Canadian Healthcare Under Siege

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Beginning in 2020, COVID-19 ushered in record profits for a few major pharmaceutical companies.[1] At the same time, the declared pandemic saw radical changes made to patients' rights to informed consent, as well as major shifts in the way in which healthcare was being, and now continues to be, offered and administered to Canadians. To put it bluntly, the pharmaceutical industry's influence upon medical treatment in general, and treatment guidelines in particular, has undermined informed consent and the ethical principles fundamental to the practice of medicine in Canada. When considering medical treatment within Canada's healthcare system, it has become essential to keep in mind the background of powerful influence that the pharmaceutical industry brings to bear at every stage—from research through development and trials, to approval, marketing, and doctors' recommendations. Remaining ever vigilant, one must recognize the unprecedented, pervasive, and alarming effect this industry is having upon decision making and policy at all levels within the Canadian public health system.

Ethical, Personalized Medical Care in Canada

The core of medical ethics in Canada, as elsewhere, is informed consent. Medical informed consent is only possible when the risks and benefits of both a treatment, and alternatives to the treatment, are provided to the patient, and when that patient is given the choice to take or refuse treatment while remaining free from fear or coercion. It is the doctor-patient relationship that both enables and safeguards this medical informed consent.

The doctor-patient relationship is focused upon the integral well-being of the individual patient. Doctors have made a promise to do no harm to their patients. This promise is the primary focus of the Hippocratic oath, a formal statement of medical ethics that dates back to the classical period of Ancient Greece.[2]

It is each doctor's fiduciary duty to provide patients with the balance of evidence for and against given treatments. The word fiduciary is derived from the Latin *fidere*, which means "to trust." As such, a fiduciary duty is when one person is entrusted to take care of the interests of another. In keeping, then, with the Hippocratic oath and the relationship of trust between doctor and patient, the evidence for and against treatment options must be presented clearly to patients, so that it facilitates their informed, yet still autonomous, decision making.

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[1] Dunleavy, K. (2022, April 12). *The top 20 pharma companies by 2021 revenue.* Fierce Pharma. http://archive.today/2022.08.05-032057/https://www.fiercepharma.com/special-reports/top-20-pharma-companies-2021-revenue

[2] Tyson, P. (2001, March 27). *The Hippocratic Oath today.* PBS Online. http://archive.today/2021.05.12-173358/https://www.pbs.org/wgbh/nova/article/hippocratic-oath-today/

To properly support a patient's informed consent, the medical professional must have an up-to-date understanding of the available research, the risks and harms of treatment options, and the patient's unique clinical situation. As the patient's advocate, the health care provider must also show consideration for the particular preferences that inform the patient's decision-making process with respect to treatment.

Of course, a given doctor can't read all the relevant research out there – nobody can. This is where medical treatment guideline development comes in. Guidelines are prepared by specialists, with expertise in a broad range of fields. These specialists work together to prepare recommendations that will help generalists customize treatment for their patients. The development of comprehensive, eminently reliable guidelines is essential to ensuring both informed consent and a high standard of personalized medical care.

Strong Medical Treatment Guidelines Ensure the Best Possible Care

Each expert within the panel of specialists working together to prepare medical treatment guidelines, possesses a mastery of a particular treatment domain. These are the people who do the clinical and preclinical research in their fields. This research is presented at conferences and published in journals, thereby adding to the published literature that describes the treatment options available in Canada. Only a select group of options are approved by Health Canada, which must always ensure a minimum level of safety and efficacy before allowing a manufacturer to market their drug to the general public.

Just because a given treatment has Health Canada approval does not mean one has to use it, nor that it is the best option available. Indeed, it's always possible that the best option for a given patient might be no treatment at all. When granted Health Canada approval, this simply means a treatment has become one of the many tools in physicians' tool-kits. In other words, Health Canada approval means that a treatment can be used for the customized therapy designed in the doctor-patient relationship, and can be chosen by a properly informed patient.

Ideally, in the creation of guidelines there should be a specialist who is able to represent and explain each and every treatment option, including the option of choosing to receive no treatment at all. Guideline development begins with identifying a set of essential clinical questions, a range of circumstances and a range of patient types—guideline developers have to be able to say, "for this type of patient, in this circumstance, you could offer this type of treatment." Specialty teams are formed to represent the relevant medical fields. These teams begin with a literature search surveying all the published data. The data is summarized, and the evidence weighed. The specialists then set out to develop the guideline by generating multi-disciplinary answers to their initial clinical questions. In doing so, they reflect on the needs of a wide variety of patients and develop different recommendations for each of these patient groups. This whole process is an essential component of personalized medicine in Canada.

For a guideline to be good and robust, it needs to satisfy a number of basic requirements. First, the guideline must be properly representative. The panel generating treatment recommendations has to involve a broad base of contributing specialists, so that all the different treatment options are both thoroughly researched and represented. Second, the guideline must be based on the best available evidence. Third, all of the guideline's recommendations should be qualified based on the level of evidence and the degree of consensus among specialists regarding their efficacy. Strong recommendations are those supported by a high level of evidence and a high degree of consensus from a broad range of experts. Fourth, the guideline must be readily understandable. The interpretation, synthesis and summary of available evidence and the recommendations for treatment must be thorough and clear.

