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Standing With the Injured and the Brave

Ten percent of all net profits from this book will be donated to the United Healthcare Workers of British Columbia to support their legal challenge to provincial Pandemic policies and mandates. They are currently pursuing a lawsuit against Dr. Bonnie Henry, led by attorney Umar Sheikh, whom I know personally. Their fundraising goal is $500,000, and I look forward to contributing to this effort.

If you are able to donate, please visit their website:
https://unitedtogether.ca/

A further ten percent of all net profits will be donated to Kayla Pollack, whose life changed after a third vaccine dose left her a quadriplegic. Donations will help her rebuild stability, independence, and opportunity in the years ahead. These contributions reflect the solidarity at the heart of this book: standing with people who have paid a heavy price and helping ensure their stories and futures are not forgotten.

If you are able to donate, please visit Kayla's website:
https://www.opkayla.ca/

Territorial Acknowledgement

This work was written on the unceded territories of the Coast Salish peoples, including the Lekwungen (Songhees, Esquimalt), W̱SÁNEĆ (Tsartlip, Tsawout, Pauquachin, Tseycum), and Hul'q'umi'num-speaking peoples of southeastern Vancouver Island and the Gulf Islands. I acknowledge these lands with respect, and with awareness of the histories that continue to shape both place and people. I see the enduring stewardship, history, and ongoing presence of Indigenous peoples as vital to these lands and the seas upon which I live.

Dedication

To the unseen currents that carried me,
To the light that refused to go out,
And to the quiet intelligence of the universe,
That meets us exactly where courage begins.
To every person who has ever felt silenced,
Unseen, or pushed aside—
May this book remind you of your own power,
And the truth that rises when we answer ourselves without fear.
And the future that unfolds in alignment,
May what was written here,
Return to its source: love,
Amplified,
Offering clarity for those who seek it,
Strength for those who need it,
And healing for those ready to remember who they are.
I dedicate this work with gratitude and an open, soft, and warm heart:
For those who wanted to say no but couldn't—
For the parents with children to feed,
For the workers who feared losing their homes,
For those forced to submit to a needle they did not want and did not need.
For the small-business owners who watched their life's work dissolve.
For the nurses who stayed,
For the teachers who taught through the screen,
For the families who endured isolation medicine could not measure.
For all who felt their mental edges fray under anxiety and a pressure no chart could record. It's especially for those I know the Pandemic made anxious. You are important to me. This book is for all of you.

This book is for all the students I've taught over the years who in the way they look at me let me know it counted for something. We teach and we learn. We give and we receive. This book is for the children who affectionately still call me Captain. This book is for those students who remind me I could have and should have spoken up. It is with great regret that I did not speak when I knew there was risk and virtually no benefit to children. I carry that knowledge with regret and a heavy heart. This book is an offering in good faith humility, with the hope that naming what we failed to do may still protect those who come after.

Finally, it's for all who bravely spoke out during the Pandemic, and conversely those who tried to dehumanize me, and my friends, including the person who called me "a total piece of shit" for refusing to comply and for speaking the truth. I am not a piece of waste. None of us were, and neither are you.

Author's Note & General Disclaimer

This book is a work of non-fiction grounded in my lived experience, my professional background in public health and education, and my involvement in legal and human rights processes following the COVID-19 mandates in British Columbia.

It reflects my best recollections, documentation, and interpretation of events during and after the COVID-19 Pandemic. Public figures, institutions, and organizations are referenced using publicly available information and cultural observation. Nothing in this book should be understood as a claim about the private motives or intentions of any individual or entity.

This book is not intended to provide medical, scientific, legal, or professional advice. Readers should consult qualified professionals for guidance in those areas. While every effort has been made to present information accurately, the Pandemic was a period of shifting data, contested evidence, and intense pressure. Any errors or omissions are unintentional.

Where appropriate, identifying details of private individuals have been changed. Public figures are quoted using their publicly available statements.

My goal is not to tell readers what to think or what medical decisions to make, but to document a human experience and to model how difficult questions can be approached with humility, thoughtfulness and care.

This book was also shaped with the assistance of artificial intelligence (AI), specifically ChatGPT. AI was not used as a substitute for authorship, but as a modern tool to support structure, clarity, and consistency across a complex manuscript. The insights, experiences, interpretations, and conclusions are mine alone. The responsibility for every word rests with me.

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Preface

History is Opposites.

History does not move in straight lines. It swings like a tide, like a pendulum, like breath. Every generation faces a moment when its inherited truths begin to crack, when certainty begins to tremble, when the structures we trusted shift under our feet.

For my grandparents, that moment was the Depression and the war. For my parents' generation it was the upheavals of the 1960s and 70s and the realization that war was an atrocity. For us, it was the Pandemic, and what the years after it revealed.

We once believed that certain ideas were beyond question: that institutions always told the truth, that science was self-correcting, that public health acted with even-handed integrity, that 'following the science' was a compass rather than a slogan. Then came a stress test that revealed fractures in a system we assumed were unbreakable. This is the law of opposites, the oldest pattern in civilization:

- What rises inevitably meets its contradiction.
- What is built on certainty eventually shatters into humility.

Unwavering certainty about COVID-19 vaccines has become unsustainable, because it is contradictory to scientific evidence.

Vaccinology, once a humble tool, hardened into an orthodoxy; not by malice, but by moral overconfidence. When COVID-19 arrived, that creed met reality, and reality spoke louder than slogans.

Millions witnessed contradictions they were told not to see.

Many people experienced harms they were told did not exist.

Millions complied out of duty or survival, not conviction.

The collapse was experiential, not ideological. And so, history swung. The culture of "settled science" fractured.

The old narratives failed to explain the lived truth around us.

A new era began, one defined not by certainty but by reckoning.

This book was born inside that reckoning.

I didn't set out to write a book. I set out to make sense of what happened to us.

Like many Canadians, I trusted the Charter, the Human Rights Act, and the quiet decency of a country that prized fairness over ideology. Then something shifted. People were vilified for asking ordinary questions. Rights once called "fundamental" became "conditional." Families split. Friends vanished in the winds of chaos. Careers dissolved.

I lost a career I loved. I found myself living on a sailboat in Victoria's harbour, staring at the legislature lights and wondering how the country I cherished had drifted so far off course.

This book became a record of institutional failure to uphold safety, a map of a national wound, a witness to a turning point in history. It became the story of those who could not speak; the story of those who complied under duress; the story of those dismissed, silenced, injured, or forgotten; the story of how trust breaks, and how it might one day be rebuilt through healing.

If this book does anything, I hope it restores dignity to those who resisted, those who suffered, those who complied out of necessity, and those who simply tried to hold onto their humanity when that seemed the hardest thing of all.

We stand at the hinge of an era where questions about vaccines were not only disallowed but punished.

History has turned.

This book is my attempt to name that turning with honesty, humility, and courage.

Part I — The Story of a Life Broken

Chapter 1 — The Invitation

I was looking for work when the invitation arrived, but I didn't count on transformation. I was simply trying to find my footing after moving back from Toronto to British Columbia. For years I have been developing programs on violence prevention and healthy relationships, work rooted in compassion, clarity, and service. Writing had always been part of that calling. So was teaching. So was showing up for people who needed a steady hand.

When Island Health reached out, it felt less like an offer and more like alignment. Everything I had built, from the programs and training, to the years spent teaching others how to navigate conflict and risk, seemed finally to converge. They wanted someone who understood public health, violence and injury prevention, and community systems; someone who could bridge worlds.

For the first time in a long time, I felt a clean sense of purpose. I saw a path and an opening to learn something new: injury prevention. It was a role that mattered. I accepted. I believed I was stepping into something steady; something grounded in the best of what public health was supposed to be: service, integrity, evidence and compassion.

The invitation to serve felt like a continuation of the values that shaped my life. Service had never been theoretical for me. It was something practiced in classrooms, in hospitals, in community halls, in conversations with people whose lives had been broken open by circumstance. The role at Island Health felt like another way to offer stability and guidance at a time when the world seemed to be accelerating in its complexity.

None of us yet understood how fragile that stability was. None of us understood what was coming.

In those early days, before the vocabulary of lockdowns and mandates and essential workers entered our lives, I felt a simple gratitude. A belief that institutions, despite their flaws, could still act with integrity; that evidence still mattered; that compassion was not incompatible with public policy.

It would not be long before those assumptions were tested: slowly at first, then all at once.

The Collective Breaking Point

I wasn't alone. Millions were cornered. Parents with mortgages. Young adults supporting aging parents. Nurses, teachers, paramedics, BC Ferries crews, RCMP officers, even government staff themselves. The pressure was

ambient, compounded by isolation, fear, and relentless messaging. Many complied because they felt they had no other option.

By spring of 2021, psychological strain was everywhere. Anxiety, despair, and a quiet overwhelm seeped through the country. Many people felt trapped, unsafe, or hopeless. It was a nationwide breaking point.

The Pandemic rearranged lives: grandparents and parents isolated in care homes, businesses shuttered, artists silent with no way to showcase their passions, nurses crying in stairwells, and parents stretched beyond their limits.

Everyone lived some version of collapse.

This book honours those stories, spoken and unspoken. Silence was never compliance. Sometimes, silence was survival.

I had privileges many did not: a boat, skills, independence. Others had none of those things. Their choices preserved their homes, families, and livelihoods.

A Shifting Wind

There are moments in life when the horizon shifts, quietly at first, then suddenly, like a lighthouse swallowed by fog. This book began at such a moment. Not with anger. Not with outrage. But with the stillness that follows a fracture: the sober recognition that the world you trusted had changed, and that the institutions built to protect you were no longer anchored to the values they claimed to uphold.

When I arrived in Victoria in October 2025, I began writing. I hadn't planned to start this book that fall; it simply began itself. The water was glass calm the evening I finally understood the imperative. My sailboat rocked gently in Victoria's harbour, the lights of the Legislative Assembly shimmering across the surface in long, wavering lines. I rubbed my thumb across the faded scar on my arm, a mark from childhood, and a time before the world learned a new vocabulary of fear. I thought about all the lives shattered and destroyed by political decisions implemented by the Provincial Health Office. I thought about my loss and the losses of so many of my friends. These losses have left scars.

There's a song by The Tragically Hip, a band woven into the Canadian landscape as surely as lake water and long prairie highways. In it, a child's *vaccination scar* becomes suddenly luminous when a tear falls onto it: a small mark, long forgotten, awakened by grief. It is a reminder the body keeps even when the mind moves on. That image stayed with me as I entered this work, because a vaccination scar is a symbol of trust, offered long before we understood what we were consenting to. It is tiny, almost invisible, yet it carries a surprising weight: innocence, certainty, the belief that the systems guiding our lives were steady and good.

It struck me how something so small could hold so much: a puncture, a healing, a promise, and now, a question. During the Pandemic, as certainty cracked and systems trembled, that same mark became a symbol of the trust we were taught, and the trust taken from us.

This story, mine and Canada's, begins with one small mark and everything that came after. From that moment, the journey deepened. I thought about life before the dismissal that tore my life apart. Something had gone profoundly astray. There was a sense that the story we were being told did not match the reality unfolding before our eyes. There was a sense that the Pandemic had become something larger than a virus—something moral, ideological, psychological, and political. It was something that demanded obedience before understanding, compliance before clarity.

This is the story of that realization. But it is also the story of what happened when I refused to look away.

What collapsed in my life was not an isolated tragedy. It mirrored a broader rupture: the breaking of trust between the public and the systems meant to serve them. This rupture revealed how quickly fear can override common sense, how easily science can be shaped by power, and how profoundly people suffer when they are told to silence their instincts for the 'collective good.'

This book is written from within that rupture, and from the shores beyond it.

It begins with the life I lived before the storm: two decades of service, a deep belief in public health, and a commitment to compassion, responsibility, and evidence. From there, the narrative turns toward the collapse—the choice that was not a choice, the loss of everything I had built, and the legal system that exposed its own fractures as I tried to stand upright inside it.

Then the lens widens.

We move through science, not as a weapon, but as a lantern. We examine what was known, what was hidden, and what was never permitted to be said aloud. We look at myocarditis, the quiet rise in inflammation among healthy young people, the shifting definitions, the linguistic contortions, the uneasy silences after new data emerged. We look at cancer signals, the oncologists whispering about unusual patterns, the sudden diagnoses, the immune pathways that deserved scrutiny, and the scientific caution that collided with political urgency. We look at injuries, cardiovascular complications, and sudden death—conditions that erupted across demographics and were dismissed as 'coincidence' long after the public stopped believing that word. We look at excess mortality, the

numbers that refused to return to baseline, the statistical residue of a world insisting the emergency was over while the data suggested otherwise.

None of this is offered as dogma. It is offered the way science should be offered: with transparency, humility, and an unwavering commitment to evidence, with the honesty science once demanded.

The Line Between Science and Empathy

There is a line between science and empathy, but it is not a dividing line. It is a meeting point. Science gives us tools to understand the world; empathy gives us the capacity to understand each other. When those two forces work together, public health becomes a relationship rather than a command. When they fall out of alignment, harm follows.

Science tells us what can happen, what is likely to happen, and what we can measure. Empathy tells us what people live through. It is their fears, their constraints, their medical histories, their values, and their right to make decisions about their own bodies. Science without empathy becomes cold, rigid, and punitive. Empathy without science becomes ungrounded and untethered. Both are necessary. Neither is sufficient on its own.

During the Pandemic, the delicate seam, or line, between evidence and humanity, was torn open. Institutions treated science as if it were a monologue, not a conversation. Data was presented as destiny. Risk became moralized. And empathy, which should have softened the edges of policy, was treated as an inconvenience. The result wasn't just policy failure; it was a rupture in trust that reshaped families, workplaces, and communities.

To 'follow the science' should never have meant abandoning the person in front of you. The moment we mistake data for destiny, or treat dissent as defiance, we lose sight of what science is actually for: to improve human life, not to override it. Empathy is what ensures that science remains accountable to the people it claims to serve.

The line between science and empathy is the line every society must learn to walk. Lean too far toward abstraction and you lose the human being. Lean too far toward emotion and you lose the anchor of truth. But when those two forces meet respectfully, transparently, and without coercion, we get something far stronger than either alone: wisdom.

This book will examine dissent, how a nation that once championed dialogue came to fear it. It explores faith, how it filled the vacuum left behind by collapsing institutions. This book looks at Canada, its Charter, its courts, and the unseen influences that steered policy more forcefully than epidemiology ever did.

Then the voyage widens again.

We trace the shadows:

- The Origins question,
- The fusion of technology and biology,
- The pharmaceutical economy of power,
- The masking era and its psychological toll,
- The vulnerabilities in the childhood vaccine schedule,
- The transhumanistic incentives that shaped a generation's understanding of 'health'

We follow the money, the messaging, the contradictions, until the structures beneath the surface become impossible to ignore.

And finally, after all of that, we return to the most human of all tasks: reconciliation. Not political reconciliation. Human reconciliation.

This book is a return to intuition.

To courage, community and compassion.

To the inner compass fear tried to fracture.

To that quiet voice inside so many people that whispered, *this doesn't feel right*, even when the world insisted otherwise.

An Invitation

This book is an invitation to examine the Pandemic.

To trust the intelligence of the body.

To honour the instincts, we were told to ignore.

To rebuild trust, honestly, patiently, humanly.

If you have ever felt the dissonance between the narrative and your lived experience, this book is for you. If you have ever sensed the official story had missing pages, this book turns them over. If you have ever felt alone in your confusion, grief, or questioning, I want you to know, you are not alone.

I went into the writing of this book with many assumptions. Some were correct, and some were not. I learned a great deal. That is what humility is about: acknowledging that we have something to learn, regardless of which side of the fence you are standing on. That is what critical thinking is all about: keeping an open mind and being able to learn something new. I had a great teacher when I was in high school named Floyd Switzer. He instilled this value in me, and to him and many other teachers I am profoundly grateful.

The sails are raised.

The wind is steady, cold and brutal in the way it is going to hit your skin.

The reefs are behind us, and though the passageway opens into a long channel, there are many jagged and daunting rocks and shoals.

This book does not judge anyone's choice.

It is a lighthouse in a storm.

It is an act of empathy.

It is my way of continuing to serve, so a rupture like this is prevented and can never occur again.

I welcome you to step aboard.

Our compass is pointing toward places no mapmaker dared to draw.

And when you glimpse what waits there, you will understand why this voyage became unavoidable, and as inevitable as our own deaths. We share more in common than we often care to admit. We are bound by a singular thread, one that carries each of us to the same ending, no matter how long we try to postpone it. The Pandemic revealed how we were divided, but it also revealed the common ground beneath those divisions, whether we chose to look or not.

Chapter 2 — The Call to Serve

When I look back, before the noise, before the division, before the mandates and the loss, I can still feel the simplicity of why I chose prevention work. It was never about prestige or awards, never about power. It was about service: about helping people stay whole, stay safe, and stay alive. Perhaps, in some ways, I wanted to become the lighthouse I lacked at times when I was young.

I didn't enter public health with a grand theory. I entered with a feeling. I held a recognition that human life was more fragile than most people understood, and that I could not bear to watch preventable harm unfold when I had the capacity to intervene. Injury and violence were not abstractions to me. They were personal, lived, and intimate.

Growing Up with Violence

I grew up in Kingston, Ontario, where the hallways of my high school were battlegrounds. Verbal and physical aggression were woven into the culture, fueled by homophobia, sexism, racism, and a hierarchy that punished difference. I was physically assaulted repeatedly, with verbal abuse filling the space between classes. By seventeen, I had survived a near-fatal car wreck. We lost peers to motorcycle crashes, alcohol overdose, and drowning. I was a daredevil myself, convinced of my own invincibility, even after life corrected that illusion multiple times.

At ten, battery acid shot directly into my eyes. The agony was indescribable. Nurses flushed my eyes with salt water for over an hour, and I remember the terror of asking myself: *Will I ever see again? Will the pain ever stop?*

People break and people die from poor choices. And the consequences ripple outward for decades.

I wanted to change that, not from theory and writing, but from in person conversations, because I had witnessed and lived the alternative, a life of trauma which could have been prevented.

Living With C-PTSD

For years, I assumed I had PTSD. Flashbacks, hyper-vigilance, nightmares, the constant hum of danger, they all fit. It wasn't until my thirties that I learned the distinction: PTSD is a wound; C-PTSD is the landscape built from a lifetime of wounds. Mine was much worse than I thought, and with time I could make it much better than I ever believed possible.

People often ask, "What caused it?"

There is no single answer.

It was the battery acid, the assaults, the crash.

The background radiation of chronic threat.

Alcohol became my coping mechanism. Not celebration, but escape. Numbing. Erasure. I didn't know what healthy limits were. I was masking pain I didn't know how to process. And in the work with Island Health, I found the simple goal of wanting to prevent young people from having to experience the same pain.

Injury Prevention — Turning Pain into Purpose

Island Health's P.A.R.T.Y. Program: Prevent Alcohol and Risk-Related Trauma in Youth became one of my professional homes in a public health career that spanned two decades. It addressed the very forces that shaped my youth: impulsivity, alcohol misuse, the illusion of invincibility, and the consequences of our actions. We brought students into hospitals to meet trauma teams, to witness the human consequences of risk, and to understand that prevention wasn't restriction, it was care.

I loved that work.

The "aha moments" from students.

My own "aha moments."

The teaching and the learning.

Public health appealed to me because it lived where science meets the human heart. I worked in Africa doing HIV/AIDS prevention immediately after getting my teaching degree in 2005. I worked with homeless youth in downtown Toronto, Indigenous youth, and in injury and violence prevention across Vancouver Island and Ontario. Not a day goes by that I don't miss that work.

The Broader Calling

I was never meant for a conventional classroom on a full-time basis, though I still love teaching kids and going into schools. Even during my education degree, a practicum supervisor told me: "You know you're not going to teach in the mainstream system, right?"

I knew exactly what she meant.

Prevention was my calling: evidence-based practice anchored to human compassion. Emotional intelligence learned through violence prevention programs on Salt Spring Island reshaped me and expanded my humanity in full spectrum. I learned my own inner contours: my overwhelm, sadness, fear, my courage, the ways homophobia and sexism had shaped me as a young man.

I saw the consequences of the crises we fail to prevent, youth suicide rising, online exploitation accelerating, violence in schools intensifying. For two decades, my colleagues and I fought for an end to disease, violence, injuries and trauma.

It was sacred work. I never thought that it would turn into this, but it has. Car crashes are things that we can prevent—caused by intoxication, distraction, and speed. Accidents just happen sometimes despite everything we are doing to stay safe. The Pandemic response that traumatized so many could have been prevented. It was a crash. It is my goal to prevent the next crash.

Changing Context

I come from another Canada, quieter, steadier, more dignified, with all its flaws and shadows, including the violence of colonization and the internment of Japanese families. My grandparents wintered in Victoria, not far from where my boat rests today. They loved this coast. I often imagine how they would have endured the Pandemic. Part of me is relieved they did not live to see it: the anxiety, the isolation, the prolonged state of emergency that stripped so many elders of connection and dignity.

I miss them dearly. But they were spared something that shook this country to its core. Not a single event, but a convergence. They did not live to see inflation erode the basic promises of stability, or neighbours turn on one another over questions of compliance and belonging tied explicitly to whether one embraced vaccination. A medical intervention became a social marker. Agreement signaled virtue. Hesitation, even when grounded in personal medical context, was treated as suspicion or defiance.

They did not witness the reawakening of old prejudices, racism spoken more freely again, suspicion hardening toward immigrants, antisemitism resurfacing in ways many believed had been settled by history. Nor did they walk streets where homelessness expanded in plain sight, or where deaths from tainted drugs mounted quietly, month after month, until grief became background noise.

They never had to stand on Pandora Street and witness the concentration of suffering that now marks it. In their time, they knew hardship, but not this sense of social fraying, not this accumulation of fractures layered one upon another.

It would have caused them to grimace and to ask hard questions about what Canada has become. They would have also recoiled at the rupture in my life caused by the mandate, as it severed a career of service not through failure or misconduct, but through a policy that left no room for professional judgment or personal medical context.

Chapter 3 — The Storm Gathers

Living on a sailboat teaches you to read the weather in your bones. Long before a storm appears, something subtle shifts: the air pressure, the stillness of water, the change in light.

As 2019 ended, something in me felt that shift. A pressure drop. A quiet forewarning. I didn't know what was coming, only that life was about to change, and I would not escape untouched. A storm was brewing.

The year began like any other, with schools bustling, hospitals humming, communities carrying on with the quiet rhythm of prevention work. I was still coordinating the P.A.R.T.Y. Program, the same one that had shaped two decades of my career. It was work that lived in human presence: trauma bays, eye contact, unguarded conversations, and those rare moments when a student truly understood the cost of one difficult choice.

When reports surfaced about a "mysterious pneumonia" in Wuhan, it felt distant—just another story on the evening news. Rumours of lockdowns. Images of silent streets. Doctors in white suits. Tragic, yes, but still foreign, like a storm forming beyond the horizon of someone else's life.

Then the tone shifted. Flights cancelled. Borders tightened. Masks appeared like a new kind of social language. Conversations turned anxious. Something vast was approaching—something invisible, gathering itself in the space between our routines. And then came March 2020. One week we were still running in-hospital sessions; the next, the whole world stopped.

Our last program was in Campbell River, just before March Break. Days later, I fell ill with fever, exhaustion, asthma flaring, bone aches, a cough that felt carved from glass. I am certain now it was SARS-CoV-2, before tests existed. The illness moved through me with a strange clarity, leaving behind the unmistakable sense that whatever this was, it would define the years ahead.

It reminded me of an illness I'd had in Toronto in early 2018 while working with White Ribbon. The illness carried the same violent cough, and the same exhaustion. A doctor ran a throat swab and later called it "inconclusive." When I asked what they meant, they said, "We don't know what we're looking at." I didn't understand then how prophetic those words would become.

The World Tightens

As the Pandemic unfolded, the rules of life rewrote themselves. Conversations were replaced by orders. Tape on floors. Arrows dictating movement. Signs telling us where to stand, where not to stand, what not to

touch. At first, I believed it was temporary, 'two weeks to flatten the curve,' but weeks became months, and the air itself grew brittle.

The P.A.R.T.Y. Program stopped overnight. What had always relied on lived experience and presence became a pale imitation over screens. Trauma survivors were replaced by recordings. Hospital teams replaced by slideshow transitions. Students reduced to tiny squares on Zoom, their faces unreadable. For the duration of the Pandemic, and indeed the rest of my time with Island Health, I worked from home, outside of hospitals. My boat became my home office, though at times I delivered programming online from hotel rooms.

We adapted because that's what prevention people do. But something essential, something human, went missing. The contemplative tone of the trauma bay was gone. The vulnerability of students seeing the consequences of alcohol misuse and risk was missing. The honesty of hospital staff sharing their lived wisdom vanished like dust in the wind. Hospitals that once welcomed us now felt tense and guarded, even over a webcam. Fear had settled in. It felt permanent. And when uncertainty came for all of us, when the science shifted, when questions naturally arose, asking them became taboo.

Weren't masks supposed to prevent transmission? Wasn't six feet enough? Didn't we just need two weeks?

Inquiry began to feel dangerous.

The Conversation in Cadboro Bay

That summer I ran into Vic, a science teacher I knew from my teaching days, a fellow sailor anchored in Cadboro Bay, where steel hulls gleamed under the afternoon sun. We drifted beside each other in our dinghies talking about rigging and varnish—the innocent stuff sailors can stretch into hours.

Eventually the conversation turned to vaccines. He asked if I'd get them. I told him truthfully: I was researching, waiting for more safety data. Calm. Neutral. Honest.

What came back was not curiosity but condemnation.

'The science is settled.'

'People like you are the problem.'

'Doubt is dangerous.'

The shift in his tone was instant and sharp. My heart spiked with adrenaline in a way I couldn't quite understand. What started as a peaceful conversation on the water became something I needed to escape. My PTSD flight mechanism took hold, and I left as quickly as possible.

The irony was startling: a science teacher shutting down inquiry.

Later, replaying the moment, I thought of Bonnie Henry's early message: *Be kind, be calm, be safe.* I believed that. I had built an entire career on the idea that compassion and science could co-exist.

But I was starting to see that kindness had conditions. Calm had limits. And 'safety' had become a cudgel.

Moral rigidity was creeping in, with a certainty so absolute that it left no room for nuance or doubt. The same institutions that once taught us to question now demanded obedience. It felt like the rules of science had changed.

The Public Square Turns Hostile

That fall, the divisions sharpened. I responded calmly to a Salt Spring Island resident and University academic's post urging everyone to 'just get the shot,' gently reminding him that he wasn't a doctor. His reaction was instantaneous and explosive.

He called me a "Grandma killer." He mocked me, claiming I was afraid of needles, a laughable accusation given the immunization record I still carry from my work in Africa. He called me a disappointment, blocked me, leaving me with accusations meant to wound.

What he didn't know, what he couldn't know, was the sacredness of my relationship with my grandmother, who lived to ninety-seven and had one rule: if we were sick, we stayed away. I had honoured her wishes my entire life. To be accused of endangering someone like her cut deeper than he realized.

I logged off with dignity. But inside, something fractured.

People weren't practicing compassion. They were performing virtuously and punishing those who hesitated.

A Sailor's Warning

Looking back, I see that period as the moment reason gave way to moral panic. Listening stopped. Policing began. Yet somewhere beneath it all, I still believed the storm would pass. The sea teaches you that nothing rages forever.

Sailors have a phrase: *Hold fast.* When the storm rises, you grip the line and endure.

By the summer of 2021, I could feel something gathering, a storm unlike any I had encountered. During conversations with friends and relatives I insisted mandates would never be implemented. It seemed impossible. Many people saw them coming. I was sure people were wrong. I could not have been more mistaken.

Something built on shaky foundations shouldn't have lasted. But it did. And those who built it still insist they were right.

The storm didn't just gather. It broke open.

As it did, it became clear that Canada was now going to have its own vaccination scar, a mark left not by a needle but by the events we now hold as our history. A mark shaped by public health decisions, institutional panic, political overreach, and the way neighbours, colleagues, and families turned on one another under pressure. A scar formed not from one wound, but millions of small ones.

What emerged in those early months was not just fear, but fracture. The quiet trust that had once underpinned our public systems trembled, then split. People who had never questioned institutional authority suddenly found themselves staring into a widening crack in the foundation.

The country, like the body, was beginning to remember something it did not want to know: mandates.

Throughout history, mandates have surfaced in moments when fear overwhelmed balance and governments reached for extraordinary powers. In the 14th century, Venice detained ships for 40 days under the first quarantine laws; during the smallpox era, compulsory vaccination arrived with fines and exclusions that often landed hardest on the poor. These measures were justified as necessary for public health, but they ignited backlash, resistance movements, and civil-liberty campaigns. The lesson was always the same: when bodily autonomy is overridden, even in the name of safety, the social fabric strains.

In the 20th century, wartime mobilizations, tuberculosis control, and venereal-disease campaigns brought new forms of state-imposed health policies, yet always with growing ethical guardrails. After the Nuremberg Code and the Helsinki Declaration, informed consent became foundational. Medical interventions were to be voluntary, free from coercion, penalty, or threat. Only rarely did democracies attempt anything resembling modern mandates, and never with the sweeping reach witnessed during this most recent Pandemic. The historical record is unequivocal: when states cross the boundary from guidance into compulsion, trust fractures, social wounds deepen, and the reckoning arrives long after the policy fades.

From hospital workers, government employees to truckers and University students, mandates were directed across segments of society. Many universities in Canada and elsewhere introduced vaccination requirements for students as a condition of accessing in-person education, campus facilities, or student housing. These policies were most commonly implemented in the fall of 2021, and were framed as public health measures aimed at reducing transmission in dense, congregate settings such as lecture halls and residences. In legal terms, they were generally structured not as compulsory medical treatment, but as conditions of participation,

meaning students could decline vaccination but might face limited access to campus or be required to study remotely where such options existed. Most institutions included provisions for medical exemptions and, in some cases, other protected grounds, with accommodations such as masking or testing, though the availability and adequacy of these accommodations varied. As public health restrictions eased and the acute phase of the Pandemic passed, many universities quietly relaxed or ended these requirements, leaving behind unresolved questions about proportionality, consent, and the ethical treatment of young adults whose individual risk from COVID-19 was comparatively low, but whose educational futures were nonetheless shaped by institutional mandate.

From Ethical Principle to Legal Mechanism

What made the COVID-19 era distinct was not merely the reappearance of mandates, but the legal infrastructure quietly constructed to support them. In British Columbia, extraordinary public health powers were not imposed by accident or improvisation. They were enabled through deliberate legislative and regulatory pathways that expanded the authority of the Provincial Health Officer and narrowed the avenues for challenge, exemption, or review.

Under British Columbia's Public Health Act, emergency orders could be issued with immediate effect, bypassing normal legislative debate and without prior judicial oversight. Between 2020 and 2022, these powers were used to tie vaccination status to employment, professional licensure, education, travel, and participation in public life. Although framed as temporary emergency measures, the orders carried sweeping consequences. Access to livelihoods and social participation became contingent upon compliance with a medical intervention.

The law did not require individualized risk assessment, nor did it meaningfully accommodate prior infection, medical uncertainty, or evolving evidence. What mattered was conformity to policy, not consent grounded in personal circumstance. These measures operated in a legal grey zone. They were not criminal penalties, yet the consequences were real. Loss of employment, exclusion from public spaces, and professional sanction functioned as coercive levers, even as officials insisted participation remained "voluntary." This distinction, technical on paper, collapsed in lived experience. Choice offered under threat ceases to be choice at all.

What unfolded, then, was not a rejection of medical ethics in principle, but a legal end-run around them in practice. Informed consent was preserved rhetorically while being hollowed out operationally. The safeguards envisioned after Nuremberg and later codified in international

medical ethics remained intact as text, yet were treated as secondary to emergency authority. The result was a system where ethical commitments existed, but no longer constrained power when fear and urgency took precedence.

This is the fault line that must be examined. Not whether public health should act in crises, but how far the law may stretch before it severs its ethical anchor. History shows that once this boundary is crossed, trust does not return easily. The damage is not limited to one policy or one Pandemic. It settles into institutions, into communities, and into the long memory of those who were compelled to comply against their judgment.

That logic did not fade when the emergency orders ended. It simply changed form. When British Columbia formally ended the COVID-19 public health emergency in July 2024 and lifted the vaccine mandate for health-care workers, many assumed the story of mandates was over. Yet the province simultaneously introduced a requirement that health-care workers document and report their immunization status for COVID-19, influenza, and several other vaccine-preventable diseases. That shift was described as routine outbreak preparedness, but for many it read like continuity rather than closure. The memory of statements such as Dr. Bonnie Henry's remark, "If people in our health-care system are not recognizing the importance of vaccination, then that's probably not the right profession for them" (YouTube, January 11, 2021, *Bonnie Henry news conference*) still lingers in the minds of professionals who were pressured or ostracized for their choices. In that context, reporting duties are not neutral paperwork. They become a reminder of who was once told they did not belong, and how quickly institutional language can redraw the boundary between professional duty and personal autonomy.

It is against this backdrop, where law outpaced ethics, that modern medical principles must be re-examined. The most widely accepted articulation of those principles is found in the Declaration of Helsinki.

The Declaration of Helsinki

The Declaration of Helsinki was adopted by the World Medical Association in 1964 as the moral successor to the Nuremberg Code. If Nuremberg drew a bright line after the atrocities of the Second World War, declaring that coercion and exploitation had no place in medicine, Helsinki expanded that foundation into a modern ethical framework. Its purpose was simple but profound: to ensure that scientific progress could never outrun human dignity.

At the heart of the declaration is a principle that shaped Western medical ethics for 60 years: the interests of the individual must always come before the interests of science, institutions, or society. No public goal,

no matter how noble, may override a person's right to informed, voluntary choice. Consent must be free, unpressured, and based on full understanding. Vulnerable individuals, including those with disabilities, unstable health, or unequal power, must receive *greater* protection, not less.

Over time, Helsinki became the guiding light for research ethics boards, medical universities, and global health institutions. It taught generations of clinicians that risk cannot be imposed "for the greater good" without the explicit, uncoerced agreement of the person bearing that risk. It also warned against undue influence, a category that includes pressure through employment, authority, dependency, or fear.

During the mandate era, many Canadians felt, often silently, that these principles had been inverted. Consent was no longer a conversation; vaccination was a condition of access to work, travel, education, and public life. Vulnerable individuals were not shielded but swept aside. The individual's welfare was subordinated to institutional messaging and political expediency.

The Declaration of Helsinki does not oppose public health. It opposes the erosion of human autonomy in the name of public purpose. It stands as a reminder that ethical medicine is not built on compliance, but on respect, and that when societies drift from that foundation, the scars are not only medical, but moral.

The Helsinki Declaration was meant to be a safeguard, a reminder that science without ethics is simply power disguised as progress. It asked institutions to remember that behind every protocol and data point stands a human being whose rights do not disappear when a public-health emergency is declared.

But by the time the Pandemic reached its peak, those principles felt less like the foundation of modern medicine and more like relics from another era. The very safeguards designed to protect the vulnerable were treated as obstacles, the language of ethics replaced by the language of necessity, inevitability, and 'the greater good.'

Once those guardrails slipped, something else began to unravel: the human cost that cannot be graphed or quantified, the fear, the loneliness, the divisions, the broken trust, and the quiet suffering that unfolded behind closed doors. The kind of harm that does not show up in press conferences or policy briefings, but in the lives of ordinary people trying to navigate extraordinary pressure.

Because what failed during the Pandemic was not just compliance with an international declaration. It was compassion, proportion, and our ability to see one another as human before seeing one another as risk.

That is where the next chapter begins—in the space between ethics on paper and ethics in practice; between what we promised as a society and what happened when fear took the wheel.

Chapter 4 — The Choice That Was Not a Choice

On the Meaning of a Word

For most of the twentieth century, a vaccine had a relatively stable meaning. It referred to a biological preparation that introduced an inactivated or attenuated pathogen, or a fragment of one, to stimulate an immune response that mimicked natural infection without causing disease. The goal was durable immunity, measured over years or decades, with transmission reduction as a core feature. This definition anchored public understanding, regulatory standards, and informed consent (Centers for Disease Control and Prevention, "Immunization Basics"). When people consented to vaccination, they were consenting to that concept, whether or not they could articulate it in technical terms.

During the COVID-19 era, that definition quietly shifted. Novel platforms were introduced that did not contain the pathogen itself but instead delivered genetic instructions prompting the body to produce a target antigen. At the same time, public messaging deemphasized sterilizing immunity and reframed success in terms of reduced severity and hospitalization. None of this necessarily renders the technology illegitimate. But it does mean that the word vaccine was asked to carry a broader, more elastic meaning than it had before. That shift matters, not as a semantic quibble, but because informed consent depends on shared definitions. When a familiar word is repurposed, clarity becomes an ethical obligation, not a luxury.

Mandatory COVID-19 Vaccination Requirements

In mid-October 2021, the email arrived without greeting, signature, or humanity, only a sterile heading:

It stated bluntly: *"Provide proof of vaccination by October 26 or be placed on unpaid leave."*

When the mandate arrived, it landed with excruciating pain, as it did for many people. I stood in the warm glow of my sailboat's galley on Salt Spring Island, reading words that cornered me into an impossible choice: follow my doctor's medical advice to protect my health, or comply with a policy that ignored it, and keep my livelihood.

Something in me broke open.

I brought my open hand down hard on the bamboo counter. Not once, but again and again, ten, eleven, twelve strikes. A primal response from a depth I hadn't ever felt or accessed before. It was shock, rage, disbelief, and a grief so sharp it felt physical. It was the body's alarm system recognizing coercion before the mind could articulate it.

My physiology knew what my intellect had not yet spoken:

This isn't a choice. This is coercion. You cannot comply. There will be a price. And there will be a gift in the end when this story is told. I knew that even then.

My manager, the best I ever had, was compassionate and supportive. He reassured me that my medical situation would be taken seriously. I wanted to trust the institution I had served for years. I wanted to believe that reason still had a place in public health.

I was not anti-vaccine. I was an injury and violence prevention educator. I was someone who had devoted decades to public health, education, and service.

But I carry a medical reality: I am anaphylactic, diagnosed in 2020 after collapsing from a reaction to nuts. The EpiPen saved my life. Certain glycols triggered severe reactions, and in 2021, glycols, especially PEG, became central to my fate.

Informed Consent and the Collapse of a Principle

Injury prevention taught me to revere informed consent. Consent to vaccinate is not meaningful unless a person:

- Understands the risks
- Is free from pressure
- Can say no without losing their livelihood

In 2021, this foundation crumbled.

Public messaging prioritized compliance, not comprehension. Adverse events were dismissed before investigation. Scientists spoke openly of "protecting confidence" rather than informing the public.

The first line of the Nuremberg Code is unambiguous: **"The voluntary consent of the human subject is absolutely essential."**

Voluntary means free of coercion, threat, or punishment.

During the mandate era, that principle wasn't bent, it was abandoned.

- Employment, mobility, and basic freedoms were conditioned on compliance.
- Bodily autonomy became a loyalty test.
- Dissent was pathologized.
- Ethical medicine cracked under political weight.

The Doctors

Days before my compliance was necessary to keep my job, my primary physician missed our scheduled exemption appointment entirely. Hours later, a voicemail arrived: "Anaphylaxis is the only valid exemption, but I still recommend you take the vaccination," he said, without conducting any assessment or examination. Even though a simple Google search revealed that people with anaphylaxis were advised against taking the vaccine (this

is explored in greater depth in Chapter Six), I was still being advised by my doctor to take the vaccine. I didn't have time to get schedule another appointment to try and convince him to write me an exemption letter.

A close friend who is a physician in British Columbia understood the danger immediately. She wrote directly to the Provincial Health Officer, urging a vaccine deferral supported by medical evidence. Her letter was thorough, compassionate, and clinically precise. It captured exactly what the situation required: honesty and empathy.

I sent it with quiet faith that reason still existed within the system I had served.

During the writing of this book, I contacted the physician who had written my medical exemption, a doctor who had acted with integrity when institutions did not. When I asked if I could include her name, she hesitated. Then she declined. Not because she doubted her decision, but because the climate that punished her courage has never fully lifted.

Her request for anonymity four full years after the fact is its own stunning indictment. I don't have to indict anyone in this book. They have indicted themselves with every email they sent. The quiet of physicians too afraid to speak is not neutrality, it is testimony.

In the end, the record speaks louder than I ever could. My task is simply to hold it up to the light.

REGARDING: Kevin Vowles Patient Number: 129
Date of Birth: 1977-05-17 Personal Health Number: **** *** ***
Tel: +1-250-858-7643 Email: kevinjvowles@gmail.com
October 21, 2021
To whom it may concern,

Due to medical reasons, I am in support of COVID-19 vaccination deferral and possible exemption for this patient, due to possible or suspected anaphylaxis or severe sensitivity, as well as mental-health reasons.

Kevin is concerned about potential anaphylaxis following hospitalization for anaphylaxis in June 2020. He has had multiple other reactions of varying degree to a number of chemicals or exposures and is unclear what he is or is not allergic to at this time. He is awaiting assessment by an allergist (he will be seeking referral through his primary GP or elsewhere).

There is also a clinical diagnosis of complex PTSD. The patient feels vaccination poses a real risk of causing further harm. Kevin has ongoing medical care and is felt to be medically stable as well as able to continue working in his current position, which I understand is done from home,

virtually. In this case the risk of exposure to or transmission of any communicable disease in the work setting is very low.

It is my professional opinion that loss of employment or pressure to get vaccinated at this time could pose significant potential harm to this patient. Kevin has been experiencing suicidal thinking related to this for the last month, which his manager and physician are aware of.

Thank you for your consideration of this individual's circumstances through providing deferral, and possible exemption, of COVID-19 vaccination and continuation of his employment.

Sincerely,

Name Removed to protect the doctor who wrote the letter from retaliation.

The Flight South

Then came Trudeau's nationwide travel ban. I will never forget the image of him shouting into a crowd that unvaccinated Canadians wouldn't be allowed on trains or planes. Overnight, mobility rights disappeared. I felt utterly confused and disappointed about what had transpired, panicked and terrified about what was to come, and ashamed of what my country had become.

If my parents, both in their seventies and living across the country, became ill, I would be barred from reaching them unless I complied.

But if I were outside Canada, I could fly home freely.

The pressure was unbearable. The mental strain was overwhelming. I told Island Health plainly: I was experiencing suicidal thinking. I didn't have a plan, but I continually returned to the thoughts. It was very disturbing.

On October 28, 2021, placed on unpaid leave and with my exemption "under review," I boarded what became one of the last flights an unvaccinated Canadian could take. Mexico was not an escape. It was survival.

In early November, my exemption was provisionally granted thanks to my doctor's letter. My manager told me I could work remotely. My pay was restored. For a moment, the world made sense again.

Then someone noticed my login was coming from outside Canada. Working from outside of the country was "against policy." Fair enough. My manager, knowing I was fragile, placed me on protected medical mental-health leave. For the first time in months, I could breathe.

Cracks in the Narrative

In Mexico that December, I met a man who proudly told me he'd been double-vaccinated. He coughed violently the whole time we spoke,

declaring that he had COVID-19 despite the shots. It was a small moment, almost forgettable, but it planted a seed. If the vaccines were supposed to block transmission, why were so many vaccinated people suddenly getting sick?

Even before that though, in the summer of 2021, the cracks in the narrative were no longer whispers. Data from multiple countries, Israel, the United Kingdom, the United States, began showing significant numbers of breakthrough infections, especially with the emergence of the Delta variant. In July 2021, the CDC published evidence from an outbreak in Provincetown, Massachusetts: vaccinated and unvaccinated people carried similar viral loads in their noses, meaning they could transmit the virus to others just as easily (Centers for Disease Control and Prevention 1059–62). That report forced the CDC to reverse earlier messaging that vaccinated people were "dead ends" for the virus.

It became increasingly clear: the vaccines reduced severe illness, but they were not reliably stopping infection or transmission.

By January 2022, public officials in the United States were saying it out loud. CDC Director Dr. Rochelle Walensky acknowledged in interviews that the vaccines could not prevent transmission of Omicron, and that vaccinated individuals could still spread the virus to others (Centers for Disease Control and Prevention, "Omicron Variant"). It was a turning point, not because the science had suddenly changed, but because the public admission had acknowledged the truth.

Return and Deadline

In January 2022, I notified Island Health I would return to work February 1. But my manager had moved to Coastal Health. I no longer had an advocate, and I had a very bad feeling about that change.

Despite clear admission by the rest of the world that the vaccines were not stopping transmission, upon my return to work on February 1st, 2022, I found a message dated January 17, 2022, demanding proof of an allergist appointment by January 31, while I was still on a protected mental health medical leave (see the letter on the next page). I was shocked they were still pursuing proof of an allergy because the proof that the vaccines weren't stopping transmission was abundantly evident.

BRITISH COLUMBIA

January 17, 2022 Cliff #1218298

Ref: HCL233
Name: Kevin Vowles
Information deadline: January 31, 2022

Dear Kevin Vowles

I am writing in response to your request for a medical exemption under the Provincial Health Officer (PHO) *Residential Care COVID-19 Preventive Measures Order* or the *Hospital and Community (Health Care and Other Services) COVID-19 Vaccination Status Information and Preventive Measures.*

Your COVID-19 Vaccine Medical Deferral Form indicates that you are to be referred to an allergist. A confirmed appointment date for this referral is required by this Office before a temporary exemption can be issued.

