the issue of post-vaccination deaths in available medical literature available at the time.[121]

N DISPARAGING / UNPROFESSIONAL CRITICISM

235 I do not understand the allegation that things I said during the relevant presentations were disparaging and/or amounted to unprofessional criticism. There was certainly no intention by me to be 'disparaging' or 'critical' of any person. Nor have I been presented with any evidence of any person who felt disparaged or criticised by things I said.

236 The COVID-19 pandemic and New Zealand's response to it was one of the most significant political moments for this country since the Second World War. There was not and there never could be one 'right' answer to the

[120] PCC disclosure at 217.
[121] [PCA-50].

question of how the country should respond to the pandemic. Clearly there were a very wide range of views about the political decisions made by the government and other institutions wielding public authority, including the Medical Council. It cannot be right that merely belonging to a profession prevents one from participating in public discourse. The statements singled out by the charge are hardly inflammatory.

237 With respect to Appendix 1 statement (e), I doubt the PCC can disprove my view (informed by discussions with many colleagues) that medical practitioners here and overseas felt pressure to toe the party line. Indeed, this whole proceeding is evidence of the drastic consequences of putting one's head above the parapet! The applied for Appendix 3 statements (d) and (e). I find it worrisome that even my expressions of feeling bullied are being singled out by the PCC for censorship.

238 With respect to Appendix 2, statement (a), I stand by my view that the uncertainties and nuances of the scientific information about the mRNA vaccines were not being discussed publicly in mainstream fora.

239 With respect to Appendix 2, statement (d), I defend my right to disagree with political decision of the government of the day, including by comparing such decisions in a metaphorical way with historical dictatorial regimes known for not tolerating dissenting thought.

O CONCLUSION

240 The purpose of this response has been to provide evidence of how I went about researching and verifying various of the many statements made by government authorities, regulatory agencies, media spokespersons, and pundits in respect to the 'safe and effective' messaging that prevailed at the beginning of New Zealand's response to the COVID-19 pandemic and which has prevailed since that time.

241 I have touched on many of the reasons for my concern that the New Zealand public had not been told the 'full story' about the Comirnaty product. I have described not only the compelling ethical principles under which all doctors must practise their profession, but also the conflicting nature of guidance from the Medical Council for adhering to the principles of informed consent in all interactions with their patients on the one hand, and then requiring that no comprehensive discussion or alternative messaging to that put forth by

those government authorities (to fully inform their patients about risks as well as benefits) would be permitted.

242 I hope that I will have conveyed through the several days of hearings that there were actually a large number of points, indeed critically important points, in which peer-reviewed literature, evaluated critically and in depth, could lead to legitimate questions about the ‘safe and effective’ messaging promoted by government authorities.

243 Lastly, and most importantly, what is on trial here is not simply one doctor’s statements, and whether they were true or not at the time spoken, but whether careful, thoughtful speech and expression, without ill-will or malice of intention, are to be preserved in New Zealand or not. What is placed in the hands of this Tribunal, in my opinion, is no less a premise than the question of whether the most foundational principles of a free and democratic people are to be preserved in our beloved country.

Dated this 3rd day of April 2023

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Dr Peter Canaday