Once medical treatment guidelines are developed, they are conveyed to treating clinicians who use them to customize patient care. To be successful, the guideline must enable the generalist physician to both understand the treatment options available and make them understood by the patient, thereby fulfilling his or her fiduciary duty to provide the best possible care while facilitating and safeguarding the patient's informed consent.

Limiting Pharmaceutical Industry Influence Upon Medical Care in Canada

So, the doctor-patient relationship is supported by the development of representative, evidence based, and clearly understandable guidelines. In Canada's personalized healthcare system, patients must be provided with safe and efficacious treatment options tailored to their individual needs and, these treatment options must be clearly presented to patients to support informed decisions regarding their treatment. As has become clear during the declared pandemic, however, the doctor-patient relationship, and Canada's personalized healthcare system in general, are vulnerable to being undermined by conflict of interest.

A conflict of interest is when a party has a competing interest that might interfere with providing the best treatment to patients. Conflicts of interest pose a great threat to the Canadian health system's ability to guarantee the integrity of the doctor-patient relationship which, in turn, guarantees and protects informed consent. The Canadian health system recognizes the potential for conflict-driven bias in the research, development, and marketing of medical treatments and has implemented an elaborate system of checks and balances to ensure that the pharmaceutical industry's interests do not eclipse those of the patient.

A first safeguard limits the ability of pharmaceutical corporations to communicate directly with patients. As members of the general public, patients are not likely to have the medical background required to assess the medical literature and, thus, may lack the trained discernment to see whether or not a drug or treatment option is being presented in a fair and balanced manner. As a result, without assistance, most patients do not possess a sufficient degree of medical knowledge to make properly informed choices.

A second safeguard requires that investigators disclose the sources of funding they have received in support of their research. It is especially important to disclose when a trial or guideline has been sponsored by a pharmaceutical company that would stand to benefit from favorable outcomes and recommendations.

A third safeguard involves the scrutiny of the results of trials by expert peers, either at conferences, or in the process of submitting research for publication in scientific journals. This peer review process is in place to ensure that published research is reliable, thereby safeguarding the integrity of the published literature.

A fourth safeguard occurs, once the peer-reviewed research has been published, when Health Canada is charged with independently evaluating the submitted research for marketing approval. The job of Health Canada is to ensure that the drug or other treatment is effective and safe for use in the designated treatment group.

A fifth and final safeguard requires that those involved in the development of comprehensive medical treatment guidelines disclose funds they have received from pharmaceutical companies. When interpreting and evaluating a guideline it is very important to consider the source of funding, particularly if pharmaceutical companies or their representatives have been involved in its development.

The Vaccine Market

Many people still aren't aware that vaccines are big, BIG business. The general public is not in the habit of evaluating vaccines in terms of profit margins. While considering them from this industry perspective can seem unnatural and can even feel disorienting, it is nevertheless essential that members of the public begin to do so—particularly if they hope to gain any practical understanding of what is at stake in the vaccine industry.

When looking at medical treatments from a business perspective, the patient population is the market. If a corporation has developed a treatment for a small patient population, then the corporation has a small market and it is unlikely that it will make a lot of profit unless it charges a lot of money for its product. If a corporation has a treatment for a really big patient population, then it has a big market and even if its product is reasonably priced it's going to get a lot of profit. So, from a profit standpoint the ideal product is the treatment that everyone needs, because pharmaceutical corporations want large patient populations and thus large markets with large profits.

Heart disease can be used to illustrate. A lot of people have heart disease. It has a big patient population, so that's a big market with big profits. But if a pharmaceutical corporation can move into prevention, if a corporation can convince healthy people that they are at risk of heart disease and need to take something to prevent the onset of this condition in the future, then it has a much bigger market. When this shift to prevention happens, however, the pharmaceutical company has moved from selling a drug to selling fear. Basically, if such corporations can convince people that they are at risk of something terrible happening, then to sell their product—they just have to scare them enough. If people are truly afraid, a pharmaceutical company could convince them, even at peak health and at low risk of severe

disease, to take a product in the hopes of preventing some future illness. As vaccines are usually administered to healthy individuals in order to prevent future disease instilling fear about potentially severe disease outcomes becomes a necessary component of vaccine marketing.

Traditionally, use of vaccines has been limited to children, with the goal of preventing common childhood illnesses. As a result, paediatric vaccination guidelines are generally developed by the Canadian Paediatric Society. The seasonal flu vaccine, however, has opened up a brand new and enormously profitable market, with vaccines that may need to be administered annually. For pharmaceutical corporations, respiratory vaccines open up one of the biggest markets there is. Not only can they vaccinate an entire population, but they can vaccinate them on an ongoing basis. The potential for profit goes through the roof for this type of universal treatment. If a pharmaceutical company has a flu vaccine that requires a shot each year to prevent seasonal illness... Well, one can imagine how profitable that could be. The only thing that would be still more profitable would be a vaccine that required multiple boosters a year to prevent infection.

Patient-Centred Care and Informed Consent Threatened by Public Health Vaccine Program

One particularly significant health system shift that we have seen in Canada in recent years is that the dispensing of vaccines has begun to move outside of the paradigm of the doctor-patient relationship. Flu vaccines have been made available outside doctors' offices; they are now available and administered in clinics and pharmacies. One of the real drawbacks of this new process for administering flu vaccines is that the health care workers who administer the vaccines in clinics are not clinicians—in other words, they are not the patient's doctor. This is concerning because those administering the vaccines know very little about the people who are receiving them and are therefore poorly equipped to support informed consent.