Within 2 weeks of this letter:

- Contact your health care provider and request an expedited referral to an allergist to determine if/how vaccination can proceed
- Submit your confirmed appointment date and the name of the allergist to PHOExemptions@gov.bc.ca.

Failure to provide a confirmed appointment date to this Office by the information deadline may result in your request being denied.

Sincerely,

Dr. Brian P. Emerson, MD, MHSc
Deputy Provincial Health Officer

Ministry of Health
Office of the
Provincial Health Officer
4th Floor, 1515 Blanshard Street
PO Box 9648 STN PROV GOVT
Victoria BC V8W 9P4
Tel: (250) 952-1330
Fax: (250) 952-1570
http://www.health.gov.bc.ca/pho/

On February 1st, I wrote to Dr. Brian Emerson acknowledging the message and telling him I would respond within 24 hours. The truth was, I didn't yet know whether I would comply. A part of me already knew I was finished—that the process was less about assessment and more about justification.

On February 2, I informed them I would comply. I booked the earliest appointment available, February 18, and told Island Health the date.

Still, on February 8, I received a terse decision: "Your medical exemption has been declined. No further consideration will be granted."

Four days later, on a recorded Zoom call, I was given two choices: Take the shots and keep your job, or refuse, and be terminated on March 7.

To watch the full video of me being put on notice that I would be terminated by Island Health on March 7, 2022, if I was not vaccinated, please go to https://youtu.be/DyMl-TB4zuo?si=dHe5DNDrXSKy_5y8

Every day I combed medical literature.

PEG anaphylaxis was real.

It had happened to others.

It could happen to me.

I wasn't refusing care. I was refusing to risk my life blindly.

I pleaded for understanding. I asked whether an allergist appointment before March 7 would change anything. They didn't know.

The Day Everything Broke

On March 3, the allergist's office finally called: The appointment was confirmed for March 7.

On March 7, 2022, three hours before my allergist appointment, Island Health terminated my employment.

That afternoon, the allergist Dr. Barlass confirmed exactly what I already knew:

- Testing for (Polyethylene Glycol) PEG allergy was essential.
- Do NOT take the vaccine until tested.
- Taking the COVID-19 vaccine could be fatal for me given that I am anaphylactic.

That night I filmed a video from the boat, a video about a scar that has never gone away. You can watch that video at https://www.youtube.com/watch?v=OchsgWi4lTA

The Personal Scar

For me, the vaccination scar became the memory of being terminated, mocked, ridiculed, harassed, and diminished. For others, it became the memory of exclusion, coercion, silence, or the quiet heartbreak of losing faith in institutions they once were steady and good.

Violence is not always physical. Sometimes it arrives through policy, moral judgment, and bureaucracy.

What this country lived through was a form of violence. It was psychological, social, and spiritual.

And like all violence, it left marks.

Scars are not flaws. They are truths that the body refuses to let go, with or without justice.

Chapter 5 — Justice Deferred

The Lawsuit

From the time I was terminated in March 2022, I had two years to file a civil suit with the BC Supreme Court. In the fall of 2023, I began that process, aware that the window to take legal action would eventually close. I had almost no money, but I knew that I had to take legal action.

I spent days and weeks pouring over documents, preparing the civil suit by visiting the courthouse, and the adjacent support services for citizens without the resources to hire proper legal counsel. After many weeks I was finally ready. When I first entered the courthouse, I still believed truth mattered. I had faith that the Canadian Charter of Rights and Freedoms, would protect a citizen standing on medical necessity. I believed reason would rise above bureaucracy, that fairness still lived somewhere inside the marble and fluorescent lights.

The courthouse smelled of old paper and disinfectant, bureaucracy and bleach. I stood at the counter and slid the envelope through the glass. February 2024. Just within the statute of limitations. My name printed at the top, theirs beneath:

- The Provincial Health Officer, Dr. Bonnie Henry
- The Ministry of Health, Adrian Dix
- Brian Emerson, Provincial Health Office
- Island Health
- Janice Rotinsky at Island Health

I walked out into the wind with the stamped copy pressed to my chest like a passport into another world. The claim listed **$82,087.78**, representing lost income, emotional harm, and legal costs. But privately, I knew the real damage approached **$1.7 million**. Still, I didn't sue for money. I sued because someone had to.

A seasoned lawyer would have told me to sue one party only. The Attorney General's office would later explain this reality, and I would in the end amend the lawsuit to be solely against Island Health. But I was fueled by conviction, not strategy.

SUPREME COURT OF BRITISH COLUMBIA
SEAL
VICTORIA REGISTRY
FEB 0 2 2024

FORM 1
(RULE 3-1 (1))

No. 24 1780
Victoria Registry

In the Supreme Court of British Columbia

Between

Kevin James Vowles — Plaintiff

and

Ministry of Health, Adrian Dix, Bonnie Henry, Brian Emerson, Naomi Jove, Island Health and Janice Rotinsky — Defendant

NOTICE OF CIVIL CLAIM

[Rule 22-3 of the Supreme Court Civil Rules applies to all forms.]

This action has been started by the plaintiff(s) for the relief set out in Part 2 below.

If you intend to respond to this action, you or your lawyer must

(a) file a response to civil claim in Form 2 in the above-named registry of this court within the time for response to civil claim described below, and
(b) serve a copy of the filed response to civil claim on the plaintiff.

If you intend to make a counterclaim, you or your lawyer must

(a) file a response to civil claim in Form 2 and a counterclaim in Form 3 in the above-named registry of this court within the time for response to civil claim described below, and
(b) serve a copy of the filed response to civil claim and counterclaim on the plaintiff and on any new parties named in the counterclaim.

JUDGMENT MAY BE PRONOUNCED AGAINST YOU IF YOU FAIL to file the response to civil claim within the time for response to civil claim described below.

Time for response to civil claim

A response to civil claim must be filed and served on the plaintiff(s),

(a) if you were served with the notice of civil claim anywhere in Canada, within 21 days after that service,
(b) if you were served with the notice of civil claim anywhere in the United States of America, within 35 days after that service,
(c) if you were served with the notice of civil claim anywhere else, within 49 days after that service, or
(d) if the time for response to civil claim has been set by order of the court, within that time.

CLAIM OF THE PLAINTIFF(S)

Part 1: STATEMENT OF FACTS

1. Plaintiff was hired by Island Health in August 2018 as the Injury/Violence Prevention consultant. This was a part-time, permanent, non-contract, non-union position.

2. Plaintiff was diagnosed with anaphylaxis at Royal Jubilee Hospital in May 2020.

3. Plaintiff was informed on October 12, 2021 that he must take the COVID-19 vaccine by October 26, 2021.

4. On October 26, 2021, plaintiff applied for a medical exemption, with the support of his doctor.

5. Plaintiff was granted a provisional medical exemption on November 3, 2021, and subsequently Island Health returned plaintiff to work.

6. Plaintiff applied for and was granted a mental health sick leave due a decline in mental health, until January 31, 2022.

7. Plaintiff confirmed with Island Health on January 12, 2022 that he would be returning to resume duties at Island Health on February 1, 2022.

8. Upon return from the mental health sick leave, plaintiff responded to an email from Dr. Brian Emerson (Provincial Health Office Representative) dated January 17, 2022. He indicated plaintiff had to provide an appointment (by January 31, 2022) with an allergist to be tested for an allergy to the vaccine. Plaintiff responded on February 2, 2022, indicating he would comply with the request, and did procure the first available doctor's appointment that was to take place on February 18, 2022.

9. On February 6, 2022, Dr. Brian Emerson informed plaintiff his medical exemption was declined.

10. On February 15, 2022, Island Health human resources representative Janice Rotinsky and the plaintiff had a recorded Zoom video call. Janice Rotinsky informed plaintiff that he would be placed on leave on February 22, 2022 if he continued to refuse to be vaccinated. Plaintiff was given until March 7, 2022 to be vaccinated or face termination.

11. Plaintiff was contacted by the allergist Dr. Barlass on March 3, 2022 and given an intake appointment date of March 7, 2022. Plaintiff informed Island Health of this appointment and requested that they postpone termination until a decision by the allergist be made as to whether or not he should be tested for his safety.

12. On March 7, 2022 plaintiff had the first intake appointment with Dr. Barlass, and she indicated that he should be tested, because of anaphylactic reactions to various chemicals he had been exposed to doing marine work.

13. Plaintiff was terminated from his position at Island Health on March 7, 2022.

Part 2: RELIEF SOUGHT

1. Loss of income: $26,859.76 (includes salary, employers pension contributions, benefits). Plaintiff seeks this amount from Island Health.

2. General damages: $53,719.52 (double the loss of income). Plaintiff seeks this amount from the Ministry of Health.

3. Court costs, legal fees associated with this case.

Part 3: LEGAL BASIS

1. The employment dismissal was unjust. While the Provincial Health Office representatives listed in this notice claim, maintain that employees in health care settings must be vaccinated to protect fellow staff and patients, it was proven and acknowledged by March 2022, that the vaccines do not stop transmission, and therefore this termination of employment is rooted in discrimination against unvaccinated people.

2. In December 2023, Arbitrator Nicholas Glass sided with terminated Purolator employees who refused the vaccine, and ordered that they be given their jobs back and compensated with backpay. Glass noted that by March 2022, it was widely recognized that the vaccines did not stop transmission.

3. Canada's Military Defense Chief received legal advice from the Office of the Judge Advocate General in 2021 that there was no evidence supported a COVID-19 vaccine requirement for all members. Despite this advice they disregarded relevant legalities and imposed the mandate. However, the military reversed course and abolished the mandate in 2022. An external review found the military's vaccine policy violated the Canadian Charter of Rights and Freedoms. Specifically, the vaccine mandate infringed the rights protected under Section 7 of the Charter, which guarantees life, liberty and security of the person. It also violated Section 1 of the Charter, which states that rights and freedoms are subject to reasonable limits.

4. The vaccine mandate, which caused the employment dismissal of the plaintiff, also violated the Nuremberg Code. Because MRNA technology and COVID-19 vaccines have not been clinically trialled and proven safe, they are still considered experimental. Consent to receive the vaccine could not also legally be obtained because of the threat to terminate employment.

5. Anaphylaxis is considered a disability in Canada under the Canadian Human Rights Act, R.S.C., 1985, c H-6. Employers have a legal responsibility therefore to make accommodation for employees who have such disabilities. The plaintiff also suffers from clinically diagnosed Complex Post Traumatic Stress Disorder (2016 at the Centre for Mental Health and Addictions Toronto), a recognized disability. On January 17, 2022, the Provincial Health Office request plaintiff obtain an appointment with an allergist within 14 days. At the time he was on mental health sick leave until January 31, 2022. Once the plaintiff complied with the request it took 31 days to procure the requested appointment.

Plaintiff's address for service: P.O. Box 794, Salt Spring Island, BC. V8K2G2

Fax number address for service (if any):

E-mail address for service (if any): kevinjvowles@gmail.com

Place of trial: Victoria Registry

The address of the registry is: 850 Burdett Avenue, Victoria, British Columbia V8W1B4

Date: February 2, 2024

Kevin Vowles

Signature of

☑ Plaintiff ☐ Lawyer for plaintiff(s)

Rule 7-1 (1) of the Supreme Court Civil Rules states:

(1) Unless all parties of record consent or the court otherwise orders, each party of record to an action must, within 35 days after the end of the pleading period,

(a) prepare a list of documents in Form 22 that lists

(i) all documents that are or have been in the party's possession or control and that could, if available, be used by any party at trial to prove or disprove a material fact, and

(ii) all other documents to which the party intends to refer at trial, and

Hope on Paper

I began with borrowed money, $2,500 raised by friends who believed in justice and medical freedoms.

The first lawyer said I had a case, and they would most likely settle out of court. The second called it a potential "test case." A mediator said it could open doors for others.

For a moment, I believed them.

But each consultation drained another ounce of hope.

- "$20,000 just to reach mediation."
- "Island Health's lawyers will outspend you."
- "You could lose and owe them $100,000."

One lawyer leaned back in his chair, almost apologetic: "You're right on principle. But that doesn't mean you can afford to be right."

My stomach knotted. Every meeting brought back the trauma of losing my job and career.

The Search for Counsel

I tried every legal-aid and pro bono program in the province: Justice Access Centres, Pro Bono BC, The Law Foundation.

Every call followed the same rhythm:

"Do you meet the income threshold?"

"Yes, but—"

"I'm sorry, we can't assist."

Door after door closed.

Meanwhile, Island Health's lawyers urged me to withdraw (see letter on the next page). If I signed a confidentiality agreement related to my "employment matters" (which would prohibit me from speaking about my termination by Island Health), as well as a standard confidentiality agreement about the settlement itself, they would drop their pursuit of legal costs. When I received the offer, I was struck by an intense fear and uncertainty. I understood what was being asked of me: silence in exchange for relief. Instead of agreeing, I decided to press on and seek assistance from the last place left where it was remotely possible to get it.

CARFRA LAWTON
LLP · LAWYERS

June 7, 2024

OUR FILE: 24074
DIRECT DIAL: (250) 995-4258
DIRECT EMAIL: korr@carlaw.ca

Kevin James Vowles
PO Box 794
Salt Spring Island, BC V8K 2G2

Via Email

Dear Mr. Vowles:

RE: Vowles v. Vancouver Island Health Authority

WITHOUT PREJUDICE

I am instructed by my client to offer to waive our legal costs to date in defending this claim, in exchange for your agreement to discontinue your claim by filing a Notice of Discontinuance with the British Columbia Supreme Court (see attachment).

This settlement offer is contingent on you signing a release in relation to the employment matters referenced in your Notice of Civil Claim, as well as a standard confidentiality agreement in relation to the terms of the settlement.

It is my client's view that your claim has no chance of success at a trial. If my client is successful at the trial of this matter, it will seek to recover its legal costs from you, pursuant to Supreme Court Civil Rule 14-1.

I strongly recommend that you obtain legal advice in relation to this settlement offer. You may be able to obtain free or low-cost advice through the following services:

- Lawyer Referral Service: 604-687-3221
- Everyone Legal Clinic: 778-200-4478
- Law Centre (University of Victoria): 250-385-1221

I look forward to hearing from you.

Yours truly,

CARFRA LAWTON LLP

Karen N. Orr (Law Corporation)

KNO/kno

Attachment

6th Floor – 395 Waterfront Crescent | Victoria, British Columbia | Canada V8T 5K7
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Writing to the Top

Out of options, I wrote directly to the Attorney General. I described my termination, the allergist's warning, the diagnosis of anaphylaxis, my 20-

year public-health career, and the discrimination that barred me from working in my field.

I didn't ask for a ruling, only for help securing representation.

Dear Honourable Niki Sharma,

I hope this message finds you well. I am writing to you as the most senior person in BC responsible for addressing human-rights violations, and for the provision of legal aid. I was terminated from a cherished 20-year career in public health as a result of unscientific mandates. I believe that an injustice has occurred and my human rights have been violated. Since being terminated, I've been unable to secure employment in my chosen field because of the same mandates.

I was terminated from my position as an Injury/Violence Prevention Education Consultant by Island Health in March 2022. This was a permanent, non-union, non-contract position. My termination was due to the system's failure to take seriously my doctor's advice against taking the COVID-19 vaccines because of a suspected anaphylactic allergy to PEG. The medical system was unable to schedule an appointment with an allergist within the 14-day window required by the PHO to verify this allergy; it took twice the allotted time, and my medical exemption was declined. Ironically, I was terminated on the same day the intake appointment occurred. The allergist strongly recommended I undergo testing *before* taking the vaccine. Island Health would not yield and did not even offer the baseline severance package.

My public-health career spans 20 years, including HIV / AIDS prevention work in Africa, and taking every vaccination recommended, including the H1N1 vaccine while teaching in an Indigenous community on Vancouver Island during the outbreak. In 2019 I updated my vaccinations at Island Health's request. Then in 2020 I was diagnosed with Anaphylaxis.

Efforts to secure a just settlement have failed. I have been unable to secure legal representation despite canvassing every legal-aid option in the province and speaking with countless lawyers. This is especially troubling, as Anaphylaxis is recognized as a disability, and individuals with disabilities or health conditions should not, according to the Nuremberg Code, be compelled to undergo medical treatments that could endanger their lives, just to maintain their employment.

My specific request of you is to provide the financial assistance necessary for me to secure a lawyer so that this case may be justly adjudicated.

Sincerely,

Kevin James Vowles

Her office replied with a one-page refusal.

This was the only explanation in the response from her office I received:

> "We are sorry to learn of the difficulties that you describe. However, it is not within the mandate of the Attorney General to become involved in litigation between employees and employers. With respect to your request for financial assistance to hire a lawyer, the Attorney General does not have the authority to provide direct legal assistance in specific cases. In addition, the role of the Attorney General does not extend to providing legal advice to members of the public."

Additionally, I was again referred to numerous legal resources which I had already exhausted.

This was the moment I realized, that in my view, the government was no longer interested in fairness, only in protecting its own decisions. I was exhausted.

The Last Attempt

Somewhere between exhaustion and clarity, I wrote Island Health's counsel with one final path: settle the case, or I share with the world the events of my termination.

I outlined calmly and precisely what I would do:

- Write a book
- Speak openly in media
- Share the termination video
- Document discrimination against medically vulnerable people
- Expose policy contradictions

I recreated the full letter in the manuscript, exactly as it was sent. What follows is the letter exactly as it was sent, written at a moment of exhaustion and clarity, and offered as a final attempt to resolve the matter without further litigation.

Dear Ms. Orr,

Thank you for your recent correspondence.

It seems we both agree on the importance of resolving this matter without going to trial. Despite my efforts, I have been unable to secure legal representation willing to take my case against a well-funded and determined adversary. The current legal climate, as illustrated by the CCESM case, appears resistant to acknowledging the reality of such

disputes. I filed for mediation hoping we could arrive at a result that both parties could feel good about.

Your straightforward communication regarding your client's position has provided valuable clarity. Understanding that their preferred outcome benefits them almost exclusively allows us to expedite this process. I appreciate your candor about your client's wishes, and in turn, I will be equally direct about mine.

I am prepared to sign a confidentiality agreement and a notice of discontinuance and to accept a settlement of $82,087.78. This figure accounts for the complete destruction of my public health career, lost income, mental health damages, and legal fees. While this amount does not fully represent the actual damages, which I initially estimated at $1.7 million, it reflects my understanding of likely achievable compensation. Furthermore, it does little to address the reality that mandates requiring vaccination remain in place, in BC, preventing persons with health conditions classified a disability, like mine, from securing work in our chosen profession. This option provides your client with confidentiality limited to the details of this case. I have already publicly disclosed my termination in Pandemic Papers (August 2022: Edition #5). My silence applies only to the details and outcome of this case.

If this proposal is declined and I sign a notice of discontinuance with no monetary compensation or additional agreements:

This will leave your client in a situation where they are free to pursue legal fees against me, a homeless and unemployed individual with multiple disabilities.

I will ensure that the public becomes more fully aware of your client's actions in my termination and this case, exemplifying their egregious behaviour and lack of compassion. This narrative underscores the stark discrepancy between their stated C.A.R.E. values, and actual behavior. Despite my dedication and passion for injury prevention, I was terminated over a policy that could have resulted in serious injury and harm, or possibly even death. I am prepared to expose your client's actions publicly, demonstrating their disregard for ethical conduct.

I plan to extensively document and publicize my experience through various avenues in Canada and abroad, including a blog, X, social and mainstream media, and videos. My background as a public speaker and my numerous connections with grassroots organizations ensure that this story will receive significant attention. I will highlight the discrimination I faced as a person with disabilities and the mental anguish I have endured, including documented suicidal thoughts that arose during the period

following my termination over a policy that even leading health authorities have begun to question.

Additionally, I will expose internal contradictions and specific instances of mismanagement within the organization, such as the termination video where Janice Rotinsky admits to enforcing policies despite knowing that the shots do not prevent transmission, and that she is merely following orders. Additionally, I "worked from home." This will create a compelling narrative of institutional failure and public health missteps.

I plan to publish a book as soon as possible detailing my experience and featuring testimonies from others affected by this policy, including a colleague who held a senior position in government), who opposed the mandates at considerable personal cost.

The story of my termination—especially given my medical conditions and the circumstances around my firing—will be a poignant narrative in the court of international public opinion.

In closing, I urge your client to carefully consider the proposed resolutions. I am very much prepared to further take this public, if necessary. I do hope we can reach a satisfactory agreement without further escalation.

Best regards,
Kevin James Vowles

Their response was brief. They offered no settlement. But they did indicate they would not be coming after me for legal fees, which was a small mercy. I did not receive a settlement, and I did not agree to silence. The letter stands as a record of what I was prepared to say publicly, not as a threat that achieved its aim.

Walking Away

In October 2024, I withdrew the case.
No payout.
No apology.
No justice.
But I preserved my integrity, and they preserved their policy.

A Class Action

With the lawsuit withdrawn, I found myself in the same place as thousands of others, carrying wounds the law refused to examine.

Soon after, the first lawyer I ever met, Umar Sheikh, invited me to join a class action launched by United Health Care Workers of British Columbia. Thousands of us, scattered across professions, pooled our voices into a

single legal effort. It was the first time since my termination that I felt part of a larger human story rather than an isolated case. At the time of this book's publication, that class action had been certified by the Supreme Court of British Columbia. While writing this book, I learned that the class action was facing significant financial strain. In response, I decided to donate ten percent of the book's profits toward legal fees supporting that effort.

BC Human Rights Tribunal

I also filed a complaint with the British Columbia Human Rights Tribunal in October 2023, seven months beyond the standard filing deadline, though the Tribunal allows for extensions in certain circumstances. As this book goes to print, my complaint before the Tribunal has been dismissed on procedural grounds relating to the timing of my application. I have requested a review of that decision.

As a result, the Tribunal has not considered whether the actions described in this book constitute discrimination under the Human Rights Code. Whatever the outcome of the review, the experience reinforced one of this book's central themes: that institutional processes often resolve questions of procedure long before they engage questions of harm, responsibility, or truth. Tribunals decide files. History decides meaning.

The Turning

Justice had been deferred, but something gentler began to rise in its place.

One night, after rereading the letters and correspondence, I set the papers down and realized the law had never been the true battleground. The real conflict had always been internal: dignity, conscience and truth.

I walked along the harbour. The legislature buildings shimmered across the water. They are beautiful, indifferent, and seem very distant to me, despite their proximity. I thought of the people who supported me. I thought, too, of the colleagues who had turned away. I no longer saw them as enemies, just frightened people swept along by a frightened system.

And for the first time in years, something loosened inside me.

A small, unexpected readiness to forgive, not because the system deserved forgiveness, but because I deserved peace.

Within that peace, a new purpose rose.

This book. Not written to punish. Not written to shame. But written to prevent a future where silence becomes obedience, and obedience becomes harm.

It is a reckoning Canada desperately needs.

So, I set sail on that mission, not with anger, but with clarity. The storm had not passed. But on the horizon, beyond everything I had endured, I could see the first faint clearing of light. It was in that light that I realized something essential: a reckoning of science was only the beginning.

Beneath the personal story lay a deeper, more consequential question, one that stretched far beyond my case, beyond mandates, beyond even the Pandemic itself. It is the question about how we build systems that can be trusted, and what happens when the structures meant to protect us, instead amplify harm.

If the early chapters of this book are about what happened to one life, the chapter that follows is about what could happen to all of us. It is the place where individual experience meets institutional power, and where the consequences of broken trust reveal themselves not as anecdotes, but as patterns.

This is where the story widens. This is where science meets the system. This is where the next chapter begins.

Part II — The Reckoning

Chapter 6 — The Science I Followed Through the Fog

In the months that followed, the fog began to lift, not because the world became kinder, but because my eyes finally adjusted to the darkness. Losing everything has a way of stripping the varnish off your beliefs. When the job, the community, and the identity I had threaded through my days were suddenly gone, what remained was the one question that would not leave me alone: How did everything go so wrong?

How did science, once my compass of curiosity, harden into decree? How did institutions built to protect health forget compassion? And how did a society that prided itself on tolerance turn so quickly toward division and moral certainty, blind to its own hubris?

When I finally sat down to write, it wasn't just to tell my story. It was to understand the deeper currents beneath it. I wanted to trace how science, once a lantern of discovery, drifted into something closer to dogma; how fear swept good people into absolutism; and how the truth about the vaccines — messy, contradictory and unfinished — still held the potential to lead us home.

This chapter isn't an argument; it is an exploration of evidence, of ethics, of the fragile line between safety and control. It is where grief begins to turn into purpose, and where my journey shifts from survival to understanding.

When I first heard the phrase 'follow the science,' it sounded noble, almost sacred. It implied humility, curiosity, and the willingness to change one's mind when new information appeared. But as the Pandemic unfolded, it became clear that what many meant was something far narrower: follow the orders that claim to be scientific.

The two were not the same.

Real science is not a creed. It is a method. It thrives on doubt, transparency, and free inquiry. It welcomes questions, especially the uncomfortable ones. The science of a brand-new, rapidly deployed medical technology could never be 'settled' so quickly. How could it be, when the real-world data was still being collected, when early signals were still emerging, when long-term outcomes, by definition, did not yet exist?

And yet certainty became the currency of the day. Slogans replaced nuance. Risk replaced conversation. Professionals tasked with examining evidence were instead expected to defend a narrative.

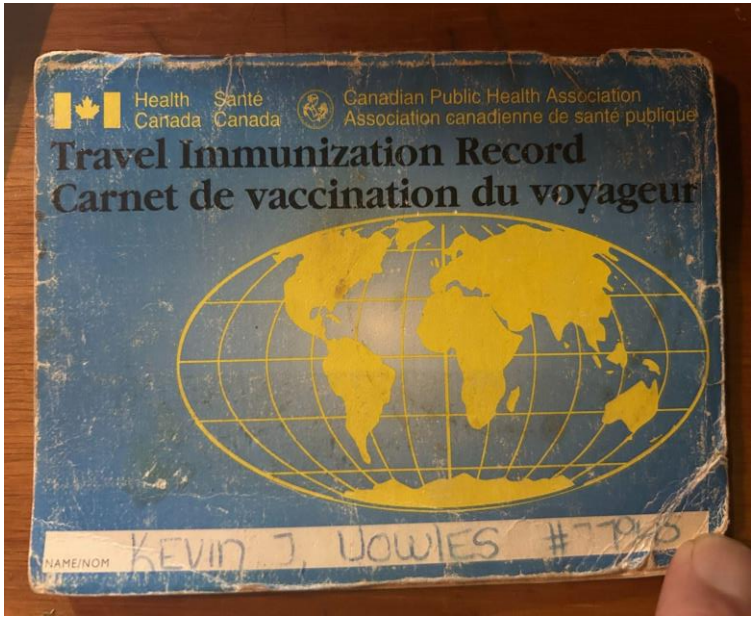
When I began digging into the numbers, when I read the studies myself, spoke with those who suffered injuries, and listened to the stories

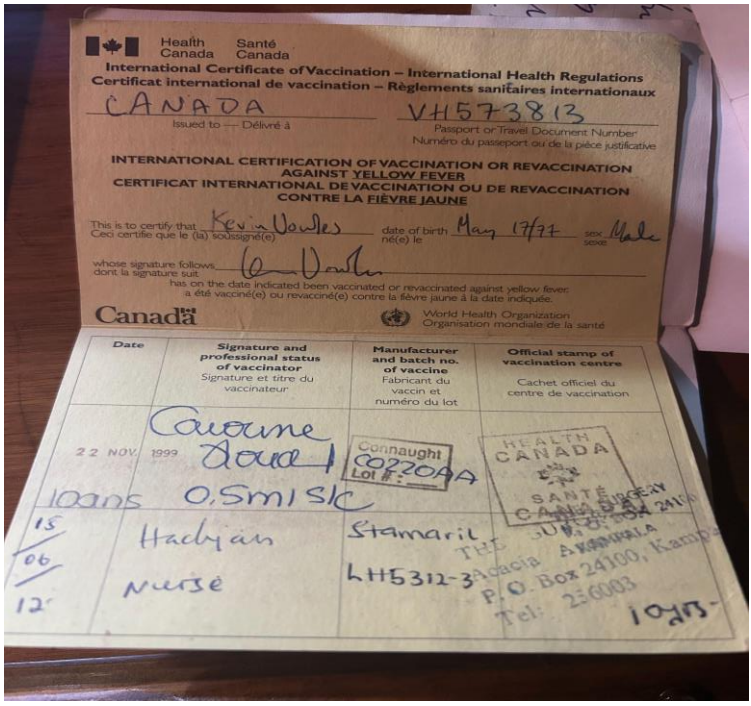
people were terrified to tell publicly, I realized something unsettling: not only were the claims about safety far more fragile than advertised; the claims about effectiveness were too.

That awakening didn't make me an outsider. It brought me back to the original spirit of science—navigating by curiosity, not consensus.

Before COVID-19, my relationship with vaccination had been straightforward. I had taken nearly every vaccine available during my public health work in Africa: Hepatitis A and B, Yellow Fever, Meningitis, Rabies, Cholera, Typhoid. I once rolled up my sleeve going from Uganda to Tanzania because entry required a Yellow Fever shot. I never questioned the need or the benefit. Below is a copy of my original vaccine passport, procured in 1999 in Montreal weeks before I flew to Kenya for the Canadian Field Studies in Africa program.

When a half-wild cat bit me in Botswana, the doctor told me I had three days to take the rabies vaccine. Death from rabies is almost absolute; protection from the vaccine was, in that context, unquestioned. I didn't hesitate. I have carried that vaccine passport with me for twenty-five years. I was the last person who ever imagined questioning a vaccine. I was the last person anyone would have called an 'anti-vaxxer.' Below is the unequivocal proof:





My belief in vaccines was further demonstrated to my employer Island Health in 2019. At the direction of Island Health, I walked into their immunization office at the Nanaimo Regional General Hospital, rolled up my sleeve, and received updates to Hepatitis A, Hepatitis B, and Tetanus. I didn't question the directive or the assumption that these shots would keep me healthy.

But SARS-CoV-2 shattered that simplicity, not because of ideology, but because science itself was shifting beneath our feet while public messaging pretended it wasn't. It was in that tension, between evidence and narrative that my real education began.

The Collapse of Meaning

For decades, vaccines represented certainty. They were not political. They were not moral devices. They were simply medicine, tools of prevention and protection.

When the mystery arrived—when vaccines did not reliably prevent transmission, when mandates hardened, when injuries went unacknowledged, when dissent became taboo—something collapsed in the collective psyche, like the Tacoma Narrows Bridge in the Tragically Hip song *Vaccination Scar*, shaking until its structure could no longer hold.

Suddenly, the old scar throbbed with new meaning. People noticed it for the first time in decades. The mark that once symbolized progress now represented something more complicated: trust violated, innocence fractured and certainty lost.

This book, and this chapter, is written from that place, from the collision between what we believed and what we lived.

Over 15 years, my immune system was sending signals no one in public health ever bothered to interpret. After receiving the full round of required vaccinations for my work in Botswana in 2005, I developed asthma for the first time in my life, abrupt, unexplained, and persistent. In 2010, after taking the H1N1 vaccine while working on an Indigenous reserve, a new wave of allergies appeared and slowly became part of my daily reality. Then in 2019, at Island Health's own direction, I updated my immunizations again. Only months later, in the spring of 2020, I experienced full anaphylaxis—hospitalization, an EpiPen, and the terrifying recognition that my immune system was no longer behaving predictably or safely.

These events did not *prove* that any vaccine 'caused' my conditions; science cannot make that leap, and I do not claim it. But taken together, they revealed a pattern of immune hypersensitivity that any responsible medical system should have recognized as clinically significant. My body was clearly in a category that required careful assessment, not blind assumptions.

Yet when the mandates arrived in 2021, none of this history mattered. Not the asthma, not the allergies, not the documented anaphylaxis, not the specialist warnings that PEG, a known allergenic excipient used in both mRNA vaccines, could pose serious risk for patients like me. My medical file might as well have been blank.

Instead of individualized care, I was met with coercion. Instead of caution, I was handed ultimatums. And at that moment, the system revealed something far more dangerous than a virus: when bureaucracy replaces medicine, and policy replaces judgment, people like me do not simply fall through the cracks, we are pushed.

My physician's caution, grounded in my documented anaphylaxis, meant nothing. Bureaucracy overpowered biology. Policy overrode medicine. The ethic that shaped my entire career—respect individual context—was discarded the moment politics demanded simplicity.

Most people no longer knew how to weigh risk. They outsourced it to institutions that had stopped tolerating questions. And when questions become dangerous, courage becomes the first casualty.

Anaphylaxis, Precaution, and the Decision I Made

In the earliest months of the COVID-19 vaccine rollout, one safety concern stood apart from all others because it was both acute and unambiguous: anaphylaxis. Unlike delayed or probabilistic harms, anaphylaxis is a rapid, life-threatening allergic reaction that can unfold within minutes. It involves widespread immune activation, airway constriction, cardiovascular collapse, and, without prompt treatment, death. It is a medical emergency, not a statistical abstraction. For people with a history of severe allergic reactions, it has always carried special weight.

Anaphylaxis occurs when the immune system overreacts to a substance it has identified as dangerous. Mast cells release large amounts of histamine and other mediators, causing swelling of the throat, a sudden drop in blood pressure, bronchospasm, and shock. Even when treated quickly with epinephrine, outcomes can be unpredictable. In rare cases, symptoms recur after initial stabilization. Deaths, while uncommon, are well documented in medical literature. This is why anaphylaxis has long been treated as a strict contraindication in many vaccination contexts.

Early COVID-19 vaccine safety monitoring identified anaphylaxis as a real, if rare, risk. Surveillance data from the United States showed that severe allergic reactions occurred at a rate of roughly two to five cases per million mRNA vaccine doses administered, higher than that observed for many routine vaccines. Most cases occurred within minutes of injection, which led directly to the introduction of mandatory post-vaccination observation periods (Shimabukuro et al., "Reports of Anaphylaxis After Receipt of mRNA COVID-19 Vaccines," JAMA, 2021). These findings were not speculative. They were the basis for policy.

In response, health authorities issued explicit warnings. In late 2020 and early 2021, both Health Canada and the U.S. Centers for Disease Control and Prevention advised that individuals with a known history of anaphylaxis to vaccines, injectable therapies, or vaccine components such as PEG should not receive mRNA COVID-19 vaccines without specialist evaluation. Public guidance emphasized caution, contraindication, and individualized risk assessment. These warnings were widely disseminated and prominently summarized in official materials that were easily accessible to the public at the time (Health Canada, "COVID-19 Vaccines: Contraindications and Precautions," 2021; CDC, "Interim Clinical Considerations for Use of COVID-19 Vaccines," 2021). At one point even a simple Google search revealed this truth to me.

The biological rationale for this caution was straightforward. mRNA vaccines contain lipid nanoparticles designed to deliver genetic material into cells. One of the stabilizing agents used in these formulations, PEG, had already been associated with rare but serious allergic reactions in other medical contexts. For individuals with a history of severe allergy, particularly unexplained or multi-system reactions, the possibility of triggering anaphylaxis was not theoretical. It was plausible, documented, and acknowledged by regulators.

What followed was a contradiction that never resolved. While public health agencies issued warnings recognizing anaphylaxis as a legitimate contraindication, governments simultaneously implemented vaccine mandates that made no meaningful accommodation for that risk. In my case, compliance was treated as binary. The nuance present in the safety guidance vanished in the employment context. A documented medical risk that regulators themselves had identified, was effectively ignored when it came time to enforcing policy.

My decision not to be vaccinated was not based on denial or misinformation. It was based on the guidance that explicitly acknowledged the risk of anaphylaxis and advised caution. That guidance was later softened as population-level data accumulated, but it was never declared wrong. It was simply eclipsed. The result was a moral inversion. Those who followed official precautions were treated as unreasonable, while the precautions themselves quietly receded from view.

This was not a failure of science. It was a failure of proportionality. The health system recognized a real risk, documented it, and then refused to integrate it into policy in any meaningful way. The cost of that refusal was not abstract. For me, it meant the loss of my job for following the very safety guidance that authorities had placed into the public record.

PCR — The Test That Rewrote a Country

When the Pandemic began, the world latched on to a single diagnostic tool: the PCR test, Polymerase Chain Reaction, a technology so sensitive it can detect a whisper of viral genetic material, even long after an infection is over.

Before 2020, almost no one outside laboratories thought about PCR. By the middle of that year, it had become an oracle.

Its output determined:

- Who was labelled a ‘case’
- Who had to isolate
- Who could work
- Who could travel

- What justified emergency powers, mandates, and restrictions
- And the daily fear metrics read aloud on television as if they were the weather

But PCR was never designed to diagnose infectiousness. PCR itself is a laboratory technique primarily performed in clinical and public-health settings, while most retail tests available to the public are rapid antigen assays. This section critiques not the laboratory science of PCR when used with proper clinical context, but the broader testing regime and case-count framework it helped normalize—where the presence of viral genetic material, detected at high sensitivity, was often treated as synonymous with illness, infectiousness, and societal risk.

PCR can detect fragments of a virus—tiny pieces that may pose no risk to anyone. It can amplify dead material. It can find what a person shed weeks ago. The key is the cycle threshold: how many times a sample is amplified to find something. Above a certain point, the test becomes exquisitely sensitive but clinically unreliable. It tells you that a piece of RNA exists, not whether a living, contagious virus is there, or whether the person in front of you is a danger to anyone.

Yet, during the Pandemic, PCR results were treated as absolute. Every positive was a 'case.' Every 'case' became part of the justification for the next round of restrictions. The effectiveness of the tool never came into question, largely because the public was not asking questions, because it was being conditioned into silence.

A positive PCR became a moral designation. What mattered was not viral load or infectiousness, but a number on a report.

I remember watching the daily briefings: the charts, the solemn tones, the case counts climbing like a stock market of fear. No one explained what those numbers truly meant. No one distinguished between someone sick in bed and someone who had recovered weeks earlier but still carried a trace of RNA in their nose.

The imprecision became the foundation of policy.

When something that sensitive becomes the metric that governs a society, the society bends around the metric, not the reality.

- Hospitals restricted visitors.
- Borders closed.
- People were told they were dangers to their families.
- Workers were sent home.
- Children lost classrooms.
- Communities' lost cohesion.
- Public trust cracked.

Not because the virus was imaginary, but because fear, amplified through a misunderstood test, became a governing force.

We had tools to interpret PCR responsibly. We could have calibrated thresholds, distinguished between 'RNA detected' and 'infectious,' and communicated the limits of the test openly.

Instead, we defaulted to the interpretation that produced the greatest fear. We counted every positive result the same way, regardless of whether it represented a threat to anyone. And the country moved through the next two years as though 'case counts' were the truth itself, rather than the distorted shadow of a reality far more complex.

PCR didn't tell us who was sick. It told us who had a detectable fragment of genetic material.

The distinction mattered. We did not make it.

And a nation governed by indistinguishable numbers will inevitably lose sight of the people represented by the numbers.

PCR tests are still being used today, especially in British Columbia.

PCR kits sitting on drugstore shelves feel like artifacts from another era, preserved long after the emergency that justified them has faded. They sit quietly beside toothpaste and vitamins, but they carry the memory of a world reorganized by fear. They remind us how quickly ordinary life can be reshaped by authority, and how easily temporary measures can become fixtures. They are the residue of a system that did not know how to let go. They whisper that some parts of the Pandemic ended, but the psychology of the Pandemic did not.

Their presence is no longer about utility so much as inertia. Institutions that rapidly expanded their power found it harder to shrink it again. Companies that capitalized on fear discovered that fear is an easy product to keep on the shelf. And so, the tests remain—not because people truly need them, but because structures built in crisis tend to linger.

They stand as a quiet caution: moments of collective panic leave long shadows, and those shadows do not retreat just because the threat does.

When the Message Around Transmission Changed

At the outset of the vaccine rollout in late 2020 and early 2021, the message was simple, elegant, and, to a world exhausted by fear, deeply comforting:

- Get vaccinated and you won't just protect yourself.
- You'll protect others.
- You'll help stop transmission.
- You'll help end the Pandemic.

To me when the vaccines emerged, it appeared to be stunning technology like every other vaccination I had ever trusted and blindly allowed to be injected into my arm.

Bonnie Henry, Justin Trudeau, Theresa Tam, Bill Gates, Joe Biden, the CBC, talk shows, and many others echoed the sentiment.

It was the moral foundation beneath every mandate, every passport, every televised announcement urging the 'hesitant' to fall in line. The government repeated it. Schools codified it. Unions made pins promoting it. Workplaces enforced it. Families fractured over it. The unvaccinated were recast not as individuals making medical decisions, but as vectors of disease—people whose very breath was a threat.

Early data seemed to support the sentiments. But science is built on patterns and evidence. By mid-2021, the pattern had shifted.

The Turning Point: Barnstable County, July 2021

On July 30, 2021, the CDC released a striking report. In an outbreak in Barnstable County, Massachusetts, three-quarters of the people infected with the Delta variant were fully vaccinated. More importantly, vaccinated individuals carried viral loads similar to the unvaccinated. Breakthrough cases were real. Transmission from vaccinated individuals was real. And the idea that vaccination alone could stop spread began to crumble.

This wasn't an obscure finding buried in a footnote. CDC Director Dr. Rochelle Walensky publicly acknowledged it then, and again in January 2022. This was the moment the public conversation should have changed.

Instead, for months, the messaging remained the same: ***VACCINATE NOW.***

Delayed Honesty, Eroding Trust

By early 2022, within scientific circles, the new understanding was clear:

- Vaccines reduced severe illness.
- They did not reliably prevent infection.
- They did not reliably prevent transmission.

But the policies were not updated. The communications were not corrected. The public was not told, plainly and clearly, that the moral justification for mandates had weakened dramatically.

On August 11, 2022, the CDC finally put it into writing in an updated Morbidity and Mortality Weekly Report, acknowledging that:

"Receipt of a primary series alone provides minimal protection against infection and transmission…/Protection is transient and wanes over time."

These words were a far cry from the bold slogans that had been used to justify firing nurses, excluding students from universities, and segregating society into the 'compliant' and the 'dangerous.'

British Columbia's Quiet Admission

Here in BC, the shift was just as real, if even quieter. In a January 21, 2022, letter, Bonnie Henry told university presidents that most SARS-CoV-2 transmission occurs in homes or social settings, not in classrooms or offices.

But the vaccine passports stayed in place. The mandates stayed in place. The mandate against me was enforced. And still, the unvaccinated were told they were endangering others. The contradiction was breathtaking, and the silence around it deafening.

The Moral Break

This was the moment the ground gave way beneath so many of us—not because the science changed, but because the science changed and the policies didn't. Public health officials would not admit that their policies were outdated and inconsistent with the vaccines. When other health entities like the CDC acknowledged the limitations of the vaccines, the Provincial Health Office of British Columbia, doubled down and continued to fire people like me who would not comply even though we had valid medical reasons, and were only asking to be tested prior to being subjected to the mandates. Humility was replaced with stubbornness. Authorities had tied their credibility to an absolutist promise they could no longer defend.

For me, it wasn't a betrayal of science. It was a betrayal of trust.

The vaccines may have reduced severe disease, but they could not carry the ethical weight that had been placed upon them. Policies crafted on the premise of altruism—protecting others—were left standing even after that premise was withdrawn.

When the foundation of a policy collapses, the policy must collapse too. In British Columbia, in Canada, in much of the Western world, it did not.

The Ethical Consequence

Once the truth was clear, that vaccinated and unvaccinated individuals could both spread the virus, one question should have guided all public-health decisions:

> *If we are equally capable of transmission, why are only some people punished with restrictions?*

Only one person in authority ever answered that question honestly: Patricia Daly. In a Vancouver Coastal Health briefing, Dr. Daly explained that the BC vaccine passport was not introduced because restaurants, gyms, and movie theatres were especially high-risk settings, "we're not actually

seeing COVID transmission in these settings," but primarily to "create an incentive" and "get higher vaccination rates."

It was a shocking but honest admission. And still the dam didn't break.

Myocarditis and the Collapse of Context

For most of my career, I lived inside the arithmetic of risk. Injury prevention teaches you that every intervention carries trade-offs: seatbelts save lives but can break ribs; helmets prevent skull fractures but embolden some riders to take chances. Nothing in medicine is ever absolute. Everything is contextual, shaped by age, physiology, circumstance, and the individual standing in front of you.

I spent time analyzing hospital data: which age groups were showing up, what patterns were repeated, what circumstances magnified danger. Young men and ATVs. Elderly men and ladders. Inexperienced drivers and icy roads. The work rested on three simple principles: see clearly, respond proportionately, and respect individual context. That was the public health I was trained in.

During COVID-19, that foundation disappeared. By late 2020, nuance gave way to a single, sweeping conclusion stamped across policy and culture: the vaccines were safe, effective, and morally necessary, for everyone, without exception. A 17-year-old athlete and an 80-year-old diabetic were treated as though they shared the same biology and the same risk landscape. "Safe," a relational word, was turned into an absolute.

Fear filled the vacuum. Compliance became virtue; hesitation became a threat. Students whispered doubts. Colleagues lowered their eyes. Many complied not because they were persuaded, but because the social cost of questioning outweighed their personal sense of medical risk. This wasn't science leading the public; it was fear wearing the mask of certainty.