Within the Canadian health system, the patient's right to informed consent is paramount. And the key to providing patients with all they need to give informed consent is the medical professional in the doctor-patient relationship. The patient's doctor not only understands the risks and benefits of a given treatment, and of all the other treatment options available, but also knows the patient's medical history and understands the patient's medical preferences. When a treatment, like the respiratory flu vaccines, is administered outside the doctor-patient relationship, the patient's ability to make an informed choice is immediately compromised.

By shifting responsibility for the respiratory flu vaccines primarily into the hands of public health, the established practice of customized patient care is effectively being replaced by a new one-size-fits-all policy. This one-size-fits-all policy can still retain some prescriptive nuance, to the extent that it can identify certain patient groups that are at higher risk than others or those that should not receive treatment. Broadly speaking, however, this is a one-size-fits-all treatment delivered by people who don't know the patient. Still more concerning, instead of being introduced to the available treatment options

by their doctor, patients are receiving this information via public health slogans disseminated through the media.

Administering vaccines in clinics under the auspices of public health disrupts the doctor-patient relationship and compromises informed consent. This problem becomes particularly troublesome when one is dealing with a vaccine that has been rushed to market and rolled out using preliminary safety data as it becomes very difficult to gather accurate safety data about adverse reactions. When the vaccine has not been proven safe through rigorous long-term testing, and when the vaccine is not good for everyone, one-size-fits-all public health messaging may involve recommendations that put a considerable segment of society at risk. Compounding these problems, there is no vaccination follow up. Unlike in the traditional doctor-patient relationship—there is no one in the public health system actively monitoring patients for treatment side effects. Instead, members of the public are left on their own to recognize, cope with, and seek care for their vaccine injuries and then to hope that their physician has recorded these injuries with the Canadian Adverse Events Following Immunization Surveillance System (CAEFISS).

Public Private Partnership—Public Health in Bed with Big Pharma

To understand the latest developments in the vaccine industry, it's helpful to go back and look at developments surrounding vaccines over time. It's important to understand that Canada has what is called a single payer system. As a result, one of the largest single item expenditures for the Canadian government is medical care. The government is, therefore, always on the lookout for ways to minimize costs.

So, the pharmaceutical corporations approach public health with a cost reduction proposition. And the pharmaceutical representatives say, "listen, if you use our relatively low-cost vaccines, you will be able to prevent a lot of illness which will reduce your overall expenditures. We know that hospital costs, together with the cost of doctors, are your highest budget items. If you partner with us, then not only will you play a key role in managing illness, but you will save hospital costs and doctor costs."

Over the last number of decades, pharmaceutical corporations have come to understand that collaborating with public health can be enormously profitable. As mentioned earlier, there are regulations in place that limit pharmaceutical corporations from directly communicating with the public. There are, however, no limits to what public health is allowed to say to the general public. Thus, while marketing and public relations campaigns can be very costly for pharmaceutical corporations, having public health pick up the bill using tax-payer dollars is an ideal situation that protects pharmaceutical profit margins and effectively allows them to circumvent regulations. Better still, from the Pharma perspective, public health is trusted by the general public and is not required to justify its endorsement of a treatment or to disclose conflicts of interest. In other words, public health is the ideal pharma partner.

Once partnered with public health, the pharmaceutical corporations have a mouthpiece that allows them to directly influence their target populations. The pharmaceutical corporations are still not able to

communicate directly with patients. But if pharma can convince public health of the benefit of the treatment they are offering, then public health will convey that message to the public at no cost to the pharmaceutical corporations themselves.

Public Private Partnership Means Public Health's Footing the Bills!

If public health is going to be successful in promoting a vaccine, it needs an effective way to communicate with the masses. As an agency of civil servants, marketing might not be one of public health's major strengths, and so they might need to enlist assistance from marketing and/or public relations firms. These firms, in turn, will develop sophisticated multi-media, marketing, and communication plans that could involve media (radio spots, TV spots and newspaper ads), social media (ads and search engine optimization) as well as billboards.

These marketing and/or public relations firms may also help develop a network of sympathetic doctors, such as emergency room physicians with overloaded emergency rooms, or pro-vaccine doctors who they can put on retainer to promote disease alarmism and vaccines when needed. In addition, they might also launch influencer campaigns that enlist trusted community leaders to encourage people to take the vaccines.

It wouldn't be surprising if the firms that work for public health in promoting these vaccines are the same ones that run the pharma vaccine campaigns. Indeed, one would imagine that if pharmaceutical marketing slogans like "safe and effective" and the "best way to protect those you love" are coming from public health, then there is very likely some behind the scenes connection. Whatever that connection may entail, these phrases sound a lot more like pharmaceutical company marketing slogans than the balance of information and clinical judgement that is meant to supply the basis for patients' informed consent.

It should also be noted that news outlets have provided major contributions to vaccine marketing. As businesses, news outlets profit from sensational news. They are therefore ideal conduits for disease alarmism, a fundamental element of any vaccine marketing campaign. Furthermore, a substantial portion of news outlets' advertising revenue comes from pharmaceutical corporations, a significant factor that might just incline them to show vaccines in a favourable light.

A Vaccine-Specific COVID-19 Response Endorsed by a Vaccine-Specific Advisory Body

As with other types of medical treatment, with vaccines there exist treatment guidelines. Health care is a provincial jurisdiction and therefore each province is tasked with the job of developing guidelines reflective of provincial standards of care. With respect to vaccines, however, the provinces might be particularly open to receiving guidance from the Public Health Agency of Canada (PHAC) which in turn

receives guidance from the National Advisory Committee on Immunization (NACI). Founded in 1964, NACI is intended to be an independent panel of experts in the fields of pediatrics, infectious diseases, immunology, pharmacy, nursing, epidemiology, pharmacoeconomics, social science and public health.[3] It was ostensibly formed to evaluate clinical data and make recommendations that would assist in developing balanced evidence-based immunization guidelines for the whole of Canada.

As health care is a provincial jurisdiction and the ultimate responsibility for treatment guidelines rests with the provincial public health officers, NACI's role in generating policy recommendations has some very clear limits. Nevertheless, they were depicted by government and public health officials and by the mainstream media as the primary public agency being consulted in the development of Canada's national COVID-19 treatment guidelines.[4, 5]

There were, in fact, other bodies advising public health on Canada's COVID-19 response, among which were NACI; the Clinical Pharmacology Task Group (an external advisory body for the Public Health Agency of Canada); and the COVID-19 Therapeutics Task Force, a public private partnership responsible for "assess[ing] and prioritiz[ing] COVID-19 therapeutic projects seeking government support."[6] Once the mRNA COVID-19 vaccines became available, however, the treatment related working groups were shut down. In the case of the COVID-19 Therapeutics Task Force: the assessment and prioritization of COVID-19 therapeutic projects was considered necessary only "[u]ntil we can immunize Canadians on a national scale with an effective vaccine." And similarly, the Clinical Pharmacology Task Group announced that its "mandate… ha[d] concluded… effective March 30, 2021… because of the welcome entry of effective and safe vaccines to the Canadian health care system."[7]

In other words, there were multiple groups besides the National Advisory Committee on Immunization working on Canada's COVID-19 response. Funding was set aside for them. Research was conducted. But the relative meagreness of these initiatives favoured a very particular desired outcome. The comparative difference in funding, while falling short of total exclusion, created a clear selection bias towards vaccines as the only or primary answer. From the beginning, the projects these groups supported were considered subordinate to the development and rollout of the genetic vaccines. Essentially, by moving NACI into the primary advisory role to the Public Health Agency of Canada, public health was favouring a vaccine-specific and pharma-friendly solution to the COVID-19 crisis.[8]

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[3] Public Health Agency of Canada. (2023, March 29). *National Advisory Committee on Immunization (NACI): Membership and representation.* Government of Canada. https://web.archive.org/web/20230514002150/https://www.canada.ca/en/public-health/services/immunization/national-advisory-committee-on-immunization-naci/naci-membership-representation.html

[4] Boynton, S. (2022, June 19). *COVID-19 boosters recommended this fall ahead of future pandemic wave: NACI.* Global News. http://archive.today/2023.04.19-201142/https://globalnews.ca/news/8957899/naci-covid-19-boosters-fall-canada/

[5] Pelley, L. (2021, April 23). *Canadians over 30 should be offered AstraZeneca-Oxford COVID-19 vaccine, advisory body recommends.* CBC News. http://archive.today/2021.04.24-073245/https://www.cbc.ca/news/health/astrazeneca-covid-19-vaccine-over-30-naci-1.6000052

[6] Innovation, Science and Economic Development Canada. (2022, March 10). *COVID-19 Therapeutics Task Force.* Government of Canada. http://archive.today/2023.04.27-230206/https://ised-isde.canada.ca/site/canadian-life-science-industries/en/covid-19-therapeutics-task-force

[7] Public Health Agency of Canada. (2021, June 15). *COVID-19 Clinical Pharmacology Task Group.* Government of Canada. http://archive.today/2022.04.01-013805/https://www.canada.ca/en/public-health/corporate/mandate/about-agency/external-advisory-bodies/list/covid-19-clinical-pharmacology-task-group.html%23a3

[8] Canadian Institutes of Health Research. (2019, April 24). *Heralded as one of the greatest medical breakthroughs of modern times, why are proven-effective vaccines suddenly getting such a bad rap?* Government of Canada. https://web.archive.org/web/20230908175700/https://cihr-irsc.gc.ca/e/51440.html

Because its panel members are significantly invested in immunization, the first sort of conflict of interest that might be expected to bias NACI's COVID-19 treatment recommendations is careerism. The careers of many NACI members are closely connected to research into respiratory infections, flu vaccine development, reducing vaccine hesitancy, and encouraging vaccine uptake. In this instance, given these individuals' long standing professional investment in vaccine or vaccine adjacent domains, it is reasonable to expect that they may be biased toward a vaccine-specific response to COVID-19. Such recommendation would further their careers as a natural extension of the work they have already been doing. Career investment in the development and promotion of vaccination naturally entails an explicit financial dimension, with almost half of NACI committee members disclosing instances of direct pharma funding.