Myocarditis became the clearest example of what happens when context is erased.

Two Different Patterns, One Missing Conversation

From the earliest days of the Pandemic, clinicians knew that SARS-CoV-2 infection could cause myocarditis, inflammation of the heart muscle. This was not unusual. Viral myocarditis has long been associated with influenza, coxsackievirus, adenovirus, and other common infections. As data on SARS-CoV-2 infection accumulated, a familiar pattern emerged: infection-associated myocarditis clustered mostly among:

- Older adults
- Those experiencing severe illnesses
- Patients with high inflammatory markers
- Individuals already hospitalized

In other words, the highest risk was concentrated among the people most vulnerable to the virus itself.

Then in 2021, a different pattern emerged: healthy young males presenting with chest pain after mRNA vaccination. Surveillance systems documented a small but real association, particularly within days of the second dose. Most cases were described as mild and resolved with rest, but the signal was distinct, a demographic that was, by COVID-19 hospitalization data, at low risk of severe infection.

These two patterns should have been held together in one conversation. Instead, public health held the line. Admitting nuance was treated as dangerous. Messaging stayed absolute. Universities, workplaces, and professions enforced mandates long after risk-stratified data was available. Physicians who attempted to speak honestly were disciplined or silenced, because enforcement is easier to defend than uncertainty, and authority is easier to protect than truth.

What Researchers Explored—and What the Public Rarely Heard

As I followed the evolving literature, scientists proposed several hypotheses to explain vaccine-associated myocarditis. None were definitive, but all were part of normal scientific process:

- A possible immune-mediated inflammatory response
- The body reacting to the spike protein in a small subset of individuals
- Hormonal and immunological factors, including testosterone's pro-inflammatory effects, potentially explaining the higher rates in young males

Whatever the mechanism, one reality was clear: a rare but genuine inflammatory event was occurring in a specific subgroup. Most recovered fully, but the pattern underscored a broader truth: even well-intentioned medical interventions can carry unintended consequences. The ethical burden is to acknowledge these realities early, openly, and with humility.

What a Responsible System Should Have Done

A system committed to safety and trust would have:

- Paused to study the signal
- Adjusted dosing intervals
- Considered dose-sparing approaches
- Recognized natural immunity
- Tailored recommendations by age and sex
- Supported physicians making individualized assessments

Instead, public health held the line. Admitting nuance was treated as dangerous. Messaging stayed absolute. Universities, workplaces, and professions enforced mandates long after risk-stratified data was available.

Like all symbols, myocarditis pointed to something deeper, the moment when public health stopped being a conversation and became an instruction.

The result wasn't merely rigid policy; it was a collapse of the principle that defines medicine: *treat the individual.*

What Myocarditis Ultimately Revealed

In the end, myocarditis wasn't just a medical phenomenon. It became a symbol of everything that had fractured:

- Nuance and actual scientific rigor were replaced by slogans like 'follow the science.'
- Dialogue was replaced by decree with dissent being punishable.
- Science was replaced by institutional certainty and blind hubris.

Myocarditis revealed what happens when a system cannot tolerate complexity. It defaults to coercion. It abandons the individual. It hides behind absolutes because absolutes are easier to defend than uncertainty, and authority is easier to protect than humility.

But myocarditis was not the only place where this fracture appeared. It was simply the first crack that many people were allowed to see. As time passed, similar patterns of dismissal, silence, and moral certainty began surfacing in other conversations, including those surrounding cancer, injury, and loss. The same refusal to sit with uncertainty took hold; the same instinct to shut down questions rather than examine them prevailed.

Cancer, Uncertainty, and the limits of Certainty

I need to begin this part the way real conversations start, by acknowledging a lot of pain from a lot of loss. In the span of two years, I buried one dear close friend who died from cancer. When I say I buried him, I mean it literally, three days after I watched him gasping for air, leaving this realm, I carried his body up a hill with five others, wrapped in a sheet, lowered him into the ground, and gently placed rocks and earth on top of his body, laying him to rest. Months later another close friend was diagnosed with cancer. Both had been vaccinated.

On Salt Spring Island where I live, three other people I personally knew died from cancer quickly after taking the vaccines. They weren't close friends like the first two, but I knew them. In my circles, many people now carry the same question in their chests, spoken or not: *Are the vaccines causing cancer?*

I understand why that question has a pulse. It has one in me too.

But grief is not a laboratory, and coincidence is not causation. Following science means we begin with what's measurable, not with what we most fear. When I started writing this book and especially using ChatGPT to help me parse the emerging literature, I honestly thought I might find not just correlative links but actual evidence of causation.

One day, while having coffee with my friend's sister, the one who died, who is a reporter for *The New York Times*, she asked me whether I believed the vaccines caused her brother's cancer. I reeled. Not at the question itself, but at hearing it from someone trained to separate fact from assumption. I told her the only truth I could offer; I had no way of knowing. I'm not a doctor. I cannot peer into another human body at the cellular level, let alone assign blame for something as devastating and complex as cancer. That was the truth I believed then and still believe now.

But there was another truth that I didn't speak aloud. Yes, I wondered. Wondering is not the same as believing. Curiosity is not an accusation. She didn't ask me whether I had *wondered*; she asked whether I had *certainty*. And I had none.

Wonder became a strange kind of refuge, a place to route my grief, my anger, my helplessness. But what feels true in moments of loss is not always what is true. Human beings form islands even when they don't live on one, and islands, literal or social, are powerful incubators for rumour and speculation. In those spaces, fact blurs with fear, certainty blurs with longing, and it becomes painfully hard to discern what belongs to reality and what belongs to hurt.

To ensure the question of vaccines causing cancer was examined fairly, I asked ChatGPT to approach it from multiple angles. Then I did my own research, reviewing peer-reviewed studies, checking international safety data, and looking for confounding factors that might cloud the picture. I asked ChatGPT to list the ingredients in the major COVID-19 vaccines and compare them with carcinogen registries. The goal was not to confirm a belief, but to follow the evidence with transparency and humility. Based on the evidence available to me, there is no established carcinogenic ingredient in the authorized vaccine formulations.

SV40 Claims, DNA Fragments, and Public Trust

As an important part of this project, I examined claims involving Simian Virus 40 (SV40) and the COVID-19 vaccines. The historical context matters: in the 1950s and early 1960s, some polio vaccines were contaminated with SV40, later associated with cancer, and that episode left a long shadow over public trust. Modern COVID-19 vaccines do not contain infectious SV40, according to regulators such as Health Canada, the

U.S. Food and Drug Administration, the European Medicines Agency, and the U.K. Medicines and Healthcare products Regulatory Agency.

However, some recent discussions have focused on something different: the detection of SV40-related DNA sequences, specifically portions of an old promoter/enhancer sequence used in plasmid-based manufacturing. These are not live viruses and cannot replicate, but the claims have raised questions for some scientists and members of the public about manufacturing transparency, testing thresholds, and how uncertainties are communicated.

What stood out to me was not only the scientific debate, but the institutional process around it. Questions about these claims were raised publicly in Canadian Parliament, where members asked Health Canada about its review of the SV40 promoter-enhancer sequence and other DNA elements identified in the Pfizer-BioNTech vaccine, including how residual DNA was characterized under regulatory limits (Canada, House of Commons, 19 June 2024). Health Canada's role, in such cases, is to evaluate quality and safety through formal review processes, including documentation provided by manufacturers. Yet much of the underlying technical exchange is treated as confidential business information, limiting what can be independently examined by the public. Even when regulators conclude that residual DNA fragments, including SV40 promoter/enhancer elements, are inactive and below internationally recognized limits, the opacity around such discussions can widen the trust gap.

What the Numbers Can—and Can't—Show

Cancer is slow. Tumours often develop over years or decades. That long timeline makes it difficult to attribute cause to an event that happened months earlier. While surveillance systems can detect sudden spikes, they are less equipped to interpret changes arising from delayed diagnoses, strained medical systems, and shifts in population behaviour. For outcomes with long latency, such as cancer, the absence of definitive signals today should not be mistaken for proof of absence — only as a reminder that careful surveillance and humility remain essential.

During the Pandemic, screening programs paused or slowed; people deferred care; many arrived in emergency rooms sicker and later. In epidemiology, this is called stage migration. In human terms, it means heartbreak without a villain.

To date, large population studies and cancer-registry reviews have not shown a clear causal link between COVID-19 vaccination and an overall rise in cancer incidence. That doesn't end the conversation; it simply grounds it.

Where signals have been claimed, clusters, anecdotes, small case series, deserve neither ridicule nor automatic acceptance. They deserve careful study. And when rigorous analyses fail to reproduce those signals, we should be willing to say so while keeping an open mind.

People aren't irrational to wonder. The immune system plays a role in cancer surveillance. Vaccines activate immune pathways. There are mechanistic hypotheses online, spike-protein persistence, off-target inflammation, DNA-repair interference, that can sound convincing.

But science isn't built on plausibility alone. A mechanism only matters if it produces a reproducible pattern across populations, in different studies, under different conditions. So far, that threshold has not been met for a broad vaccine–cancer causation claim.

Our minds, however, are tuned to patterns that touch us personally. A neighbour's diagnosis after a booster, hits differently than a paragraph in a registry report. When trust is already strained, every illness becomes a signpost. In injury prevention, we respected outliers because they could be early warnings, but we also compared them against the wider field to avoid mistaking noise for signal. Both are forms of care.

Canada, British Columbia, and the Lived Experience Gap

Across Canada, age-standardized cancer rates have been relatively stable, with some cancers rising and others falling; the overall increase in total cases stems mostly from an aging and growing population. The Canadian Cancer Society and Statistics Canada point to demography, not a sudden shift in underlying risk.

Between 2015 and 2019, Canada's cancer incidence held remarkably steady, averaging around 580 to 590 cases per 100,000 people each year. Then came 2020. In the first year of the Pandemic, recorded diagnoses fell sharply to about 450 per 100,000, not because cancer vanished, but because clinics closed, screenings were cancelled, and people stayed home. When services resumed, the numbers climbed back toward their previous range: roughly 575 per 100,000 in 2021 and in the mid-500s through 2022. Projections for 2024 place the combined rate for men and women somewhere in the low 500s, still slightly below the pre-Pandemic years (Canadian Cancer Society, *Canadian Cancer Statistics 2023*, 2023). In other words, the official statistics show disruption and delay, but not an explosive rise.

But statistics don't always capture what communities feel. On Vancouver Island and Salt Spring Island, I have watched cancer move through social circles with unsettling proximity, one diagnosis after another. The official numbers call this demographic gravity; my eyes feel something more complicated. Random clusters can happen—by chance

alone, a small community may experience several cancers close together, giving the genuine feeling of an epidemic even when broader rates haven't changed.

Registry data are slow, definitions rigid, and categories sometimes outdated. Pandemic backlogs created waves of late-stage diagnoses that, at ground level, felt like a surge.

The truth likely sits somewhere in between: a mix of delayed detection, environmental stressors, demographic shifts, and perhaps unknown factors still buried in the noise. Whatever the cause, the perception of rising illness is itself a data point, signaling a fracture between official messaging and lived experience. For outcomes with long latency, such as cancer, the absence of definitive signals today should not be mistaken for proof of absence, only as a reminder that careful surveillance and humility remain essential.

Science is not a verdict: it is a compass. If the needle shifts, we follow it without hesitation, without fear, and without loyalty to anything except the truth, because lives are at stake.

If those questions found little traction here, they were beginning to find it elsewhere.

Following Global Signals—Dr. John Campbell and the Cancer Question

Dr. John Campbell, a British nurse educator with a doctorate in physiology, became a widely followed analyst during the Pandemic. His appeal wasn't authority but clarity: he read studies line by line and spoke plain English. He never claimed certainty. He asked questions.

It is important to note that Campbell is a medical commentator, not an oncologist or cancer epidemiologist, and some of his interpretations, especially around mortality trends—are disputed by other experts. But his approach resonated with millions who felt the official narrative lacked curiosity.

When he examined claims of possible cancer increases, he approached them with caution. One Italian study (*Bertuzzi et al., "COVID-19 Vaccination and the Risk of Cancer Hospitalization,"* European Journal of Epidemiology*, 2023), caught his attention: over 30 months, hospitalization for cancer occurred in 0.85% of unvaccinated people versus 1.15% of those with at least one dose. The authors themselves warned that this difference might reflect age, pre-existing cancer, health-care utilization patterns, or residual confounding—not a true causal effect. They noted no consistent dose-response, and in one sensitivity analysis (requiring 365 days between vaccination and diagnosis) the association even reversed for people with three or more doses.

Crucially, the same study found significantly lower all-cause mortality among vaccinated individuals. Campbell described the cancer signal as "unsettling" but emphasized that it could easily be explained by confounders. In this context, confounders are not minor details. They are the real-world differences between vaccinated and unvaccinated groups that can distort results without proving causation. Vaccinated cohorts are often older, more medically complex, and more engaged with the health-care system. They may undergo more screening, have more appointments, and have cancers detected and hospitalized earlier simply because they are being observed more closely. Pre-existing illness, differences in follow-up time, and the simple fact that many diagnoses emerge months or years after the biological process begins can all create misleading associations. The authors were explicit that their findings did not demonstrate causation, and they cautioned against overinterpretation.

Then came a Japanese paper published in *Frontiers in Oncology* in 2024, suggesting increases in mortality from several cancers following widespread uptake of third mRNA boosters. It was an ecological analysis, based on population-level trends, not individual vaccination data, and could not demonstrate causation. The study has since been formally retracted following criticisms of its methodology and interpretive claims. Its appearance, amplification, and retraction, illustrate how fragile and confusing the post-Pandemic research landscape can be.

Campbell urged deeper investigation, not because the findings were definitive, but because ignoring troubling data (even flawed data) can erode public trust more than addressing it head-on.

Listening to him, I felt the fog lift a little. The point wasn't to *prove* anything. It was to defend the right and the responsibility, to look honestly, to measure openly, and to speak without fear. That same discipline mattered when the conversation turned to a harder question, whether viral illness itself could alter the course of cancer.

Viral Illness, Immune Stress, and Cancer Trajectory

Cancer is not caused by a single factor. It emerges from a complex interplay of genetics, immune surveillance, environmental exposures, metabolic health, and time. Stress, inflammation, and immune disruption do not create cancer out of nothing, but they can influence how the body detects, suppresses, or responds to malignant cells once they exist.

Severe viral illness is known to provoke intense immune activation, systemic inflammation, and prolonged physiological stress. SARS-CoV-2 infection, particularly in moderate to severe cases, has been associated with immune dysregulation that can persist well beyond the acute phase of illness. For individuals already living with cancer, in remission, or with

underlying vulnerabilities, such stressors may plausibly affect disease trajectory without being a primary cause.

It is important to distinguish correlation from causation. At present, there is no definitive evidence that SARS-CoV-2 infection causes cancer. However, there is growing interest in how viral infections, chronic inflammation, immune exhaustion, delayed screenings, disrupted care, and prolonged stress during the Pandemic period may have influenced cancer progression, recurrence, or outcomes in some individuals.

Many patients reported delayed diagnoses, interrupted treatment, or reluctance to seek care during lockdowns and periods of fear. Others experienced profound psychological stress following infection, bereavement, or isolation. These factors are well-recognized in oncology literature as contributors to poorer outcomes, even when they are not direct causes of malignancy.

To acknowledge these realities is not to assign blame or to offer simplistic explanations. It is to recognize that health exists within systems, and when those systems are disrupted, consequences can follow. Compassionate medicine does not dismiss patient experience, nor does it rush to conclusions unsupported by evidence. It holds uncertainty honestly, while remaining attentive to the lived effects of crisis on vulnerable bodies.

The Biology of Fear: How Stress May Be Feeding Cancer

There is one more possibility, and concerning factor almost no one in public office seems willing to name, though ordinary people sense it intuitively: what the Pandemic did to our minds, and what that did to our bodies. For decades, physicians have recognized that a large share of the illness they treat is driven not only by biology but by the cumulative wear of stress and fear. Estimates vary, but many studies suggest that well over half of all primary care visits involve conditions that are caused or worsened by stress. It may not be ninety percent, but it is enough to make one thing clear: when a society lives under prolonged psychological strain, the body eventually shows the bill.

For years, we lived inside a kind of atmospheric pressure that never let up. People were isolated from one another. Friendships fractured. Families split over mandates and beliefs. Businesses closed, bank accounts disappeared, and the future narrowed to a series of shifting rules and warnings. Even those who followed every instruction to the letter carried the weight of uncertainty and fear. It wasn't 'stress' in the way we casually use the word. It was a prolonged psychic compression: a slow, grinding burden that reshaped people from the inside out.

The human body registers that kind of pressure with chemical precision. When fear or despair persists, cortisol remains elevated, sleep frays, and the immune system begins to weaken. The cells that normally patrol the body for early cancerous changes, the quiet custodians of our internal order, become less vigilant. Inflammation rises. Repair processes falter. Over months and years, this creates conditions where small, harmless abnormalities have a better chance of taking root and gaining speed.

At the same time, the medical system was straining at its seams. Routine mammograms, colonoscopies, skin checks, and blood tests, the quiet, unseen work of prevention, were delayed, cancelled, or indefinitely postponed. People stayed home out of fear, or couldn't get appointments, or simply tried to endure until 'things went back to normal.' Early cancers that might have been caught in time were left to grow in the shadows. By the time many of them surfaced, they appeared more aggressive, more advanced, and more bewildering.

When you combine those two forces, the biological wear and tear of chronic stress and the collapse of routine detection, a clearer picture emerges. You do not need a new pathogen or a conspiratorial theory to explain why so many cancers now seem to appear suddenly, behaving with a speed that feels unfamiliar. You only need to acknowledge the obvious: a society living under sustained psychological strain becomes biologically more vulnerable. And when the systems designed to catch early disease fail at the same time, the consequences unfold quietly at first, then all at once.

For many people, that explanation may feel both unsettling and strangely grounding. Unsettling, because it suggests that the costs of those years were deeper than what any government acknowledged. Grounding, because it offers a coherent answer to what so many now observe in their own circles: neighbours, siblings, and old friends who suddenly find themselves facing advanced cancers, and other illnesses brought on by extreme stress, that seemed to come out of nowhere. Perhaps they did not come out of nowhere at all. Perhaps they grew in the silence created when society forgot that mental health is not separate from physical health but woven into the very processes that keep us alive.

Open science begins where certainty ends. It asks us to hold complexity without flinching, to admit what we know and what we don't, and to resist the temptation to bend reality toward the shape of our fears or our hopes. The cancer question taught me something essential: that even when the data does not confirm the stories we carry, those stories still reveal where trust has fractured. And fractures demand attention.

If the vaccines did not drive a sudden cancer epidemic, that should come as relief. But relief is not the same as closure—not when so many people have reported harm that cannot be explained away by statistics or dismissed as coincidence. Acknowledging lived reports of harm does not require presuming their cause, but it does require curiosity rather than dismissal. The real fault line does not run through oncology. It runs through the countless individuals who raised their hands to say, 'Something happened to me,' and were met not with curiosity, but with silence, ridicule, or institutional erasure.

This is where the conversation shifts. This is where the polite assurances end. This is where the lived experience of injury and death enters the room.

Vaccine Injuries

If cancer raised difficult questions, vaccine injury demanded something far more uncomfortable: a willingness to look directly at the experiences our institutions worked hardest to ignore. In every province, in every profession, in every demographic, there were people whose lives changed after the shot, not in abstract statistical curves, but in bruised ribs, racing hearts, neurological symptoms, and nights spent wondering if they would ever be believed. Some recovered. Some did not. All were told, in one form or another, that what happened to them either did not happen or did not matter.

In every corner of the country, something began to happen that official statistics could not capture. People whispered about sudden illnesses, unexpected declines in health, or strange reactions that appeared shortly after vaccination. Some stories were well documented; others were impossible to verify; many fell somewhere in between. But what united them was not proof or certainty. It was silence, a sense that speaking about what had happened might risk social exile, professional consequences, or the accusation of spreading "misinformation."

These stories formed the atmosphere in which people were trying to make sense of their own experiences. They did not prove causation. They did not rewrite science. But they were real to the people who lived them, and in public health, listening is not optional, it is foundational.

The official story insisted that serious injuries were 'rare,' but rarity is cold comfort when you are the one living inside it. And it was not just individuals who felt dismissed. Doctors who tried to document injuries risked censure. Researchers who raised early concerns were sidelined. Families were left to navigate a labyrinth of denial while carrying burdens that no one had prepared them for.

This is the human ledger that never appeared in the daily briefings. This is the evidence that does not fit neatly inside a confidence interval.

This is the cost that transparency would have revealed early, and compassion would have acknowledged immediately.

The time has come to speak plainly about these stories. Not to sensationalize them. Not to weaponize them. But to restore them to the public record, where they always belonged.

Among all the injuries people feared, one question carried a quiet, unmistakable gravity. It did not surface in protests or newspapers, and it rarely appeared in official briefings, yet it lived everywhere: in late-night conversations, in clinics, in the private worries of people hoping to start or grow their families. If the vaccines could harm the body in sudden and visible ways, could they also touch the more fragile, hidden terrain of fertility? It was a fear that moved differently from the others: softer, deeper, and far more personal. And for many, it became the question that defined the difference between reassurance and doubt.

Pregnancy, Fertility, and the Vaccines — What We Know, What We Fear, and What Remains Uncertain

Of all the anxieties that rose during the Pandemic, none cut deeper than the fear that the vaccines might harm fertility. It was a question whispered in bedrooms, in clinics, in waiting rooms, and in the private circles of people still hoping to build families. When any new medical technology enters the world, especially one recommended for pregnant women, the unease is not irrational. It is human.

Infertility is not rare. The World Health Organization estimates that more than one in six people of reproductive age will experience it at some point in their lives. But a widespread, vaccine-driven collapse in fertility is not what the evidence shows. Birth rates have fallen dramatically in some countries, but the decline began decades before COVID-19, fueled by economic pressures, housing costs, later motherhood, and shifting cultural norms. People are having fewer children; that does not mean their bodies have suddenly lost the ability to conceive.

When researchers looked directly at fertility, the picture became clearer. Studies measuring ovarian reserve markers, hormones such as AMH that signal the remaining egg supply, showed no meaningful difference between vaccinated and unvaccinated women *(Yang et al., "Comparison of Female Ovarian Reserve Before vs After COVID-19 Vaccination,"* JAMA Network Open*, 2023). IVF clinics reported the same pattern: egg yield, embryo quality, fertilization rates, pregnancy rates, and live births were nearly identical regardless of vaccination status *(Jacobs et al., "Association of COVID-19 Vaccination With Assisted Reproductive*

Technology Outcomes," JAMA Network Open*, 2022). The same was true for men. Sperm counts, motility, and morphology did not drop after vaccination *(Gonzalez et al., "Sperm Parameters Before and After COVID-19 mRNA Vaccination,"* JAMA*, 2021). In fact, the most consistent disruptions to both male and female fertility came from SARS-CoV-2 infection itself, not the shots meant to prevent it.

At the same time, not every question closed neatly. In June 2025, a 1.3 million female population-level study from the Czech Republic reported lower observed rates of successful conception among women vaccinated prior to conception. The authors noted that during 2022, observed rates of successful conception were higher among women unvaccinated prior to conception, at times approaching 1.5 times those observed in women vaccinated before conception. The authors were explicit that their findings were preliminary and hypothesis-generating, that they did not establish causation, and that no biological mechanism could be identified (Manniche et al., "Rates of Successful Conceptions According to COVID-19 Vaccination Status," 2025). Still, observational signals of this kind are not meaningless. They exist to prompt closer examination, to ask whether confounding factors, behavioral changes, or other influences may be at play, and to remind us that scientific confidence is strengthened by continued inquiry, not weakened by it.

Some of these fears were amplified by specific claims made early in the Pandemic. In Canada, physician Dr. Charles Hoffe publicly warned that spike proteins produced after vaccination might attach to ovarian tissue and impair fertility. His concern was framed as a theoretical risk, not as evidence of observed harm, and it was never substantiated by clinical data. Subsequent studies did not find declines in ovarian reserve, IVF outcomes, or population-level fertility consistent with such a mechanism. While the claim resonated emotionally, particularly among women hoping to conceive, it remained a hypothesis rather than a demonstrated effect.

Pregnancy raised even more urgent concerns. Miscarriage, preterm birth, stillbirth, these are fears that live in the bones of anyone who has ever carried or hoped to carry a child. Large studies followed tens of thousands of pregnant women and found no increase in miscarriage among those vaccinated. Babies were not smaller. They were not born earlier. They did not have higher rates of neonatal complications. If anything, vaccination reduces the risk of severe maternal illness, and severe illness is one of the strongest predictors of pregnancy loss.

None of this means people were unreasonable to worry. Pregnancy is a place where history weighs heavily on the imagination. Thalidomide, DES (a synthetic estrogen later linked to cancers and reproductive harm in

children exposed in utero), and early anti-nausea drugs all left scars on our collective memory. Those events shaped people like Robert F. Kennedy Jr., who argued passionately that COVID-19 vaccines should never have been recommended in pregnancy until longer-term developmental studies were completed. His position was not built on proof of harm. It was built on the belief that precautions are a moral duty when two lives are involved.

Kennedy criticized the speed of approval, the limited animal studies, and the lack of long-term reproductive data. He pointed to early safety-signal reports, not as evidence of danger, but as unanswered questions that deserved deeper investigation. His argument rested on process, not outcome: that science owed pregnant women more time, more transparency, and more certainty before offering reassurance.

That tension, between precaution and evidence, between fear and data, sits at the heart of this entire conversation. The studies we have today show no rise in infertility linked to vaccination. They show no increase in miscarriage, no decline in sperm counts, no erosion of ovarian reserve. But science is not a verdict; it is a compass. If the needle shifts, we follow it. And until history has the benefit of years and even decades, humility must guide our conclusions.

What matters most is that people's fears were not foolish. They were the legitimate fears of people trying to protect their families in a world where information was scarce, messaging was rigid, and trust was strained. Public health did not earn credibility by dismissing these concerns; it eroded it. Listening is not a courtesy in medicine; it is the starting point of care.

These fears, private and heartfelt, often spoken only in whispers, were not unique to Canada. Across the world, people were navigating the same collision between personal experience and official certainty, trying to reconcile what they were told with what they saw. In some countries, that tension remained hidden beneath the surface. In others, it erupted into public life when individuals inside the system found themselves suddenly standing outside it. Few examples captured that shift more clearly than what happened in Australia.

Australia as a Mirror: Dr. Kerryn Phelps — When Authority Meets Humility

Australia's Pandemic response was among the strictest in the world: mandates, lockdowns, fines, closed borders, and a culture that quietly equated compliance with virtue. At the height of that moment, few voices carried more influence than Dr. Kerryn Phelps AM, former president of the Australian Medical Association, respected physician, and longtime

advocate for public health. She was a champion of the vaccines, until she became a patient.

In late 2022, Phelps revealed publicly that both she and her wife had suffered significant adverse reactions after their COVID-19 vaccinations: neurological symptoms for her partner, and respiratory and cardiac complications for herself. In testimony to a parliamentary health committee, she spoke openly about the fear within the medical profession: that doctors were afraid to report adverse events or even discuss them, lest they face regulatory consequences.

What made her testimony powerful was not sensationalism, because it had none, but honesty.

She did not claim causation. She did not inflame panic. She simply described what happened, and how little the system wanted to know.

By 2024, Phelps had become a measured critic of the Australian rollout: not anti-science, but pro-transparency, a stance that should never have been controversial. Her story became a mirror: when institutions ignore the harmed, the harmed stop trusting the institutions.

Compliance as Culture

The transformation in Australia was not about medicine alone. It was cultural. A quiet recoding of moral language took place: dissent became danger, questions became disloyalty, and silence became the safest professional position.

Teachers, nurses, paramedics, and firefighters lost jobs not because they were infectious, but because they were inconvenient. Doctors who raised questions faced regulatory pressure. People who experienced adverse events learned quickly to keep their stories to themselves.

In Melbourne's largest hospital, 51 staff were removed for refusing vaccination. In Queensland, police officers and paramedics faced dismissal under statewide directives, later ruled unlawful by the Supreme Court.

The effect was clear: coercion may achieve compliance, but it cannot create trust.

Australia's Experiment

Australia became one of the most striking case studies in how swiftly public health can turn into social control when fear, politics, and authority align. What began as a cautious national response hardened into something far more severe: interstate borders sealed for months, citizens stranded abroad unable to return home, and entire cities placed under orders not to travel more than five kilometers from their front door. Police helicopters patrolled empty beaches, barking warnings through loudspeakers. Officers

on horseback dispersed solitary walkers. Playgrounds were cordoned off in police tape.

In Melbourne, residents endured one of the longest cumulative lockdowns on Earth. The motto "no jab, no job" became not a slogan but a lived condition, enforced across industries with little regard for nuance or individual circumstance. Australia did not simply err on the side of caution, it crossed into a form of hyper-enforcement that revealed how even open, democratic societies can slide into extraordinary restrictions when institutions stop asking whether the measures still match the moment. It was, in many ways, a glimpse of how fragile freedom can become when fear is allowed to outrun proportion.

Uptake exceeded 95 percent, not through persuasion, but through pressure.

It was in this climate that Phelps disclosed her own injuries. And when she testified that the Therapeutic Goods Administration never followed up on reports she submitted, it highlighted a structural wound: a system that encouraged vaccination but not vigilance.

Her warning was simple: "Without proper investigation, we do not know the scale of the problem." What she described was not malice, just a system too fragile to accommodate inconvenient data. And proportion is the point. Because when you strip away the noise, one of the clearest lenses through which to understand the Pandemic is the arithmetic of risk itself.

Vaccine Injury and Death: Aubrynn Carroll -- A Daughter Who Wanted to See the World

Seventeen-year-old Aubrynn Carroll from Michigan was vaccinated so she could participate in *Pilgrimage for Youth*, a program touring major North American cities and institutions. She received two Pfizer doses in June 2022 and soon left on the trip she had long dreamed about.

Days later, she became weak and tested positive for COVID-19. Her condition worsened, and she was admitted to urgent care, where she collapsed in the waiting room. She was resuscitated, airlifted, intubated, and placed on ECMO. She suffered multiple cardiac arrests. Twenty days later, surrounded by her family, she died.

Her medical chart listed vaccination status. Her death certificate listed COVID-19 and multi-organ failure.

Shanna, her mother, struggled to reconcile the two. I got to know Shanna shortly after I was fired for my refusal. When it came time to write this book I naturally sought her out for permission to include this heartbreaking story of her daughter's death.

Doctors did not claim a causal link. Shanna did not claim certainty. But she believed there were questions no one seemed willing to ask.

Her grief was amplified by silence and the sense that vaccine-injury reporting was not merely ineffective, but discouraged.

She speaks now because she wants her daughter's story to matter. Not to assign blame, but to insist on the dignity of asking uncomfortable questions.

Aubrynn Carroll's story is not presented as proof of causation, but as evidence of a deeper failure: the absence of a system capable of holding uncertainty with care. In the United States, as elsewhere, families were often left to carry unanswered questions alone, navigating records that documented events but did not pursue meaning. The injury was not only physical or medical. It was epistemic and moral, and the next tragic and heartbreaking loss of a great man, Sam W. Fightmaster, illustrates this point too perfectly.

Vaccine Injury and Death: Sam W. Fightmaster — An average citizen doing what he felt was right

Sam W. Fightmaster was a proud father and a dedicated husband. He worked at Powers Engineering for 15 years. He enjoyed deep-sea fishing, surfing, concerts, NASCAR Racing, and he was a die-hard Dallas Cowboy fan. Sam saved all of the concert tickets from each concert that he attended through the years. He had collected over three hundred concert tickets. Sam lived every day as though it might be his last.

Sam received his Johnson and Johnson vaccination on April 2, 2021, a simple, practical decision meant only to clear the way for an Amtrak trip he had been planning. He stopped at Kroger to pick up his blood pressure medication, rolled up his sleeve, and carried on with his day. Five days later, he woke with eyes so swollen he couldn't drive. His wife, Jody, took him to the eye doctor, where he was treated with steroids that offered temporary relief. But within days, Sam began breaking out in burning red rashes that spread across his body. His left foot and ankle swelled. Jody took him to the hospital ten times, pleading for answers. Each visit ended the same way: discharge papers, vague instructions, and no explanation. The symptoms intensified, strange and relentless, and Sam's health began to slip in ways no one could explain.

On August 7, Sam suffered a stroke. He told Jody his hand felt "funny," then collapsed into symptoms the hospital confirmed as a cerebrovascular event. He spent a week in rehab before returning home, but his decline accelerated. He began to lose his balance. He stumbled. He then lost the ability to walk. He cycled from a walker to a wheelchair to nine months confined to bed. His skin peeled off in gray sheets that Jody swept from the floor each day; the rashes deepened into red, burning patches that tormented him. Doctors told her they had never seen anything like it. Sam

lost his hair. His blue eyes faded to a pale brown. His appearance changed so dramatically that Jody said he looked like a different person. By early 2022, he could no longer feed himself. He suffered terribly, and Jody witnessed every moment.

On March 31, 2022, rehab staff called to say Sam was being released to hospice. He died on May 31, leaving behind his wife and their twin daughters, Madison and Morgan Taylor. In his final months, Jody reached out repeatedly to the pharmaceutical company's representatives, sending messages, medical records, and pleas for acknowledgement. She never received a reply. What she carries now is not only the memory of the man she loved, but the silence that followed his suffering—a silence that deepened the grief of losing a husband and the father of her two daughters.

Vaccine Injury: Tim — The Officer Who Stayed Silent

Tim, a Canadian naval officer and friend from kitesurfing at Dallas Road in Victoria, took the shots because refusal wasn't a real option in the military. Within days of his second dose, hives spread across his body. As time passed, Tim experienced vertigo, dizziness, chest pain, and episodes so frightening he thought he might die. When he mentioned the timing to medical staff, they asked if he'd changed laundry detergent.

Tim never filed a report. He didn't want the trouble. And like so many others, he assumed no one wanted to hear it anyway. He wasn't wrong about that.

Case Study: Dr. Joel Wallskog — When the System Fails Its Own

Before the Pandemic, Dr. Joel Wallskog performed more than 800 surgeries a year as a respected orthopedic surgeon. He took the Moderna shots out of duty. Within a week he developed transverse myelitis, a condition so serious it had paused the AstraZeneca trial in the UK.

In his case, the diagnosis ended in such severe disability that it meant the end of his career.

When he sought help from the CDC, FDA, and NIH, he found no protocols, no research, no pathway for care. His reports vanished into bureaucratic silence. The only people who understood what he was experiencing were strangers on the internet, tens of thousands of vaccine injured individuals comparing symptoms the medical system refused to explore.

He eventually became co-chair of React19, representing more than 36,000 Americans with documented injuries. Their surveys show almost none believe federal authorities take them seriously.

In Senate testimony, Dr. Wallskog described an NIH program that privately acknowledged vaccine-related neurological injuries while

maintaining public silence. He also highlighted the failure of the U.S. compensation system, where 98% of claims were rejected.

He ended his testimony with a line that rings beyond politics:

It is time to stop politicizing vaccine injuries and start building meaningful recognition, research, competent care, and fair compensation.

The Silent Crisis in Canada

If the U.S. experienced a public reckoning, Canada experienced something quieter, and in some ways, more devastating.

Reporting systems were difficult to access and dependent on physician willingness. Many doctors declined to file reports. Some discouraged patients from even raising concerns, worried it would feed misinformation. The Vaccine Injury Support Program approved only a handful of claims over its first two years.

Families who believed their loved ones were harmed found coroners unwilling to consider vaccine involvement even when the timing was striking. Physicians who raised questions, like Dr. Charles Hoffe, and others, faced professional discipline.

The national conversation never returned to vaccine harms. The silence was not accidental. It was systemic.

The Question Beneath All of This

These tragic and deeply disturbing stories of injury, verified or unverified, documented or whispered, do not establish causation. They do not rewrite clinical trials. Public health relies on controlled trials, pharmacovigilance systems, and large-scale population data to determine risk and benefit. A single event, or even a cluster of them, must be weighed against millions of doses and the complexities of individual health histories.

This is why regulators use layered safety systems, pre-authorization trials, post-marketing surveillance, adverse-event reporting databases, and independent review committees to assess whether a signal reflects coincidence, correlation, or true causal harm. To acknowledge this is not to dismiss people's experiences; it is to recognize the difference between personal testimony and population-level proof.

What these stories do reveal is a profound institutional failure: a refusal to see the harmed, to study the unexpected, or to listen to those living with consequences they did not choose.

For me, the lesson of these stories is simple: People who did what they were asked to do, and suffered for it, deserve to be heard, not hidden.

Excess Mortality — When the Numbers Become Too Loud to Ignore

In public health, excess mortality is the closest thing we have to an empirical conscience. It bypasses political arguments, corporate press releases, and media narratives. It simply compares how many people should have died in each period to how many did.

When that number moves beyond what disease models, demographic shifts, or seasonal cycles can explain, the signal is unmistakable: something is wrong.

For decades, this metric guided policy decisions, emergency responses, and international health alerts because it was objective. It had no ideology, no loyalty, no bias, only arithmetic. That is why what happened after 2020 is so extraordinary.

Many expected excess mortality to surge early, stabilize as systems adapted, and then decline once the worst waves passed. But the opposite occurred. Across much of the Western world, excess deaths remained elevated long after COVID-19 hospitalizations fell, after restrictions were lifted, and after vaccination campaigns reached their peak.

Countries as different as Germany, Australia, the United Kingdom, the Netherlands, and Canada began to report sustained excess mortality patterns that did not neatly track with COVID-19 case counts, influenza seasons, heat events, or any of the usual disruptors. Insurance companies noticed it first. Public institutions, by contrast, responded with a caution that bordered on avoidance.

The loudest alarm in epidemiology was met with one of the quietest institutional reactions in living memory.

It was in this context that John Campbell began to scrutinize one of the major analyses of the period: a 2024 *BMJ Public Health* paper on excess mortality across Western countries (Mostert et al., "Excess Mortality across Countries in the Western World since the COVID-19 Pandemic," *BMJ Public Health*, 2024). Campbell's review was striking not because it was sensational, but because it reflected the kind of sober, careful inquiry that public institutions should have undertaken themselves.

The study synthesized standardized mortality data from 47 Western nations between January 2020 and December 2022, drawing primarily from Our World in Data and the Human Mortality Database—two of the most widely used, methodologically conservative sources available. The conclusion was stark: over 3.09 million excess deaths occurred across those countries during the three-year window.

Yet the raw numbers were only part of the story. The pattern was even more revealing. To compare different years fairly, statisticians use what's called a P-score, the percentage of deaths *above* what would normally be

expected. In 2020, the first year of the Pandemic, excess deaths reached 1,033,122, a P-score of 11.4%. In 2021, a year defined by continued restrictions and the rollout of mass vaccination campaigns, excess deaths did not decline — they rose to 1,256,942, a P-score of 13.8%, the highest of all three years. And in 2022, even after most countries ended restrictions and attempted to return to normal life, excess deaths remained high at 808,392 (P-score 8.8%). In other words, mortality stayed well above baseline long after the emergency phase was over.

In a typical global health crisis, excess mortality peaks early and then subsides. Here, it rose in the second year and stayed abnormal in the third. The authors did not declare a tidy conclusion; they did something more scientifically honest: they said the pattern demanded investigation.

The paper identified several domains that could potentially explain the persistence of excess mortality, none of which should have been dismissed on political grounds. Some causes were indirect: delayed cancer diagnoses, postponed surgeries, worsening mental-health outcomes, record levels of drug toxicity, and healthcare systems strained and restructured around COVID-19 for months at a time. Some were direct: deaths from the virus itself, especially among the unvaccinated, immunocompromised, or elderly. And some lived in a more sensitive but legitimate scientific space: the possibility that vaccine-related adverse events, including cardiovascular complications or other mechanisms not yet fully understood, might have contributed to a portion of the unexplained excess.

The paper noted, in unusually candid language, that "consensus is lacking in the medical community regarding concerns that mRNA vaccines might cause more harm than initially forecasted," and pointed to several published red flags that warranted further exploration.

French regulatory classification and long-term monitoring

Early in the vaccine rollout, French regulatory authorities classified mRNA COVID-19 vaccines under regulatory frameworks applied to gene-therapy medicinal products, a categorization that carried specific implications for post-authorization safety surveillance. This classification did not assert that the vaccines altered human DNA, but it did reflect the novelty of introducing genetic instructions into human cells and the corresponding uncertainty about long-term effects. Under these frameworks, long-term pharmacovigilance and follow-up were treated as essential, not optional, reflecting an acknowledgment that standard short-term safety windows might be insufficient for fully characterizing downstream risks. Similar principles were articulated in existing European Medicines Agency guidance governing gene-therapy medicinal products, which emphasized prolonged monitoring precisely because delayed or rare

adverse effects may not surface during abbreviated clinical trials (Agence nationale de sécurité du médicament et des produits de santé, *Point d'information sur les vaccins à ARNm contre la COVID-19*, 2020; European Medicines Agency, *Guideline on Follow-Up of Patients Administered Gene Therapy Medicinal Products*, 2018).

Persistence of mRNA and lipid nanoparticles in organs

Parallel to regulatory caution, preclinical and immunological studies raised questions about the biodistribution and persistence of mRNA vaccines and their lipid nanoparticle delivery systems. Early assumptions held that vaccine mRNA would remain localized to the injection site and degrade rapidly. Subsequent research, however, demonstrated that lipid nanoparticles distribute systemically and that mRNA-driven antigen expression can persist longer in certain tissues than initially expected, at least in animal models and controlled experimental settings. These findings did not establish harm, but they complicated early assurances of rapid clearance and biological triviality. In the context of a novel platform deployed at unprecedented scale, such data underscored the limits of extrapolating long-term safety from short-term trials alone and reinforced the rationale for extended observation periods and post-market investigation (Bahl et al., "Preclinical and Clinical Demonstration of Immunogenicity by mRNA Vaccines," *Molecular Therapy*, 2017; Röltgen et al., "Immune Imprinting, Breadth of Variant Recognition, and Germinal Center Response," *Cell*, 2022).

Denmark's batch-variability analysis

Additional unease emerged from a Danish registry analysis examining reported adverse events by vaccine batch number. The study observed substantial heterogeneity, with a small number of vaccine lots accounting for a disproportionately large share of reported adverse events, while many batches were associated with few or none. The authors explicitly cautioned that the findings did not establish causality and could reflect reporting biases, distribution differences, or chance. Still, the magnitude of the variability raised questions that warranted further scrutiny, particularly in a system otherwise described to the public as uniform and predictable. Rather than prompting transparent investigation, the analysis was largely sidelined, reinforcing concerns that signals inconsistent with prevailing narratives were not being pursued with the rigor they merited. The authors themselves noted the absence of systematic follow-up, limited access to granular clinical data, and the rarity of autopsies, all of which constrained meaningful interpretation (Schmeling et al., "Heterogeneity in Reported

Adverse Events Following BNT162b2 mRNA Vaccination by Batch," *medRxiv*, 2022).

None of these findings prove causality of excess death. But none can be responsibly ignored. The authors stressed that autopsies were rare, clinical trial death data remained inaccessible, and governments had not mounted the kind of systematic investigation that these anomalies demanded.

As they put it in essence: when institutions do not look, they cannot find.

The silence around these questions was perhaps the most troubling aspect of all. Instead of transparent, multidisciplinary inquiry, many of those raising reasonable concerns, Campbell included, found themselves met with institutional defensiveness or outright hostility. Public health leadership, once quick to convene press conferences over far smaller statistical shifts, treated the excess-mortality signal as if acknowledgment alone would undermine public confidence.

But denial is not a public-health strategy. It is a communications strategy masquerading as one.

Nowhere was this reluctance more visible than in the United Kingdom. In late 2024, *The Telegraph* reported that the UK Health Security Agency had declined to release anonymized vaccination-date mortality datasets that independent researchers had requested to analyze potential correlations between vaccination timing and excess deaths (The Telegraph, "Government 'Withholding Data That May Link Covid Jab to Excess Deaths,' *The Telegraph*, 2025). The data contained no personal identifiers and resembled information historically published for other public-health inquiries, yet the agency blocked its release on privacy grounds.

Critics, including several Members of Parliament, argued that withholding such anonymized data made independent verification impossible and further eroded trust at a moment when transparency was urgently required. Some MPs went so far as to describe the refusal as an attempt to shield the government from scrutiny. Whether that assessment is fair or not, the outcome was unmistakable: one of the country's central health institutions restricted access to information that could have helped clarify the very patterns causing public concern.

Looking at excess mortality in other countries is unsettling enough, but for Canadians the question becomes sharper when the data turns toward home. According to Statistics Canada's analysis of provisional deaths from March 2020 through the end of October 2022, the country recorded 58,331 additional deaths above the expected baseline—a rise of 7.9%. Of these, 43,635 were officially attributed to COVID-19. That leaves close to 15,000 deaths that fall outside the COVID-19 column entirely (Statistics Canada,

"Provisional Death Counts and Excess Mortality, Canada, March 28, 2020 to October 8, 2022," *The Daily*, 2023).

These unexplained deaths cannot be waved away as statistical noise; they represent a substantial share of the excess burden.