The second sort of conflict that could bias NACI recommendations has to do with both pharma-backed research funding and pharma-backed research priorities. Some NACI members received grants for COVID-19 research directly from pharmaceutical corporations. Other NACI members have been receiving grants from Canadian public funding bodies whose research priorities have been developed in conjunction with the World Health Organization and GloPID-R, the Global Research Collaboration for Infectious Disease Preparedness, which describes itself as a "global coalition of research funders."[9]

These two organizations have played a key role in coordinating the pandemic response and research efforts internationally. They are both intertwined with global pharmaceutical interests in their efforts to advance research and development of pharmaceutical products with a major focus on vaccine development. The membership of GloPID-R includes both the World Health Organization, Gavi the Vaccine Alliance, and the Coalition for Epidemic Preparedness Innovations, alongside 30 other private organizations and public institutions, among which many national research councils and the Canadian Institutes of Health Research.[10] In February 2020, one month before the official declaration of the pandemic, Canadian researchers gathered alongside other international researchers at the World Health Organization (WHO)-Global Research Collaboration for Infectious Disease Preparedness (GloPID-R) joint meeting in Geneva to coordinate research efforts to bring an end to the pandemic.[11] Subsequent to this meeting, Canada's research priorities in response to COVID-19 response were largely correlated with the "Global COVID-19 Research Roadmap" developed and published (in March 2020) as a collaboration between GloPID-R and the WHO R&D Blueprint Team.[12, 13]

One might like to assume no conflict of interest can arise when funding comes from public sources. In this case, however, throughout the declared pandemic, Canadian research and funding bodies have adopted research priorities largely set by global pharma-directed research and funding entities heavily invested in vaccine development. It is, therefore, reasonable to assume significant conflict of interest in

[9] Fondation Mérieux. (2022, October 11). *Who are we and what do we do? A short introduction to GloPID-R.* YouTube. https://www.youtube.com/watch?v=vYBgUyIHCUI
[10] *Members*. GloPID-R. Retrieved September 8, 2023, from https://www.glopid-r.org/members/
[11] Harris, M., & Jasarevic, T. (2020, February 12). *World experts and funders set priorities for COVID-19 research.* World Health Organization. https://web.archive.org/web/20230908180218/https://www.who.int/news-room/detail/12-02-2020-world-experts-and-funders-set-priorities-for-covid-19-research
[12] *Our milestones.* GloPID-R. Retrieved March 29, 2023, from http://archive.today/2023.03.29-221117/https://www.glopid-r.org/our-milestones/
[13] Cochrane. (2021, October 18). *Cochrane Convenes keynote from Dr Charu Kaushic* [at 12:43]. YouTube. https://youtu.be/qpy3MGNqcM0?si=k4TLeSpeSwkW-aeO

the case of NACI members not only when they are receiving COVID-19-related research funds directly from pharmaceutical corporations but also when these funds are coming through public funding bodies following GloPID-R's roadmap of research priorities. Indeed, the NACI chair, Dr. Caroline Quach-Thanh, has gone on to receive more than 10 million dollars in research grants over the past three years alone.[14, 15, 16, 17, 18]

Within advisory committees like NACI, the Chair and Vice Chair set the tone for the group. At the outset of the declared pandemic, both the NACI chair, Dr. Caroline Quach-Thanh and the Vice Chair, Dr. Shelley Deeks were already heavily invested in respiratory infection and vaccine research. At the beginning of the declared pandemic, Dr. Quach-Thanh received a 2.6-million-dollar operating grant from the Canadian Institutes of Health Research (CIHR) for research into COVID-19 diagnostics.[19] Those inquiring into the development of Canada's COVID-19 pandemic policy might well ask whether interested parties—the same interested parties that comprise the corporate membership of global funding coalitions like GloPID-R—stood to benefit if Dr. Quach-Thanh, as an infectious disease specialist, agreed COVID-19 was serious enough to warrant use of a novel tech in anticipation of the launch of the coming mRNA vaccine. Given her own career investment in this particular field of research, and the enormous amount of funding available for further research contingent upon there being a pandemic, how likely would it be for someone in Dr. Quach-Thanh's position to question the appropriateness of this pandemic designation? That there were grounds, in the first place, for declaring a pandemic appears to have been a largely unexamined assumption. When one looks at the manner in which the first CIHR grant was written, Dr. Quach-Thanh appears to have been tasked—from the beginning—not so much with the critical appraisal of Canada's rapid, vaccine-specific response to the global pandemic, but rather with the development of high-quality and real-time evidence to support that response.[20] In other words, Dr Quach-Thanh wasn't being asked to do something out of the ordinary in terms of her own career. On the contrary, she was being asked to do work within her speciality to support a global pandemic response. Given her commitment to immunization and the degree of her professional investment in infectious disease, it would be preposterous to imagine that Dr. Quach-Thanh could offer unbiased recommendations on the gravity of the pandemic and the necessity of dramatic counter-measures.

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[14] Racine, É., Boivin, G., Longtin, Y., McCormack, D., Decaluwe, H., Savard, P., Cheng, M. P., Hamelin, M., Carbonneau, J., Tadount, F., Adams, K., Bourdin, B., Nantel, S., Gilca, V., Corbeil, J., De Serres, G., & Quach-Thanh, C. (2022). *The REinfection in COVID-19 Estimation of Risk (RECOVER) study: Reinfection and serology dynamics in a cohort of Canadian healthcare workers.* Influenza and Other Respiratory Viruses, 16(5), 916–925. https://doi.org/10.1111/irv.12997

[15] *Vaccine surveillance Reference group (VSRG).* COVID-19 Immunity Task Force. Retrieved March 22, 2022, from https://web.archive.org/web/20220322055241/https://www.covid19immunitytaskforce.ca/vaccine-surveillance-reference-group-vsrg/

[16] Social Sciences and Humanities Research Council of Canada. *Grants and Contributions - Canada Research Chairs - 207-2020-2021-Q3-00264.* Government of Canada. Retrieved March 21, 2022, from http://archive.today/2022.03.21-214815/https://search.open.canada.ca/en/gc/id/sshrc-crsh,207-2020-2021-Q3-00264,current

[17] Canadian Institutes of Health Research. (2022, February 17). *Deciphering the immunopeptidomic landscape of COVID-19 disease.* Funding Decisions Database; Government of Canada. http://archive.today/2022.03.23-021330/https://webapps.cihr-irsc.gc.ca/decisions/p/project_details.html?applId=443349&lang=en

[18] *Huit projets au CHU Sainte-Justine financés dans le cadre du concours de subventions Projet de l'automne 2020 des IRSC.* (2021, March 10). Centre de Recherche du CHU Sainte-Justine. https://web.archive.org/web/20220417051604/https://recherche.chusj.org/fr/Communications/Nouvelles/2021-(1)/Sept-projets-au-CHU-Sainte-Justine-finances-dans-l

[19] Canadian Institutes of Health Research. (2020, June). *Operating Grant: COVID-19 Rapid Research Funding Opportunity - Diagnostics.* Government of Canada. http://archive.today/2022.03.21-215952/https://search.open.canada.ca/en/gc/id/cihr-irsc,236-2020-2021-Q1-00639,current

[20] Sturgess, L. (2022). *National Advisory Committee on Immunization: A brief introduction to Canada's COVID-19 vaccine regulators.* OSF Preprints, 9–10. https://doi.org/10.17605/OSF.IO/AJ5GW

A third sort of conflict that could bias NACI's COVID-19 treatment recommendations concerns direct ties between its members and global organizations like the WHO, Gavi, and CEPI—organizations which, as already mentioned in relation to the Global Research Collaboration for Infectious Disease Preparedness's membership—are heavily invested in vaccine development. Doctor Shelley Deeks, who is the current NACI chair, was serving as Vice Chair in March 2020. In the years leading up to the declared pandemic Dr. Deeks has been heavily involved with organizations promoting a global vaccine agenda; she has contributed to Polio initiatives through the World Health Organization[21] and the advancement of novel vaccine technology through Gavi, the Vaccine Alliance.[22] Closer to home, she is a member of the Management Committee for the Canadian Immunization Research Network (CIRN), which receives almost half of its substantial funding from industry, including Pfizer.[23][Annual Report 2019-2020. (2021, August). Canadian Immunization Research Network. https://web.archive.org/web/20230328075033/https://cirnetwork.ca/wp-content/uploads/2021/08/AR.2019-20.Final_.pdf] Designated principal investigator, Dr. Deeks received a 3.5-million-dollar grant as part of CIRN's COVID-19 Vaccine Readiness program.[Canadian Institutes of Health Research. (2022, February 17). Canadian Immunization Research Network: COVID-19 Vaccine Readiness. Funding Decisions Database; Government of Canada. http://archive.today/2022.03.20-223116/https://webapps.cihr-irsc.gc.ca/decisions/p/project_details.html?applId=433192&lang=en] The CIRN grant was issued in July 2020 several months before there was any randomized control data available on the COVID-19 vaccines. It therefore presupposed that mRNA vaccines were a viable answer to COVID-19–a precipitous conclusion aligned with the interests of the global organizations involved in setting Canada's national research priorities.

The conflicts of interest affecting NACI's membership introduce an undeniable and profoundly disturbing potential for bias in its recommendations on how best to manage Canada's response to COVID-19. The Chair and vice chair benefited from highly lucrative COVID-19 grants and had significant ties to organizations—like the WHO and Gavi—openly involved in promoting a global vaccine agenda. Many more NACI members stood to gain considerable prestige and profit from the recommendation of mRNA vaccination and the exclusion of other competing treatment candidates. So, if one were to looking at the COVID-19 moment and wonder why the guidelines are so vaccine specific, a major contributing factor would be that the National Advisory Committee on Immunization, in which the Public Health Agency of Canada and, ultimately, the provincial public health officers urged Canadians to place their unequivocal trust, is a significantly conflicted, vaccine-specific organization.

Both the National Advisory Committee on Immunization and the Public Health Agency of Canada fulfill an advisory role in relation to provincial public health officers. NACI, however, is highly regarded as the immunization authority. The relationships between these organizations within the Canadian public health system can be a source of confusion. In the present instance, it would appear that the vaccine agenda

[21] *SAGE working group on polio*. (2023, February 3). World Health Organization. http://archive.today/2023.04.19-193056/https://www.who.int/groups/strategic-advisory-group-of-experts-on-immunization/working-groups/polio-vaccine

[22] Vaccine Innovation Prioritisation Strategy. *VIPS Steering Committee members.* Gavi, the Vaccine Alliance. Retrieved April 19, 2023, from https://web.archive.org/web/20230419193638/https://www.gavi.org/sites/default/files/about/market-shaping/VIPS%20Steering%20Committee%20Members_FINAL.pdf

[23] *Dr. Shelley Deeks.* Canadian Immunization Research Network. Retrieved March 19, 2022, from https://archive.ph/2021.05.06-163040/https://cirnetwork.ca/researcher/dr-shelley-deeks/

launched in response to COVID-19 was initiated by the WHO; was supported within Canada by PHAC in collaboration with NACI, and was then recommended to the provinces as the most viable option for managing COVID-19.