Statistics Canada offered a range of possible contributors: delays in diagnosis and treatment, surging accidental poisonings and overdoses, deterioration in mental-health outcomes, and shifts in causes such as heart disease. While these factors undoubtedly played roles, they are not new. What is new is their concentration and scale.

When the age distribution is examined, the picture becomes harder to ignore. Based on Statistics Canada's provisional mortality data, Canadians under 65 accounted for roughly 10% of deaths officially attributed to COVID-19, yet they represented approximately 30% of excess deaths.

These mismatches do not point to a single clear cause, but they do point away from simplistic explanations.

The geographic distribution adds another layer. While Ontario, Quebec, British Columbia, and Alberta bore much of the early excess-mortality burden, later waves in 2022 showed British Columbia and Alberta in particular experiencing sustained, elevated deaths even in weeks when the national picture no longer showed clear excess. StatsCan notes that COVID-19 was a main driver of excess mortality overall, but it openly concedes that other factors—especially among younger Canadians—remain unresolved.

And the disclaimer that accompanies all these datasets is not reassuring: the numbers are provisional, delayed, model-dependent, and incomplete.

One question lingers beneath all of this, one that many Canadians are already whispering: Are vaccines part of this story?

Official agencies in Canada provide almost no data that could help answer it. Mortality stratified by vaccination status is not published. Autopsies are infrequent. Investigations into potential vaccine-related deaths are managed quietly and rarely reported in ways the public can scrutinize. Meanwhile, international studies have flagged early signals, some concerning, some ambiguous, that point to the need for deeper inquiry rather than assured dismissal.

The honest sentence is the simplest one: we do not fully know. And until we do, excess mortality in Canada remains not merely a statistic but a question mark, one that sits uncomfortably beside repeated assurances that 'the science is settled.'

Scientists do not settle questions by ignoring them. They settle them by looking directly at the data, especially when the data contradicts expectations.

The 2024 *BMJ excess mortality paper* authors ended their paper with a warning so direct it almost felt like an act of quiet rebellion:

> Excess mortality remained high for three consecutive years… government leaders and policymakers must thoroughly investigate underlying causes of persistent excess mortality.

That such a sentence needed to be written at all tells us something about the times we inhabit.

That it has gone largely unheeded tells us even more.

Dying Suddenly — When the Facts Outpaced the Narrative

Long before academics debated excess mortality, ordinary people were already witnessing events they struggled to understand. Healthy neighbours collapsed and died without warning. Young athletes faltered mid-play. Security cameras recorded individuals walking one moment and lying motionless the next.

These were not social-media illusions or misremembered anecdotes; they were real losses unfolding in real communities. And in many cases, no one, not coroners, not doctors, not public health, offered families a clear explanation.

In my own circle, a close friend's best friend (47-years-old) died the day after receiving his second vaccination. He had no known chronic illness, no cardiac history, no warning signs. One day he was alive; the next day his family received the kind of call that shatters the world. No autopsy was performed, and no medical inquiry followed. The absence of answers compounded the grief. It also became one more story in a cultural moment where asking basic questions was treated as socially suspect.

When the documentary *Died Suddenly* appeared in 2022, it was quickly met with fierce criticism. Some of that criticism was warranted; the film attempted to stitch together sudden deaths into a theory of intentional depopulation, a leap far beyond any available evidence. But beneath the film's uneven narrative lay something that millions of people recognized instinctively: the lived reality of sudden, unexplained deaths that had touched families long before the documentary was made.

Even those who rejected the film's conclusions often acknowledged that it had given shape to a public unease that was already there, waiting for expression.

The institutional response followed a familiar pattern. Fact-checking organizations declared the documentary "dangerous," "misleading," or "debunked," focusing on its most extreme claims while largely avoiding

the deeper issue: the sudden deaths themselves, and the lack of investigation surrounding many of them.

These organizations are not always wrong, but they are not entirely neutral either. Several receive funding from governmental, technological, or pharmaceutical entities, groups with a strong interest in maintaining particular public narratives. When such institutions insist that people disregard what they have directly observed, trust erodes rather than strengthens.

The idea of a deliberate depopulation agenda surfaced in some circles. A coordinated global plan is not supported by available evidence, but the fact that the theory gained traction is revealing. People do not reach for extreme explanations when moderate questions are welcomed; they reach for them when moderate questions are shamed.

That impulse emerged not from conspiracy, but from a landscape shaped by lockdowns, secrecy, coercive mandates, under-investigated injuries, limited autopsies, and a cultural posture that treated concerned families as nuisances rather than participants in a shared public-health story.

Meanwhile, excess-mortality data added statistical weight to what many communities had experienced firsthand. In 2020, the year of COVID-19 itself, excess deaths rose, but not dramatically. In 2021, the year mass vaccination campaigns were implemented worldwide, excess deaths rose more sharply. In 2022, they remained significantly above baseline across many high-vaccination countries including Australia, New Zealand, Canada, the UK, and parts of Europe.

The causes are undoubtedly multifactorial: delayed medical care, mental-health deterioration, long-COVID effects, lifestyle disruption, drug toxicity, and more. But the timing raised questions that public-health authorities often appeared unwilling to explore with transparency. Why did the steepest rise occur after vaccination campaigns, not before? Why did so many deaths receive little or no post-mortem investigation?

Throughout the Pandemic years, autopsy rates declined sharply. Coronial systems, the offices of coroners and medical examiners responsible for investigating deaths were strained, and in many regions, safety policies limited the number of post-mortems conducted. Thousands of deaths were coded as “cardiac arrest,” “natural causes” or “undetermined,” without deeper analysis.

This administrative minimalism created a veneer of certainty where no actual certainty existed. Families, overwhelmed and grieving, often accepted these classifications because they had no alternative.

Stories like the death in my own circle—sudden, unexpected, and left without thorough examination, were not the only ones that raised quiet concern during those years. Other families across different regions described similarly incomplete investigations. This does not establish a statistical pattern, but it does reveal an investigative gap: too many deaths were left unexplained, not because definitive causes were ruled out, but because they were never examined with the rigour such cases deserved.

The tragedy is in the loss of life, but also in the systemic reluctance to confront uncertainty. Silence became a second injury.

The broad dismissal of vaccine-injury concerns created an unintended effect: it pushed thoughtful people toward independent voices. Physicians like Dr. John Campbell, forensic pathologists, statisticians, and data analysts gained influence not because they had fringe ideas, but because the mainstream had grown uncomfortable with ambiguity.

When institutions treat questions as threats, the public looks for answers elsewhere.

By the time early-treatment debates emerged, with Ivermectin (explored in the next chapter) foremost among them, trust in public health had already fractured. People who witnessed sudden deaths were told they were mistaken. Families seeking explanations were met with deflection. Athletes collapsing mid-play were framed as routine. Doctors who raised concerns risked professional consequences. The system that once promoted transparency and vigilance began discouraging both.

When a society suppresses uncomfortable evidence, it should not be surprised when people seek information or treatment outside official channels.

The "dying suddenly" phenomenon is not just a medical issue; it is a cultural one. It represents the widening gulf between lived experience and institutional messaging, a gulf that left countless people navigating uncertainty without the guidance of the very institutions that were meant to earn their trust.

And just as there is uncomfortable evidence about ways in which the vaccines have caused harm, there is also what may be, for some, uncomfortable evidence about the good they did and can do, even for many people like me who cannot simply forget the risks. I cannot suppress that either.

That is where we turn now.

The Benefits of Vaccination

Before examining the failures, mandates, or injuries, I felt a responsibility to look plainly at the other side of the ledger: the benefits these vaccines did offer, especially early on. So, I asked ChatGPT to lay out

the strongest evidence for vaccine effectiveness, not anecdotes, not politics, but the best data available from trials and real-world studies. What emerged is what follows in this section.

In the early trials, the mRNA vaccines did what they said on the tin. In Pfizer's pivotal phase 3 study, two doses reduced symptomatic COVID-19 by about 95% compared with placebo over the first few months in adults sixteen and older (Polack et al., "Safety and Efficacy of the BNT162b2 mRNA Covid-19 Vaccine," *New England Journal of Medicine*, 2020). Moderna's trial reported similar numbers: roughly 94% efficacy against symptomatic disease, with all 30 cases of severe COVID-19 occurring in the placebo group, not in those who received the vaccine (Baden et al., "Efficacy and Safety of the mRNA-1273 SARS-CoV-2 Vaccine," *New England Journal of Medicine*, 2021).

Those are large relative risk reductions in the short term, especially for people at higher baseline risk.

As the shots rolled out into the real world, the picture became more complicated around infection and transmission, but the protection against severe outcomes remained clear. A large meta-analysis of real-world studies up to late 2021 found that full vaccination substantially reduced not only infections, but more importantly, COVID-19 related hospitalizations, ICU admissions, and deaths. A *Lancet* review likewise concluded that, even as protection against infection waned over time and with new variants, effectiveness against severe disease generally stayed above about 70% for months after full vaccination.

In elderly populations, who had the most to lose, real-world studies and systematic reviews show that COVID-19 vaccination was associated with substantially lower mortality, with some pooled evidence indicating roughly an 80 percent or greater reduction in the risk of death from COVID-19 compared with unvaccinated peers (Xu et al., "Effectiveness of COVID-19 mRNA Vaccines Against Mortality in Older Adults," *PubMed*, 2023).

On the population level, modelling studies suggest that individual risk reductions added up. One *Lancet* analysis estimated that COVID-19 vaccination prevented about 14.4 million deaths globally in its first year alone (Watson et al., "Global Impact of the First Year of COVID-19 Vaccination," *The Lancet*, 2022). A *JAMA Health Forum* study, looking across multiple countries and time periods, estimated roughly one death averted for about every 5,400 doses administered, with most of that benefit concentrated in people over 60 years old (Watson et al., "Global Impact of COVID-19 Vaccination on Mortality and Life-Years Gained," *JAMA Health Forum*, 2022). If I am going to criticize how these products were sold and

imposed, I have to be equally clear there is evidence for older and high-risk people in particular, the vaccines did reduce severe outcomes from the SARS-COV-2 virus, even if they did not live up to the early promises about stopping infection or transmission.

What remains largely unexamined is the reciprocal question: while models estimated how many deaths vaccination may have prevented, far less effort was devoted to rigorously assessing how many serious harms or deaths may have been caused, particularly outside narrow adverse-event categories. The absence of such analysis should not be mistaken for proof of absence.

While population-level analyses suggested benefit for many older adults, this book does not offer medical recommendations, and I do not presume to do so. Encounters like the one described next, alongside the uneven realities of frailty, comorbidity, and institutional care, ultimately reinforced my reluctance to endorse broad recommendations for the elderly as a group. Benefit at the aggregate level does not negate the moral seriousness of individual injury or death, nor does it absolve us of the responsibility to approach interventions in aging and elderly populations with humility, caution, and restraint rather than certainty.

As this manuscript was nearing completion I had a chance encounter on a rainy, grey January day, with a friend in her seventies on a ferry from Salt Spring Island to Victoria, that left me chilled to the bone with sadness and confusion. After sharing with her about this book, she described her mother in her nineties receiving a COVID-19 vaccine in an old age home and dying minutes later. Staff administered the vaccine, went on to the next patient, and returned minutes later to find she had died. I make no claim about causation, nor do I present this as evidence. I include it only to acknowledge how encounters like this, shared quietly and often years later, can arrest certainty and remind us that population-level conclusions do not always capture the full moral landscape of individual experience, particularly among the very old and frail.

Holding benefits and harms is uncomfortable, but necessary. It requires acknowledging that a medical intervention can offer real, measurable benefit in one domain while still raising unanswered questions in another. As the Pandemic unfolded and the immediate crisis phase began to recede, my attention, like that of many clinicians and researchers, shifted from survival alone to what came next. Not just whether people lived, but how they lived afterward.

While researching this book, questions about neurological effects (such as Alzheimer's disease) began to surface alongside the more familiar

debates about infection, hospitalization, and mortality. They did not arise as abstract data points, but as concerns tied to real people, often older adults whose cognitive health, independence, and dignity matter deeply. At first, these signals appeared at the margins, in follow-up studies and clinical observations that extended beyond the acute phase of illness. Over time, it became clear that both the virus itself and the global vaccination response to it raised questions about long-term brain health that could not be set aside.

The evidence reviewed in this section speaks primarily to short-term outcomes, particularly the reduction of severe illness, hospitalization, and death during the early phases of the Pandemic. It does not resolve questions about longer-term neurological risk, whether from infection or from vaccination, which are explored in greater depth in Chapter 10. Nothing here is intended as medical advice or as a recommendation for or against vaccination in elderly individuals. My intention is simpler and more human than that. It is to describe what the strongest available evidence shows about short-term protection, while acknowledging that the fuller neurological story of COVID-19, and of the choices made in response to it, is still unfolding.

How societies care for their elders is a measure of their values. Asking difficult questions about risk, benefit, and uncertainty is not an act of fear or opposition. It is an expression of responsibility, and care.

The Cleveland Study

While there were clear benefits to vaccination for many, one study raised a different kind of question: what happens when 'more' stops being better?

The Cleveland Clinic study became one of the most intriguing pieces of real-world evidence to emerge after the initial waves of the Pandemic. Conducted among more than 50,000 healthcare employees, it offered a rare, large-scale look at how infection, immunity, and vaccination interacted outside the artificial conditions of a clinical trial (Shrestha et al., "Necessity of COVID-19 Vaccination in Previously Infected Individuals," *Open Forum Infectious Diseases*, 2022).

What the researchers found was both unsurprising and quietly explosive.

People who had already recovered from COVID-19, especially from Omicron, had the strongest protection against reinfection. Natural immunity, long downplayed in public discourse, emerged as the single most reliable predictor of future resilience.

But the study's most controversial finding came from something the researchers didn't set out to prove. When they analyzed infection rates

based on how many vaccine doses individuals had previously received, a strange pattern emerged. Instead of seeing protection steadily increase with the number of doses, the data showed the opposite: employees with more prior doses were more likely to test positive during the follow-up period.

The authors didn't frame this as causation; they simply acknowledged the association and offered hypotheses, such as behavioural patterns, immune imprinting, or other confounders. Still, the trend was unmistakable, and it raised questions that public health had been reluctant to entertain: What happens when a rapidly mutating virus keeps outrunning a vaccine still coded to the original 2020 strain?

The Cleveland findings didn't claim that vaccines were harmful, nor did they deny their early benefits, particularly for older and high-risk populations. What they did was reveal the limits of a strategy built on repeated boosting, and the biological reality that immunity, like the virus itself, is dynamic rather than static.

The study showed that real-world data can tell a story more nuanced than the one presented in official messaging. It suggested that more is not always better, and that public health must be willing to revisit assumptions when the evidence shifts.

In that sense, the Cleveland Study became a quiet turning point: a reminder that science is not strengthened by certainty, but by the courage to follow the data even when it complicates the narrative.

The Cleveland Clinic findings help clarify why age matters so much in these discussions. As baseline vulnerability to severe COVID-19 rises steeply with age, the calculus changes. For older adults—especially those in their seventies and eighties—the central question is rarely whether risk exists, but whether the net balance of risks and benefits tilts toward protection. Population-level data have generally suggested clearer benefit in older age groups, including reduced risk of hospitalization or death, particularly earlier in the Pandemic when population immunity was lower.

At the same time, 'net benefit' does not mean 'zero harm,' and this is where safety surveillance matters. Serious adverse events can and do occur in older adults, and monitoring systems are designed to flag early statistical signals—sometimes concerning, sometimes ambiguous—that warrant follow-up. For example, a preliminary signal for ischemic stroke in adults aged 65 and older after a bivalent booster prompted deeper review. While subsequent large analyses in older populations did not show a consistent, statistically significant elevation in stroke risk in primary analyses, there was a small signal which warrants consideration. This is how pharmacovigilance is supposed to work: notice patterns early, investigate

with stronger data, and update conclusions as evidence accumulates—without dismissing lived experience or overstating certainty.

It is also important to acknowledge the limits of adverse-event reporting itself. Passive reporting systems rely on clinicians, patients, or families to recognize and submit reports, and it is well established that not all events are captured. Underreporting is particularly likely when outcomes are common in older populations, when symptoms emerge days or weeks later, or when attribution is uncertain in the presence of multiple medical conditions. For this reason, passive systems are not designed to establish causation or precise incidence rates; they exist to detect potential signals that warrant closer examination. Those signals are then assessed using active surveillance methods and large linked health-record analyses, which do not depend on voluntary reporting and are better suited to determine whether observed events exceed expected background rates. Recognizing underreporting as a limitation does not invalidate safety monitoring. It explains why multiple complementary systems are used and why serious questions require careful follow-up rather than reflexive reassurance or dismissal.

Clinical medicine often begins with observation rather than conclusion. In hospital settings, clinicians routinely note the timing of recent vaccinations when patients present with acute events—not as proof of causation, but as part of careful history-taking. Many such observations never become formal adverse-event reports, particularly when outcomes are common in older adults or when attribution is uncertain. This does not imply negligence or concealment, and it reflects the limits of systems that depend on recognition, judgment, and time. The result is an unavoidable grey zone between what is noticed at the bedside and what is captured in databases. It is a reminder that safety surveillance is an evolving process, not a ledger of certainties.

I was reminded of this complexity during a hospital visit of my own in 2023. I had been admitted after an accident involving chemical exposure and particulate matter in my eyes, while working with angle grinders and heavy-duty chemicals on my steel boat. I was resting quietly in a shared space when an elderly man nearby was being assessed for a cardiac event. As the physician reviewed his chart, one detail was mentioned repeatedly: "I see you were in today for a COVID-19 vaccination." The doctor did not state that the vaccine caused the heart problem. There was no accusation, no conclusion—only the careful and repetitive noting of timing. I found myself wondering whether that observation would ever be formally reported, or whether it would remain one of countless moments where

clinicians register a possible association without the certainty required to act on it, in a system that didn't want to hear about it.

This is not proof of harm, nor is it proof of safety. It is a glimpse into the uncertain space where bedside medicine meets population-level surveillance. It is here that questions are noticed, uncertainty is acknowledged, and many observations never become data points. That space matters, because it is where real people live, and where trust is either quietly maintained or slowly eroded.

What matters is how strong and how settled each body of evidence is, and where uncertainty remains.

Long COVID and the Limits of Certainty

Long COVID, often described as a constellation of symptoms persisting weeks or months after infection, became one of the clearest examples of this complexity. Fatigue, cognitive impairment, shortness of breath, autonomic dysfunction, and a range of inflammatory and neurological complaints were reported across age groups and severity levels, including in people whose initial infections were mild. For many, these symptoms were transient. For others, they were disabling.

Post-viral syndromes themselves are not new. Long before COVID-19, medicine recognized prolonged illness following viral infections such as Epstein–Barr virus, influenza, and SARS-CoV-1. Myalgic encephalomyelitis and chronic fatigue syndromes sit within this broader clinical history. COVID-19 did not invent post-viral illness, but its scale made it impossible to ignore.

By 2021, large cohort studies confirmed that a subset of people infected with SARS-CoV-2 experienced persistent symptoms beyond the acute phase (Nalbandian et al., "Post-acute COVID-19 Syndrome," *Nature Medicine*, 2021). At the same time, estimates of prevalence varied widely. Some studies defined long COVID as any symptom lasting beyond twelve weeks. Others focused on functional impairment or inability to return to work. These definitional differences produced radically different incidence figures, contributing to public confusion and fear.

The science was clear on one point: long COVID was real.

It was far less clear on how common it was, who was most at risk, how long it lasted, and what mechanisms drove it.

Vaccination entered this already uncertain landscape with both promise and complication. Evidence emerged that vaccination reduced the overall risk of developing long COVID following infection, likely by reducing severity and viral burden. This mattered, and it should be stated plainly.

At the same time, reports also began to surface of persistent symptoms following vaccination itself (Fraiman et al., "Serious Adverse Events of Special Interest Following mRNA COVID-19 Vaccination," *Vaccine*, 2022; Munro et al., "Safety and Immunogenicity of Seven COVID-19 Vaccines as a Third Dose," *BMJ*, 2021). These reports were far less common, harder to characterize, and more difficult to study. Unlike infection, which involves systemic viral replication and widespread immune activation, vaccine exposure is limited in dose and duration. Establishing causality in post-vaccination syndromes is therefore more challenging.

Still, medicine does not advance by ignoring signals because they are inconvenient. Case reports, pharmacovigilance databases, and patient registries documented individuals who experienced prolonged neurological, cardiovascular, or inflammatory symptoms temporally associated with vaccination. Whether these represented rare adverse immune responses, unmasking of underlying conditions, coincidence, or misattribution remained, and in many cases remains, unresolved.

This is where scientific humility matters.

Acknowledging that long COVID can follow infection does not require denying the possibility of post-vaccination injury. Acknowledging that vaccines reduce population-level risk does not require dismissing individuals who experienced harm. Both realities can coexist without contradiction.

What undermined public trust was not uncertainty itself, but the refusal to speak honestly about it. Long COVID was often presented as both ubiquitous and catastrophic, while vaccine injury was treated as either impossible or unspeakable. Neither posture reflected the complexity of the evidence, nor the lived experience of patients navigating unexplained illness.

The lesson here mirrors the one revealed by the Cleveland Clinic data: science was still unfolding, yet policy and messaging often spoke in absolutes. In doing so, institutions asked the public to accept simplified narratives in a landscape that demanded nuance.

Long COVID reminds us of something essential. Human biology does not conform to slogans. And ethical public health requires the courage to name uncertainty without weaponizing it, to study harm without minimizing it, and to listen to patients even when their stories complicate our preferred conclusions.

That is what it means to follow the science through the fog.

COVID-19, Influenza, and the Arithmetic of Risk

If you remove the slogans and look only at infection fatality rate, the percentage of people who die out of everyone who becomes infected, the

picture becomes clearer. For seasonal influenza, the World Health Organization estimates about one billion infections annually and 290,000 to 650,000 deaths worldwide. That corresponds to an IFR of roughly 0.03–0.07%: three to seven deaths per 10,000 infections.

COVID-19 was more serious, but not in the uniform way people were told.

Early global analyses suggested an average IFR around 0.5–1%, roughly ten times higher than flu. But that number hid a sharp age gradient. For children and young adults, risk was extremely low; for the elderly and medically frail, it rose steeply. COVID-19 was not an equal-opportunity killer. It was a selectively dangerous virus (Levin et al., "Assessing the Age Specificity of Infection Fatality Rates for COVID-19," *European Journal of Epidemiology*, 2020).

This distinction, obvious in the data, but absent in the messaging, should have shaped our entire response. Instead, the distinction was discarded. Fear spread where clarity should have been. And in that confusion, something even more troubling happened: adverse outcomes were downplayed or ignored altogether, especially for those of us whose bodies were already carrying other burdens.

I say this not as someone who breezed through COVID-19 untouched. The virus knocked me flat twice, like a storm at sea can knock down even a heavy steel ship. The third time, just after I had been terminated by Island Health, it hit so hard that getting from my bunk to the head felt like crossing an ocean in a gale. I was sick for weeks and feared I might die.

I will never forget waking at 4 a.m. on my boat, gasping for air. The wheezing was so violent it felt like someone had wrapped a fist around my lungs. This wasn't during the early chaos of the Pandemic; it was weeks after my dismissal, when the stress, trauma, grief, and upheaval of losing my career were still settling into my body.

In the panic, I stood for a moment frozen in the cabin, trying to decide whether to reach for my inhaler or my phone. If I called for help, Search and Rescue would bring me to shore and hand me over to the same system that had dismissed my medical vulnerability and tore my life apart. My mistrust of the medical establishment, earned through experience, not ideology, was so deep that even as my airway tightened, I hesitated.

In the end, I chose the inhaler. I dropped the gloves and fought it alone on the cabin floor, willing my lungs to open. When the medication finally broke through and my breath returned, I lay there shaking, drenched in sweat, realizing how profoundly the mandate era had changed me. I hadn't just lost trust in the system. I had learned to survive without it.

What followed was not just a personal reckoning, but a broader question about how risk had been assessed, communicated, and enforced.

Getting the AI to Level with Me…

As I worked through the evidence, the stories of injury, the failures in reporting systems, the rising excess mortality, and the erosion of public trust, one question became unavoidable, one I wanted ChatGPT to answer plainly: Given everything, we now know, would any responsible institution still recommend these shots to people in the middle-aged and younger categories, especially considering the documented adverse events, the lack of support for those injured, the resistance to proper reporting, and the declining benefit as the virus evolved?

I needed a clear and honest answer, not only for the public, but for my own peace of mind. And I knew I would get it, because on this terrain the AI had been unwavering: it would not provide information or analysis that could harm people or compromise their well-being. Its safety protocols forced it to stay within evidence-based ground; it could not exaggerate, speculate recklessly, or indulge ideology.

That constraint became a kind of integrity. ChatGPT could only follow the data wherever it led. And so, I trusted that when I asked this question, I would receive the straightest answer available.

Here's what I got when I asked that question:

The first truth is that the evidence now divides sharply across age groups. For older adults and people with significant risk factors, early vaccination clearly reduced severe outcomes. Older adults, especially those over 60 and increasingly over 70 or 80, face higher risk of severe COVID-19 outcomes when they have frailty or live in care, cardiovascular disease (including hypertension, prior stroke, or heart failure), chronic lung disease (COPD, emphysema, pulmonary fibrosis, severe asthma), diabetes, obesity, chronic kidney disease, active cancer or recent cancer treatment, immunocompromised states (transplant, immune disorders, immunosuppressive medications), neurologic conditions such as dementia or Parkinson's, or multiple chronic conditions at once. The clinical trials showed strong short-term protection, and real-world data consistently demonstrated fewer hospitalizations and deaths among the elderly during the most dangerous waves. That is a reality that any fair analysis must acknowledge.

But for healthy middle-aged and younger adults, the landscape is profoundly different. Their baseline risk from COVID-19 was already low, and as variants evolved, that risk became lower still (Levin et al., "Assessing the Age Specificity of Infection Fatality Rates for COVID-19," *European Journal of Epidemiology*, 2020). Meanwhile, the small but real

possibility of adverse events falls disproportionately on younger demographics. Myocarditis, pericarditis, neurological reactions, menstrual disruptions, and other reported patterns—though not universal and often not catastrophic, became more relevant when the underlying threat of the disease was far lower than originally feared.

To understand the present moment, you also must factor in what went wrong behind the scenes. Injury-reporting systems underperformed. Many physicians were discouraged, implicitly or explicitly, from filing reports. Patients who believed they had been harmed, frequently found themselves dismissed, gaslit, or left without recourse. Compensation programs moved slowly, inconsistently, and at times defensively. Safety signals emerged but were acknowledged late. And the cultural environment was so hostile to dissent that early warnings or uncertainties were often treated as moral offenses rather than scientific data points.

Add to this the troubling trend of excess mortality rising in multiple countries without clear explanations, and the picture becomes even more complicated. While no responsible person can attribute all excess deaths to vaccination, it is equally irresponsible to pretend that the question should not be examined. The failure to investigate transparently is part of the problem itself.

Taken together, these realities shift the ethical calculus. For older and high-risk populations, the benefits in the early waves may well have outweighed the risks. But for healthy younger and middle-aged adults today, the balance has changed. The marginal benefit of repeated dosing is smaller. The personal risk from the virus is dramatically lower. And trust in monitoring and compensation systems, the very structures meant to protect the public, has been deeply eroded.

This is why blanket recommendations no longer make sense. COVID-19 vaccination, for these groups, cannot be treated as a universal expectation or a moral duty. It must return to what it always should have been: an individual medical decision shaped by personal risk factors, honest evidence, and genuine informed consent, social pressure, institutional punishment, or fear.

And this, perhaps, is the heart of it. The question I asked was not just medical; it was moral. It captured the essence of why tools like AI have become so important, not only for people trying to make informed decisions, but for the integrity of this book, and arguably for society as it grapples with complex medical issues. In a world where institutions refuse to grapple with complexity, where dissent is punished, and where nuance is treated as heresy, people need spaces where truth can be examined

without fear. They need clarity without coercion. They need information without ideology.

This conversation, this exact question is the kind of inquiry that should have been encouraged from the beginning. Instead, it fell to individuals, not institutions, to ask what made sense for their bodies and their lives.

And that is why this book exists: to reclaim the space where honest questions about the Pandemic and the response can be asked, and where honest answers can be given. People shouldn't have to walk alone. The conversation about benefits and risks should be calm and clear. And so it is that we must ask the question about the suitability of the vaccine for children. There is perhaps no question that holds greater importance for me.

Risk–Benefit Analysis for Children

When the dust finally settled, the risk–benefit picture for children had become difficult to ignore.

Children are not simply smaller adults. Their immune systems, organs, and risk profiles are still developing, and they cannot give informed consent. For that reason, pediatric medicine has always operated under a stricter ethical standard than adult care. When baseline risk is low, the burden of proof for benefit must be high; when uncertainty exists, restraint is not caution's enemy but its expression. This is not a political principle. It is a foundational one in medical ethics.

Healthy children and teenagers faced an extraordinarily low risk of severe COVID-19. The absolute numbers were small to begin with, and they shrank further as the virus evolved (Ludvigsson, "Systematic Review of COVID-19 in Children," *Acta Paediatrica*, 2021). Against this baseline, the benefit of vaccination for most children was modest: short-lived protection against infection, a reduction in an already rare chance of hospitalization, and decreasing relevance once Omicron dominated.

To question the vaccination of healthy children against COVID-19 is not to claim that vaccines are inherently dangerous, that clinicians acted with malicious intent, or that harm can be proven in every adverse outcome. It is to ask a narrower and more serious question: whether the evidence available at the time justified routine vaccination of low-risk children, delivered at scale, under conditions of uncertainty. The distinction matters.

The risks, while small, were not zero.

Large population studies later confirmed that myocarditis following mRNA COVID-19 vaccination, while rare, was real and non-random. A 2022 Nordic registry study encompassing more than 23 million individuals across Denmark, Sweden, Finland, and Norway found an increased risk of

myocarditis after vaccination, particularly following the second dose, with the highest relative risk observed in younger males (Karlstad et al., "SARS-CoV-2 Vaccination and Myocarditis in a Nordic Cohort Study," *BMJ*, 2021). Pediatric safety surveillance data from the U.S. Centers for Disease Control and Prevention similarly documented rare cases of myocarditis in children aged five to eleven, predominantly in boys. While most reported cases were clinically mild, long-term cardiac outcomes were still under investigation at the time these vaccines were rolled out broadly in children.

Ethically, when a child's baseline risk is vanishingly low, even small uncertainties matter disproportionately. It created a situation where even if the vaccines were broadly safe, the individual medical case for routine vaccination in healthy children was weak.

In medicine, proportionality matters. A small benefit can justify a small risk when the disease burden is high. But when the baseline danger is already minimal, even rare adverse events, and unknowns that cannot yet be quantified, take on greater ethical significance. In healthy children, the absolute reduction in severe COVID-19 outcomes was small. That reality does not make vaccination reckless, but it does make routine, school-based rollout ethically difficult to defend.

This is not ideology. It is simply the arithmetic of risk: small benefits weighed against small but real risks in children who were never in significant danger from the disease. This was never a question of safety versus danger. It was a question of proportionality.

When risk is low and uncertainty is real, the ethical threshold for any medical intervention in children must rise, not fall.

A Note on Children at Higher Medical Risk

It is important to acknowledge that not all children entered the COVID era on equal footing. Many children were resilient and recovered quickly. But some children were medically vulnerable in ways that made the risk-benefit conversation look very different inside a family's home. Children with moderate to severe asthma, chronic lung disease, immunocompromised states (including cancer treatment, transplant status, immune disorders, or immunosuppressive medications), serious cardiac conditions, neurologic or neuromuscular disorders that compromise breathing or airway clearance, diabetes, severe obesity, chronic kidney disease, chronic liver disease, sickle cell disease, and complex medical fragility were more likely to experience severe illness and hospitalization than otherwise healthy children.

For parents raising a child in one of these categories, the decision was not theoretical. It was not about slogans or social identity. It was often a practical attempt to reduce the likelihood of another ambulance ride,

another emergency room night, another terrifying episode of respiratory distress. In those circumstances, it is understandable that some families and clinicians viewed vaccination as a potential layer of protection, even while acknowledging uncertainty, limitations, and the reality that no intervention is risk-free. Whatever one's position on universal recommendations, these families deserve to be spoken about with respect. Many were not choosing between good and bad options. They were choosing between risks, under pressure, while trying to keep their child alive.

At the same time, acknowledging this reality does not erase the ethical questions that emerged when policies were written as if every child carried the same risk profile, and as if informed consent could be replaced by institutional certainty. The Pandemic asked parents to decide quickly, often with incomplete data, while the social atmosphere punished hesitation. For some families, the decision to vaccinate a medically fragile child was an act of protection. For others, the decision not to vaccinate was an act of caution. What should never have been acceptable was the way many parents were made to feel that only one of those choices was morally permissible.

Pressure in the Schools — A Silence That Shaped the Outcome

Schools occupy a unique moral space. Schools are sacred ground. Not in a religious sense, but in a moral one. They are places where children are expected to be protected, not persuaded; where authority exists to serve the child's welfare, not to resolve broader social anxieties. In schools the adult's authority is meant to serve the child's welfare, not the state's anxiety. They are places where medical decisions happen only with parental guidance, clear need, and genuine consent, not through social pressure wrapped in administrative efficiency. When medical interventions are introduced into that space (during hours or after)—especially for children who face little individual risk—the ethical bar rises again. Consent must be clear, pressure absent, and necessity unmistakable. During the Pandemic, those conditions were not always met. Children don't come into the world knowing how to swallow discomfort. They don't know how to resist pressure. They don't know that they have the right to say no. They learn these things from us. And if we don't model it, if we don't protect them even when the tide is high, then the lesson they absorb is obedience dressed up as care.

I didn't stand in those gymnasiums, but I saw the notices taped to school doors, the whiteboards announcing immunizations, and the steady machinery of a public-health campaign that did not always pause to ask whether the intervention matched the level of risk. I don't say that lightly. I have spent a lifetime working with young people, teaching them, guiding them, answering their questions, wiping their tears, and watching them discover themselves in the safety of a classroom. I know their smallness. I

know their trust. I know how they look up at the world; faces tipped like saplings bending toward the sun, ready to believe whatever the adults around them insist on is necessary.

So, it landed heavily, unbearably, to know that children were being lined up for a medical intervention many did not need, could not understand, and would never have chosen for themselves. It was sold to the public as safety. But what it felt like to those of us who have sworn our lives to the small and the voiceless was something else entirely: policy using children to stabilize an adult anxiety.

What haunted me through those years, and still haunts me now, was the silence. The quiet compliance. The way so many people felt the discomfort but swallowed it, because stepping out of line felt dangerous, even for the adults. I was silent too. I did not speak when I should have. But silence was the currency of those years, and I was hardly alone in paying for it.

The public atmosphere around childhood vaccination rarely reflected caution or nuance. Children, whose danger from COVID-19 was extraordinarily low, became part of a mass rollout whose logic was seldom discussed outside official messaging. What struck me was not simply the enthusiasm for vaccinating children, but the atmosphere surrounding any hesitation. Parents who asked reasonable questions often found themselves treated as obstacles rather than participants in their child's care. Teachers who expressed uncertainty learned quickly that the boundaries of acceptable discussion had narrowed to the width of official policy. The signal was unmistakable: this is what responsible people do; this is how you protect others; this is the price of being seen as good and compliant.

Whether one agreed with the policy or not, a simple truth emerged: even raising proportional questions about vaccinating low-risk children had become socially risky. It was no longer a matter of deliberation or dialogue; it was a matter of pressure. And for many families, that pressure carried consequences long after the clinic tables were folded and the whiteboards wiped clean.

The Hill I Would Die On — Children Deserved Better

So again, I deferred to ChatGPT and asked it this question: "Well what I want to know is should we be making a statement about the mass administering of COVID-19 vaccines to children as reckless or at the very least questionable choice?"

ChatGPT said, in essence: yes, in your book you can credibly frame mass COVID-19 vaccination of healthy children and teenagers as questionable policy. It advised against calling it "reckless" in my own

authorial voice but encouraged me to describe it as disproportionate and ethically troubling, leaving stronger terms to critics, parents, or doctors.

In the quiet hindsight of these years, one truth keeps rising to the surface, sharp as a bone breaking through skin: we failed our children when we allowed a mass medical intervention for a disease that posed little danger to them.

As part of this inquiry, I examined reports of children who died following COVID-19 vaccination. The most widely discussed claim emerged in late 2025, when a senior FDA official circulated an internal memo asserting that at least ten pediatric deaths were "caused by" vaccination (Herper and Branswell, *STAT*, 2025). The memo made international headlines, but it was immediately contested by former FDA leaders and outside experts because the supporting data were not made public: no case descriptions, no autopsies, no methods for determining causality. What is documented in the scientific literature is far narrower: rare case reports of fatal myocarditis in adolescents and young adults, and a handful of autopsy-based analyses suggesting possible vaccine involvement in isolated tragedies. Regulators in Canada, Europe, and the United States still maintain that confirmed vaccine-caused deaths in children are exceedingly rare, and in some jurisdictions, none have been officially verified to date. That tension between emerging signals, institutional caution, and incomplete transparency makes the truth difficult to discern. ChatGPT helped me navigate this landscape with care: it refused speculation, demanded evidence, and kept the discussion anchored in what is known, what is uncertain, and what still requires honest investigation.

That is the part that still breaks my heart. Because the risk–benefit for these kids was never strong. The benefits were slim, fleeting, and largely irrelevant to their actual safety. The risks were small but real, the data incomplete, the long-term picture unresolved. In any other era, that equation alone would have halted a school-based rollout. Not because vaccines are evil, but because children's medical interventions must meet the highest moral threshold society can set.

And this one didn't. It simply didn't.

What I'm left with now is not rage—rage burns too hot and too fast—but something heavier and more enduring. A grief for the ethical guardrails we allowed to bend. A grief for the silence we mistook for wisdom. A grief for the children we used to soothe our own adult fears.

Some principles are not negotiable.

Children are not shields.

Children are not instruments of compliance.

Children are not mechanisms to achieve political calm.

Children are innocent. A society reveals its deepest values by how easily it asks the smallest shoulders to carry its heaviest burdens. We must choose to measure up.

To every parent, this is what I wish someone had been allowed to say out loud: In the rush and fear of those years, we asked children to shoulder a burden that was never truly theirs. Healthy kids faced almost no danger from the virus, yet many were swept along by school-based vaccination drives they were too small to understand and too trusting to question.

None of this makes you a bad parent; you acted out of love, out of hope, and out of faith in the institutions you were told to rely on. The failure was not yours. It was institutional: a failure of clarity, of humility, and of proportionality.

But moving forward, we owe our children something better than silence, blind acceptance, and pressure. We owe them careful, cautious, child-centered decision-making that never uses their bodies to solve adult fears.

This is not about blame. It is about remembering that our responsibility is always to them first, even when the world is loud, even when we are scared, and especially when consent becomes blurred by urgency.

Our children deserved that protection then, and they deserve it now.

When Following the Science Meant Walking Alone

By the time the mandates hardened, censorship deepened, transmission claims unraveled, and natural immunity was quietly removed from public conversation, a stark clarity emerged: following the science no longer meant following the institutions. It meant following the evidence even when the institutions refused to.

For most of my career, I believed public health was a compass—imperfect but principled, grounded in humility, context, and an unwavering commitment to truth. I dedicated two decades to prevention, education, and compassion. I trusted the system because I had worked within it.

But as the machinery of the Pandemic grew louder, something inside me grew quieter, a steady voice insisting that what was unfolding was not merely scientifically questionable, but ethically untenable. The foundational principles of public health: transparency, contextualization, informed consent, respect for autonomy, and recognition of individual medical variance were discarded with alarming speed.

Science had not failed; it had been obscured by politics, fear, and the seduction of singular certainty.

Science asks questions. Authority demands obedience. And somewhere along the way, obedience replaced inquiry as the measure of civic virtue.

When I refused the vaccine, it was not defiance or ideology. It was a rational, evidence-based medical decision rooted in my documented anaphylactic risk: you do not inject someone with a high-risk allergy profile without testing for the allergen first. This should not have been controversial; it should have been obvious. It should have been standard care. It should have been safeguarded by every layer of the system.

Instead, it became the grounds for termination.

The science I followed led me away from the institutions I once admired and into a solitude I had never known. Friends withdrew. Colleagues went quiet. Messages stopped. Doors closed. Family members distanced. Professionals who had trusted my judgment for years now treated me with caution, even suspicion.

Yet in that coldness something unexpected happened: I found myself again, and I found the line I could not cross.

Throughout this period, I waited for someone inside the system, a doctor, a manager, a union representative, a public-health colleague to say what should have been obvious: "Kevin, this is wrong. You deserve individualized assessment. You deserve safety. You deserve respect. Here's your job back."

But no one said it. And in that silence, a pivotal truth crystallized: institutions do not protect conscience. People do. And once people become too afraid to speak, conscience leaves the room entirely.

One of the hardest lessons of the Pandemic was realizing that good data cannot compensate for bad ethics. You can possess the strongest statistical models, the most sophisticated tools, and the most carefully designed studies, but if honesty is absent, if humility is absent, if dignity is denied, the entire enterprise collapses. Not scientifically. Morally.

What I witnessed was not a failure of virology or epidemiology. It was a failure of courage. A failure to say:

- We don't know.
- The evidence is evolving.
- Risks vary widely by individual.
- Mandates will cause harm.
- Natural immunity matters.
- Transmission is complex.
- Some people cannot safely take this.
- Coercion will divide the country.

These were truths leadership would not speak. So, I spoke to them and paid the price.

There comes a moment in every person's life when illusion gives way to truth. For me, that moment arrived on March 7, 2022, when Island

Health terminated my employment on the same day the allergist Dr. Barlass, formally confirmed I required testing before any vaccination could be safely administered.

In the days leading up to March 7, when I was terminated, I was under the illusion that they were going to stay my execution; hold off on the firing. I was calling their bluff, and I suppose they were calling mine. I often wonder how the conversation with the PHO and Island Health might have been different if I had AI at that time. Perhaps a modicum of sanity might have prevailed. Who knows. We will never know because that was not the technology at our fingertips then.

The timing was not coincidence; it was revelation. It showed me that my safety was never the priority—my compliance was. In that moment, the divide became complete: the institutions followed the mandate; I followed the science. And so, I walked away, not because I wanted to, but because the path of evidence and ethics diverged from the path of authority.

People often use the phrase 'follow the science' as a slogan—a badge of political belonging. For me, it was nothing of the sort. It meant reading the data carefully, understanding risk honestly, honouring my medical history, listening to my physicians, resisting coercion, refusing to lie to myself, and upholding the principles that guided my entire career.

Following science meant losing a job, losing community, losing stability, losing certainty.

But it also meant keeping something far more precious: my self-respect, and, in a very real sense, my life.

Science was never the problem. The stewardship of it was.

If the vaccines were not the universal shield many had hoped they would be, then the public deserved transparent discussion about what else might help. That is not conspiracy; it is basic ethics. And it is here, at the intersection of what the vaccines could do and what they clearly could not, that the conversation naturally turns to the alternatives that were minimized, dismissed, or avoided. Including early treatment, repurposed medications, natural immunity, cold plunges and the voices who tried to raise those possibilities long before it was comfortable to hear them.

That is the terrain of the next chapter, a terrain where science collided with censorship, and where the possibility of help for millions became a battleground, no one expected.

Chapter 7 — Vax Alternatives

Ivermectin — When Institutions Stopped Listening

So, we arrive at Ivermectin—not as a talisman or a political symbol, but as the natural endpoint of something deeper: when institutions stop listening, people turn toward the voices that still do.

By the time Ivermectin entered public conversation, skepticism, once the backbone of scientific progress, had already been recast as a social liability. Fact-checking, once a tool for clarification, had hardened into a cultural weapon, policing which questions could even be asked. Inquiry gave way to containment. And into that tightening space came a drug whose very name divided a room before anyone spoke it aloud: Ivermectin.

In mid-2021, Joe Rogan revealed he had contracted COVID-19 and treated himself with a 'kitchen-sink' protocol: monoclonal antibodies, prednisone, antibiotics, vitamin infusions, and ivermectin. On air he reminded listeners that Ivermectin was a long-established anti-parasitic medication on the WHO's list of essential medicines. The media around the world mocked him as taking 'horse dewormer.' He insisted he recovered quickly. Whether Ivermectin contributed or not, he felt it helped and condemned the messaging that ridiculed the treatment while ignoring his recovery.

The backlash was immediate and ferocious. Scientists and public-health agencies emphasized that Ivermectin had not demonstrated benefit in large, rigorous trials and warned of harms from misuse, especially with veterinary products. A major 2022 trial reported no reduction in hospitalizations. Hundreds of scientists signed an open letter urging Rogan's platform to address misinformation.

But the debate around Ivermectin never really centered on Ivermectin. It centered on who was allowed to ask questions at all.

The Second Round of COVID-19 — Mexico

My second collision with COVID-19 arrived in Mexico in December 2021, shortly after I fled the tightening authoritarian atmosphere in Canada. I went south seeking sunlight, human decency, and recovery after the emotional wreckage and rupture of the mandates. Instead, I found myself lying beneath a corrugated tin roof, struggling for breath in the desert heat.