Conflict of Interest on the Global Stage

When one looks at potential conflicts of interest at a global level things become even more troubling than they are within the NACI membership. The WHO—which played a pivotal role in both declaring the pandemic as well as coordinating the pandemic response which focused almost exclusively upon vaccines—has considerable potential for conflicts of interest of the highest order. Microsoft co-founder-turned-philanthropist Bill Gates is heavily invested in pharmaceutical corporations that develop vaccines, including Pfizer,[24] Moderna,[25] BioNTech,[26] Janssen,[27] and AstraZeneca.[28] He is also a primary funder of both the WHO and Gavi, the Vaccine Alliance, and as such, wields considerable influence over the direction of global public health policy.[29, 30] It is therefore not surprising that vaccines were the primary solution proposed by the WHO.

United States health institutions have also taken leading roles in the global pandemic response. The US is home to the National Institute of Allergy and Infectious Diseases (NIAID) and its parent organization, the National Institutes of Health (NIH)—two major public institutions with abundant ties to global pharmaceutical companies through patents. Since the 1980s, as a result of the Bayh-Dole Act, NIH scientists have been permitted to hold patents on inventions that they, as public servants, helped discover.[31] As such, the NIH holds the patent to the modified spike protein used in both the Pfizer-BioNTech and Moderna vaccine products.[32] This means that every time they recommend COVID-19 vaccines as the primary pandemic remedy, NIH scientists such as those on Anthony Fauci's staff are profiting from that decision.[33]

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[24] *Pfizer*. Bill & Melinda Gates Foundation Strategic Investment Fund. Retrieved June 22, 2021, from http://archive.today/2021.06.22-183302/https://sif.gatesfoundation.org/investments/pfizer/

[25] *Bill & Melinda Gates Foundation — Advancing an mRNA-based antibody combination to help prevent HIV infection.* Moderna. Retrieved March 21, 2022, from http://archive.today/2021.08.23-023928/https://www.modernatx.com/ecosystem/strategic-collaborators/foundations-advancing-mrna-science-and-research

[26] Boehler, M. (2019, September 4). *BioNTech announces new collaboration to develop HIV and tuberculosis programs.* BioNTech. http://archive.today/2022.01.03-191438/https://investors.biontech.de/news-releases/news-release-details/biontech-announces-new-collaboration-develop-hiv-and

[27] *Bill and Melinda Gates Foundation donations made to Janssen Vaccines & Prevention B.V.* Vipul Naik. Retrieved March 29, 2023, from http://archive.today/2023.03.29-052407/https://donations.vipulnaik.com/donorDonee.php?donor=Bill+and+Melinda+Gates+Foundation&donee=Janssen+Vaccines+%26+Prevention+B.V.

[28] Canellis, D. (2020, June 5). *Bill Gates commits $750M to help Oxford vaccinate the world against COVID-19.* TNW | Fintech-Ecommerce. http://archive.today/2023.02.25-123239/https://thenextweb.com/news/bill-gates-covid-coronavirus-vaccine-750-million-oxford-azd1222

[29] *Voluntary contributions by fund and by contributor, 2021.* (2022). World Health Organization. https://web.archive.org/web/20220516042059/https://apps.who.int/gb/ebwha/pdf_files/WHA75/A75_INF5-en.pdf

[30] *The Bill & Melinda Gates Foundation*. (2022, December 31). Gavi, the Vaccine Alliance. https://web.archive.org/web/20230908185334/https://www.gavi.org/investing-gavi/funding/donor-profiles/bill-melinda-gates-foundation

[31] Office of Research & Innovation. (2020, April 28). *Bayh-Dole Act.* Drexel University. http://archive.today/2021.08.18-100743/https://drexel.edu/research/innovation/technology-commercialization/bayh-dole-act/

[32] Rizvi, Z. (2020, June 25). *The NIH vaccine.* Public Citizen. https://www.citizen.org/article/the-nih-vaccine/

[33] *COVID-19 vaccines: Dr. Fauci's team may personally profit.* (2020, October 11). Informed Consent Action Network. http://archive.today/2023.03.01-015445/https://icandecide.org/article/covid-19-vaccines-dr-faucis-team-may-personally-profit/

In the present COVID-19 moment, what this means is that those who have been profiting from the sale of vaccines were also highly influential in developing the global pandemic health policies themselves. These policies were developed at the global level within alarmingly conflicted health organizations. It then appears that they were handed off to Canada's highly invested pro-vaccine group, NACI, which recommended that the COVID-19 vaccines be approved and adopted as standard of care before there was any definitive data to support this decision.

Manufacturing Consensus and Excluding Informed Consent: Canadian Healthcare in Crisis

Returning to the legal context in which Canadian medicine is practiced, Canadian doctors are subject to regulatory colleges that are tasked with enforcing policy and guidelines. Once the vaccine-specific policy guideline was endorsed by NACI, and formally locked in by public health with the approval of Health Canada, these colleges began requiring that doctors follow it. Canadian doctors then had no choice; either they followed that guideline, or they faced discipline and in some instances loss of their medical licenses for going against public health policy.

Over the course of the declared pandemic, Canadian doctors, who are their patients' advocates, and who are tasked with safe-guarding and facilitating informed consent, were marginalized and silenced. As a result, a great many people either ignored or had to learn–for the first time–the basic premise of informed consent. With physicians' counsel formally restricted, and vaccination administered outside of the traditional doctor-patient relationship, the requisite education for informed consent wasn't included in any part of the process. Instead of providing people with a personalized risk benefit analysis, those receiving vaccines were provided with an "informed consent" form. In spite of its name, this form did not, in itself, provide the type of full and balanced information–complete with accurate information on risks and benefits–required for medical informed consent. What the use of this form effectively did was to turn "informed consent" into a semantic game to guard against liability while overlooking the well-being of the individual patients and their right to properly informed, autonomous decision making with respect to treatment.

To make matters worse, the Canadian health system has seen public health officials implementing pharma-styled vaccine marketing campaigns and vaccine-specific COVID-19 guidelines. The legacy media, now heavily dependent upon pharma advertising revenue, has been reinforcing public health's marketing efforts by selectively broadcasting only on-narrative views. *CBC News*, Canada's public broadcaster, itself heavily dependent upon federal funding, has again deferred to public health.[34] Thus, uncontested by mainstream media messaging, and with dissenting doctors effectively silenced by the colleges, public health has been able to manufacture the illusion of medical consensus and to exclude the very possibility of medical informed consent.

[34] *2018-2019 Annual Report - Revenue and other sources of funds.* CBC/Radio-Canada. Retrieved April 21, 2023, from http://archive.today/2023.04.21-230122/https://cbc.radio-canada.ca/en/impact-and-accountability/finances/annual-reports/ar-2018-2019/financial-sustainability/revenue-and-other-funds

The dismantling of personalized medical care in Canada is extremely alarming. In the general population, however, people have the sense that whatever public health officials are saying must be true because they're not hearing many dissenting voices. People think to themselves, "if there was a problem with this treatment, or if there was another viable option, then my doctor would have said something, or those guideline-specialists would have said something." In fact, however, what has happened is that any potentially dissenting doctors have been effectively muzzled by the Colleges.[35]

Where, then, does this leave Canadians? What are they faced with in Canada today? Canadians have a health care system—designed to support the highest level of evidence-based care and informed consent—that has been compromised at multiple levels by those who stand to profit from vaccine research, development, and sales. What is particularly concerning is the fact that a vaccine-specific policy was developed at a global level and then handed off to a vaccine-specific national advisory committee, which then played a significant role in shaping Canada's response to the COVID-crisis. Compounding poor decision-making, political pressure was applied from multiple levels to ensure the approval and rollout of COVID-19 vaccines based solely on preliminary data. These severely under tested vaccines were then pushed on Canadians by public health as a one-size-fits-all solution using pharma-styled vaccine marketing and propaganda likely developed by public relations firms. In a moment of apparent madness, and political opportunism, and also perhaps under pressure from constituents and advocacy groups, many premiers supported vaccine mandates, in stark violation of the rights of their constituents. Once the vaccines were locked in as the standard of care by NACI, clinicians were obliged to align themselves with this guidance or risk losing their licenses. Finally, the vaccines have been administered not just by doctors but by public health employees and pharmacists, with none of the rigorous follow-up that patients might expect within the traditional doctor-patient relationship. And now, three years into the declared pandemic, Canadians still have public health officials stating that the benefits of vaccination outweigh the risks.[36] These same officials continue to present each retooled vaccine as "safe and effective." Despite the fact that there is mounting evidence that challenges this conclusion, they still persist in trumpeting this slogan. And that is what it is—not a scientific consensus but a marketing slogan.

What needs to become crystal clear to Canadians is how thoroughly their medical system has been compromised by pharmaceutical corporations and the global organizations with which they are aligned at every level. Canadians need to be aware that the propaganda being pushed by their public health officials show they have departed radically from the traditional risk benefit proposition that ensures benefit for the individual—the individual whose informed consent and personalized medical care are supported and safeguarded by the doctor-patient relationship. Indeed, Canada's public health officials are no longer prioritizing the health, well-being, and rights of the individual. Instead, they have worked to champion global pharmaceutical industry interests while claiming to serve the collective good. By

[35] Kirkey, S. (2023, April 18). *Ontario doctors give up licences after complaints over COVID vaccine exemptions, misinformation.* National Post. http://archive.today/2023.04.18-182504/https://nationalpost.com/news/canada/doctors-resign-licences-covid-19-vaccine-exemptions-misinformation

[36] National Advisory Committee on Immunization. (2023, March 3). *Guidance on an additional COVID-19 booster dose in the spring of 2023 for individuals at high risk of severe illness due to COVID-19.* Public Health Agency of Canada. https://web.archive.org/web/20230903204633/https://www.canada.ca/content/dam/phac-aspc/documents/services/publications/vaccines-immunization/national-advisory-committee-immunization-guidance-additional-covid-19-booster-dose-spring-2023-individuals-high-risk-severe-illness-due-covid-19/statement.pdf

claiming that it is prioritizing the collective good, public health appears to be trying to legitimize its violation of the individual's rights and its undermining of the doctor-patient relationship that exists to support and protect those rights. Ultimately, however, public health does not appear to be setting priorities at all. Instead, it appears to be submitting to the priorities set by global pharmaceutical interests. By submitting to direction from global private interests and orchestrating Canada's COVID-19 response as it has, public health has compromised the safety of Canadians, violated their right to informed consent, and undermined both the ethical practice of medicine and personalized care in Canada.