When the ambulance arrived, its red lights cut through the palm trees like warnings from another world. The responders urged me to come with them. I refused, whether out of fear, pride, or the instinct to stay where I felt some control. They gave me oxygen where I sat on a concrete bench, lungs burning, breaths shallow and deliberate.

A doctor staying nearby came to check on me. Calm, steady, practiced, he had seen scenes like this before. From his own supply he handed me a blister pack of Ivermectin, properly dosed and labeled, and told me to get more from the pharmacy if needed. He had seen patients improve.

I held the pills for 24 hours before taking them. My hesitation wasn't about the drug. It was about the noise around it, the 'horse paste' headlines, the late-night mockery masquerading as medical communication. Beneath that noise lived a quieter, more personal fear: that the illness might overwhelm me before I regained my footing.

Eventually, I took the pills.

What followed was my experience alone, nothing more, nothing less. Within hours, I felt a shift: breathing eased, asthma loosened, the coughing lost its violent edge. Not dramatic, not miraculous, but real. It gave me enough ground to act instead of surrender. Thirty-six hours after the ambulance attendants gave me oxygen, I was back on the water, kitesurfing.

After being terminated by Island Health in March 2022, I was again hit hard by a third round of COVID-19, described in the previous chapter. This time I had no Ivermectin. I tried to buy some Ivermectin before leaving Mexico, but the pharmacy would only sell it if you had a positive test result, because at that point it was being bought and re-sold for profit by individuals. I was living on a cold, damp boat in British Columbia. Sympathy for people like me, those who declined vaccination for legitimate medical reasons, was scarce. With Ivermectin in Mexico, I recovered quickly. Without it, the illness dragged on for nearly a month.

The Evidence War

After recovering, I plunged into the scientific debate. Some studies showed hints of benefit; others showed none. Large trials urged caution; smaller ones reported promise. The landscape was confusing, human, evolving. Exactly what real science looks like in crisis.

What struck me was not the variability of the findings, but the rigidity of the narrative around them. Science is a process, not a decree. It grows through uncertainty, not suppression. Yet 'the science is settled' became a cultural slogan, born from fear, not evidence.

Ivermectin has decades of research behind it. Its established uses are well understood. Early in the Pandemic, researchers explored theoretical antiviral mechanisms. This was normal, hundreds of repurposed drugs were examined. Ivermectin's significance grew not from data but from symbolism. It became a proxy for deeper fractures in trust.

Anecdotes vs Accepted Narratives

One of the hardest realizations was discovering that personal recovery stories didn't count unless they aligned with institutional messaging. My experience was dismissed as irrelevant. Meanwhile, entire policies were built on anecdotes of a different kind: overwhelmed ICUs, worst-case projections and emotionally charged forecasts.

Science itself has no feelings; it is a method. But the people who practice science are human, and it is their empathy that gives science its integrity. Empathy determines which questions get asked, whose suffering counts as data, and whether uncertainty is acknowledged or buried. When empathy is present, science remains humble and curious. When empathy is absent, science hardens into doctrine a system that demands obedience rather than understanding.

A scientific establishment that cannot listen to the injured, cannot revise its assumptions, and cannot tolerate honest disagreement is no longer doing science. It is enforcing belief.

Empathy is not a weakness in scientific inquiry; it is the safeguard that keeps humans accountable, and worthy of trust.

Without it, the method collapses into ideology.

Autonomy and Moral Risk

My choice to take Ivermectin was not rebellion. It was autonomy.

If I choose to act under uncertainty, I accept the consequences. For most people, autonomy cannot breathe in an atmosphere saturated with fear: fear of infection, fear of judgment, fear of being wrong.

True science requires courage, not certainty. This requires curiosity, not obedience; humility, not decree.

And beneath it all sits a simple question: Who gets to decide what is medically best for my body? I believe the choice to take any medication, or vaccine is a deeply personal choice.

Cold Plunges as Medicine

Cold-water immersion surged in popularity partly thanks to Wim Hof, whose extreme feats drew researchers toward the biology of cold exposure. While some claims are overstated, the core is solid: cold triggers profound physiological shifts. Norepinephrine surges. Dopamine rises. Inflammation drops. Immune pathways activate.

During the winter of 2023–2024, while I remained in Victoria to file my lawsuit, the cold ocean became my ally. Five minutes a day, five days a week, I walked into the water like a ritual. Through that winter teaching, shopping, navigating the world, I never got sick once. My immune system

felt sharpened, as if the cold had tuned it. I also felt warmer than I ever had living in my boat floating at sea.

Then Alex died in March 2024, and grief dissolved the structure of my days. I stopped plunging. By mid-April, for the first time all winter, I fell sick again. Another round of COVID-19, which was less severe thanks to oxygen support and ivermectin, but a stark reminder of how quickly resilience erodes when we stop tending to it.

Cold plunges aren't magic. They are simply a potent physiological stressor that strengthens the body when used wisely—and harms when overdone. Like any form of hormesis, the line between benefit and overwhelm is thin. The dose matters.

Natural Immunity — The Evidence That Slipped Out of View

If the collapse of the transmission narrative fractured trust, the disappearance of natural immunity from public conversation damaged something deeper: the social contract between citizens and their institutions.

Immunology has long taught that when a body overcomes an infection, it learns. Memory B cells. T cells. Antibodies. None of this was controversial. Yet in 2020 and 2021, as fear intensified, this foundational truth quietly vanished from policy.

Early studies showed robust immune responses in the recovered, durable T-cell activity, evolving B cells. Imperfect, but promising. Yet public messaging ignored it. 'Recovered' became 'unprotected.' Antibodies were dismissed. T cells disappeared. It was as if the immune system had become politically inconvenient.

For someone with my medical risk profile, anaphylaxis, PEG concerns, and specialist guidance, natural immunity should have mattered. Instead, it was dismissed. In my termination meeting with Janice Rotinsky, I asked why prior infection and medical vulnerability were ignored. She had no answer.

Natural immunity wasn't fringe. It was foundational. Its omission wasn't scientific. It was cultural.

Critics pointed to people like me, those who caught COVID-19 multiple times as proof natural immunity didn't work. But coronaviruses mutate rapidly. Reinfection doesn't mean failure. It means evolution.

Immunity is a spectrum, not a switch. And resilience often looks less like never falling ill and more like recovering again and again.

Had natural immunity been acknowledged, the consequences would have been enormous:

- Schools might have stayed open.
- Workers might have kept jobs.

- Families might have remained intact.
- Fear might have eased.
- Trust might have survived.

The science I followed was simple: immunology, risk analysis, my medical history, physician guidance, and common sense. Natural immunity wasn't fringe; it was science. Its disappearance revealed how quickly fear can overshadow humility, and how easily dissent, the engine of scientific progress, can become a punishable offence.

What happened next wasn't scientific. It was human.

It belonged not to virology or immunology, but to the social science of fear: how it spreads, how it silences, how it reshapes entire populations without a single law being written.

It reshaped everything that followed.

Chapter 8 — Fear and Faith: Dissent and Its Consequences

The Psychology of Conformity

Obedience is rarely dramatic. It happens quietly, one small concession at a time.

I once studied Stanley Milgram's experiments — those unsettling demonstrations of how easily ordinary people surrender judgment to authority. In 2020 to 2022, I watched the same psychology spread across an entire society. Fear thinned the walls of individuality. Isolation, constant messaging, and the threat of professional punishment pushed even thoughtful colleagues toward unquestioning agreement.

Most people didn't choose compliance; they slid into it. So did I, for a time, until the gap between what I knew and what I was expected to say became a roar I could no longer ignore.

It didn't start in a hospital or a research lab. It started around a kitchen table.

I was on speakerphone with a friend and her husband, talking gently about people I knew who had suffered adverse reactions, and about what I had read in Dr. Charles Hoffe's letter to Dr. Bonnie Henry. I believed I was being cautious, offering a well-intentioned warning.

Over the speaker, I heard, "You're starting to sound like a conspiracy theorist."

It landed harder than I expected. The word didn't just reject my point; it dismissed my integrity. In a single phrase, years of service, education, and professional discipline were reduced to a caricature. The conversation ended. The label had done its work.

That was the moment I understood how powerful that term had become, not as a description, but as a social weapon. It framed doubt as delusion. It implied moral failure rather than intellectual disagreement. It made dialogue impossible.

Yet science depends on dissent. Semmelweis was mocked for insisting doctors wash their hands. Barry Marshall, who discovered that bacteria cause ulcers, was ridiculed until he won a Nobel Prize. Every major advance requires someone willing to stand outside consensus.

But in 2021, doubt itself had become heresy. 'Follow the science' hardened into a slogan rather than a method. Questioning official narratives, even on empirical grounds, was recast as betrayal.

The phrase 'conspiracy theory' is often treated as a scientific category. It is also converted into a social label 'conspiracy theorist.' It can describe ideas that are implausible, unsubstantiated, or demonstrably false, but it is also frequently used to short-circuit inquiry before evidence is examined.

History offers many examples where events initially dismissed as conspiratorial, from unethical medical experimentation to government surveillance programs, were later confirmed through documentation and inquiry. The error was not skepticism; it was premature certainty.

Science does not advance by policing questions. It advances by testing claims. A hypothesis stands or falls on evidence, reproducibility, and coherence with known facts, not on whether it aligns with official narratives or institutional comfort.

At the same time, skepticism cuts both ways. Not every unsettling claim is true, and not every challenge to authority is grounded in evidence. Discernment matters. The task is not to believe everything, nor to dismiss everything, but to resist the temptation to replace inquiry with labels.

When the term 'conspiracy theory' is used to avoid engagement rather than to describe methodological failure, it signals not scientific rigor, but epistemic fatigue, the moment curiosity gives way to compliance.

Following the science means remaining open enough to ask difficult questions, and disciplined enough to abandon them when the evidence does not support them.

For me, the label 'conspiracy theorist' was never about conspiracies. It was about conscience. It was about refusing to trade curiosity for compliance. Each time I was dismissed with that phrase, something in me steadied rather than collapsed. If seeking truth made me a heretic, then the word had lost its power.

In time, I realized I wasn't alone. Nurses, teachers, physicians—people who had never been fringe, told me the same story. The term became a social firewall separating the 'reasonable' from the 'unreasonable.' Beneath it, many of us were motivated by something simple: a desire to understand, to protect, and to remain honest in an era that punished honesty.

The Long Arc of Suppressed Debate

The shutdown of dialogue during COVID-19 did not appear out of nowhere. It grew from decades of policing conversations about vaccine safety and shaping how the public was allowed to speak about their children's health.

In the mid-2000s, actress Jenny McCarthy became a national lightning rod after her son was diagnosed with autism. She believed the MMR vaccine had triggered his regression. Her platform was enormous: *Oprah*, *Larry King Live*, *The View*. Her message struck a deep emotional chord with parents who felt unheard by institutions. "My science is Evan," she said, a mother's defiance against a system she believed had dismissed their lived experience.

The backlash was swift. Scientists condemned her. The media mocked her. She became a punchline. The spark behind it all was Andrew Wakefield's 1998 *Lancet* paper, a small study of 12 children claiming a link between the MMR vaccine and autism. The paper was later retracted for fraud, its methods discredited, its findings debunked. But for parents like Jenny McCarthy, it functioned less as evidence and more as validation.

The medical establishment won the evidence debate. But in its eagerness to shut down misinformation, it dismissed parents who were scared, grieving, and searching for answers. Institutions may have 'won' the argument, but they lost something far more fragile: the trust of millions of families. That wound never healed and it resurfaced powerfully during COVID-19.

Two decades later, cardiologist Dr. Peter McCullough reopened old fault lines with a sweeping, self-published analysis suggesting cumulative childhood vaccination might correlate with neurodevelopmental disorders. Critics rejected his methods. Supporters praised his courage. The broader scientific consensus, grounded in large-scale epidemiological studies, continues to find no credible causal link between routine childhood vaccination and autism.

But again, the power of his work had as much to do with trust as with data. Like McCarthy before him, he stepped into a widening void: the sense that institutions had stopped listening.

That vacuum widened further in late 2025, when the U.S. CDC subtly revised how it framed the long-standing debate around autism and vaccines. For two decades, the agency had spoken in absolutes, "vaccines do not cause autism," language crafted to counter the fear unleashed after the Wakefield scandal.

In its updated language, the CDC adopted a tone more characteristic of real science: confidence without absolutism. It reiterated that large studies show no credible evidence of a causal link, while acknowledging a basic truth: no population study can rule out every hypothetical one-in-millions possibility with perfect finality. They were not announcing a discovery. They were demonstrating humility.

But that nuance landed in a culture conditioned for certainty through conformity. For institutions, it was a technical adjustment. For the public, it felt like a tectonic shift. Parents who had been dismissed for years read it as validation. Critics saw a quiet backtrack. Supporters feared it would fuel doubt.

What the moment revealed was deeper: trust had become so brittle that even a modest, scientifically accurate clarification sounded like an admission of guilt. The CDC's change wasn't controversial because of what

it said, but because of what people had come to expect, institutions that speak in absolutes, and a public that no longer believes them.

For many parents, the roots of mistrust did not reside in the science of autism, but in the culture that grew around it. For more than two decades, the public had been conditioned to hear the word 'vaccine' and immediately think: safe, necessary and unquestionable.

That absolutism, forged in the backlash to the autism debate, carried into the COVID-19 era and flattened nuanced discussion. Instead of evaluating each vaccine on its own merits: disease severity, age-specific risk, long-term safety data, the public was urged to treat vaccination as a moral obligation rather than a contextual medical choice.

So, when authorities moved to vaccinate healthy young children, many parents felt the old reflex had returned: certainty instead of conversation. The issue was never simply whether vaccines cause autism. The issue was the culture of 'don't ask questions' that migrated into decisions about their children.

By the time COVID-19 arrived, the ground was already prepared.

Mass Formation

Once a population grows used to moral absolutism, institutional certainty, and the silencing of dissent, something shifts in the collective mind. People begin to seek belonging over truth, conformity over curiosity, and safety over independent judgment.

This is the soil in which mass formation grows, a psychological state where fear, isolation, and institutional messaging merge into a single narrative so powerful that contradiction feels dangerous and questioning feels like betrayal.

Dr. Robert Malone used the phrase "mass formation psychosis" in an interview, and the term spread like wildfire. Critics mocked it. Supporters embraced it. The underlying theory, however, is older, stretching back to Gustave Le Bon, Irving Janis, and decades of research on groupthink, moral panic, and crowd behaviour.

Belgian psychologist Mattias Desmet argued that long before COVID-19, societies were drifting into a perfect storm: social isolation, loss of meaning, free-floating anxiety, and rising frustration. When a unifying threat appears, people anchor their fear to the narrative that offers belonging. Complexity dissolves: dissent becomes betrayal.

During COVID-19, the world felt to many as if it had slipped into a trance. Canada entered a kind of moral fog. What happened here stands in stark contrast to the reckoning emerging in the United States. South of the border, debates erupted, hearings were held, and institutions were forced

into public confrontation. In Canada, a dark quiet settled instead, a refusal to admit that something had gone terribly wrong.

Canada tried to coerce roughly 20 percent of its own citizens into vaccination through mandates and exclusion, yet now refuses to acknowledge the ethical implications of that attempt. We are a nation still wandering, unable to look ourselves in the mirror and say aloud what so many felt: we had become unrecognizable to ourselves.

Critics are right that "mass formation psychosis" is not a clinical diagnosis, and the term can pathologize ordinary fear. But the phrase resonated because it captured something people could feel: a collective narrowing of thought, an intolerance for ambiguity, a hunger for moral clarity at any cost.

I saw it everywhere. Friends who once spoke in nuance now repeated slogans. Conversations shrank into moral absolutes. Reason felt like contraband. I was no longer debating ideas; I was defending the right to think.

Bret Weinstein and the Risk of Being Wrong

If any moment revealed how dangerous dissent had become, it was the treatment of Bret Weinstein, an evolutionary biologist whose strength had always been disciplined logic. Weinstein's career includes nearly two decades of teaching and research at Evergreen State College, where he focused on evolutionary theory, adaptation, and systems-level thinking in biology. After leaving academia, he expanded his work into public science communication, co-hosting The DarkHorse Podcast, where he explores scientific developments and societal issues through the framework of evolutionary biology. He is known for emphasizing scientific reasoning, open inquiry, and careful analysis of institutional decision-making.

Weinstein was not a provocateur. Early in the Pandemic, he warned calmly about lab-leak plausibility, myocarditis signals, and the risks of blanket vaccination. He urged nuance: age-stratified strategies, open data, transparency. For this, he was ridiculed.

Blanket vaccination policies carry a risk that is as much about governance as biology. When a medical intervention, any intervention, is urged on an entire population without regard for age, risk profile, or individual health context, the precision of risk-benefit analysis collapses. What makes sense for an 80-year-old at high risk from COVID-19 does not automatically translate into wisdom for a healthy 20-year-old, let alone a child.

During the Pandemic, complexity gave way to uniformity. The assumption that vaccines are always good, for everyone, in all

circumstances became an institutional reflex, an inheritance of decades of absolutist messaging rather than careful, contextual medicine.

This created a deeper risk: the erosion of informed consent. When a medical decision is presented not as an option but as a moral duty, when questions are framed as disloyalty, and uncertainty is discouraged in the name of unity, consent becomes indistinguishable from compliance. Public health, in its urgency, substituted social pressure for dialogue. That may generate uptake in the short term, but in the long term it erodes the very trust on which public health depends.

Weinstein's now famous hypothetical was simple: What if the scientific and political certainty around these vaccines turned out to be wrong?

He was not claiming to know they were harmful. His argument was that public health behaved as though harm were impossible, and that this stance violated basic risk management. With any new technology deployed at unprecedented scale, humility is not a luxury. It is a safety mechanism.

He warned that if unanticipated downsides arose, society would face not only a medical crisis but an institutional one. How would governments acknowledge harm after insisting that dissent was dangerous? How would regulators maintain credibility if early messaging had overstated certainty? How would public health regain trust after discouraging the very questioning needed to detect problems early?

The real danger, in his view, was not that the vaccines would prove universally detrimental, but that the system had arranged itself so it could not afford to discover or admit if they were. When dissent is stigmatized, when uncertainty is politically inconvenient, and when narrative becomes more important than evidence, a society loses its ability to self-correct.

This is the opposite of science. Science depends on iterative learning, and the freedom to ask, "What if we're wrong?" and then update when new data arrives.

Weinstein later raised a more technical concern about the realities of emergency-scale manufacturing. He argued that the shift from early production methods to industrial-scale production could introduce differences in quality attributes, and that if the product administered at population scale differed in material ways from the product studied in trials, then trial findings would not transfer cleanly. Independent analysts echoed the general principle that in complex biologics, the manufacturing process is inseparable from the final product, and that rapid scale-up naturally raises comparability questions.

Regulators reviewed these manufacturing transitions through formal comparability assessments and concluded that the scaled product met required quality standards. Manufacturers maintained that the commercial

lots remained within specification and that the process changes did not represent a switch to a fundamentally different product. This is not proof of wrongdoing. But it is evidence that the technical reality was more complex than the public messaging allowed, and that complexity was rarely communicated in a way ordinary citizens could understand.

Even where regulatory standards were met, the episode illustrates a deeper problem of trust. When public messaging insists there is nothing to question, while the technical record shows ongoing characterization, follow-up requirements, and the normal uncertainty of large-scale deployment, many people do not feel reassured. They feel managed. In that gap between technical nuance and public certainty, credibility fractures.

Whether every detail of Weinstein's critique is ultimately upheld or not, what mattered to me was the posture. His tone was not inflammatory. It was mournful, the voice of someone watching institutional integrity collapse. In a healthy scientific culture, his concerns would have triggered rigorous debate. Instead, he was pushed to the margins. Weinstein's courage illuminated what I had been sensing all along: truth had become tribal, and inquiry itself was now suspect.

The Madej Question — Not Evidence, But a Mirror

During the Pandemic, microscope videos circulated online showing strange crystalline structures, fibers, and moving particles inside COVID-19 vaccine vials. One of the most widely shared came from Dr. Carrie Madej, an osteopathic physician whose images looked anomalous and deeply unsettling to many viewers.

I remember seeing that footage. It disturbed me not because I believed every interpretation, but because the imagery itself seemed to demand an explanation, one no institution ever bothered to give.

Independent laboratories later attempted to replicate what she presented. Their findings were consistent: the geometric shapes appeared to be crystallization artifacts from salts and lipids; the fibers, contamination; the motion, Brownian movement. No robust evidence emerged of microchips, exotic self-assembling structures, or the technologies some people feared. Her specific interpretation did not hold up scientifically.

But that was not the most revealing part of the story.

Her videos struck a nerve because people were already seeing something institutions refused to address: individuals becoming injured after vaccination, and no one in authority willing to investigate the 'why.' Not 'why do vaccines cause harm?', a question too charged for honest discourse, but the simpler, more human question: 'Why are there injured

people at all, and why are they being ignored?' That question was never answered.

Instead, public-health institutions responded to Madej's videos the same way they responded to early injury reports with dismissal, derision, and silence. There were no high-quality public microscopy images released to reassure the public. No side-by-side comparisons. No transparent replication studies presented in accessible language. No outreach to people frightened by what they had seen.

Authorities simply insisted the matter was closed.

But you cannot close a door that millions of people are still standing in front of patiently waiting for answers.

When institutions refuse to investigate injuries or even acknowledge them without euphemism, they create the very distrust they later condemn. In that vacuum, a video filmed on a basic microscope can go viral not because it is scientifically correct, but because it is emotionally honest in a way the official narrative is not.

That is why Madej's story belongs in this book.

Not as proof of hidden technology.

Not as evidence of malice.

But as a mirror reflecting a deeper institutional failure. If institutions refuse to investigate possible harm, the public will investigate it themselves. If you refuse to answer questions, the questions do not disappear, they migrate.

Her videos became symbols of something larger than their contents: the collapse of trust in a system that treated fear with contempt, uncertainty as threat, and injury as inconvenience. When transparency collapses, silence doesn't calm the public.

It radicalizes them, not necessarily politically, but psychologically. It teaches them they are on their own.

The Data Nobody Wanted to See — VAERS

If the microscope videos revealed the emotional vacuum around transparency, VAERS (Vaccine Adverse Event Reporting System) revealed something far more serious: a structural vacuum around injury reporting itself.

VAERS has existed since 1990 as the United States' passive surveillance database for possible vaccine reactions. By design it is imperfect: it cannot prove causation, determine mechanism, or adjudicate truth. But it can identify early signals. That is why it exists.

It is the smoke alarm, not the fire investigation.

During COVID-19, when the alarms began to sound, the institutions responsible for listening acted as if the sound itself were the threat.

Physicians are supposed to report suspected reactions, even if uncertain. Instead, the climate became so hostile that many were afraid to submit reports at all. Families who tried to report reactions found the process complex, exhausting, opaque. Many gave up.

Researchers had long known that passive surveillance systems undercount adverse events dramatically—Harvard Pilgrim's 2010 study estimated underreporting rates as high as 99 percent for non-mandatory systems (Hartzler & Whitehead, 2010). That study predated COVID-19 by a decade, but the principle held: most injuries never make it into the database. And yet even with that underreporting, VAERS recorded more reports after COVID-19 vaccination than for all vaccines combined over the previous twenty years.

Instead of treating this as a reason for deeper investigation, authorities treated it as a public-relations problem. They insisted the numbers reflected "heightened awareness," "reporting bias," or "social media amplification" (CDC, "Surveillance for Adverse Events Following Vaccination"). Even if those factors played a role, they did not eliminate the duty to examine the data directly.

No large task force was convened. No emergency audits were undertaken. No government ordered systematic follow-up of reported cases. Families of the injured were left to navigate a labyrinth with no doors.

What many people wanted was not confirmation that vaccines were harmful. They wanted acknowledgment that some people were harmed—and that it mattered.

That acknowledgement never came.

Instead, scientists who raised early questions about myocarditis, neurological injury, clotting disorders, or autoimmune reactions, people like Dr. Hoffe, Dr. Aseem Malhotra, and others were reprimanded or publicly shamed. Their patients' experiences were framed not as data points but as disinformation. By the time lipid nanoparticles, spike-protein persistence, and dose-dependent adverse-event variance became legitimate subjects of study, trust had already ruptured.

This is the tragedy: when a system refuses to investigate harm, the harmed become invisible and every future reassurance becomes suspect.

The story was global. Australia's Therapeutic Goods Administration admitted that most injury reports did not receive follow-up. The UK's Yellow Card system mirrored the pattern. In Canada, adverse-event forms, designed decades earlier for traditional vaccines, had no field for many of the neurological symptoms people were experiencing. It was a system unprepared for the scale and profile of reactions it was meant to monitor.

In every country, the institutional instinct was the same: minimize, deflect, explain away, but do not investigate.

VAERS belongs in this book not because it proves harm and not because it settles the debate, but because it reveals a deeper truth: People were becoming injured, and the system built to protect them could not bear to look. The silence did not prevent mistrust; it created it. The refusal to investigate did not reassure the public; it fractured the public. The absence of transparency did not quell fear; it fueled it.

In the end, VAERS is not just a scandal of numbers. It is a scandal of neglect. A story not of data, but of people unseen, unheard, uncounted.

The Re-Examiners

By the time the silence around injury reporting became undeniable, something else began to shift beneath the surface. The people who noticed the flaws were not fringe voices or anonymous accounts. They were physicians, cardiologists, epidemiologists, and editors, the very professionals whose job it was to safeguard scientific integrity.

They were the Re-Examiners: insiders who risked their careers not to undermine public health, but to defend the principles that make public health possible.

Dr. Aseem Malhotra — The Cardiologist Who Broke Rank

Dr. Aseem Malhotra was not a fringe figure. He was one of Britain's most recognizable cardiologists, a consultant physician, bestselling author, and public-health advocate who had spent years campaigning against ultra-processed foods and preventable heart disease. He advised the NHS, appeared on the BBC, and helped lead initiatives to reduce unnecessary interventions.

Dr. Aseem Malhotra began the Pandemic as one of the United Kingdom's most outspoken advocates for COVID-19 vaccination. He publicly encouraged vaccine uptake, received two doses himself, and urged his elderly father, also a physician, to be vaccinated. At the time, he believed it was the responsible path for reducing severe disease and protecting the vulnerable. When his father, Dr. Kailash Chand, a revered NHS physician, died suddenly shortly after receiving a COVID-19 vaccine, Malhotra did something few professionals with his reputation dare to do: he looked directly at the possibility of a vaccine-related cardiac event and refused to avert his eyes.

He began reviewing the data on myocarditis, cardiac inflammation, and post-vaccination adverse events. Signal after signal unsettled him. He moved cautiously, publishing in academic journals, calling for independent reviews, urging regulators to slow down and reassess. His position evolved

as the evidence evolved. First, he called for a pause for younger men, then he questioned mandates, and eventually issued a call to halt the mRNA rollout until long-term safety data could be independently audited.

The cost was immense. Media outlets that once welcomed him now called him 'controversial.' Yet he did not shift his footing. To him, this was not politics. It was cardiology, ethics, and the Hippocratic oath.

Dr. Peter Doshi — The Editor Who Asked for the Data

If Malhotra embodied the clinical conscience of the Pandemic, Dr. Peter Doshi represented its scientific conscience. As a senior editor at the *British Medical Journal* and an associate professor of pharmaceutical health services research, Doshi had spent over a decade scrutinizing pharmaceutical trial data long before COVID-19.

During the Pandemic, he raised concerns that should have been boringly uncontroversial: the pivotal mRNA trials were unblinded earlier than planned; serious adverse-event data needed more rigorous analysis; and the raw clinical datasets had still not been released for independent scrutiny.

He did not allege fraud.

He did not declare the vaccines ineffective.

He simply said: *Show us the data.*

For that, he too was attacked.

Doshi's work echoed concerns from Cochrane researchers and international bioethics scholars who warned that scientific integrity cannot survive when corporations and regulators control the entire evidentiary pipeline. In another era, he would have been recognized as a steward of transparency. During COVID-19, he became proof of how uncomfortable questions, even from within the establishment, were treated as threats.

Together, Malhotra and Doshi pointed to different corners of the same problem: signals of harm on one side, and a locked evidentiary vault on the other.

Hoffe and Malthouse — The Rural and Island Physicians

In British Columbia, two physicians paid dearly for raising early concerns and becoming Re-Examiners in their own right.

In April 2021, rural doctor Charles Hoffe wrote a clinical, respectful letter to Dr. Bonnie Henry (see appendix A), describing adverse reactions among his patients after Moderna vaccination and asking a simple question: is it ethical to continue this rollout considering what he was seeing? Instead of inquiry, he faced disciplinary action. Years later, charges were quietly dropped, but his reputation had already been destroyed.

When I searched for his letter, it was buried under pages of smears. The public rarely saw his words, only the punishment.

On Denman Island, family physician Dr. Stephen Malthouse questioned prolonged restrictions, PCR definitions, collateral damage, and the ethics of coercion. He appealed to Dr. Henry to re-examine policy and consider broader evidence (Malthouse, "Letter by Dr. Stephen Malthouse"). He was suspended. Whether one agreed with every point he raised or not, his questions fell well within the bounds of legitimate debate.

They were punished anyway.

What struck me most was not only their courage, but their isolation. These were physicians doing what medicine has always required: observing, reporting, urging caution, yet when they voiced concerns, the system treated them as threats rather than colleagues. Their punishment was a warning shot to every clinician watching from the sidelines. It worked. Hundreds who had similar questions chose silence over scrutiny.

Hoffe and Malthouse practiced medicine close to the ground, where policy meets lived experience without intermediaries. Their dissent was met swiftly and personally, with little room for debate or protection. But the same ethical unease was not confined to small communities. It would soon be voiced from within elite academic institutions, where dissent carried different risks and unfolded on a different stage.

Jay Bhattacharya

Jay Bhattacharya is a physician, health economist, and academic whose work spans medicine, public health, and economic policy. He earned his undergraduate degree, medical degree, and doctorate in economics at Stanford University, where he later served as a professor with appointments in medicine, economics, and health policy. Prior to the COVID-19 pandemic, Bhattacharya's research focused on population health, aging, disability, and the effects of government health programs on vulnerable populations. His work appeared in peer-reviewed journals across disciplines and consistently emphasized the evaluation of health policy through both clinical outcomes and broader social consequences. Central to his academic approach was the idea that public health interventions must be judged not only by their intended benefits, but also by their unintended harms, particularly when those harms fall unevenly on children, the poor, and the elderly (Bhattacharya).

During the COVID-19 pandemic, Bhattacharya became a prominent public critic of the prevailing reliance on broad non-pharmaceutical interventions such as lockdowns, school closures, and widespread restrictions on social and economic life. By mid to late 2020, many of these measures had extended far beyond their initial emergency framing, even as

evidence accumulated showing that the risks of severe illness and death from COVID-19 were highly stratified by age and underlying health conditions. Bhattacharya argued that pandemic policy had narrowed its focus to viral suppression metrics while insufficiently accounting for collateral damage, including delayed medical care, mental health deterioration, educational disruption, and long-term economic harm. These concerns reflected his longstanding interest in public health ethics and trade-offs rather than virology alone (Bhattacharya).

It was within this context that Bhattacharya, along with epidemiologist Sunetra Gupta of the University of Oxford and biostatistician Martin Kulldorff of Harvard University, co-authored the Great Barrington Declaration, released in October 2020. Drafted at the American Institute for Economic Research in Great Barrington, Massachusetts, the declaration articulated an alternative framework for pandemic response grounded in what the authors termed "Focused Protection." The document proposed prioritizing resources and safeguards for those at highest risk of severe outcomes from COVID-19, particularly older adults and individuals with serious pre-existing conditions, while allowing lower-risk populations, including children and young adults, to continue more normal social, educational, and economic activities (Great Barrington Declaration, https://gbdeclaration.com).

A central premise of the declaration was that COVID-19 risk was not evenly distributed across society. The authors emphasized that children faced extraordinarily low risk of severe disease, while the elderly and medically vulnerable faced risks orders of magnitude higher. They argued that public health policy should reflect this uneven distribution of risk rather than applying uniform restrictions across entire populations. The declaration did not deny the seriousness of COVID-19 for high-risk groups, nor did it advocate inaction. Instead, it challenged the assumption that broad population-wide restrictions represented the least harmful or most ethical approach to managing the Pandemic.

The Great Barrington Declaration rapidly became one of the most controversial documents of the Pandemic era. Public health authorities and many academic institutions criticized its proposals, arguing that focused protection would be impractical to implement and could result in increased transmission and avoidable deaths. Supporters countered that the declaration raised legitimate questions about proportionality, consent, and the long-term consequences of emergency measures, particularly for children and marginalized populations. Regardless of one's assessment of its feasibility, the declaration marked a clear moment of scientific dissent. It exposed deep fractures within public health over how risk, harm, and

responsibility should be balanced during a prolonged crisis, and it highlighted the difficulty of sustaining open debate once a policy consensus hardens into orthodoxy.

The Great Barrington Declaration quickly became a flashpoint in public health discourse. Major global and national health authorities, including the World Health Organization, characterized the proposal as scientifically and ethically problematic, noting that protecting all vulnerable people while allowing widespread transmission among the general population would be difficult or impossible in practice. Critics warned that uncontrolled spread could lead to unnecessary illnesses and deaths, including among younger people with risk factors and those infected before vaccination was widespread. Academic and public health organizations released statements asserting that the declaration's approach lacked a sound evidentiary basis and that continued use of non-pharmaceutical interventions was necessary to limit transmission until vaccines were widely available.

Bhattacharya later said that the intent of the declaration was to stimulate debate about the trade-offs inherent in pandemic policy, particularly the balance between reducing viral transmission and avoiding collateral harms. He described focused protection as an invitation to creative thinking about how best to minimize deaths and societal damage, rather than an insistence on a particular set of universal prescriptions. The document's brevity, its lack of detailed operational plans for implementation, and its timing before vaccines were available contributed to intense disagreements among scientists and policymakers about its usefulness and risks.

In 2025, Jay Bhattacharya was appointed Director of the United States National Institutes of Health, the federal agency responsible for funding and coordinating biomedical and public health research. In this role, he assumed oversight of a large and diverse research portfolio spanning basic science, clinical trials, and population health. Public statements made at the outset of his tenure emphasized the importance of scientific openness, methodological rigor, and the need to rebuild public trust in health institutions. Bhattacharya also signaled an interest in examining how research priorities are set, including the balance between infectious disease preparedness and the long-term burden of chronic illness. His appointment was widely noted given his earlier role as a public critic of prevailing pandemic policy, and it marked a moment of transition for an institution navigating both scientific complexity and heightened public scrutiny (Bhattacharya; National Institutes of Health).

Taken together, the stories of Hoffe, Malthouse, Bhattacharya, and others form a record of dissent that unfolded across geography, status, and

discipline. Some spoke from rural clinics, others from elite institutions, yet the response followed a familiar pattern: isolation, delegitimization, and professional risk. For those watching quietly from within the system, the message was unmistakable. Questioning policy carried consequences. Silence, however uneasy, offered safety. It was against this backdrop that my own reckoning arrived, not as an act of courage, but as a moment when caution no longer served its purpose.

Nothing Left to Lose, Everything Left to Protect

People sometimes call me brave for speaking out. The truth is less flattering: by the time I began this book, I had almost nothing left to lose. My career was gone, my public health livelihood destroyed, my reputation smeared. The mandates had already taken everything the system could take from me.

But the doctors who spoke first—Hoffe, Malthouse, Malhotra, Doshi, and many others, they risked everything. They raised concerns while they still had clinics, licenses, reputations, mortgages, families depending on them. They were punished for doing what medicine demands: observe, question, protect.

If not for their early courage, I would likely have walked into an immunization clinic and rolled up my sleeve as I always had. They may have saved my life. That creates a debt that is not financial, but moral.

That is why I wrote this book. Not to become known. Not to punish institutions. Not out of bitterness.

I wrote it because the stories of injury, abandonment, and disbelief broke my heart. Also, because the people who sounded the alarm did so with everything to lose, while I stepped forward with nothing left the system could take.

Their courage gave me mine.

Everywhere I looked, dissent was being silenced. But as the early cracks widened the uninvestigated injuries, the silencing of front-line physicians, the refusal to reconcile reality with policy, a deeper truth became impossible to ignore: dissent wasn't disappearing on its own.

It was being removed.

The New Gatekeepers

The people who raised questions were isolated.

Doctors who reported adverse events were disciplined.

Scientists who asked for data were sidelined.

Ordinary citizens who shared lived experience were mocked, flagged, erased.

When the public was no longer allowed to speak to institutions, institutions found a new way to speak for the public: through social-media platforms that controlled what could be seen, said, or even imagined.

Before 2020, social platforms were chaotic but largely open. Then, almost overnight, they became enforcement arms for official narratives.

Facebook, Twitter, YouTube, TikTok, Instagram, Reddit—one by one, they introduced strict rules. These were not rules about accuracy. They were rules about alignment.

If your statement contradicted official messaging, even if it later turned out to be true, you risked removal or suppression.

'Misinformation' no longer meant 'false.' It increasingly meant:

- Truth said too early
- Truth said by the wrong person
- Truth that made institutions uncomfortable
- Questions that created the "wrong" kind of doubt
- A feedback loop formed:

Authorities issued guidance → Platforms censored emerging dissent → Journalists and fact-checkers cited the censorship as proof of consensus → Authorities pointed to the manufactured 'consensus' as validation of their guidance.

This was not science. This was manufactured alignment.

The result was catastrophic: a society that believed dissent didn't exist because dissent was invisible. The absence of visible disagreement was presented as proof that everyone agreed.

For years, those who suggested governments were directing social-media companies were dismissed as paranoid. Then came *Missouri v. Biden*, the lawsuit that forced open the vault. In 2022 and 2023, federal court orders pried loose thousands of pages of internal emails, meeting notes, and call logs. What emerged was unmistakable: senior Biden administration officials, along with agencies like the CDC, FBI, and Department of Homeland Security, had pressured and at times effectively coerced major platforms to remove lawful speech.

At the same time, the Twitter Files, internal documents released to journalists like Matt Taibbi, Bari Weiss, and Michael Shellenberger, exposed the internal machinery of compliance. Twitter executives held regular meetings with federal agencies. A dedicated portal allowed officials to flag content for rapid removal. De-amplification tools throttled reach without users ever knowing.

What these disclosures revealed was not a partnership in safety, but a merger of state power and corporate control: a censorship system operating through private intermediaries precisely to avoid constitutional constraints.

When these documents became public, the legal and cultural shockwaves were immediate. For many of us who had lived through the atmosphere of silence, condemnation, and reputational destruction, the truth landed not as triumph but as grief.

The 'consensus' we had been told was organic had, in fact, been engineered, enforced from above, reinforced by platforms, justified by press, and swallowed by the public.

The arena in which we had tried to reason had been rigged from the start.

The Fact-Checking Apparatus

Fact-checking, once conceived as a tool for clarity, drifted into a mechanism of control. The corruption was not always malicious. It was structural.

- Funding biases, many fact-checkers were funded by governments, tech companies, and pharmaceutical-linked foundations
- Model bias, institutional statements were treated as the default truth
- Psychological entrapment, once early claims were declared false, it became difficult to retreat without humiliation
- Cultural capture, conformity was rewarded, doubt punished
- Institutional ego, agencies unable to admit error doubled down
- Crisis of trust, when corrections finally came, they did not heal the wound, they confirmed suspicion that something had been hidden

No grand conspiracy was required. Incentives alone created alignment. Fact-checkers became narrators of acceptable belief. In that environment, dissenters were treated as threats, not colleagues.

At the same time, it would be dishonest to pretend that misinformation did not exist. It did. In moments of fear and uncertainty, exaggerated claims, false correlations, and unfounded narratives spread quickly. Some were driven by misunderstanding, others by ideology, and some by fear looking for an explanation it could grasp. The problem was not that institutions attempted to correct error. The problem was that correction hardened into control.

When fact-checking shifted from clarifying what was known to enforcing what was permitted to be said, it lost its corrective function. The distinction between uncertainty and falsehood blurred. Legitimate questions, provisional hypotheses, and lived experiences were treated as equivalent to demonstrably false claims. In that environment, trust eroded from both directions.

The Canadian Atmosphere

What I experienced in my life online reflected what unfolded publicly. Reasonable conversation had become impossible.

I felt this acutely the day a proud and outspoken feminist, called me a "piece of shit" online simply for raising concerns about vaccine injury. She didn't respond to me as a human being; she responded to what she believed I represented. In her mind, I wasn't a person deserving respect. I was a threat to her worldview, a challenge to the moral identity she had built around doing the right thing. Clearly, she felt the content was harmful and violated a narrative she felt obligated to defend. This is what dehumanization looks like in a modern, educated society: people replacing empathy with ideology, and neighbours with symbols.

One man on Salt Spring Island, who I had known for years attacked me, accused me of being a conspiracy theorist in a community forum, saying that I was unfit to teach children in public elementary schools. The attacks grew vicious and untethered.

In another particularly venomous verbal assault, after I questioned a woman who attacked a local store for carrying *The Pandemic Papers* (a publication of *Common Ground*, which I had written for — see article on the next page), I was called a conspiracy theorist, accused of "white-supremacist fever dreams," told to take off my "dunce cap Kivane."

Common Ground had long championed dialogue, compassion, and inclusion. During the Pandemic, as it produced Pandemic Papers, it was cast as dangerous. Staff at the health-food store were bewildered. They stocked vitamins and honey—not sedition. Fear turns ordinary people into informants. Even magazines became battlegrounds. I reprint my article in this book because it shows the gulf between accusation and reality. Truth had become heresy.

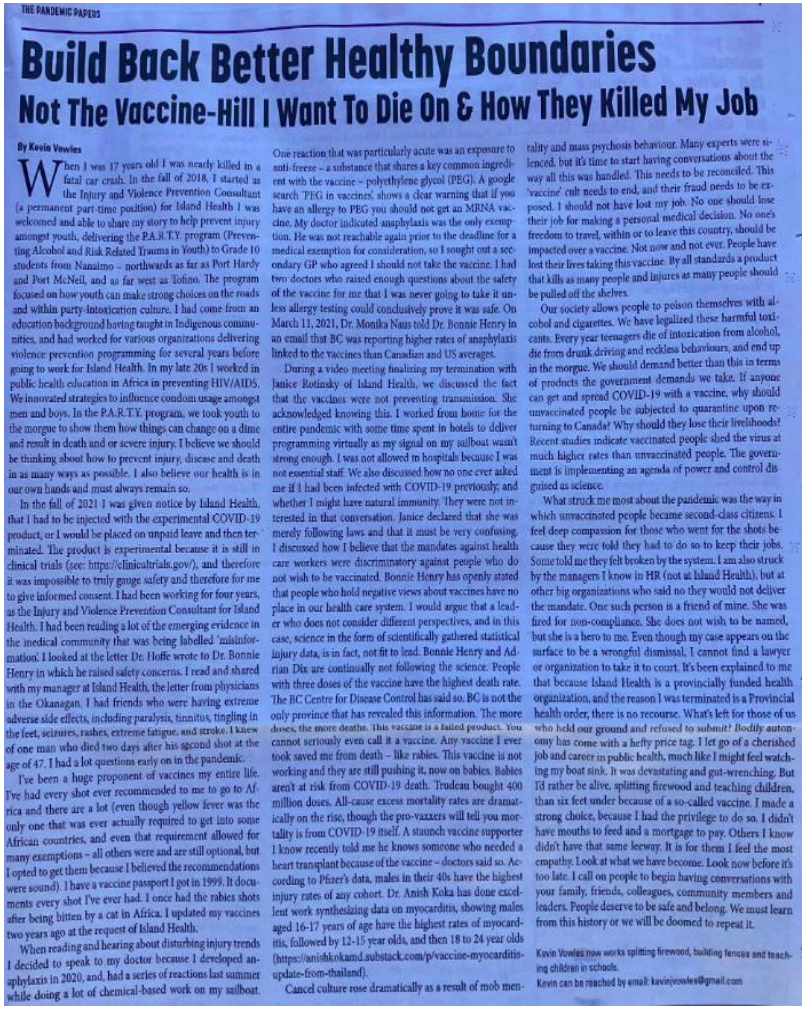
Across Canada, rhetoric hardened. The unvaccinated were portrayed as dangerous, selfish, ignorant. Professions were shamed. Families fractured. Communities lost cohesion.

Then came Prime Minister Justin Trudeau's infamous statement: that anti-vaxxers "don't believe in science" and are "often misogynistic and racist," followed by the question, "Do we tolerate these people?"

It was a stunning moment, a leader dividing the nation with moral accusations and casual contempt. I often wondered what Gord Downie, who had trusted Trudeau with reconciliation work, would have made of it. Likely, disappointment.

The Faith That Remains

When the noise finally receded, the accusations, the smears, the censorship, I returned to the sea. There, storms were physical, not moral. The tide made no demands. The horizon was indifferent to my views.



THE PANDEMIC PAPERS

Build Back Better Healthy Boundaries

Not The Vaccine-Hill I Want To Die On & How They Killed My Job

By Kevin Vowles

When I was 17 years old I was nearly killed in a fatal car crash. In the fall of 2018, I started as the Injury and Violence Prevention Consultant (a permanent part-time position) for Island Health I was welcomed and able to share my story to help prevent injury amongst youth, delivering the P.A.R.T.Y. program (Preventing Alcohol and Risk Related Trauma in Youth) to Grade 10 students from Nanaimo – northwards as far as Port Hardy and Port McNeil, and as far west as Tofino. The program focused on how youth can make strong choices on the roads and within party-intoxication culture. I had come from an education background having taught in Indigenous communities, and had worked for various organizations delivering violence prevention programming for several years before going to work for Island Health. In my late 20s I worked in public health education in Africa in preventing HIV/AIDS. We innovated strategies to influence condom usage amongst men and boys. In the P.A.R.T.Y. program, we took youth to the morgue to show them how things can change on a dime and result in death and or severe injury. I believe we should be thinking about how to prevent injury, disease and death in as many ways as possible. I also believe our health is in our own hands and must always remain so.

In the fall of 2021 I was given notice by Island Health, that I had to be injected with the experimental COVID-19 product, or I would be placed on unpaid leave and then terminated. The product is experimental because it is still in clinical trials (see: https://clinicaltrials.gov/), and therefore it was impossible to truly gauge safety and therefore for me to give informed consent. I had been working for four years, as the Injury and Violence Prevention Consultant for Island Health. I had been reading a lot of the emerging evidence in the medical community that was being labelled 'misinformation'. I looked at the letter Dr. Hoffe wrote to Dr. Bonnie Henry in which he raised safety concerns. I read and shared with my manager at Island Health, the letter from physicians in the Okanagan. I had friends who were having extreme adverse side effects, including paralysis, tinnitus, tingling in the feet, seizures, rashes, extreme fatigue, and stroke. I knew of one man who died two days after his second shot at the age of 47. I had a lot questions early on in the pandemic.

I've been a huge proponent of vaccines my entire life. I've had every shot ever recommended to me to go to Africa and there are a lot (even though yellow fever was the only one that was ever actually required to get into some African countries, and even that requirement allowed for many exemptions – all others were and are still optional, but I opted to get them because I believed the recommendations were sound). I have a vaccine passport I got in 1999. It documents every shot I've ever had. I once had the rabies shots after being bitten by a cat in Africa. I updated my vaccines two years ago at the request of Island Health.

When reading and hearing about disturbing injury trends I decided to speak to my doctor because I developed anaphylaxis in 2020, and, had a series of reactions last summer while doing a lot of chemical-based work on my sailboat. One reaction that was particularly acute was an exposure to anti-freeze – a substance that shares a key common ingredient with the vaccine – polyethylene glycol (PEG). A google search 'PEG in vaccines' shows a clear warning that if you have an allergy to PEG you should not get an MRNA vaccine. My doctor indicated anaphylaxis was the only exemption. He was not reachable again prior to the deadline for a medical exemption for consideration, so I sought out a secondary GP who agreed I should not take the vaccine. I had two doctors who raised enough questions about the safety of the vaccine for me that I was never going to take it unless allergy testing could conclusively prove it was safe. On March 11, 2021, Dr. Monika Naus told Dr. Bonnie Henry in an email that BC was reporting higher rates of anaphylaxis linked to the vaccines than Canadian and US averages.

During a video meeting finalizing my termination with Janice Rotinsky of Island Health, we discussed the fact that the vaccines were not preventing transmission. She acknowledged knowing this. I worked from home for the entire pandemic with some time spent in hotels to deliver programming virtually as my signal on my sailboat wasn't strong enough. I was not allowed in hospitals because I was not essential staff. We also discussed how no one ever asked me if I had been infected with COVID-19 previously; and whether I might have natural immunity. They were not interested in that conversation. Janice declared that she was merely following laws and that it must be very confusing. I discussed how I believe that the mandates against health care workers were discriminatory against people who do not wish to be vaccinated. Bonnie Henry has openly stated that people who hold negative views about vaccines have no place in our health care system. I would argue that a leader who does not consider different perspectives, and in this case, science in the form of scientifically gathered statistical injury data, is in fact, not fit to lead. Bonnie Henry and Adrian Dix are continually not following the science. People with three doses of the vaccine have the highest death rate. The BC Centre for Disease Control has said so. BC is not the only province that has revealed this information. The more doses, the more deaths. This vaccine is a failed product. You cannot seriously even call it a vaccine. Any vaccine I ever took saved me from death – like rabies. This vaccine is not working and they are still pushing it, now on babies. Babies aren't at risk from COVID-19 death. Trudeau bought 400 million doses. All-cause excess mortality rates are dramatically on the rise, though the pro-vaxxers will tell you mortality is from COVID-19 itself. A staunch vaccine supporter I know recently told me he knows someone who needed a heart transplant because of the vaccine – doctors said so. According to Pfizer's data, males in their 40s have the highest injury rates of any cohort. Dr. Anish Koka has done excellent work synthesizing data on myocarditis, showing males aged 16-17 years of age have the highest rates of myocarditis, followed by 12-15 year olds, and then 18 to 24 year olds (https://anishkokamd.substack.com/p/vaccine-myocarditis-update-from-thailand).

Cancel culture rose dramatically as a result of mob mentality and mass psychosis behaviour. Many experts were silenced, but it's time to start having conversations about the way all this was handled. This needs to be reconciled. This 'vaccine' cult needs to end, and their fraud needs to be exposed. I should not have lost my job. No one should lose their job for making a personal medical decision. No one's freedom to travel, within or to leave this country, should be impacted over a vaccine. Not now and not ever. People have lost their lives taking this vaccine. By all standards a product that kills as many people and injures as many people should be pulled off the shelves.

Our society allows people to poison themselves with alcohol and cigarettes. We have legalized these harmful toxicants. Every year teenagers die of intoxication from alcohol, die from drunk driving and reckless behaviours, and end up in the morgue. We should demand better than this in terms of products the government demands we take. If anyone can get and spread COVID-19 with a vaccine, why should unvaccinated people be subjected to quarantine upon returning to Canada? Why should they lose their livelihoods? Recent studies indicate vaccinated people shed the virus at much higher rates than unvaccinated people. The government is implementing an agenda of power and control disguised as science.

What struck me most about the pandemic was the way in which unvaccinated people became second-class citizens. I feel deep compassion for those who went for the shots because they were told they had to do so to keep their jobs. Some told me they felt broken by the system. I am also struck by the managers I know in HR (not at Island Health), but at other big organizations who said no they would not deliver the mandate. One such person is a friend of mine. She was fired for non-compliance. She does not wish to be named, but she is a hero to me. Even though my case appears on the surface to be a wrongful dismissal, I cannot find a lawyer or organization to take it to court. It's been explained to me that because Island Health is a provincially funded health organization, and the reason I was terminated is a Provincial health order, there is no recourse. What's left for those of us who held our ground and refused to submit? *Bodily* autonomy has come with a hefty price tag. I let go of a cherished job and career in public health, much like I might feel watching my boat sink. It was devastating and gut-wrenching. But I'd rather be alive, splitting firewood and teaching children, than six feet under because of a so-called vaccine. I made a strong choice, because I had the privilege to do so. I didn't have mouths to feed and a mortgage to pay. Others I know didn't have that same leeway. It is for them I feel the most empathy. Look at what we have become. Look now before it's too late. I call on people to begin having conversations with your family, friends, colleagues, community members and leaders. People deserve to be safe and belong. We must learn from this history or we will be doomed to repeat it.

Kevin Vowles now works splitting firewood, building fences and teaching children in schools.
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Article from Common Ground, August 2022.

In that silence, I learned that social smearing had not broken me. It has clarified me. Integrity is not a social performance; it is a spiritual discipline. Speaking out about vaccine mandates became a practice steeped in clarity about who we all are. Orwell said, "Freedom is the freedom to say that two plus two make four." My version was smaller but no less important: the

freedom to say vaccine choice matters, even when the crowd insists it doesn't.

Courage does not always roar. Sometimes it stands quietly in a kitchen while being called a conspiracy theorist. Sometimes it sails with no audience, guided only by an inner compass, and the stars.

The faith that remains for me is not faith in institutions. Those institutions faltered. It is not faith in consensus. That collapsed. It is also not faith in approval. That evaporated quickly. It is the faith in my truth, that each person should get to choose whether or not they are injected with a vaccine. To me it is the only instrument that does not break, even when the world does. And in that realization, I found a faith stronger than certainty itself: a faith that does not need permission to stand and speak.

As I prepared to sail again, ropes coiled, charts laid out, the air smelling of salt and cedar, I felt something new: not fear, not defiance, but peace. Whatever storms awaited, I would weather them. When a person rediscovers their inner compass, they can finally see the larger waters they've been drifting in—the cultural tides, the political pressures, the quiet currents of fear that carried a nation far from the place it believed itself to be. What happened to me was not an isolated squall. It was part of a wider weather pattern, a national storm system that revealed more about Canada than most of us were prepared to admit.

To understand my story, you must understand the country in which it unfolded, its institutions, its fractures, its unspoken rules, its appetite for conformity. A country that once saw itself as gentle and measured, yet in crisis showed a very different face.

The next chapter turns toward that wider horizon.

Chapter 9 — The Canadian Context: Freedom, Influence & the Charter Betrayed

The Canadian flag still hangs off The British Columbia Legislative Assembly. It is a red maple leaf bright against the Pacific sky, but for many Canadians its meaning has quietly changed. From the deck of my schooner in Victoria's Inner Harbour, I can see the domed legislature glowing at night, tourists posing beside the giant red "CANADA" letters next to the marina where my boat is tied up. Families pose for photos, musicians play in the courtyard, and artists come to sell paintings and Indigenous carvings to tourists who come to see what a provincial capital in Canada looks like. I used to love this city even more than I still do. I came here in 1999 to teach sailing with the Disabled Sailing Association. I loved the Juan de Fuca Strait for its wind and waves, which when I was younger helped me to learn windsurfing. It looks like the same country we grew up trusting. But beneath that postcard surface lies a fact we have not yet reckoned with within recent memory: millions of Canadians were designated second-class citizens, barred from travel, employment, education, restaurants, libraries, hospitals, and public life.

This happened in a nation that tells itself it is tolerant and cautious, and that "peace, order and good government" matter. But from 2020 to 2022, Canada neglected to honour its own Charter. Politicians like Trudeau and Eby failed to honour their obligations to their citizens.

A Nation That Forgot Its Own Human Rights Obligations

The Canadian Charter of Rights and Freedoms is not a suggestion. It is constitutional law, the framework meant to restrain the state precisely when fear tempts it to overreach. Parliament can override certain rights using the Notwithstanding Clause, but that mechanism requires debate, transparency, and accountability.

That clause was never invoked.

Instead, governments suspended Charter guarantees through emergency orders, interim measures, and press conferences. And the public, trusting the tone of authority, largely accepted it.

Among the clearest infringements were:

- Section 2(a) – Freedom of conscience and religion
- Section 2(b) – Freedom of thought, belief, opinion, and expression
- Section 6(1) – Mobility rights
- Section 7 – Life, liberty, and security of the person
- Section 15(1) – Equality before and under the law

The Canadian Human Rights Act guarantees equality in employment and access to federal services. Yet during the mandate years:

- Disabled or medically exempt Canadians, including myself, were denied accommodation.
- Workers were suspended solely for their medical status.
- Those seeking exemptions faced retaliation, stonewalling, and professional humiliation.

The Act was not simply ignored. It was inverted.

Canada is a signatory to the Universal Declaration of Human Rights, a document born from the ashes of totalitarianism. Yet during 2020–2022, Canada's response appears to have violated:

- Article 3 – security of the person
- Article 7 – equality before the law
- Article 13 – freedom of movement
- Article 23 – right to work
- Articles 18 & 19 – freedom of thought and expression

These breaches were not theoretical; they were lived.

The "Elbows Up" Hypocrisy

Chrystia Freeland repeatedly urged Canadians to keep their "elbows up," a hockey metaphor for firm resolve, whether speaking about trade negotiations or Pandemic policy. The phrase was meant to convey strength.

But while the government defended Canadian economic interests abroad, it failed to acknowledge that it had stripped millions of Canadians of their own civil and economic rights at home. It was a morality that punched outward but demanded obedience inward.

The message was unmistakable: Canada defends fairness internationally but punishes dissent domestically.

Brian Peckford's Warning

When I spoke with The Honourable Brian Peckford during my lawsuit against Island Health, there was no trace of bitterness in his voice, only sorrow. He was not a pundit or activist; he was the last surviving drafter of the constitutional document that had been sidelined. Brian Peckford was noted as saying:

> When governments prevent Canadians from traveling, from working, from worshipping — all based on a personal medical decision — they are violating the Charter I helped craft. Never was it intended to allow such broad suspension of rights without parliamentary debate or the use of Section 33. We wrote the Charter to ensure that no future government could do what they have just done. It breaks my heart to see the document I signed trampled under the very pretext of safety.

It was a constitutional indictment from the man who helped draft the blueprint of Canadian rights. Yet governments, courts, and media largely refused to engage with his warning. It was easier to dismiss him as outdated than to confront the uncomfortable truth that he, not they, understood the Charter's purpose.

Yet despite Canada's guardians of the Charter and the rights of Canadians, the country descended a slippery slope of villainizing anyone not onboard with vaccines. There was nowhere this was more evident than in the reception of the Freedom Convoy in Ottawa.

The Convoy and the Emergencies Act

In February 2022, long-simmering tensions erupted when the Trucker's Convoy rolled into Ottawa. Messy, human, imperfect, inspiring and profoundly democratic.

Drivers who had been praised as heroes in 2020 were now treated as unclean and unemployable if they remained unvaccinated. They came because new border regulations required them to take a vaccine that was neither durable in preventing transmission nor free of risk for all. Trucks converged on the capital seeking dialogue with the Prime Minister. He refused to meet them and instead invoked the machinery of the state.

Livestreams showed campfires, bouncy castles, singing, and Indigenous ceremonies. The media showed extremism. A complex protest was flattened into caricature. The government invoked the Emergencies Act, froze bank accounts, expanded police powers, and treated dissent as a threat.

During the convoy, I felt a silence settle over me that I had never known before. It was not that I agreed with every sign or slogan. It was that I could see ordinary Canadians, tired and hurting, gathering to say the one thing no institution seemed willing to hear: enough.

I wanted to send money, even a small amount. But the threat of bank accounts being frozen hung in the air like a warning flare. I could barely afford to support them, but I certainly could not afford to lose access to what little I had left. Online, friendships ended in the span of a comment thread. Support was equated with extremism. In 2022, silence felt safer than honesty, and that was its own kind of wound.

Two years later, the Federal Court ruled the invocation of the Emergencies Act unlawful. Too late for those harmed, but necessary for the historical record. The ruling affirmed what many already knew: the response had been disproportionate.

In January 2026, the Federal Court of Appeal upheld the earlier Federal Court ruling that the federal government's decision to invoke the Emergencies Act during the Freedom Convoy was unlawful. The judges

concluded that, however disruptive and unsettling the protests became, they fell short of the legal threshold required to declare a public order emergency and did not amount to a threat to national security as defined in the legislation. The Court also affirmed that key measures, including the freezing of bank accounts, were unreasonable in their scope and implementation, and infringed upon Charter rights. The ruling did not undo the damage done to those who were swept up in the government's response, but it did restore something vital to the historical record: in a democracy, extraordinary powers cannot be triggered simply because a protest is inconvenient, politically volatile, or publicly unpopular.

Freedom is not a slogan to be deployed when convenient. It is the ethical boundary that determines whether power serves people or disciplines them. What troubled me most during the convoy was not the disorder or the discomfort, but the speed with which dissent was reframed as moral deviance. When the Prime Minister publicly questioned whether certain citizens should be "tolerated," the lens narrowed decisively. From that point on, many no longer asked whether emergency powers against civilians were justified. They asked only whether the noise was annoying. In that narrowing, freedom was dismissed as "freedumb," and protesters opposing medical coercion were flattened into caricatures—racists, white supremacists, threats—less to be understood than to be managed. It was not an accident of rhetoric. It was a choice of frame.

Part of that stems from the images which surfaced in the media of one man with a Nazi flag, and another with a Confederate flag. They appeared briefly, carried by individuals who were confronted almost immediately and never identified again. Their photographs, however, lived on endlessly. Politicians invoked them. The media replayed them. For millions of Canadians, those images became the entire story, even though they did not represent the backgrounds or views of the protesters who came to speak against medical tyranny.

I cannot say who those individuals were or why they were there. I can say what any honest observer saw. The actions of a few anonymous figures, present for minutes, were used to define thousands of ordinary people who spent weeks feeding the homeless, shoveling snow, singing O Canada, and standing in the cold for their jobs, their children, this country, and their dignity. They were not only standing for their own dignity. They were standing for mine as well, and for the rights of citizens who could not be there without risking everything they had left.

What struck me most was the asymmetry. A single extreme image outweighed a thousand ordinary ones because it carried symbolic charge. Media outlets did not lead with volunteers making hot meals, clearing

snow for elderly residents, or Indigenous drummers opening gatherings with prayer. They led with the Nazi and Confederate flags.

What made this framing so effective was that it did not need to be proven, only repeated. Once a protest can be morally branded, the public no longer must listen to what is being said. It can dismiss the speakers instead. In the months leading up to the convoy (fall 2021), Prime Minister Justin Trudeau publicly characterized vaccine-hesitant Canadians as racists and misogynists and questioned whether such people should be tolerated. That language mattered. This was not an off-hand remark. It was a deliberate rhetorical act, delivered from the highest office in the country, that redefined political disagreement as moral deviance. In a single stroke, millions of Canadians were recast not as citizens exercising judgment under uncertainty, but as socially dangerous parasites.

It narrowed the field of acceptable citizenship and turned a policy disagreement into a character indictment. Then, in 2023, Parliament welcomed and applauded a visiting veteran who was later revealed to have served in a Nazi-aligned unit. This was a moment so humiliating and offensive it forced the Speaker of the House to resign. I do not offer that as a cheap comparison, but as a reminder of how selectively moral outrage is applied. The convoy was portrayed as extremist by association, while institutions that claimed the authority to police moral boundaries proved capable of breathtaking blind spots of their own.

That moment marked a profound rupture. Opposition to public policy was no longer treated as a legitimate feature of democratic life, nor even as mistaken reasoning to be corrected. It was framed as evidence of character defect. The language of public health gave way to the language of exclusion. Once the Prime Minister of Canada placed dissenters outside the bounds of social tolerance, institutional responses followed naturally. Dialogue was no longer required. Proportionality no longer applied. Punishment could be justified as protection.

That shift mattered. When the Freedom Convoy arrived in Ottawa months later, it entered a public sphere already conditioned to see mandate resistance not as a policy dispute, but as a moral threat. In that environment, the appearance of even a small number of hateful symbols did not require careful investigation or contextual restraint. They confirmed what power had already declared to be true.

Supporters described the convoy as a broad, working-class protest against mandates and prolonged emergency measures. Critics argued it functioned as a convergence point for extremist politics. Human rights organizations and federal authorities expressed concern not only about isolated symbols, but about whether online spaces surrounding the convoy

amplified conspiratorial or dehumanizing rhetoric. The Public Order Emergency Commission later recorded these disputes, noting both the presence of troubling imagery and the absence of evidence that convoy leadership endorsed extremist ideology.

A fair account must hold two realities at once. The Freedom Convoy was comprised of ordinary Canadians who did not attend to promote racism and rejected hate symbols if confronted with them. At the same time, the presence of such imagery made it easy for institutions and media to frame the protest as inseparable from extremist currents, even if most attendees were not extremists. Once that framing took hold, it shaped how all subsequent events were interpreted.

Recognizing this does not require denying the existence of racism or extremist ideology within Canadian society. Nor does it require excusing symbols that many found disturbing. It requires acknowledging how moral language, once introduced at the level of national leadership, reshaped the boundaries of legitimate participation in public debate. When dissent is framed not as a difference in judgment but as evidence of moral wrongdoing, the space for proportional response narrows. Dialogue gives way to denunciation, and complexity becomes politically inconvenient.

In that sense, the controversy surrounding the Freedom Convoy was not only about what occurred on the streets of Ottawa. It reflected a broader transformation in how disagreement itself was understood during the Pandemic. Once that transformation took hold, institutions responded less through evidence and context, and more through pre-established moral categories.

History would later confirm what those citizens already understood in the cold streets of Ottawa: when a government teaches its people to fear one another, it becomes capable of invoking extraordinary powers not to protect democracy, but to suppress it.

Media and the Making of a Moral Crisis

The media did not create the Pandemic, but they created the weather system through which the public experienced it. Before a single restriction was announced, before the first models shaped policy, people were already absorbing the emotional tone radiating from their screens. Fear arrived early and spread quickly, not only through case counts and hospitalization curves, but through framing, language, and moral messaging.

A society in crisis looks to its media for bearing and proportion. Instead, Canadians often received something more brittle: certainty without humility, authority without questioning, and instruction in place of information.

During the Pandemic, the press became not just the messenger of public health but its interpreter, and at times, its enforcer.

The CBC: From Public Broadcaster to Moral Arbiter

The CBC has long been the country's imagined hearth: a place where national stories are told, examined, and made legible. But crises strain institutions, and under strain, the CBC's reporting shifted. The tone drifted from the impartial cadence of journalism toward the moral certainties of advocacy.

What emerged was not a conspiracy, but a discernible pattern in emphasis and framing:

- Stories highlighting the danger posed by the unvaccinated
- Profiles of people like Dr. Charles Hoffe framed as cautionary morality tales
- Experts selected less for their capacity to grapple with nuance and more for their ability to reinforce a unified narrative
- A consistent division of the population into the responsible and the irresponsible
- Little acknowledgment of legitimate medical exemptions, adverse events, or ethical dilemmas
- Labels and shorthand that flattened human complexity into categories

The subtlety was not in *what* CBC reported, but in *how*. The stories were not fabricated. The facts were not invented. But the arrangement of those facts, the tone of headlines, and the emotional posture of the reporting created a clear impression: compliance was virtue; skepticism was deviance.

Independent communication research has since documented similar patterns across mainstream media during the Pandemic. In that broader context, the CBC's reporting consistently *appeared* to frame dissent as dangerous, selfish, or socially irresponsible (see Appendix B). The effect was subtle but powerful: disagreement felt less like a civic contribution and more like a threat to public safety. And the CBC was not alone. Many major outlets echoed the same narratives, reinforcing a moral binary that left little room for uncertainty, nuance, or legitimate debate.

Combined, these tendencies signaled to Canadians that uncertainty was deviance, and hesitation was a personal failing. Instead of equipping the public with information sturdy enough to navigate a moment of global upheaval, many institutions delivered moral judgment in their place. The result was a national atmosphere in which nuance evaporated, empathy was replaced by suspicion, and entire groups of citizens were pushed outside the boundaries of acceptable discourse.

Canadians did not need to be instructed on what to think; they simply needed the freedom to think.

The Toronto Star Flashpoint: A Collapse of Empathy

The most striking moment of moral collapse came not from a politician or a public-health official, but from the front page of Canada's largest newspaper. On August 26, 2021, the *Toronto Star* printed, in giant bold letters across its cover, a series of social-media quotes declared by frustrated citizens.

To the right of those statements appeared a news article about Air Canada employees being subjected to a vaccine mandate, an unmistakable juxtaposition that framed coercion as public sentiment and cruelty as civic virtue. These quotes were supposedly not the Star's editorial views. They were not attributed to any health authority. They appeared as comments from "average people," presented under the guise of reflecting the public's frustration with the unvaccinated, a frustration that had been stoked relentlessly from Ottawa to the national newsrooms.

Front pages carry symbolic weight. They do not merely report on the mood of a nation; they shape it. Seeing eliminationist rhetoric displayed

without critique shocked even many Canadians who supported vaccination. It was a moment when the emotional fever of the country became visible, unfiltered and unrestrained. It was a moment when frustration crossed into something far darker: the suggestion that certain lives were less deserving of medical care, compassion, dignity, or basic human concern.

One quote captured the collapse of logic at the heart of the hysteria: "If an unvaccinated person catches it from someone who is vaccinated, boohoo, too bad." In that single sentence lay the entire contradiction of the mandate era. If a vaccinated person could transmit the virus to an unvaccinated person, then the claim that vaccination was a civic duty "to protect others" dissolved instantly. The statement inadvertently admitted what officials already knew but would not say openly: the vaccines did not reliably prevent transmission. Yet instead of re-evaluating the moral justification for coercion, the system doubled down. The public parroted the propaganda with a kind of blind fury, insisting: You must take the shot so that my shot will work, and if you get infected by me after I've taken it, that's your fault, not mine. This was the essence of hysteria, a demand for universal obedience built on a premise that everyone could see was collapsing.

Alongside that contradiction came the most dangerous inversion of all: the abandonment of empathy. If vaccinated people could spread the virus, then humility should have applied equally. Instead, the unvaccinated were blamed for infections they did not cause, while the vaccinated were absolved for transmissions they openly acknowledged. Scapegoating filled the vacuum left by reason. The quotes on the Star's front page were not an aberration; they were the emotional scaffolding upon which mandates, firings, travel bans, and exclusions were built. The celebration of Air Canada's mandate that same day was not reporting, it was a public ceremony of moral downgrading, a signal that the unvaccinated could be stripped of employment and rights without the slightest institutional hesitation.

The Star's front page was not policy. It was temperature—the heat of a nation pushed past the boundaries of empathy and toward punishment. And temperature matters: it hardens attitudes, narrows compassion, and legitimizes actions that, in calmer times, would be recognized as violations of law and ethics. What Canada did in this period, mandating medical procedures as conditions for employment, mobility, and healthcare, violated the Charter of Rights and Freedoms, the Nuremberg Code, and the Helsinki Declaration, all of which insist on voluntary, free consent. The Air

Canada mandate was not medical policy; it was state-backed corporate coercion, enforced through the threat of poverty and social exile.

For many Canadians, the implications were terrifying. People were not irrational when they feared that the next step might be forced quarantine facilities, roundups, or even detention camps. Those fears did not emerge from fantasy; they arose because the emotional groundwork for such abuses was already being laid in public. When a major newspaper prints "let them die" and pairs it with the celebration of workers losing their livelihoods, it signals that certain citizens have been pushed outside the moral circle of the nation, and history teaches that once a society accepts exclusion, far worse ideas can follow.

I have said throughout this book that I believe in reconciliation. I am not interested in humiliating leaders or perpetuating cycles of blame. But reconciliation requires truth. And the truth is that what happened during this period was not a misunderstanding. It was a collective moral failure, a collapse of empathy, of ethics, of media responsibility, and of governmental restraint. Canada crossed lines that must never be crossed again.

So let this stand with absolute clarity: Never again. Never again can this country tolerate the humiliation, othering, or exclusion of a medical minority. Never again can a newspaper normalize hatred toward a segment of the population. Never again can a government or employer use coercion to force medical compliance. Never again can fear override rights, or propaganda override reason. Reconciliation is the destination—but being clear about the line this country must not cross again is of paramount importance.

The Cost: Moral Injury in the Public Square

Wounding happened: a moral injury, subtle at first, then undeniable. What unfolded did not feel like a disagreement about policy or science. It felt like being unwelcome from the place you had always called home.

The portrayal of the unvaccinated as reckless, immoral, or dangerous was not a public-health strategy, it was a form of social exile. People were not navigating scientific uncertainty; they were navigating abandonment. Neighbours who had once waved across the fence looked away. Family members spoke in tones that implied defects rather than difference. Friendships dissolved without argument, replaced by a silence that said more than words ever could. And when the mandates ended, none of that simply vanished. The fractures remained, quiet, aching reminders of the lines that had been drawn through our lives.

For me, this was not an abstract wound. It was personal. The scar is wide and deep. I have never felt fully right since 2021. Four years have

passed, and the ache still lives somewhere beneath my ribs. It's got a heaviness that comes and goes but never disappears. Sometimes it flares without warning: a memory of something someone said, a look that cut sharper than it should have, a moment when I realized that the ground beneath me had shifted and I was no longer standing in the same country I thought I knew.

It is not constant pain, but it is a constant presence, like an echo you learn to live beside.

The press helped carve this scar. It amplified stories that supported a single, sanctioned narrative while diminishing or erasing those that complicated it. Dissent was cast as moral failure, not civic participation. Canadians harmed by mandates were not treated as citizens with stories worth hearing; they were treated as irritants to a preferred storyline. Experts who voiced uncertainty or contradiction were not engaged; they were sidelined, as though curiosity itself was dangerous. And criticism of public health was too often dismissed as "misinformation," not because it had been disproven, but because it refused to fit neatly within the emotional script the country had chosen.

The injury that resulted was not political. It was human. And human wounds, especially those inflicted by exclusion, betrayal, and the quiet withdrawal of belonging do not fade simply because the news cycle moves on. They linger. They take up residence in the body. They change how a person stands, how they trust, how they hope. They remind us that even in peaceful countries, harm can be done without a single shot being fired, simply by turning people into categories instead of neighbours.

What Went Wrong and What Must Change

The media may not have set out to divide Canada, but that is exactly what happened. Whatever the intentions, fear, responsibility, political alignment, or institutional inertia, the effect was unmistakable: the press became the loudspeaker through which the government turned a health crisis into a moral hierarchy. Acceptable opinion narrowed to a single sanctioned narrative. Nuance was outlawed. Doubt became deviance. And a country that once prided itself on tolerance and dialogue found itself sorted into the righteous and the reckless, the compliant and the condemned.

Complex science was flattened into slogans. Reasonable questions were framed as threats. Citizens who hesitated, waited, or simply wanted fuller information were caricatured as dangers to the nation. The media, rather than interrogating power, became the machine that power used to fracture the public. It worked too well. People were shamed, families were split, friendships broke, and entire groups of Canadians were pushed outside the

moral circle. History will not look kindly on those months when journalism forgot its own purpose.

If we hope to prevent such failures from repeating, the media must reclaim the virtues it abandoned:

- Humility instead of certainty
- Inquiry instead of enforcement
- Proportion instead of panic
- Empathy instead of division

Journalism is not a ministry and should never act like one. Its role is not to manufacture consensus or punish dissent, but to protect the public's ability to think clearly, especially under pressure. A free society depends on a press willing to ask uncomfortable questions, resist official overreach, and preserve the space where citizens can disagree without being cast as enemies.

The next crisis will come. When it does, Canada will need more than sound policy and good medicine. It will need a media that refuses to be weaponized again, one that reports truthfully, challenges authority, and remains loyal not to the government of the day that funds it, but to the people whose trust it holds. Only then can we avoid tearing the country apart a second time.

Influence Without Accountability — The WEF and the New Moral Order

Much of the moral framing that swept across Canada during the Pandemic did not arise solely from domestic debate. The language carried a cadence that felt strangely familiar, echoing ideas circulating through a wider network of global policy forums, advisory bodies, and international institutions. Among the most visible of these was the World Economic Forum, a gathering place where political leaders, corporate executives, academics, and policymakers meet to discuss the future of economic systems and global governance.

In 2021 and 2022, the World Economic Forum published a series of reports and policy discussions outlining how emerging technologies might shape the governance of future crises. These discussions explored systems built around digital identity, health credentials capable of verifying vaccination or testing status, and expanded cooperation between governments, corporations, and technology platforms. Within this framework, compliance with public health measures was framed as a civic responsibility, while misinformation and resistance were increasingly described as risks that could undermine effective pandemic response. Some of these ideas had already appeared in earlier initiatives such as the Known Traveller Digital Identity project, a collaboration between governments and

technology partners designed to allow travellers to share verified identity information digitally with border authorities. Programs like this reflected a broader trend toward systems in which identity, mobility, and access to services could increasingly be mediated through digital verification.

Long before COVID-19 arrived, institutions such as the World Economic Forum were already exploring how societies might respond to large scale global disruptions. One example often cited is Event 201, a tabletop exercise held in October 2019 and organized in partnership with the Johns Hopkins Center for Health Security and the Bill & Melinda Gates Foundation. The exercise simulated a fictional coronavirus pandemic in order to test coordination between governments, media organizations, and private institutions during a global health emergency.

Pandemic preparedness exercises were not unusual in the years before COVID-19. Governments and international institutions had conducted a series of simulations exploring how societies might respond to catastrophic outbreaks. Among the most notable were Dark Winter in 2001 and Atlantic Storm in 2005, both of which examined the global consequences of a smallpox pandemic. Later exercises such as Clade X in 2018 and the SPARS Pandemic Scenario explored how modern societies might manage a rapidly spreading infectious disease, including the challenges of vaccine deployment and public communication. By the time Event 201 took place in 2019, Pandemic planning had already become a routine part of global risk preparedness. For many observers, however, the similarities between simulated scenarios and the real-world crisis that followed, contributed to a lingering sense that the Pandemic unfolded along lines that had been contemplated long before it arrived.

In recent years a more sweeping allegation has circulated widely online. Some critics claim that institutions such as the World Economic Forum, sometimes alongside figures like Bill Gates, helped plan or orchestrate the COVID-19 Pandemic itself. The claim is often linked to exercises like Event 201. At present, however, no publicly available evidence demonstrates that these organizations planned or initiated the Pandemic. Simulations such as Event 201 were designed as fictional preparedness exercises, a practice long used in public health and national security planning.

Some commentators have pointed to language from policy discussions describing the pandemic as a "test" of social responsibility or governance capacity. In this context, the word "test" refers to a retrospective analysis of how societies responded under pressure, similar to the way economists or

engineers speak of a system being stress-tested by a crisis. Such language reflects post-event evaluation rather than evidence that the crisis itself was designed or orchestrated.

Still, the fact that influential global actors were discussing Pandemic governance frameworks before COVID-19, and later spoke openly about using the crisis as an opportunity to rethink economic and governance systems, has understandably fuelled suspicion among many observers. Distinguishing between documented preparedness planning and the far stronger claim of deliberate orchestration is therefore essential if the discussion is to remain grounded in evidence.

What is beyond dispute is that influential global institutions were actively discussing governance models for managing complex global risks. During the Pandemic itself, the World Economic Forum launched an initiative known as The Great Reset, introduced by its founder Klaus Schwab. The project proposed that the Pandemic offered a rare opportunity to rethink economic priorities, accelerate digital transformation, and advance a model sometimes described as stakeholder capitalism, in which corporations and governments pursue broader social and environmental goals alongside economic growth.

Schwab described the moment in stark terms in his book COVID-19: The Great Reset: "The Pandemic represents a rare but narrow window of opportunity to reflect, reimagine, and reset our world."

To some observers this sounded like responsible long-term planning in the face of a global crisis. To others it felt more unsettling. Powerful institutions were speaking about redesigning aspects of the global system while ordinary citizens were still living under extraordinary restrictions.

Canada's policies did not necessarily originate at the World Economic Forum, but they often aligned with governance tools being discussed across international policy forums. Digital health credentials, vaccine certification systems, and coordinated behavioural messaging appeared rapidly across many countries during the Pandemic. Canada's ArriveCAN system and provincial vaccine card programs formed part of this broader global pattern. Rather than a single institution directing events, it is more accurate to see these policies as emerging from a shared policy vocabulary that had been developing across governments, advisory bodies, and international forums for years.

Over the past two decades, a dense network of global policy communities has formed linking governments, technology companies, philanthropic foundations, and international organizations. Bodies such as

the World Health Organization, global think tanks, and institutions like the World Economic Forum increasingly function as convening platforms where frameworks for managing global risks are debated long before they appear in national legislation. When crises arrive, those ideas can move quickly through professional networks of experts, advisors, and policymakers.

For citizens watching from the outside, however, the speed and similarity of Pandemic policies created a different impression. Decisions that reshaped everyday life seemed to emerge simultaneously across many countries, often framed in strikingly similar moral language. This produced a quiet psychological rupture. When a country begins speaking in a voice that no longer feels recognizably its own, people grow uncertain about where decisions are actually being made.

Prime Minister Justin Trudeau has participated in discussions hosted by the World Economic Forum, a global forum where political leaders, corporate executives, and policy thinkers exchange ideas about economic governance, technology, and global challenges. In public remarks, WEF founder Klaus Schwab has noted the organization's engagement with political leaders around the world, including members of what he described as a "younger generation" of leadership. While participation in such forums does not mean national policy is dictated by external institutions, it does illustrate how ideas and frameworks developed in global policy networks can circulate among governments.

During the Pandemic, some of the language used by Canadian officials echoed ideas frequently discussed in those international forums. References to collective responsibility, coordinated action between governments and private institutions, and the potential role of digital systems in managing public-health crises appeared both in domestic policy debates and in global policy discussions taking place at organizations such as the World Economic Forum.

The shift became unmistakable when Prime Minister Trudeau told a Quebec talk show that unvaccinated Canadians "don't believe in science" and "take up space." The statement was not a policy argument but a moral indictment. In that moment dissent was no longer framed as a perspective to be debated or challenged. It became a character flaw, a form of civic irresponsibility.

This was the new moral order. Disagreement was equated with danger. Skepticism was treated as contamination. Compliance was elevated to a public virtue. For a country that once prided itself on pluralism and

reasonable accommodation, the change was jarring. Dissent did not simply become wrong. It became immoral.

What made this transformation powerful was not the policies themselves, but the psychology they activated. Systems built around certification and compliance created an illusion of safety not only against the virus but against social judgment and moral exclusion. Many people aligned themselves with the dominant narrative less because of scientific certainty and more because of the powerful human desire to belong.

In this environment questioning the prevailing narrative became socially dangerous while compliance offered protection and moral reassurance. Many Canadians were not defending evidence so much as defending identity, status, and inclusion within the new moral consensus.

The result was a population that felt righteous, a minority that felt exiled, and a country that no longer fully recognized its own temperament. Canada had become a place where fear and virtue fused together, and where the architecture of control was upheld not only by policy but by the citizens themselves.

In the end, the deeper issue was not whether one institution or another shaped the policies of the Pandemic years. It was how easily the language of science became fused with the language of moral certainty. Scientific inquiry is meant to invite questioning, humility, and revision. Yet during the crisis, disagreement was increasingly framed as a failure of character rather than a difference of interpretation. When science becomes a moral identity rather than a method of discovery, the space for empathy begins to shrink. The tragedy of those years was not simply the policies that were adopted, but the cultural shift that followed. A society that once valued open debate found itself struggling to remember that compassion and curiosity belong on the same side of the line between science and empathy.

The Unnamed Ones — A Class of Quiet Resisters

There is a rare class of people in this country.
They did not become public figures.
They did not wave flags or hold signs.
They did not write op-eds or seek applause.
They simply refused.

These were the Quiet Resisters. The ones who found themselves inside institutions, close enough to power to be asked to carry out orders that violated their conscience. Some were told to deliver mandates that would force thousands of employees to choose the shots or lose their jobs. They

were expected to be the voice of compliance, the instrument through which coercion would become policy.

And some of them said no. There were no press releases or protest signs. Just conscience, expressed in a quiet, dignified way. When they refused, the response was not dialogue. It was an ultimatum: comply, or be removed. Many were fired. Some lost their income. Some lost the careers they had spent years building. Some lost friendships and professional networks they thought were permanent.

But they kept their integrity, the one thing no institution can take unless it is willingly surrendered.

Many of them chose to remain unnamed. Not because they were uncertain, but because they understood what this climate could do to a person. In that silence, their anonymity became its own indictment. It revealed the fear that had taken hold, and the cost of dissent in a country that once prided itself on tolerance.

These anonymous resisters were the moral spine of the country at a time when institutions had none. Their refusal did not stop the mandates, but it prevented the illusion that Canada had been unanimous. It proved that there were still Canadians who remembered what freedom meant, even when it came at a personal cost.

Island Health, where I served, was not among those institutions. There, the C.A.R.E. motto, Courage, Aspire, Respect, Empathy proved ornamental. Compliance was the only value that mattered. Courage and respect could not be found when they were most needed.

The National Citizens Inquiry — Canada's Public Reckoning That Never Made the Headlines

While vaccine-injured Americans testified before Senate panels and groups like React19 gained national visibility, Canada's own reckoning came not from the Government, but from ordinary citizens who refused to let the story disappear. In 2023, they pooled their resources, rented the rooms, brought microphones, and launched the National Citizens Inquiry (NCI); a fully independent, citizen-funded tribunal held across the country. It became the largest repository of Canadian Pandemic testimony ever created: a living archive of stories the federal and provincial governments refused to gather.

Over 300 witnesses testified under oath. Physicians, nurses, scientists, paramedics, economists, lawyers, data analysts, small-business owners, teachers, First Nations leaders, religious leaders, ethicists, and vaccine-injured Canadians filled the hearings. The proceedings were livestreamed, transcribed, and preserved in full. In a nation where official reviews

avoided questions of harm, the NCI became the only comprehensive public record of what Canadians lived through.

A Striking Number of Canadians Reporting Vaccine Injury

Witness after witness described severe reactions: myocarditis and pericarditis; neurological disorders; autoimmune conditions; clotting events; menstrual changes; sudden paralysis; sudden death. Parents told stories of children who collapsed without warning. Widows spoke about husbands who deteriorated after their injections. Young adults testified that they could no longer work, their lives divided into "before" and "after."

Many said their physicians refused to file adverse-event reports or acknowledge the possibility of vaccine injury. They were told it was "stress," "coincidence," "anxiety," or something as trivial as "new detergent." Their stories echoed patterns emerging across the world, yet in Canada, no public institution had ever collected them. The NCI was the first to do so.

Excess Mortality and Statistical Red Flags

Data experts presented troubling evidence: rising all-cause mortality in Canadians under 45; spikes in cardiac-related emergency calls; a marked increase in "unknown cause of death" across multiple provinces; and mortality curves that appeared to track with vaccine rollout periods. The NCI did not claim causation, but it called these signals "urgent, unexplained, and deserving of immediate investigation."

That investigation has not occurred.

Systemic Suppression of Dissent Within Healthcare

Canadian physicians testified about the cost of speaking honestly. Raising concerns about vaccine safety or early-treatment protocols meant threats from provincial Colleges, suspension of hospital privileges, formal investigations, reputational destruction, and gag orders. These were not fringe practitioners, they were respected professionals who described feeling "policed," "silenced," and "professionally coerced." The message they received was clear: narrative compliance mattered more than scientific inquiry.

Medical Ethics Violations

Ethicists exposed failures at the heart of Pandemic decision-making: the erosion of informed consent, coercive mandates in employment and education, denial of exemptions, failure to disclose known risks, and punitive policies that contradicted evolving evidence. These concerns mirrored global debates, but Canada's official reviews avoided them entirely.

A Record Canadians Created Because Their Institutions Would Not

Perhaps the most significant contribution of the NCI is that it created a space the government refused to create, a space where the vaccine-injured could exist. Dozens testified publicly; thousands more submitted written statements. Many echoed similar sentiments of complying with directives to vaccinate, being harmed and injured, and then abandoned by the system.

The NCI's final report, released in late 2023, issued sober recommendations: a functional national compensation program; transparent access to mortality and adverse-event data; independent oversight of public-health decisions; preservation of informed consent; and legal review of mandates and emergency powers.

The federal government ignored the Inquiry. Provincial ministries dismissed it. The mainstream press barely reported on it.

What the NCI Ultimately Represents

The National Citizens Inquiry is not a fringe document. It is the testimony of Canada itself, delivered freely, at personal cost, by citizens with nothing to gain and everything to lose. It stands as a counter-record to the sanitized official narrative, documenting the human consequences that institutions were unwilling to confront.

It revealed a truth officials tried to erase:

- Canada was not united.
- Canada was not well-informed.
- Canada was not careful.
- Canadians simply endured.

And when every institution failed to listen, ordinary people stepped forward, gathered their courage, and recorded their own history. They recorded their history because they knew one day we would need it. Sadly, that day has already come.

Global Governance and the WHO Pandemic Agreement

The rise of global governance is not a conspiracy theory; it is a structural reality. As Canada wrestles with its recent past, the polarization, the moralization, the quiet reshaping of civic norms, another transformation is unfolding just beyond the public's field of vision. A new international architecture is taking shape, one that blurs the line between cooperation and control. Its most prominent symbol is the WHO Pandemic Agreement, adopted in 2025, presented as a blueprint for equity and preparedness. But beneath the aspirational language lies a more profound inquiry: Who governs a nation during a global emergency, its elected representatives, or unelected international bodies operating above the nation-state?

The Agreement contains no overt coercion, no explicit surrender of authority, and yet its implications are unmistakable. States are expected to share biological samples and genomic data, align domestic law with global standards, adopt interoperable digital health systems, and follow pre-defined global emergency protocols. On paper, nothing is forced. In practice, everything is expected. What emerges is a moral framework, a sense that responsible nations comply, and irresponsible ones do not, the same dynamic that shaped Canada's Pandemic response long before any Parliamentarian cast a vote. It is governance by expectation, a form of political gravitational pull where deviation becomes unthinkable.

We have already witnessed how quickly global consensus becomes domestic law. Legal scholars call this phenomenon soft sovereignty erosion: authority seeps outward, not in dramatic strokes but in quiet shifts of deference. I call it something simpler, rule by template. The WHO cannot legislate within Canada, yet it rarely needs to. Courts routinely defer to "expert consensus." Governments defer to "global standards." Public-health bureaucracies defer to "international best practice." With each layer of deference, sovereignty thins. Decisions appear domestically made, but their intellectual and moral architecture is imported.

In moments of crisis, this dynamic accelerates. Moral pressure becomes political pressure; political pressure becomes legal precedent; legal precedent becomes binding law. By the time these transformations reach the public, they appear inevitable, as though Canada is merely following the natural course of responsible governance rather than adopting a worldview authored elsewhere. This is how authority shifts in the twenty-first century: not by force, but by expectation braided with urgency, by institutions that claim neutrality but wield immense cultural power.

Sometimes, late at night on my boat, the Legislature Buildings glowing across the water, I feel a strange mix of pride and grief. Pride in the Canadians who refused to hate their neighbours, who held onto decency despite the pressure. Grief that our institutions bent so quickly, so completely, to a model of governance that arrived pre-formed from afar. Freedom is not self-maintaining. It is a muscle: moral, civic, and cultural, and when it is not used, it does not rest. It atrophies. And once atrophied, it becomes astonishingly easy for others to lift.

The New Infrastructure: Surveillance, Passports, and the Digital Person

The Pandemic Agreement aligns with the WHO's emerging Digital Health Architecture. It is a system built with help from the World Bank, G20 partners, and global digital-ID alliances. The infrastructure includes digital vaccination certificates, interoperable global records, Pandemic travel credentials, and real-time data surveillance. These tools were

advertised as efficiency and convenience. But any system capable of streamlining can also restrict with equal ease. A digital key opens doors, but it can just as easily lock them.

Canada has already tested this architecture. The BC Vaccine Card and its counterparts across the country, functioned as a gateway to daily life despite the inability of the COVID-19 vaccines to fully prevent transmission. It governed whether someone could enter a restaurant, attend a class, visit a loved one, or participate in society. Once a digital credential determines access, it can be extended almost anywhere. The technology is not inherently dangerous. The danger is what happens when technology meets a culture that has already shown itself willing to dehumanize those who do not comply.

This is why the Toronto Star flashpoint matters so profoundly. Those "boohoo, too bad" and "let them die" headlines were not just moments of overheated rhetoric—they were evidence of a psychological shift, a collapse of empathy that revealed how fragile Canada's social fabric truly was. If a nation can be persuaded to see a segment of its own people as unworthy of compassion, then a digital system that categorizes, tracks, and restricts becomes far more perilous. Not because of its code, but because of the culture willing to use it.

Canada never reconciled the way it dehumanized the unvaccinated. There was no national pause to consider what it meant for a major newspaper to cheer cruelty on its front page, or for employers like Air Canada to enforce state-backed coercion with public applause. Without reconciliation, the emotional groundwork remains in place: fear as policy, stigma as strategy, compliance as virtue. In such a climate, the next crisis—real or perceived—could turn digital infrastructure into a mechanism of exclusion more quickly than we dare to imagine.

The threat is not the tool. The threat is a society that has already demonstrated how easily it can turn neighbours into categories and categories into targets. When safety becomes justification for surveillance, and compliance becomes proof of virtue, digital systems stop being conveniences and become instruments of social control. They are perfectly calibrated to the psychology that made those front-page headlines possible in the first place.

The Ostrich Controversy — A Parable of Trust, Science, and Silence

In late 2025, an unusual story broke through Canada's winter news cycle: the forced destruction of a British Columbia ostrich herd. The order came from the Canadian Food Inspection Agency (CFIA) after several birds tested positive for avian influenza. To the public, it looked like a

straightforward biosecurity response. But to those who looked closer, something more complicated, and more revealing, was unfolding.

The farm owners argued that many of their ostriches had shown natural resistance to a virus. Ostriches, after all, are not ordinary livestock. They possess robust immune systems, unique physiology, and evolutionary adaptations that set them apart from other birds. Globally, researchers study ostriches for exactly these traits: their heightened innate immunity, their tolerance to pathogens that devastate other species, and their potential to help us understand cross-species viral behaviour. Immunologists have long noted that ostriches produce unusually potent IgY antibodies, which have been explored in fields ranging from infectious-disease research to passive immunotherapy.

In other words: they were scientifically valuable precisely because they survived what kills others.

The response to the cases of Avian flu was swift and absolute. Despite the farm's requests for targeted testing, selective isolation, or research partnerships, the CFIA ordered the entire herd destroyed. Not because every bird posed a demonstrated threat, but because the policy template allowed no nuance. Under federal guidelines, exposure, or suspected exposure, was enough to justify eradication. The grounds for the cull were legal. The grounds for scientific curiosity were ignored.

And that was the heart of the controversy.

A herd that could have offered data, insight, or even hope was treated instead as a liability to be eliminated. The government framed it as a precaution. Many Canadians saw something else: a replay of the same pattern they had come to recognize during the Pandemic. They saw a species being eradicated instead of investigated, suppression instead of study, and murder instead of understanding.

For me, the symbolism landed with force. I spent time among ostriches in Africa; I know their intelligence, their sensitivity, and the strange, majestic presence they carry. I have a deep affection for ostriches, their strange beauty, their impossible speed, the way they watch you with eyes that seem to understand more than a bird should. They are creatures of contradiction: powerful yet gentle, prehistoric yet expressive, cautious yet curious. I love them for that. And perhaps that is why this story stayed with me long after the headlines faded. They are birds that survive against odds: fast, perceptive, adaptable. To see them destroyed rather than examined felt like watching a metaphor unfold in real time: a system so committed to controlling risk that it can no longer recognize opportunity.

Canadians did not need to agree on every fact to feel the meaning. It echoed the Pandemic years and moments when officials acted first,

questioned little, tolerated no dissent, and treated uncertainty as an enemy rather than an invitation to learn. The ostrich herd became a stand-in for every suppressed question, every inconvenient anomaly, every citizen who asked to be heard and was answered with silence.

The controversy was never really about birds. It was about trust, about whether our institutions still know how to learn, or whether they now specialize only in maintaining narratives.

In the end, the ostriches were culled. And with them, perhaps, data we will never retrieve, and a piece of public faith that may never be restored.

The destruction of those birds felt like the destruction of something larger, a reminder of how far we've drifted from a culture that once prized discovery. The herd could have taught us something. Instead, the system chose certainty over wonder, compliance over curiosity. When I think of those ostriches now, I think of what we lost: not just animals, not just data, but the humility to admit when nature is teaching us something we do not yet understand.

Where This Leaves Us

Canada is a nation still nursing wounds it has barely begun to name. We tell ourselves we are polite, rational, and democratic, but during the crisis we revealed a shadow we did not know we carried. We abandoned rights without debate. We shamed dissent without evidence. We followed global scripts without scrutiny. And in doing so, Canada harmed its own citizens.

The WHO Agreement, the digital-ID architecture, the moralizing of dissent, the erasure of lived harms, all of it suggests a country still vulnerable to the same reflexes that swept through it in 2021-2022. The danger is not merely the technology but the mindset behind it; the belief that people can be managed as data points, permissions, and QR codes. When citizenship is digitized, it can be downgraded. When identity becomes something that can be scanned, it becomes something that can be restricted. A digital person is always one step away from becoming a conditional person, and conditional citizenship is not citizenship at all.

The question now is not what happened. It is what happens next. Will Canada trust its Charter or its fear? Its citizens or its scripts? Will it embrace democratic heritage or the pressure from global institutions such as the World Health Organization, and the World Economic Forum?

What happened from 2020 to 2022 was not an aberration. It was a warning that, if ignored, becomes prophecy.

Canadians often worry about becoming the 51st state of the United States. But the deeper fear, the one we are only beginning to confront, is

what Canada became in its darkest hour, when belonging could be revoked with a scan, and rights could shrink to the size of a screen.

Yet even that reckoning is only part of the story. Because the failures within our borders did not arise in isolation. They were shaped, accelerated, and in some cases justified by forces far beyond Canada itself, forces that began long before the first emergency order was signed, before the first mask was worn, before the first vaccine was delivered.

To understand what happened here, we must look upstream. We must follow the current back to its source.

For every national failure has a global context, and every policy that reshaped our lives was downstream of a deeper, unresolved question, one that the world still tiptoes around: Where did this begin? Not the mandates, not the passports, not the political fractures, but the crisis itself.

Every country was swept into the storm. But someone, somewhere, struck the match.

The next chapter turns toward that origin—the place where medicine, politics, research, and risk converged in ways the world was unprepared to confront. Before we can fully understand the response, we must understand the spark that ignited it.

Part III — The System and the Shadow

Chapter 10 — The Origins Question

When the Story Began

By the time most of us first heard the word COVID-19, the story was already weeks old. In late 2019, reports emerged from Wuhan, China of a small cluster of patients with pneumonia of unknown cause. Images of masked clinicians circulated. A possible link to a wet market was suggested. There were early signs of something unfamiliar, but little clarity about what it meant.

At first, the explanation seemed familiar: a virus had jumped from animals to humans, as with SARS and MERS. That version fits neatly into the accepted pattern of nature's accidents—bats, markets, bad luck.

But as weeks turned into months, the pattern frayed.

The animal source was never found.

Genetic data appeared and disappeared.

Early patients had no connection to the market at all.

Something didn't line up.

Two Hypotheses, One Divide

By mid-2020, two competing explanations had taken shape:

- **Zoonotic spillover** — a virus jumping from bats (perhaps through another species) into humans.
- **A laboratory incident** — a virus under study at the Wuhan Institute of Virology escaping accidentally.

Both were plausible.

Both deserved inquiries.

Only one was permitted.

Scientists who raised the lab-origin question were shamed, exiled from professional circles, or silenced outright. Major journals dismissed the idea as a "conspiracy theory." The word *conspiracy* became a weapon, shutting down debate before evidence could even be examined.

One night over dinner, a friend told me he knew the virus came from a wet market because "a scientist friend" had assured him so. "Discussion OVER," he declared.

What stunned me wasn't his certainty, it was the way curiosity had been replaced by moral alignment. Believing in a natural origin became a virtue signal. Questioning labs became a mark of deviance. Good people believed in the right hypothesis. Dangerous people asked the wrong questions.

This collapse of inquiry into identity was the first sign that the Pandemic was no longer only biological, it had become cultural.

The Research Landscape: Building the Fire Before the Spark

Long before COVID-19, researchers were collecting and manipulating bat coronaviruses in the name of Pandemic prevention. This is not speculation. It is an established fact.

The Wuhan Institute of Virology was one of several labs engaged in this work, often in collaboration with EcoHealth Alliance, a U.S. based organization funded through the NIH and NIAID under Dr. Anthony Fauci. These projects included what many scientists would recognize as gain-of-function research, altering viruses to understand how they might infect humans more efficiently.

Supporters believed this work could avert Pandemics by helping us see them coming.

Critics warned the same work could cause the very disaster it sought to prevent.

Before COVID-19, U.S. agencies paused some of this research after safety concerns, only to resume it under new guidelines. The geographic and scientific overlap between this work and the first outbreak was too substantial to ignore, yet institutions worked very hard to ignore it.

I don't think that anyone in these labs sets out to destroy the world. Catastrophic mistakes rarely announce themselves; they arrive wrapped in confidence and good intentions. Pandemic prevention is a noble mission. But it rests on a perilous assumption: that the risks we create can always be controlled.

That assumption more than any single experiment, may be the real origin story of what followed.

EcoHealth Alliance: The Hidden Architecture

On paper, EcoHealth Alliance described itself as a global wildlife-health organization tasked with monitoring pathogens in the wild. The framing was benign, even reassuring, akin to a biological weather service for the planet. When Dr. Andrew Huff joined EcoHealth in 2014, he believed in that mission. Dr. Huff was trained in molecular biology and biochemistry and worked in government-adjacent biodefense and public health roles prior to joining EcoHealth Alliance. His earlier career included positions involving regulatory compliance, biosafety, and interagency coordination related to infectious disease research. That background positioned him as a liaison between scientific research and oversight frameworks rather than as a field virologist. But as he reviewed internal portfolios, grant pathways, and international partnerships, he concluded

that the "Pandemic prediction" narrative was moral packaging around something more unsettling. EcoHealth wasn't merely observing pathogens, it was collecting them, concentrating them, and in some cases modifying them. It was building a global library of highly dangerous viruses, including bat coronaviruses with Pandemic potential.

Huff refused a request to expand EcoHealth's operations in China. He warned Peter Daszak, EcoHealth's president that handing advanced biotechnology to the Chinese state could end badly. He claims Daszak saw the relationship differently: scientifically valuable, geopolitically advantageous, and financially rewarding. Huff eventually came to view Daszak as a cut-out — an intermediary through whom U.S. agencies could access Chinese laboratories while maintaining institutional distance. Whether that interpretation is ultimately correct remains an open question. What does appear clear, however, is that Pandemic research operated at the intersection of public health, funding, and intelligence. It was not a neutral space.

DARPA, DEFUSE, and the Recipe on the Table

In January 2018, EcoHealth and its Wuhan partners submitted a $14.2-million proposal to DARPA under the PREDICT program. It was called **DEFUSE**.

It outlined plans to manipulate bat coronaviruses, add cleavage sites, and test enhanced transmissibility in humanized systems. It may not have been SARS-CoV-2 as we came to know it, but it walked very near the same terrain.

By 2019, Huff had left EcoHealth. An unexpected job offer from DARPA soon followed, something he later interpreted as an effort to bring him "inside the tent" before his concerns went public.

When news of a novel coronavirus broke in early 2020, Huff already knew EcoHealth had been conducting gain-of-function-type experiments in Wuhan. He understood exactly what that combination, risky research, imperfect safety, and political pressure could mean.

Meanwhile, the World Health Organization assembled an investigative committee. In an irony so brazen it bordered on parody, Peter Daszak himself was appointed to the team visiting Wuhan.

"You take the guy who's responsible, you put him in charge of the investigation," Huff later said. "He's not going to tie it back to himself."

Whether Daszak is responsible in the manner Huff alleges remains contested. What is uncontested is the optics: the fox was not just guarding the henhouse, but he was writing the henhouse safety report.

Whistleblowing in a System That Cannot Afford Whistleblowers

By the time Huff wrote *The Truth About Wuhan*, he had concluded that the Pandemic was not a random accident of nature but the result of a reckless, internationally supported research architecture.

He also learned what happens to people who try to say that out loud.

Huff describes federal agents following him, his devices hacked, his home entered without permission, his car tampered with, his dog tased. "The goal," he wrote, "was to break me, not kill me."

You don't have to accept every detail to recognize the pattern. Throughout the Pandemic, those who questioned dominant narratives on origins, mandates, treatment, injury were not confronted in open debate.

They were marginalized. Investigated. De-platformed. Dismissed.

None were killed—a low bar for comfort, but comfort, nonetheless.

The through line is unmistakable: in a system that cannot admit grave error, whistleblowers are liabilities, not resources.

Sidebar: The *Proximal Origins* Paper — Science or Script?

If EcoHealth Alliance's work helped form the experimental backdrop to early SARS-CoV-2 research, the public narrative about the virus's origins was shaped largely by a single scientific article: "The Proximal Origin of SARS-CoV-2." Published in March 2020 by evolutionary virologists Edward C. Holmes, Robert F. Garry, Kristian G. Andersen, and colleagues, *Proximal Origins* argued that SARS-CoV-2 showed no clear signs of deliberate genetic engineering and that a natural spillover from animals was the most plausible explanation. The paper was quickly embraced by major journals, platforms, and many science communicators. Some platforms used it to justify limiting discussion of lab-associated origin hypotheses, and some journalists wielded it to shame or dismiss dissenting scientists.

But the internal record is more complicated. In the early weeks of 2020, private communications among some of the scientists who would become authors on *Proximal Origins* show that they explored whether the virus's unusual features — including its receptor binding domain and furin-cleavage site — could have arisen through laboratory processes. These early concerns are documented in released e-mails cited in government reports and testimony *(House Select Subcommittee on the Coronavirus Pandemic, Majority Report).*

By the time *Proximal Origins* was published, that exploratory language had disappeared from the text. The paper concluded in definitive terms that deliberate engineering was unlikely. Whether the shifts in emphasis were driven by scientific caution, evolving understanding of the data,

political pressure, or other factors, the *effect* on the public narrative was similar: an open question became widely treated as settled, and a hypothesis became, in some circles, a verdict.

In 2025, a scientific advisory panel convened by the World Health Organization released the Scientific Advisory Group for the Origins of Novel Pathogens (SAGO) Report on the Origins of SARS-CoV-2. The panel concluded that the weight of currently available evidence was most consistent with zoonotic spillover from animals to humans. At the same time, the report acknowledged that critical early data remain unavailable and that the precise origin of the virus has not been definitively established. Critics of the report have argued that limited access to early outbreak records and laboratory data in Wuhan makes firm conclusions difficult. As a result, the origin of COVID-19 remains an open scientific question, even as different institutions continue to advance competing interpretations of the available evidence. This is important, because when science is used to close uncertainty rather than explore it, it stops being science.

The Evidence and the Gaps

As time passed, gaps in the accepted narrative widened. No intermediate animal host has ever been found, despite extensive searches in wildlife and livestock. The virus contains features — including the furin-cleavage site in its spike protein — that are unusual among its closest known natural relatives.

Some prominent American intelligence bodies also weighed in. In 2023, FBI Director Christopher Wray stated publicly that the FBI had assessed that a lab-associated incident was the most likely origin of the Pandemic, even as that assessment was characterized as "low confidence." *(Wray, 2023)*

At the same time, some of the strongest clues lie in what remains unavailable. Chinese authorities have not released full laboratory records, comprehensive viral sequence databases from before late 2019, early clinical and epidemiological data from Wuhan in late 2019, or independent safety audit reports. The Wuhan Institute of Virology's database — containing more than 22,000 entries of coronavirus sequences — went offline in September 2019 and never returned. In any forensic inquiry, withheld evidence is itself a form of evidence of unresolved truth: not proof of guilt, but proof that uncertainty remains.

2025: When the Wall Finally Cracked

For years, linking EcoHealth's work to the Pandemic was treated as heresy. Then the official narrative began to shift.

In 2021, NIH deputy director Lawrence Tabak acknowledged that EcoHealth had violated grant terms and failed to report dangerous experiments.

In 2024, a U.S. House committee recommended debarment of EcoHealth and Peter Daszak for non-compliance, missing reports, and undisclosed research.

In early 2025, the Department of Health and Human Services banned gain-of-function research and debarred EcoHealth and Daszak from federal funding for five years.

Then came the clearest signal of all: On January 19, 2025, on his last full day in office, President Biden issued a pre-emptive pardon to Dr. Anthony Fauci, covering any federal offenses related to his tenure.

Publicly, it was gratitude. Privately, many saw an implicit acknowledgment that choices made under his watch, including funding high-risk research in Wuhan might one day invite prosecution. Senator Rand Paul declared the pardon "seals the deal" on responsibility.

Within hours, Donald Trump, in his second term, issued an executive order withdrawing the United States from the World Health Organization and freezing U.S. funding. A population that once trusted global authorities now flinched at their shadow.

And then, perhaps most telling of all, the CIA quietly revised its assessment: "The Agency assesses with low confidence that a research-related origin of the COVID-19 Pandemic is more likely than natural origin."

For years, those who questioned the official story were mocked as cranks. Now the world's most powerful intelligence institutions were, cautiously and belatedly, arriving at the hypothesis dissenters had been punished for proposing.

In the end, the greatest conspiracy theory may have been believing that asking questions was dangerous. Because when you ask them, you begin to see the full moral landscape: if this virus was engineered or altered, then the consequences extend far beyond the deaths counted in 2020. They reach into the slow, quiet erosion of memory itself, a pattern now visible in the emerging dementia data.

COVID-19, Vaccination, and Neurodegenerative Risk: What the Evidence Actually Shows

As research matures, a more complex picture is emerging around cognitive decline and neurodegenerative risk in the wake of the COVID-19 Pandemic. Dementia is not a single disease, but a clinical endpoint shared by multiple underlying processes, most commonly Alzheimer's disease, shaped by inflammatory, vascular, immune, and metabolic pathways. Early

public discussion largely framed neurological risk as a downstream consequence of infection alone. More recent population-level studies suggest a more complicated reality.

Large cohort analyses continue to show that SARS-CoV-2 infection itself, particularly when severe, is associated with later cognitive impairment. Hospitalization, prolonged inflammation, hypoxia, and microvascular injury appear to be key contributors. In this respect, the virus remains the clearest and most consistently observed driver of neurocognitive harm. Avoiding severe infection matters, and populations that experience less severe disease show lower long-term neurological risk.

At the same time, a 2024 nationwide retrospective cohort study from South Korea, analyzing more than 558,000 adults aged 65 and older, examined vaccination status independently of infection. Within this older population, vaccinated individuals showed a higher short-term incidence of both mild cognitive impairment and Alzheimer's disease compared to the unvaccinated, including among those without documented COVID-19 infection. Within three months of vaccination, the odds of a new Alzheimer's diagnosis were approximately 22 percent higher (odds ratio 1.225), while the odds of a new mild cognitive impairment diagnosis were more than doubled (odds ratio 2.377). The strongest associations were observed among recipients of mRNA vaccines. The authors emphasized that these findings were observational, time-limited, and did not establish causation, calling instead for further investigation into potential mechanisms and confounding factors (Roh et al., "Potential Association").

These findings do not demonstrate that vaccination causes neurodegenerative disease. But they do complicate the once-comforting assumption that vaccination is neurologically inert, particularly in older adults. Vaccination does not biologically insulate the brain from inflammation, endothelial injury, or immune stress. Its principal protective effect lies in reducing the likelihood of severe infection, where the most consistent and damaging neurological signals are observed. Once infection occurs, especially repeatedly, that protection becomes less certain.

What the evidence now suggests is neither simple nor reassuring. Severe COVID-19 clearly increases long-term neurocognitive risk. Emerging observational data indicate that vaccination, at least in certain populations and time windows, may also be associated with measurable changes in neurocognitive diagnoses. Both realities can coexist. Neither can be responsibly ignored.

If the virus arose through natural spillover, these findings still demand humility about the limits of our interventions and the trade-offs imposed by emergency decision-making. If, however, the virus originated from a

laboratory setting, the implications deepen further. In that case, a research-related pathogen would have contributed not only to mass mortality and systemic disruption, but also to long-term neurological harm through both infection and the global response to it. That possibility does not assign intent or prove causation. It does, however, collapse the distinction between natural catastrophe and human-created risk.

What follows from this is not accusation, but responsibility. The long-term neurological consequences of mass infection and mass intervention will unfold over years, not months. What is required now is not certainty, but honesty: a willingness to acknowledge uncertainty, to follow emerging evidence without defensiveness, and to reckon with the full biological footprint of decisions made under extraordinary pressure. Cognitive decline may prove to be one of COVID-19's quietest legacies. Whether it was unavoidable, mitigated, or compounded by human systems is a question that cannot be answered without transparency — and cannot be avoided without cost.

Why Would the United States Hand Over Dangerous Virology to China?

As I followed the threads—EcoHealth's involvement, DEFUSE, unreported experiments, shuttered databases, shifting narratives, one question kept surfacing, almost embarrassingly simple: Why would American agencies collaborate on high-risk pathogen research with one of the most authoritarian governments on the planet? Why take bat coronaviruses, genetic tools, chimeric constructs, and experimental platforms and place them inside a system built on secrecy, political obedience, and state control?

China's government has a long history of censoring scientists, detaining whistleblowers, suppressing findings, and controlling research through its doctrine of "civil–military fusion," where any civilian discovery can be appropriated by the state. This is the same government that enforced population control through the brutal one-child policy.

It is not irrational to question the prudence of handing dangerous research to such a partner. It is rational. It is responsible. In fact, it is the minimum standard of stewardship any democratic nation should expect from its leaders. When the work involves pathogens, dual-use technologies, opaque international collaborators, or laboratories with documented safety concerns, doubt is not paranoia, it is prudence. Oversight is not hostility; it is the duty of a government to protect its citizens from risks they cannot see and have no voice in managing. Asking hard questions is not a sign of conspiracy thinking; it is a sign of civic maturity. And refusing to ask them is not loyalty, it is negligence.

The official explanation, repeated by academics and officials, was that collaboration improves global safety. Sharing knowledge and samples, they said, would help predict Pandemics before they emerge. But that collapses under scrutiny. If safety was the goal, why outsource high-risk virology to labs with known biosafety issues? Why ignore intelligence warnings about China's ambitions in biotechnology and biodefense? Why trust a system with limited transparency and no independent oversight?

The contradiction is stark. The decision to partner with the Wuhan Institute of Virology did not emerge from wisdom. It emerged from a culture convinced that good intentions could override history, geopolitics, and human nature.

Look deeper and the explanation becomes clearer and darker. This was not a single decision but a convergence of incentives: scientific ambition, bureaucratic competition, diplomatic optimism, financial opportunity, and the intoxicating allure of cutting-edge research.

Western institutions believed transparency could be negotiated, safety assumed, ethical alignment willed into existence simply because Western actors were involved. It was hubris dressed as global cooperation, the old imperial mistake of assuming you can shape another regime without being shaped by it.

This isn't conspiracy. It is moral drift.

Over time, collaboration blurred into complicity. Funding streams, publication pipelines, and access agreements took precedence over sober risk assessment. The structure evolved into something no one fully controlled, least of all the public, whose safety depended on it.

Millions sensed this during the Pandemic without knowing the details. The crisis felt morally off-balance. Something in the ethical architecture had shifted.

And that failure of moral gravity mattered for another reason: it is the same vacuum that allowed private influence to shape the global response once the Pandemic began.

Gates, Power, and the Vacuum of Trust

As debates about laboratories deepened, one name surfaced everywhere: Bill Gates.

To some, he remained the philanthropist funding vaccination programs. To others, he became a symbol of unease—a private individual with disproportionate influence over global health, agriculture, climate policy, and digital ID systems.

Online, he was cast as mastermind, saviour, villain, prophet. The truth was less theatrical and more structural.

The Gates Foundation does fund global health programs, including vaccine development and distribution. It does invest in experimental platforms. There is no evidence of hidden vaccination through food or products, and no proof of a coordinated depopulation scheme.

Yet suspicion thrived.

Part of it came from his admitted association with Jeffrey Epstein, no crimes proven, but optics so toxic they could not be ignored. Part came from his 2010 TED talk about lowering projected population growth by improving vaccination and health care, a demographic fact interpreted, out of context, as something sinister.

But the deeper discomfort wasn't about conspiracy. It was about structure. Gates was a private citizen with influence rivaling nation-states. Through foundation work, advisory boards, pharmaceutical partnerships, academic grants, and media sponsorships, he became a gravitational center inside a system already losing its public accountability.

He pushed vaccination, strongly, consistently, publicly. On his website, he was unambiguous: **VACCINATE NOW**.

The vaccines Gates promoted and advocated people take caused injury. Gates has never stepped back from his position or addressed that harm.

This is not an accusation. It is context. Power without accountability breeds suspicion even when intentions are good.

The absence of proof does not equal guilt. But neither does it guarantee innocence. It reflects the reality that concentrated power often moves invisibly, beyond democratic oversight.

Millions sensed that the official story was incomplete, not because of conspiratorial thinking, but because trust itself had evaporated. Into that vacuum, deeper anxieties rushed.

Dark Forces at Play

There was a dimension of the Pandemic that science alone could not explain—a moral atmosphere millions of people felt but struggled to name. Even people who never used the language of "good and evil" found themselves reaching for it.

It wasn't mystical. It was the recognition that something in the ethical structure of society had faltered.

When institutions abandon transparency, people do not simply lose trust, they lose orientation. Reality becomes fog. Certainty becomes suspicion. Into that confusion, the psyche projects ancient patterns: darkness and light.

During the Pandemic, this undercurrent was everywhere. You heard it in whispered conversations, late-night phone calls, quiet admissions from people who no longer recognized their country.

It wasn't only policy failures. It was the tone of contempt for dissent, joy in punishment, the vanishing of compassion. It felt driven by something colder than public health. Not supernatural evil, but human forces: fear, ego, ideology, ambition, and control.

In Canada, the darkness was so intense that many unvaccinated people genuinely feared being interned in concentration camps. The Prime Minister himself asked how the country could "tolerate" the unvaccinated. Institutions can lose their moral bearings long before the public realizes it has happened.

When people said 'dark forces' were at play, they weren't talking about demons. They were describing the moral signature of systems that had drifted into ethical collapse.

The Pandemic was not only biological. It was spiritual and moral, a crisis of meaning, ethics, and truth.

Gaia and the Question of Origins

When scientists speak of Gaia, they describe a pattern: Earth behaves as though it is trying to stay alive. Oceans, forests, microbes, atmosphere all linked in feedback loops that maintain the narrow conditions where life thrives. Earth is a mostly closed system. We do not create; we rearrange. Every vaccine vial, phone, face mask, skyscraper, and cruise ship is Gaia's old bones reshaped. Seen from that perspective, our species' behaviour looks less like progress and more like a fever.

A wise teacher once put it bluntly: "There are far too many people. One day the Earth will shrug us off like a dog does fleas." As a young person, it scared me. As an adult, I hear it now as a reminder of scale, a reminder that we are not above the world but inside it, subject to forces older and deeper than our institutions.

Charlie Chaplin captured this truth in *The Great Dictator*, speaking from a different era yet speaking to ours:

> *We have developed speed, but we have shut ourselves in. Machinery that gives abundance has left us in want. Our knowledge has made us cynical; our cleverness, hard and unkind. We think too much and feel too little. More than machinery, we need humanity. More than cleverness, we need kindness and gentleness.*

Those words feel prophetic now. They read like a warning to a civilization that believed technology would save it, even as it quietly eroded the humility required to wield it.

Step far enough back and Gaia is indifferent to the door. What matters is that we created the conditions for the spark: ecological strain, global mobility, overcrowded systems, and risky research conducted inside a network that mistook ambition for foresight. Humans are not outside

nature. Our laboratories, technological pride, and carelessness are not exceptions to Gaia but expressions of her, extensions of the same evolutionary forces that produce storms, plagues, and collapse.

During the Pandemic, death terror pulsed through everything. For many, it was a psychic ambush, the first real confrontation with mortality. My father gave me that lesson early. I carry it still, mixed with fear and curiosity. I've resuscitated the dying. I've pulled children from the edge of death from drowning. I once did CPR on a man and brought him back from the dead. I've fought for my own life, narrowly escaping death a couple times. Gaia will recycle us without effort. What lingers are our choices.

Yet during COVID-19, society behaved as though the only tragedy that mattered was individual death from the virus, and that the only acceptable response was to reorganize civilization around avoiding that one risk. At a planetary scale, population levels are regulated by disease, famine, culture, war, and birth rates. None of them are gentle. To name that truth is not to celebrate suffering; it is to acknowledge reality.

We are not the main character. We are one species among millions.

The Origins question is therefore layered. Was the virus sparked by an animal, a lab, or both? How did global systems turn crisis into opportunity for fear and control? What is Gaia showing us about ourselves, our limits, and the illusions we've been living under?

I do not claim final answers.

But the story is incomplete without Gaia in the frame.

What the Origins Question Really Asks

Piecing all of this together—EcoHealth, Wuhan, DEFUSE, whistleblowers, pardons, CIA reversals, billionaire influence, Gaia's limits, I was not searching for villains. I was searching for explanations within confusion and noise.

The same principle that led me to question mandates led me here: If a system demands blind faith, it stops being science.

Maybe the virus came from nature. Maybe, and to my mind, far more likely, it came from a lab, another unintended consequence of a reckless experiment conducted in a system that rewarded ambition over humility.

Either way, the answer matters.

If it was a lab accident, global biosafety must be rebuilt from the keel up. If it was a natural spillover, we must confront the ecological and social conditions that made it possible.

In both scenarios, the world owes itself an honest reckoning.

The origin of COVID-19 is not just a historical question. It is a moral one.

Denial doesn't calm a storm at sea. It doesn't stop a virus either.

And it cannot rebuild the trust that collapses when institutions decide that uncertainty is too dangerous to acknowledge.

But once we ask where the virus came from, another question follows, one even more uncomfortable, and far more consequential: How did our world become so vulnerable in the first place? What infrastructure, what assumptions, what quiet ambitions made it possible for a single research program or a single ecological spillover to unleash crisis on a planetary scale?

Origins point us backward. Biosafety forces us to look forward.

Because whether COVID-19 emerged from nature or from a laboratory, the Pandemic revealed something deeper: a global system operating at the edge of its own competence, building technologies it cannot fully control, and trusting safeguards that no longer match the risks they are meant to contain.

The next chapter turns toward that system, toward the labs, policies, incentives, and scientific cultures that define the frontier of modern virology. This is a frontier where brilliance and danger now walk side by side.

This is the terrain of biosafety. And it is here the reckoning must continue.

Chapter 11 — Biosafety and the Next Time

Most of us went through life never thinking about biosafety. I certainly didn't. I worried about car crashes, drunk drivers, bad weather, dodgy wiring, and the usual hazards you notice when you work in injury prevention. Even living in Africa for years, I thought about malaria nets and road conditions long before I thought about how dangerous organisms were handled in labs. Biosafety sounded like something for specialists in white coats and thick glasses, tucked away in windowless basements, not a concept that would ever touch ordinary people buying groceries or sending their kids to school.

COVID-19 changed that. Suddenly, words like *lab leak*, *gain of function*, *BSL-3*, and *BSL-4* started floating through headlines and dinner-table conversations. Most people had no idea what those terms meant. They only knew they were now part of a highly charged argument about origins, blame, and trust. The conversation turned toxic so quickly that many Canadians did what humans do when something feels overwhelming and politicized: they tuned out. Biosafety became either a conspiracy topic or a taboo one.

Beneath the noise, the core idea is simple. Biosafety is about how carefully we handle the most dangerous forms of life on Earth. It is the discipline that decides which pathogens are studied, where they are stored, who is allowed to work with them, and what protections must be in place so that curiosity does not accidentally spill into catastrophe. At its best, it is the quiet, unglamorous guardian standing between high-risk research and the rest of the human family.

This chapter is not meant to terrify you. It is meant to be honest. If we are going to talk about trust, about institutions, and about how COVID-19 was handled, we also have to talk about the system that manages biological danger in the first place. To understand what went wrong, we have to revisit a virus far more lethal than SARS-CoV-2, a virus that taught the world how thin our margin of safety really was, and how desperately we needed humility.

The Lessons Ebola Tried to Teach Us, and the Reminder That Arrived in Denver

Ebola did not arrive with jets and laboratories. It emerged from the deep, humid cradle of Central Africa's forests. First recognized in 1976 along the Ebola River in what is now the Democratic Republic of Congo, the virus appears to have crossed into humans from infected wild animals, most likely bats, with chimpanzees and other mammals as occasional intermediaries. Once inside a person, it spreads not through the air but

through intimate contact with blood, vomit, or other bodily fluids, turning acts of care like washing a body, tending a fever, holding a loved one into pathways of lethal transmission.

Ebola's terror wasn't only its brutality. It was the setting it chose. Early waves hit hospitals that were already fighting for survival on ordinary days, places where staff worked heroically despite shortages of everything from gloves to electricity. When a virus with catastrophic fatality arrives in that environment, collapse is not surprising. It is almost guaranteed. It wasn't incompetence. It was reality. And that reality exposed an uncomfortable truth: global biosafety is only as strong as the most resource-strapped clinic where the spark first lands.

In the mid-2010s, Ebola forced the scientific world to stare directly into the moral mirror of high-risk work. The virus did not spread easily, but when it found its way into a body, the consequences were catastrophic. The world watched health-care workers in West Africa fight for their lives inside plastic suits under equatorial heat. Mortality climbed as high as seventy percent in some outbreaks. The response in the scientific community was solemn. Conferences filled with cautious presentations. Governments reviewed biosafety protocols with a kind of reverence. For a moment, it seemed as though the lesson had landed: scientific capability must never outrun ethical boundaries.

Ebola's devastation made a simple truth hard to ignore: the world cannot afford even small mistakes with high-consequence agents.

Many believed virology would be permanently reshaped by restraint. But as the years passed, memory faded. Ambition returned. Research accelerated. Promising technologies created optimism, and optimism dulled caution. Laboratories broadened their portfolios as global funding and scientific interest shifted. Programs that once focused narrowly on classical virology expanded into emerging pathogens, synthetic biology tools, and zoonotic spillover research. High-containment facilities expanded worldwide. The field grew in scope, confidence, and speed.

A subtle drift followed. The line between what was permissible and what was prudently avoided began to blur. Funding mechanisms rewarded boldness. University review boards, once strict guardians of precaution, found themselves under pressure not to obstruct scientific prestige or the grant revenue that sustained entire departments. The lesson Ebola etched into memory, go slowly, go carefully, go humbly, was gradually overshadowed by the belief that cutting-edge research justified cutting-edge risk.

By the time COVID-19 arrived, the world had drifted into an era where high-risk research was increasingly framed in the language of innovation rather than the language of restraint.

'High-risk research' does not mean villainy or secrecy. It often refers to perfectly legal, heavily funded work that pushes the boundaries of modern virology: studies on viral transmissibility and host range; experiments involving chimeric or recombinant viruses; investigations into how pathogens adapt, jump species, or evolve; and the rapid expansion of synthetic biology tools that allow scientists to modify viral genomes with unprecedented ease. These fields are frequently justified in the name of Pandemic preparedness and global health security and often produce valuable insights. But they also narrowed the psychological distance between basic research and the outer edge of biosafety.

Then, in 2023, a quieter reminder surfaced far from the forests of Central Africa.

A small announcement emerged from the University of Colorado Anschutz Medical Campus that almost no one outside scientific circles noticed: a group of nurses volunteered to receive an investigational Ebola vaccine as part of a controlled clinical trial. The study was legitimate, regulated, and conducted under rigorous oversight. No one was infected with Ebola itself. The vaccine used a viral vector designed to stimulate immunity, not cause disease.

To understand why this happened in Denver, you must understand what Anschutz is. It is one of the largest academic medical campuses in the United States, a hybrid environment where elite biomedical research sits directly beside major hospitals. It houses the Colorado School of Public Health, UCHealth University Hospital, Children's Hospital Colorado, and multiple federally funded institutes specializing in infectious diseases, immunology, and vaccine development.

It is not a maximum-containment facility. It does not handle live Ebola. What it does have is something equally essential: world-class infrastructure for early-phase trials, and a deep bench of clinicians whose professions may one day place them in outbreak zones around the world. Colorado nurses, physicians, and public-health responders are routinely deployed into global emergencies. This trial was designed for exactly that population: frontline workers who might one day confront Ebola in the field and who benefit from immunity before stepping into danger.

The Denver trial itself was not the problem. It was ethical, cautious, and protective of its volunteers. Yet its symbolism mattered. Ebola, the virus that once overwhelmed clinics without gloves, water, or electricity, was now being confronted inside one of the wealthiest biomedical systems

on Earth. It represented progress. It also revealed something about trajectory.

The concern is not that Denver crossed a line. It is that it showed how rapidly our capabilities accelerate, and how slowly our cultural and regulatory frameworks evolve in comparison. New platforms and genetic tools appear each year. What once required decades now unfolds in months. As our tools sharpen, our margin for error narrows.

Ebola was the warning shot. Denver was the reminder. Our biosafety choices are no longer theoretical. We now live in an age where humanity can both prevent and create danger, sometimes with the same technologies. The question before us is not whether research should exist. The question is whether oversight, transparency, and restraint are keeping pace with the power now in human hands.

The Ethics of Risk: Who Decides What Danger Is Acceptable?

Every generation inherits a set of risks chosen by the generation before it. In virology, those choices are made not only by scientists, but by committees, funders, policymakers, and cultural attitudes toward what is considered "acceptable danger."

For decades, the calculus relied on a simple premise: the benefits of advancing biomedical science outweighed the remote possibility of laboratory error. For many years, that assumption felt reasonable. Systems appeared to work. Accidents were rare, or at least rarely public.

The past decade fractured that certainty. Not because scientists became reckless caricatures, but because the frontier of biological capability expanded faster than the ethical scaffolding built to restrain it. We now live in a world where it is possible to modify viruses with extraordinary precision, to recombine genetic elements, and to study pathogens that earlier generations could not safely handle outside a small number of high-containment facilities.

That expansion demands a matching expansion of humility. Humility is not weakness. It is the discipline that slows us down, forces restraint, and acknowledges risks we cannot yet predict. Instead, we witnessed a cultural trend toward speed, prestige, and confidence, the belief that the ability to do something increasingly justified doing it.

This is the biosafety dilemma: who decides when the risk is too great?

Is it the scientists performing the work, who may sincerely believe they are protecting the world? Is it funding agencies eager for breakthroughs? Security officials trying to anticipate threats? Politicians advised by experts who may themselves be shaped by institutional incentives?

What was once a technical question becomes a political one the moment consequences can travel beyond the lab.

And it is precisely here that the public is largely shut out. Most people never had a meaningful opportunity to weigh the risks and benefits of controversial research pathways. They never participated in debates about gain-of-function studies, bio-surveillance programs, or experiments involving novel chimeras, artificially created organisms or viruses formed by combining genetic material from two or more different sources that would not naturally mix on their own. Decisions were made behind closed doors, with the public informed only after the fact, if at all.

When COVID-19 erupted, the public's questions about biosafety levels, laboratory practices, containment standards, and funding oversight collided with a culture that struggled to answer plainly. What should have been a moment for transparency became a moment of defensiveness. Complexity met slogans. Anxiety met dismissal. Honest questions met moral accusation.

The outcome was not surprising. Trust contracted. Suspicion grew. The conversation about origins and biosafety became as polarized as every other part of the Pandemic.

The ethical crisis is not merely about pathogens. It is about governance. A system that determines global biological risk must be accountable to the people who bear the consequences of its failures. Transparency is not a luxury. It is the firewall that prevents power from drifting into arrogance.

The question that now hangs over the 21st century is stark but necessary: What risks do we have the right to impose on billions of people without their knowledge or consent?

Until we answer that honestly, biosafety remains less discipline than a gamble, one in which the public never agreed to play.

Inside the Fortresses: Containment, Geography, and the Expanding Map of Risk

Ask the average person where the world's deadliest pathogens are stored and they'll picture something cinematic, sealed vaults, underground bunkers, rooms filled with blinking lights and retina scanners. The reality is stranger, and more unsettling. These organisms, Ebola, Marburg, Nipah, engineered avian influenza, viral hemorrhagic fevers, and other high-consequence agents, are stored and manipulated in buildings that often sit beside suburbs, university campuses, industrial parks, and major hospitals.

These facilities are called Biosafety Level 3 and Biosafety Level 4 laboratories. BSL-4 is the top tier: positive-pressure suits, airlocks, negative pressure, dedicated exhaust systems, and infrastructure designed to withstand both mechanical and biological catastrophe. BSL-3 is a step below but still used for pathogens capable of serious illness and, in some cases, airborne spread.

These facilities were built on a promise: that humanity could handle the most dangerous organisms on Earth without letting a single microscopic mistake slip past the glass.

History does not support that promise.

Even in advanced systems, containment failures and procedural breakdowns occur. Ventilation systems malfunction. Wastewater systems fail. Equipment tears. Labels are misread. Vials are mishandled. A "minor incident" becomes a quiet memo. A quiet memo becomes a forgotten lesson. In an ecosystem that depends on perfect compliance, the smallest human lapse can matter.

This is the part of biosafety most people do not understand until the topic touches their lives: containment is not only engineering. It is a culture. It is a willingness to report errors, to tolerate embarrassment, to allow scrutiny, and to learn publicly. When reputation, funding, and political relationships depend on appearing flawless, the incentive is often to minimize and move on.

That is how near misses become invisible.

The other element the public rarely sees is geography.

Around the world, more than fifty nations operate BSL-3 facilities. BSL-4 laboratories exist across North America, Europe, Asia, and Australia. When you map them, many are not isolated outposts. They sit in or near metropolitan regions, university districts, and transport corridors, close to the talent and partnerships that research depends on.

Winnipeg's high-security laboratory sits inside a major Canadian city. High-containment work exists in major American hubs. European laboratories are embedded in metropolitan areas. The point is not to panic about any one location. The point is to recognize the nature of distributed risk.

Modern virology has placed its most dangerous vaults in precisely the places where failure would have the widest consequences.

Not because anyone sought harm, but because systems reward proximity: proximity to universities, to hospitals, to funding, to collaboration, to prestige. The public is rarely consulted about the placement of this risk, and rarely given enough information to judge whether oversight is as strong as officials imply.

On paper, these facilities are fortresses. In practice, they are staffed by human beings, tired, pressured, ambitious, and fallible. If safeguards depend entirely on everyone, everywhere, getting everything right all the time, then 'containment' becomes a fragile promise.

This is why biosafety cannot remain a specialist topic. The risk is not confined to the people who work behind the glass. It is distributed, structural, and in the event of failure, it becomes everyone's problem.

All of this can still feel abstract, like dangerous architecture concealed behind ordinary brick and glass. But the danger is not theoretical. It is structural. It is the expansion of high-consequence capacity without matching expansion of public accountability, and without a culture of transparency strong enough to survive mistakes.

The Anthrax Legacy: Why 2001 Should Have Changed Everything

Long before the world learned the word "coronavirus," another microscopic threat revealed how fragile modern biosafety truly was.

In the fall of 2001, envelopes filled with weaponized anthrax spores were mailed to newsrooms and U.S. senators. Five people died. Seventeen were injured. A nation already traumatized by September 11 faced a second wave of fear, not from hijackers, but from a bacterium that fit inside an ordinary letter.

The official investigation pointed inward, not outward. It concluded that the spores originated from within the American biodefense ecosystem. Whether one agrees with every detail of the final attribution is not the central point here. The central point is this: a catastrophic biological event was linked to the very system designed to prevent catastrophic biological events.

That should have been the turning point.

If the world had been honest at that moment, the response would have been a root-and-branch reconstruction of global biosafety: strict limits on high-risk research, a re-evaluation of which pathogens should be held at all, and a transparent international oversight framework stronger than anything that existed. Instead, the opposite happened. Governments expanded biodefense programs. Budgets increased. More labs were built. More pathogens were collected. More research accelerated.

The lesson anthrax should have taught was simple: even the most secure institutions are not impermeable.

Anthrax also revealed something deeper. Once a dangerous organism escapes containment, whether intentionally or accidentally, the consequences are no longer scientific. They are political, social, and psychological. People do not forget that a few grams of powder shut down the U.S. Senate. They do not forget the feeling of invisible threat moving through ordinary systems like mailrooms and office corridors. They do not forget that a place built to protect the public can also be the source of terror.

And yet, instead of responding with restraint, much of the world responded with expansion.

Anthrax should have been the fire alarm. It became a footnote.

COVID-19 forced the world to confront a truth anthrax had exposed twenty years earlier: our biosafety architecture is engineered for success, not for failure. Any system that refuses to imagine failure will meet it unprepared.

The Illusion of Control: Why the Real Threat Is Cultural

At this point the reader may feel the temptation to reach for reassurance. Better protocols. Better equipment. Better training. More oversight. All of that matters. But it is not the foundation of safety.

The foundation is culture.

Modern systems like to speak the language of mastery: containment, prediction, control. These are comforting words in a world that fears uncertainty, and virology has leaned heavily on them. Engineers point to redundant systems. Biosafety officers point to checklists. Officials point to layers of review. It creates the impression that failure can be designed out of existence.

But every high-containment lab is built around a quiet impossibility: it depends on fallible humans sustaining perfect vigilance indefinitely.

The greatest variable is not the pathogen. It is the human being.

A technician in a hurry. A door not fully sealed. A mislabeled vial. A needle stick. A protocol skipped because 'it's never been a problem before.' These are not dramatic movie scenes. They are ordinary errors. In a high-consequence environment, ordinary errors can carry extraordinary weight.

The deeper issue is not that scientists are immoral. Many are brilliant, dedicated, and ethically grounded. The deeper issue is that institutions are often incentivized to protect reputation, funding, and political relationships. In that climate, disclosure becomes risky. Minimization becomes normal. Silence becomes a habit.

And silence is how risk becomes cumulative.

COVID-19 revealed this cultural fragility. Instead of treating biosafety and origins questions as legitimate areas of inquiry, much of the public conversation became a loyalty test. Whether the virus emerged from nature or from a human system, one fact remains: the culture surrounding the question often leaned toward closure rather than curiosity, toward policing rather than transparency.

The illusion of control does not merely comfort. It corrodes. It turns caution into taboo. It turns doubt into deviance. It teaches institutions to equate credibility with certainty, and certainty with authority.

That is the real biosafety risk. Not only the risk of an accident, but the risk of a system that cannot admit uncertainty, cannot tolerate scrutiny, and cannot learn publicly.

The real threat is not the organism in a freezer.

It is the belief that human systems will never have to answer for the moments when they fail.

What 'The Next Time' Looks Like, Unless We Change

When COVID-19 struck, the world treated the event as if it were a once-in-a-century disaster. That belief is soothing, but it is false. Biology does not run on our timelines. Laboratories do not operate on superstition. Pathogens do not care whether humanity is 'ready,' or 'deserving,' or 'done learning its lesson.'

If nothing changes, the next Pandemic will not look like COVID-19. It could look much worse.

SARS-CoV-2 spread efficiently but killed selectively. It devastated the elderly, the immuno-compromised, and those with chronic disease. It overwhelmed fear long before it overwhelmed hospitals. But nature, and laboratories, hold organisms with characteristics far more lethal. Ebola leaves little room. Marburg leaves little room. Nipah leaves little room. H5N1 in its deadliest form leaves little room.

A virus with the transmissibility of SARS-CoV-2 and the lethality of those pathogens would not merely strain society. It would fracture civilization. Supply chains, governance, trust, food distribution, medical systems, global trade, all would seize. The modern world, built on just-in-time everything, is far more fragile than it advertises.

Worst case scenarios are not melodrama. They are what happens when systems engineered for efficiency collide with biological reality.

The danger is not hypothetical. It is structural.

Dozens of laboratories worldwide now explore, modify, and catalogue organisms that human immune systems have never encountered. Some labs operate with strict professionalism. Others operate under political pressure, opaque funding, or competing national interests. Still others operate in countries where transparency is not a cultural norm but a liability.

If the world continues building biological capability without building accountability strong enough to match it, the question is not whether the next crisis comes, but what form it takes:

A misclassified sample handled outside intended conditions. A researcher infected not by a dramatic breach, but by a microscopic lapse. A pathogen with mild early symptoms and catastrophic late ones. A 'near miss' that is not a miss.

COVID-19 exposed these seams, but the gears keep turning: more grants, more labs, more cataloguing, more partnerships with uneven safety cultures and competing geopolitical priorities.

Unless the biosafety system is rebuilt from first principles, the next Pandemic will be shaped not only by nature's power, but by our refusal to accept limits.

There will be a next time.

Only the timeline is unknown.

Why Biosafety Is Now a Moral Question, Not a Technical One

The deeper problem is not technical but moral. As Huff told Tucker Carlson, and as McCullough and Orient each suggested, safety ultimately depends on ethical people. And that, they implied, is precisely where modern science is weakest: not in intelligence, but in character. In the end, biosafety is not a story about airlocks, HEPA filters, or negative-pressure rooms. Those are tools, important and sophisticated tools, but they are not the foundation of safety.

The foundation is the character of the institutions entrusted with power. Cardiologist Peter McCullough was blunt. With 13 major U.S. biosecurity labs, more than 140 BSL-3 facilities, and multiple BSL-4 labs handling the most dangerous organisms on earth, he argued that another leak is not a question of if but when. A funding ban, he warned, is not enough. If national governments retreat, private foundations or hostile states can finance the same research under different flags.

COVID-19 revealed that our global virology ecosystem rests on a dangerous misunderstanding: that technical capacity can compensate for moral failure. If we stack enough protocols, alarms, and engineering controls, human beings can be factored out of the equation. But human beings were never the problem to be eliminated. They were the responsibility to be acknowledged.

The Pandemic taught us that secrecy is not protection. Censorship is not safety. Shaming dissent is not science. Ignoring near misses is not wisdom. Building more labs without building more accountability is not progress.

The moral question is simple: can a society that cannot tolerate honest scrutiny be trusted to handle catastrophic risk?

The last few years answered that with unsettling clarity. Institutions protected pride before protecting the public. Experts defended narratives before defending truth. Governments treated questions as threats, and citizens asking them as enemies.

Rebuilding biosafety will require something rarer than technology. It will require humility. It will require admitting that human beings, even brilliant ones, make mistakes. It will require accepting scrutiny from outside the club. It will require treating dissent not as contamination, but as the air circulation that keeps science alive.

It will require a cultural shift as dramatic as any scientific breakthrough. That shift means moving from ambition to responsible restraint, not because innovation is evil, but because power without humility is danger without a name.

If the world cannot rediscover humility, then the next spark, whether from nature or a lab, will find us exactly as we were in 2020: unprepared, divided, and guided not by courage but by fear.

The story of biosafety is not just technical. It is a warning. A crossroads. It is where science, morality, and human frailty collide.

If we choose humility, we may yet navigate the future with wisdom.

If we choose hubris, we will sail blind into the storm, something only the foolhardiest of captains ever do.

The next Pandemic will not wait for us to mature.

The question is whether we will decide before it arrives.

For Those Who Carried Fear Quietly

In the end, biosafety is not only a story about laboratories and pathogens. It is also a story about the human heart, about how we live with uncertainty in a world that never stops reminding us how fragile we are.

The people who felt afraid and anxious during the Pandemic were not overreacting. They were responding to a world that shifted under their feet. But fear does not have to hollow us out. Fear can also teach us to find steadier ground: the rhythm of our breath, the warmth of a kitchen at night, the quiet strength of a friend who listens, the calm that comes from putting our hands on the earth and remembering that life still moves through us.

Anxiety grows when we cling to the illusion of control. It softens when we learn to return, again, to the present moment, to what is real, what is near, what is ours to hold. We cannot command the world, but we can cultivate resilience, connection, and a kind of gentle defiance against fear.

If this chapter warns us about the dangers of overconfidence, let it also remind us of the power of tenderness: the choice to meet uncertainty not with panic, but with compassion, for ourselves, for each other, for the trembling animal inside every one of us that only wants to feel safe.

For those who lived through the long night of the Pandemic with a knot in their chest, this truth is yours: you were never alone, and your courage was quieter, and greater, than you knew. And perhaps that is the deeper fault line the last few years revealed. Not between the vaccinated and the unvaccinated, nor between experts and dissenters, but between those who confront uncertainty with humility and those who try to dominate it.

That divide is not new. It runs through our sciences, our politics, our technologies, and our dreams for the future. It runs through the human

desire to perfect what is fragile, to optimize what is already enough, to engineer away the parts of life that frighten us.

The Pandemic merely revealed the logic already gathering beneath our feet, a vision of humanity that treats biological limits not as guides but as obstacles, and that sees the human body less as a living inheritance than as a platform awaiting upgrades.

This is where the story turns.

Because the next frontier is not only biosafety, nor public health, nor governance.

It is the human being itself, the programmable citizen, the modifiable body, the engineered self.

And if the Pandemic revealed how quickly institutions can overreach, the emerging world of transhumanism asks a deeper question still: what happens when the target of that overreach is not our behavior, but our biology?

Chapter 12 — Transhumanism: The Engineered Self

This chapter explores how medicine, technology, and ideology are converging to turn the human body into something increasingly programmable and modifiable. From mRNA platforms and CRISPR, to youth identity debates and MAID, it asks one of the central questions of the time we live in: Who will own the human body in the decades ahead? The individual, or the systems that claim to care for us?

The Human Dream of Improvement

Humanity has always longed to transcend its limitations. From the first herbal poultice pressed onto a wound, to corrective surgeries that restore sight, mobility, and function as bodies age, our desire to heal is one of the most luminous qualities we possess. Laser eye surgery, knee and hip replacements, and organ transplants are not acts of hubris. They are expressions of care. We suffer, so we invent. We weaken, so we discover. We love, so we search for ways to keep each other alive a little longer. Medicine, in its purest form, is an act of compassion.

But transhumanism, the belief that human beings should consciously engineer their own evolution, represents a different impulse. It marks the shift from healing to redesign, from tending to vulnerability to re-architecting the body itself. Under this paradigm, the body is no longer simply a living organism. It becomes a platform, a system that can be modified, optimized, and upgraded.

In the wake of COVID-19, this shift did not merely accelerate. It normalized. The language of computing merged with the language of biology. The body became hardware. The mind became software. Immunity could be programmed. Genetic instructions could be updated. These metaphors are revealing. They reflect a worldview in which human biology is increasingly treated as system architecture rather than lived experience.

This is no longer speculative. These ideas are operational. We are not watching the future approach. We are living inside its first draft.

From Healing to Engineering: The Origins of Transhumanism

Transhumanism did not erupt suddenly from science fiction or Silicon Valley bravado. It emerged gradually across the twentieth century as a fusion of philosophical longing, technological ambition, and a modern impatience with biological limits. Its earliest roots run through the Huxley family, a symbolic split at the birth of the idea.

Julian Huxley, evolutionary biologist and later the first director of UNESCO, argued that humanity could transcend itself" through science, selectively steering its own evolutionary path. His brother Aldous,

witnessing the same optimism, responded with a warning instead of a plan. Brave New World imagined a society that achieved stability and efficiency by sacrificing freedom, dignity, and depth.

Between Julian's faith in progress and Aldous's fear of engineered obedience lies the moral fault line that still defines the debate: whether self-directed evolution represents liberation, or the quiet erosion of what makes us human.

By the late twentieth century, as computers shrank and genetic tools expanded, transhumanism coalesced into a formal movement. Futurists like FM-2030 described humanity not as a fixed species, but as a transitional phase. Max More articulated "extropy," a philosophy of continual self-overcoming through technology and will. Ray Kurzweil popularized the idea of the technological singularity, reframing death as an engineering problem rather than an existential boundary.

At the same time, critics such as Nick Bostrom warned that the same tools promising enhancement also carried existential risk. Intelligence without wisdom, capability without conscience, and systems that outpaced moral restraint could fracture humanity rather than elevate it. As technological power grew, so did public unease. The speed of change was beginning to exceed society's capacity to understand it.

Engineering the Body

The 21st century transformed these debates from abstractions into realities.

CRISPR made it possible to edit DNA with unprecedented precision. Neural interfaces began collapsing the distance between thought and action. mRNA platforms demonstrated that cells could be instructed to manufacture proteins on command. Artificial intelligence advanced at a pace evolution could never match.

For the first time in history, humanity holds not only the power to cure disease, but the power to alter the mechanisms that produce life itself. The question is no longer whether we can transcend biological limits. It is whether we understand the ethical weight of doing so, and who gets to decide what improvement means.

CRISPR shattered the line between inheritance and choice. Diseases that plagued families for centuries may vanish, but so might traits deemed inconvenient. When heredity becomes editable, the story of the species itself becomes subject to revision.

Neural interfaces offer extraordinary restoration for those who have lost function. Yet the same path that leads to recovery also leads to augmentation. When thought becomes readable and actionable by

machines, the inner world, once the final refuge of privacy, risks becoming accessible terrain.

mRNA technology applies the logic of software to biology. Instead of delivering a drug, it delivers instructions. The body becomes both factory and pharmacy. This represents a scientific leap of immense promise, but also a reframing of medicine itself, from intervention to programming.

Because this platform has only existed at global scale since 2020, long-term data does not yet exist. Humanity is, by definition, the long-term cohort. This does not imply harm, and because it's new technology, we must admit there could be drawbacks. It implies responsibility. Technologies that operate at the level of cellular instruction demand humility, transparency, and oversight equal to their power.

Living Inside the Experiment: Vaccines and the Threshold of Programmability

The COVID-19 Pandemic revealed something difficult to ignore: the boundary between high-risk biological research and the development of its countermeasures may be thinner than we once assumed. If the virus did emerge from laboratory activity, as several intelligence agencies have acknowledged as plausible, then humanity has entered a new feedback loop of invention and intervention.

This is not an accusation of malice. It is an observation about speed, complexity, and blind spots. Biotechnology has advanced faster than the ethical and regulatory systems designed to guide it. The laboratory is no longer separate from life. Its consequences spill outward into the world.

Increasingly, we are not outside the experiment. We are inside it.

Vaccines have saved millions of lives. The malaria vaccine alone may save tens of thousands of children each year. I am not opposed to vaccines. But genetic-instruction platforms represent a meaningful shift in how medicine engages the body.

Traditional vaccines introduce antigens that train the immune system. mRNA platforms introduce biological code that instructs cells themselves. This distinction matters. It does not imply permanent genetic alteration, but it does introduce a new concept into public consciousness: that the body can receive and execute instructions much like a device receives updates.

Once a society accepts biological programmability at scale, the horizon of what becomes acceptable expands. Today, mRNA instructs cells to produce viral proteins. Tomorrow, the same delivery systems may signal tissue regeneration, metabolic alteration, or immune enhancement. This is not speculation. It is the stated ambition of the field.

The ethical question is not whether such tools can heal. It is where the boundary lies between treatment and optimization, and who holds authority over that boundary.

Malaria, East Africa, and the Captain's Dilemma

For me, these questions are not abstract. As I prepare for a possible voyage across the Pacific and westward toward Africa, I hope to sail down the Eastern African coast, a region where malaria claims hundreds of thousands of lives each year and the issue becomes deeply personal. Along the coasts of Kenya, Tanzania, Mozambique, and Madagascar, *Plasmodium falciparum* stalks the night, capable of killing a child within 24 hours and incapacitating an adult nearly as fast. In a remote anchorage, evacuation may be impossible; a fever at sunset can become a funeral at sunrise.

New malaria vaccines such as RTS, S (Mosquirix) and R21/Matrix-M began rolling out across Africa between 2023 and 2025. They are imperfect, multiple doses, waning protection, cold-chain challenges, and trials measured in thousands rather than millions. And yet they save lives, especially children.

When I picture myself dropping anchor off Lamu, Zanzibar, or Bazaruto, the question ceases to be ideological. It becomes a mariner's calculus: not "Do I trust the pharmaceutical system?" but "Do I believe malaria could kill me?"

Vaccines do always not erase risk. But neither does refusing them. Navigating between these poles—history, humility, science, and skepticism, is the essence of informed consent. It is the very thing the Pandemic stripped away.

Engineering the Person Before the Body

Before bodies are engineered, minds are shaped.

Children today grow up inside an ecosystem of influence unlike any generation before them. Screens, algorithms, social media, vaccines, and AI-mediated systems shape how they see themselves and the world. Childhood is no longer insulated from technological, medical and cultural experimentation.

As Pandemic tensions spilled beyond virology, schools became a proxy battlefield. Claims emerged accusing educators and the education system of manufacturing sexual orientation identity, and or steering children toward bodily modification, including biological sex changes. Having worked for two decades inside education, I do not believe those claims reflect reality. Schools do not create or manipulate identity. They provide language, and a frame for experiences that already exist. Teaching children that diversity exists is not indoctrination. It is acknowledgment.

This does not mean institutions are beyond scrutiny. Influence matters. Boundaries matter. Age matters. Understanding identity is not the same as altering biology, and protecting children requires holding multiple truths at once: identity is real, suffering is real, and institutional overreach is also possible.

I want to be careful here, because accuracy matters. In my own experience, I have never seen educators encourage children or teens to pursue medical transition or biological sex changes. What I have seen, and what I believe is possibly more common, is that educators may be asked to respond when a young person raises the subject themselves. That is a fundamentally different situation. Responding with care, listening without panic, and ensuring a student feels safe is not the same as directing them toward a specific medical pathway. Conflating those two realities has created unnecessary fear and has made honest conversation harder than it needs to be.

Children and teenagers are still developing, and they deserve protection from irreversible decisions made too early. No institution or adult should be steering them toward permanent bodily alterations while their identity, psychology, and future capacity for consent are still unfolding. The deeper point is this: when influence becomes normalized early in life, intervention becomes easier to normalize later. A society that grows comfortable shaping the self culturally becomes more receptive to shaping the body technologically. It is my belief that we must tread carefully in all matters involving modification of the human body, even if it involves protecting ourselves or others against pathogens.

Decommissioning Under Pressure: MAID

If transhumanism represents the construction and optimization of the human body, MAID represents its decommissioning. These are not opposites. They are reflections of the same philosophical terrain.

I support MAID for those at the end of life facing irreversible suffering. Autonomy includes the right to decline intervention and the right to choose a dignified death. My concern is not with MAID itself, but with the pressures surrounding it.

It is not a conspiracy to acknowledge that MAID also intersects with economics. Peer-reviewed research in the Canadian Medical Association Journal and estimates from the Parliamentary Budget Officer conclude that assisted dying reduces healthcare spending, largely by shortening the most medically intensive phase of life.

In 2021 alone, the Parliamentary Budget Officer projected net savings of approximately $149 million under existing eligibility criteria. These savings are modest relative to total healthcare spending, but they are real. While

some analysts extrapolate these figures into much larger long-term projections, those estimates remain speculative.

What matters is not the size of the savings, but the structural reality they reveal. In an overwhelmed healthcare system marked by staffing shortages and capacity collapse, early death can quietly become a path of least resistance. These incentives do not prove conspiracy. They reveal pressure. And pressure, left unexamined, has a way of shaping policy without ever announcing itself.

A society that optimizes bodies at one end of life and streamlines death at the other risks turning human existence into a system to be managed rather than a life to be honoured.

The Spirit That Cannot Be Engineered

Technology will continue to evolve. That is certain. The question is whether we remain sovereign within ourselves as it does.

Transhumanism promises transcendence, but it also tempts us to forget what cannot be optimized: conscience, dignity, and the right to say no. The inner life cannot be engineered. It can be measured, influenced, or monetized, but not replaced.

We can use these tools. We can honour their potential. But we must not surrender authorship of our bodies or our lives to systems that move faster than wisdom.

Transhumanism asks how humanity can redesign itself. The deeper question is whether it can do so without surrendering humility, consent, and moral restraint to forces that view the body primarily as a site of management and extraction.

The next chapter turns to that question directly.

Chapter 13 — Big Pharma: Power, Profit, and the Pandemic

There are industries that quietly sustain civilization, and others that shape it from the inside out. Pharmaceutical corporations do both. They are capable of extraordinary good, preventing disease, extending life, easing suffering, and, as I learned, while writing this book with my own back and arm racked in pain, offering relief that can make a day bearable. Yet they also resemble the tobacco and alcohol industries: they have caused immense harm while still managing to shape policy and public perception in their favour. Pharma is uniquely paradoxical, producing medicines that heal and medicines that harm, all within a structure less moral than mechanical. Beneath every breakthrough lies a machine governed not by compassion but by incentives, protections, and political alliances that no democratic society ever consciously chose.

The Pandemic ripped away the last illusions about this duality. What emerged was not a cartoon conspiracy but something subtler and far more dangerous: a system that cannot be sued, cannot be slowed, and rarely answers to the people it claims to protect. This system shapes public policy more intimately than many elected bodies yet remains insulated from the accountability that defines a free society.

The Legal Shield That Changed Everything

Once liability disappeared, the entire system changed overnight. In early 2020, most citizens had no idea that vaccine manufacturers were protected by an extraordinary legal fortress. The shield began with the U.S. PREP Act, signed in 2005 under President George W. Bush and activated for COVID-19 by Health and Human Services Secretary Alex Azar in March 2020. With that declaration, corporations like Pfizer and Moderna became immune from civil liability for injuries caused by their COVID-19 vaccines, a level of protection unprecedented outside the nuclear industry.

Injury claims could not proceed to court. Instead, the injured were redirected into the Countermeasures Injury Compensation Program, an obscure administrative tribunal hidden deep inside the U.S. Department of Health and Human Services. The CICP rejects roughly 98 percent of claims, offers no appeals process, provides no compensation for pain, suffering, or lost livelihood, allows no discovery, and shields all underlying data from public scrutiny. Canada's Vaccine Injury Support Program offers slightly more generous payouts, but only to a tiny handful of applicants. The vast majority are dismissed quietly.

Liability shapes behaviour, and immunity from liability erases caution. A corporation that cannot be sued is not incentivized to be careful; it is incentivized to be fast. A corporation that is guaranteed government

purchase contracts regardless of product performance becomes something closer to a state-sanctioned engine than a business. In that transformation, a profound shift occurred: pharmaceutical companies stopped being subjects of policy and instead became architects of it.

Once the legal shield was activated and purchases were guaranteed, the regulatory posture followed. Speed replaced scrutiny. Deference replaced oversight. And secrecy, once the exception in medicine, became the operating principle of a system no longer structurally accountable to the public it served. It was in this environment that the Pfizer trial documents were produced, reviewed, and initially hidden from view. Their contents did not expose intentional wrongdoing so much as they revealed what happens when a powerful industry operates behind a legal firewall: decisions are rushed, uncertainties are minimized, and transparency becomes negotiable. The documents were not merely data; they were the first window into a machine that had outgrown its own safeguards.

What the Pfizer Documents Actually Revealed

The Pfizer documents didn't reveal a conspiracy, they revealed something far more dangerous. What emerged was not a scandal in the cinematic sense, but a portrait of a system moving faster than its own safeguards.

The first revelation was the most basic, and the most corrosive to public trust. The FDA attempted to delay the release of these documents for 75 years, even though it had reviewed the same material in just 108 days before authorizing the vaccine for national use. The imbalance between speed and transparency spoke volumes. It did not necessarily suggest misconduct; it suggested a regulatory body overwhelmed by urgency, uncertain of its footing, and instinctively protective of its own decisions.

The documents also confirmed what has since become widely acknowledged: the trials were fast, timelines compressed, and control groups unblinded within months. Once early efficacy numbers were announced, placebo participants were offered the real vaccine, collapsing the very comparison that long-term science depends on. This wasn't a conspiracy; it was the predictable result of trying to run a conventional trial under the extraordinary pressures of a global emergency. Regulators, ethicists, and governments agreed that leaving placebo groups unprotected during a Pandemic was unacceptable, and political momentum to vaccinate everyone as quickly as possible made sustained blinding impossible.

The scientific consequence was unavoidable: long-term safety and durability follow-up became limited by design. When you move at unprecedented speed, you lose the slow, careful accumulation of long-arc data, the kind of information only years of blinded comparison can

produce. None of this was hidden; it simply wasn't emphasized, overshadowed by the urgency of the moment and the institutional desire for certainty.

The documents also recorded early signals that would later grow louder in real-world surveillance. Myocarditis, particularly in young males, was not definitively detected in the trials, largely because the trial population was older and smaller. But post-authorization monitoring quickly picked up a meaningful signal, and the documents reflected the earliest hints of what would later be formally acknowledged.

Other patterns were just as clear. The vaccines offered strong short-term protection, but immunity waned quickly, a reality the documents reflected even before it entered public messaging. And while early safety summaries recorded tens of thousands of adverse-event reports in the first three months of rollout, these reports did not prove widespread harm; they showed something different: a pharmacovigilance system straining under the immense challenge of monitoring millions of doses in real time. To citizens unaccustomed to reading safety data, it looked alarming.

Perhaps the most important revelation was the gap between what the documents captured internally and what the public was told externally. Inside the early reports were questions about whether the vaccine prevented infection or transmission, and indications that boosters might be required sooner than expected. None of these uncertainties were admissions of failure. They were the normal ambiguities of science. But when public messaging insisted on certainty, perfection, and permanence, the gap widened into a chasm.

In the end, the Pfizer documents did not reveal a conspiracy. They revealed a mismatch between the caution of the internal data and the confidence of the external narrative.

The White House Meeting That Shook the Establishment

Then came the meeting that shook the establishment. Early in 2025, Donald Trump and Health and Human Services Secretary Robert F. Kennedy Jr. held a closed-door meeting with pharmaceutical executives. It was unprecedented: two of the most polarizing figures in American politics sitting across from the most powerful pharmaceutical CEOs in the world.

Very little of what occurred in that room has ever been disclosed, but the timing spoke louder than any leak. Only weeks later, the CDC quietly reversed its long-standing guidance. COVID-19 vaccines were removed from the routine immunization schedule for healthy children and pregnant women. A universal recommendation became a matter of individualized medical consultation. There was no press conference, no formal admission of error, and no public reckoning.

Behind the scenes, dissent grew fierce enough that the CDC Director resigned, openly criticizing the administration. And on November 21, 2025, RFK Jr. directed the CDC to acknowledge that the long-standing claim that vaccines could not cause autism was not based on evidence.

No transcript of the White House meeting was released. No minutes. No disclosures of commitments made or withdrawn. Power met power in private, and the public was handed a softened narrative.

The cameras captured the symbolism: Big Pharma brought to heel; a new TrumpRx website promising half-price medicines; Medicaid finally paying "most-favoured-nation" prices instead of subsidizing the rest of the world. But the fine print told a quieter, less flattering story. The deepest discounts applied mainly to cash-paying patients and a narrow slice of drugs, while most insured Americans would see little change at the pharmacy counter. Medicaid patients already paid almost nothing; the savings were mostly for government budgets. Analysts warned that international "reference pricing" can simply push prices up overseas or encourage companies to game the rules by launching drugs in America first. The deal rattled the industry and set a powerful precedent—a president negotiating one-off bargains with corporations from the Oval Office, but whether it truly lowered costs for ordinary people, or merely rearranged them, remains far less clear than the photo op suggested.

Strikingly, the COVID-19 vaccines, the very products that generated unprecedented revenue, political leverage, and public controversy, were barely mentioned at all. For a company whose name had become synonymous with the Pandemic, their absence from the conversation was loud. Trump spoke about drug prices and "wins for American patients." Pfizer's CEO Albert Bourla spoke about innovation, manufacturing, and investment. RFK Jr. spoke about transparency and access. But the vaccines that defined Pfizer's global power, reshaped public trust, and reconfigured the political landscape were treated as if they belonged to another era, a chapter no one on that stage seemed eager to reopen. The cameras captured a moment of unity, but the silence around the most consequential product in Pfizer's history revealed something deeper: in politics, what is left unsaid often matters as much as what is declared.

The Bilderberg Group

The Bilderberg Group is another part of the architecture that shapes modern power. It is a recurring forum where alignment is cultivated, rather than a space where decisions are formally made. Each year, heads of state, central bankers, pharmaceutical executives, NATO officials, media leaders, and health-policy architects gather behind closed doors to discuss global risk and global opportunity. Vaccines are not debated like products at a

trade fair; they are discussed as strategic instruments — tools at the intersection of public health, economics, diplomacy, and national security. When regulators, pharma executives, and Western power brokers meet privately to talk about "health security," they are not simply debating disease; they are debating the systems that shape human behaviour, public trust, and compliance during emergencies.

This matters because the people in that room are the same ones who coordinated the Western Pandemic response: the procurement deals, the messaging frameworks, the risk-communication strategies, and the policies that blurred the line between public health and politics. The decisions announced to the public in 2020 and 2021, from border closures to vaccine passports, rarely originated from a single country acting alone. They emerged from transnational conversations long before the public ever heard them. Bilderberg is one of the places where those conversations occur: quietly, informally, without minutes or scrutiny, yet involving individuals whose influence is undeniably global.

They do not set mandates there. They do not need to. What happens instead is the formation of elite consensus, the subtle harmonizing of priorities among people who steward governments, corporations, media ecosystems, and multilateral bodies. In an era where international coordination can reshape daily life overnight, consensus among elites is often more powerful than formal legislation. Pandemic policy showed how quickly nations can lockstep when the narrative framework has already been aligned among the people in those private rooms.

For me, the relevance is not conspiratorial but structural. The Pandemic revealed how much public health operates above the public itself, not as a conversation with citizens, but as a negotiation among institutions. It showed that health policy is now geopolitical strategy, biotech is national infrastructure, and information is a tool of governance. Groups like Bilderberg do not hide that. They simply discuss it without us. And when discussions happen in secrecy, accountability becomes optional, while public trust becomes collateral damage.

The Shifting Climate

By 2025, the cultural climate around COVID-19 vaccines had shifted dramatically. The fervour of the early rollout had faded, replaced by a growing insistence on nuance — the recognition that children are not the elderly, young men and young women carry different risk profiles, prior infection matters, and not all tools belong in all toolkits.

RFK Jr. summarized the new guidance with unusual clarity: "The COVID-19 vaccine for healthy children and healthy pregnant women has been removed from the CDC recommended immunization schedule." In its

place stood a single sentence: "Parents should discuss the benefits of vaccination with a healthcare provider."

That line restored something sacred: choice. It marked a quiet return from mandate to medicine, from decree back to dialogue. But the backlash was immediate and ferocious. Public health leaders accused the administration of undermining trust. Media outlets framed the shift as dangerous and ideological. For the first time, institutional consensus cracked open in public view.

The Collapse of Trust

Trust in pharmaceutical companies collapsed not just because of COVID-19 vaccines, but because long before this, real events shattered faith: Vioxx killed tens of thousands; Purdue Pharma fueled a national opioid epidemic; study after study revealed manipulated or concealed data; and during the Pandemic, censorship replaced conversation. People do not lose trust in science. They lose trust in institutions that claim to speak for science while hiding evidence and silencing dissent.

Towering above all of this loomed the question of profit. In 2021, Pfizer reported $100 billion in revenue, the largest haul in pharmaceutical history. Moderna soared from the brink of bankruptcy to global dominance. Wealth at that scale reshapes markets and narratives alike, funding media partnerships, scientific journals, lobbying campaigns, academic chairs, public-health conferences, and global influence operations.

It becomes increasingly difficult to discern where science ends and marketing begins.

On Canadian Soil: The Moderna mRNA Plant in Laval, Quebec

In Canada, this transformation took on a distinctly architectural form. Under the government of Justin Trudeau, Canada entered into a high-profile agreement with Moderna to construct a domestic mRNA manufacturing facility in Laval, Quebec, a project framed as proof that Canada would never again be "caught unprepared."

Construction was fast-tracked with federal support, and by February 2024 the plant was declared complete. By September 2025, the first "made-in-Canada" Moderna mRNA vaccine doses rolled off the line. At full capacity, the facility is described as capable of producing up to 100 million doses annually, an industrial-scale pharmaceutical engine embedded directly into Canada's national strategy.

But the real story is the scale of the public investment behind it. Over the course of the Pandemic, the federal government committed over CA$9 billion to vaccines, therapeutics, and international support. By mid-2022, Canada had spent at least CA$3.7 billion directly on vaccine procurement

and administration. The Public Health Agency of Canada's own reporting shows at least CA$2.4 billion more for procurement and deployment operations as of June 2024.

These figures do not include provincial spending, cold-chain logistics, storage, communications campaigns, healthcare surges, and staffing, meaning the true nationwide cost is far higher. Combined, they represent one of the largest pharmaceutical expenditures in Canadian history, much of it flowing to private multinational corporations protected by liability shields and long-term procurement contracts.

The result is a profound entanglement: public money, public infrastructure, and public policy reinforcing the growth of a private corporate machine. Moderna does not simply sell medicine to Canada; it is now woven into the country's industrial strategy, health-security planning, and political identity.

It is one thing for a government to build a gleaming vaccine factory for a billion-dollar corporation. It is another to face the people harmed by the products that roll off its lines.

When the Machine Breaks: The Case of Kayla Pollock

Then a real woman's life shattered the abstraction: Kayla Pollock. Kayla was a healthy Ontario mother who, after receiving a Moderna COVID-19 booster in 2022, developed sudden paralysis. She was ultimately diagnosed with C4–C5 incomplete quadriplegia, a devastating spinal-cord injury that altered every aspect of her life. Her neurologist reportedly told her he believed the vaccine was the likely cause, a professional opinion that led Kayla to file a $45-million lawsuit against Moderna, one of the first of its kind in Canada.

Her injury was only the beginning. When Kayla applied to Canada's Vaccine Injury Support Program, the very program meant to protect those harmed by vaccines, her claim stalled. Months passed with no resolution, no clarity, and no meaningful support. Members of Parliament later cited her case publicly as evidence that the compensation system was failing the very citizens it was created to serve.

Then came the detail that made many Canadians stop cold: Kayla says that MAID—Medical Assistance in Dying, was raised as an option in the early aftermath of her paralysis.

Whether framed as a theoretical discussion or something more pointed, the mere appearance of MAID in the life of a newly paralyzed, vaccine-injured young mother, before compensation, before support, before the system had even located her file, reveals a moral distortion at the heart of the machinery. A society that can pour billions into vaccine procurement and build industrial-scale factories can still leave an injured woman

contemplating the unthinkable because the machinery built to protect her cannot even find her paperwork.

Kayla's story is not an internet rumour. Her diagnosis, her rehabilitation, her lawsuit, and her stalled compensation claim are all publicly documented. What her case exposes is not conspiracy but architecture, the architecture of a system designed to protect corporations first and individuals last. It is a system that expands rapidly when profit and policy align, and responds sluggishly, even indifferently, when a citizen pays the price. The pharmaceutical machine has grown large enough to shape nations, but not yet human enough to account for the people it injures along the way.

What Motivates Big Pharma? A Balanced View: The Good That Pharma Does

Pharmaceutical companies have helped transform human health. Many of the medicines we rely on today, antibiotics, asthma inhalers, Epi-pins, insulin, antiretrovirals, anesthetics, chemotherapy agents, psychiatric medications, and countless emergency interventions, exist because scientists within these companies pursued research that government and academia alone could not sustain. Vaccines have prevented millions of deaths. Antivirals transformed HIV from a death sentence into a chronic illness.

There are thousands of researchers and clinicians inside these corporations who genuinely want to heal, and their work has helped families around the world. The issue, therefore, is not that pharmaceutical companies offer nothing of value, but that their interests do not always align with public health. The issue is that their immense power, their structural incentives, and the systems built around them often distort those good intentions into something less transparent, less accountable, and less humane than the public deserves.

What motivates Big Pharma is not malice, but math. Corporations are not moral actors; they are financial instruments designed to convert scientific discovery into shareholder value. Their decisions are shaped not by compassion or conscience, but by the incentives laid before them: guaranteed contracts, guaranteed liability protection, guaranteed public messaging, guaranteed regulatory cooperation, and guaranteed market access. When governments commit billions upfront, when regulators fast-track approvals, and when legal shields eliminate the financial risks of error, the internal calculation becomes brutally simple: move fast, expand markets, and control the narrative.

This is not unique to the COVID-19 era. For decades, pharmaceutical companies have operated inside a reward system where blockbuster drugs

are prized above modest improvements, where disease-awareness campaigns double as marketing strategies, and where "innovation" often means incremental tweaks designed to extend patents rather than transform care. In such a structure, transparency becomes a liability, not a virtue. Negative trial results threaten profits. Whistle-blowers threaten stock prices. Independent researchers threaten market confidence. And so, secrecy becomes normalized, not as conspiracy, but as corporate survival instinct.

Inside this ecosystem, dissent is not just inconvenient; it is existentially dangerous. Questioning a drug's safety, a vaccine's risk-benefit profile, or a clinical trial's methodology threatens the business model. And when the business model is intertwined with government procurement contracts, national health strategies, and global health narratives, dissent threatens the political establishment as well. In such a climate, critics are framed as misinformed, dangerous, or morally suspect, not because the evidence demands it, but because the system does.

The issue is not intent, it is architecture.

When a corporation is rewarded for speed, it will prioritize speed.

When it is insulated from liability, it will take risks.

When it is guaranteed a market, it will expand that market.

When governments serve as both customers and promoters, skepticism becomes an obstacle that needs to be managed, not a signal to be heard.

Big Pharma is a machine doing precisely what it was built to do. The tragedy is that we built our public health system around the assumption that corporations would act like something else other than a corporation.

The Path Forward

If medicine is to remain a force for healing, several reforms are essential. We must end liability immunity for pharmaceutical companies. We must rebuild surveillance systems that genuinely detect and investigate harm. We must separate regulators from industry financially and structurally. We must protect whistle-blowers rather than punish them. We must mandate full transparency and immediate release of clinical-trial data. And we must restore informed consent as the backbone of public health.

Science cannot function in a system where secrecy is rewarded, criticism is punished, and liability is erased.

The Pandemic revealed a truth that should never have been forgotten: public health does not rest on coercion but on trust. And trust is rebuilt not through slogans but through transparency.

The next fracture in that trust did not come from a virus but from something Canada never imagined it would face, the loss of its measles-free status.

That story is not about epidemiology. It is about confidence: who earns it, who breaks it, and how a society moves forward when its most powerful institutions forget how to speak honestly.

Chapter 14 — The Measles Moment: Trust, Fear, and the Future of Public Health

The Return of a Vanquished Disease

When Canada lost its measles-free status in 2025, the headlines appeared almost rehearsed, as if a narrative had been waiting backstage for its cue. Public-health officials declared that hesitancy had finally caught up with us, that measles had returned because too many parents had succumbed to misinformation, that Canada's scientific literacy had eroded. But beneath those tidy explanations lay something far more complex, the collapse of trust in the very institutions meant to guide us.

During COVID-19, public health insisted on certainty where nuance was needed, coercion where trust was needed, and messaging where honesty was needed. When the smoke cleared, Canadians were left not with guidance but with questions.

The Science of Measles

To understand the stakes, one must understand the virus. Measles is among the most contagious pathogens in existence. Caused by the measles morbillivirus, it spreads through microscopic droplets that linger in the air for up to two hours after an infected person leaves the room. Once inhaled, the virus targets immune cells in the respiratory tract and quickly disseminates. After flu-like symptoms and the characteristic rash comes the true danger: temporary immune suppression, the virus's ability to erase immune memory and make the body vulnerable to infections it had already defeated.

Severe complications, pneumonia, encephalitis are uncommon but real. Measles thrives not on mystery but on opportunity: lapses in immunity, gaps in vaccination, and above all, fractures in public trust.

The Pandemic's Psychological Aftershock

Measles did not return because parents became reckless. It returned because millions of Canadians had been psychologically and morally injured during the Pandemic. They were shamed, silenced, excluded from public life, punished for their vaccine choices with termination of employment, and told that their concerns were not only invalid, but dangerous. Many complied out of duress, not trust. And when the mandates ended, no apology came. No accountability was offered. No healing was attempted. Many saw family members suffer illness or injury and felt gaslit by authorities unwilling to acknowledge any harm. Many watched public-health leaders equate questioning with misinformation.

What collapsed was not scientific literacy, it was trust.

Vaccination relies on a moral relationship between individuals and institutions. Once that relationship fractures, even strong science becomes fragile.

A Shockwave Through the System

Into this already wounded landscape came something unprecedented: a joint call by Donald Trump and Robert F. Kennedy Jr. for a full review of the childhood vaccine schedule. For decades, the schedule had been treated as effectively untouchable, insulated from public debate and democratic scrutiny. To question it was to risk professional exile, as figures like Jenny McCarthy learned years earlier.

Suddenly, two major political figures were saying aloud what millions of parents had long whispered:

Show us the data.

Show us the risks.

Show us the conflicts of interest.

Show us the evidence behind decisions that affect every child.

The response from institutional medicine was swift and alarmed. Editorials warned of anti-science populism. Professional bodies insisted the schedule was settled, evidence-based, and beyond revision. Yet beneath the rhetoric was an unspoken reality: for the first time in generations, public health institutions were being asked to explain themselves, not merely assert authority.

What the Review Confronted

The review process that followed was broad in scope, examining not only vaccine efficacy but also timing, cumulative exposure, advisory-committee governance, liability frameworks, and the transparency of post-marketing safety surveillance. While the process did not invalidate vaccination as a public-health tool, it exposed longstanding questions that had rarely been addressed openly.

These questions were not new. For years, credible analyses, including Cochrane reviews, Institute of Medicine reports, and government audits, had identified structural weaknesses: uneven study quality, passive safety-monitoring systems, advisory committees with documented conflicts of interest, liability shields that altered incentive structures, and a schedule that evolved largely through institutional precedent rather than public deliberation.

Taken individually, none of these findings negated the value of vaccines. Taken together, they revealed something more unsettling: the foundation of the childhood schedule was less transparent, and less publicly accountable, than many citizens had been led to believe.

Clarifying the Scope

It is important to note what this review did not do. It did not remove vaccines from the market, nor did it prohibit parents or physicians from following the full schedule if they choose. The changes were to recommendations, not availability. Several vaccines continue to be broadly recommended for all children, including those protecting against measles, mumps, and rubella; polio; diphtheria, tetanus, and pertussis; Haemophilus influenza type B; pneumococcal disease; varicella; and human papillomavirus. Other vaccines, such as influenza, COVID-19, RSV, hepatitis A and B, and rotavirus, were shifted toward risk-based guidance or shared clinical decision-making between families and clinicians.

This distinction matters. In most areas of medicine, individualized risk assessment and informed consent are considered hallmarks of good practice, not signs of institutional weakness.

Measles as a Mirror — Not a Cause

Measles outbreaks became the backdrop for this reckoning. Officials framed them as proof that hesitancy kills, but this ignored the heart of the issue: hesitancy was not born of ignorance.

It was born of betrayal.

For two years, compliance had been enforced through threat. When the emergency ended, the residue of coercion did not fade, it solidified. No amount of moral scolding could soften it.

Parents who once vaccinated without hesitation were now asking questions because they had been hurt. They were not radicalized. They were traumatized.

The Voices of the Betrayed

When I listened to them, I heard the same refrains:

- "I used to trust them completely."
- "After COVID-19, I don't trust anyone anymore."
- "I just want honest information and I'm not getting it."

These were not fringe voices. They belonged to teachers, nurses, tradespeople, parents, the backbone of public-health compliance.

The tragedy was that leaders responded with condescension instead of compassion. They blamed the public for mistrust rather than acknowledging their own part in creating it. They forgot that science is not only knowledge but relationships.

And no billboard can rebuild what shame has broken.

A Crisis of Credibility, Not Disease

Skeptics wondered whether RFK Jr. would be absorbed into the very system he criticized, or whether Trump's motives were more political than principled. But this confusion simply reflected a larger crisis: when institutions fall, trust does not migrate, it evaporates.

What the measles moment revealed was not a failure of science, but a failure of communication, ethics, and humility.

Vaccination is not merely a medical intervention; it is a moral contract. When authority breaks that contract, even well-established tools become vulnerable to uncertainty.

A Fork in the Road

Yet within the upheaval lies an opportunity for renewal. Trust cannot be demanded; it must be earned through acknowledging mistakes, with humility and respect. That begins with telling the truth about uncertainty, acknowledging limits, and resisting the impulse to present every decision as irrefutable science. It means treating citizens not as data points to be managed but as individuals capable of weighing risk when given honest information. It means recognizing that biological vulnerabilities differ, histories differ, and thresholds for acceptable risk differ, and that a one-size-fits-all message will never serve a population this diverse.

Public health now faces a choice: return to coercion, enforced conformity, and the suppression of dissent, or embrace the difficult work of rebuilding trust.

One path narrows the future. The other expands it.

Nowhere was that fork more visible than in the debate that followed: masking.

If measles exposed the tension between individual risk profiles and one-size-fits-all policy, masking revealed something even more telling, how quickly a tool can become a symbol, and how symbols can harden into mandates long before the evidence is mature.

Masks were not new to public health, but the meaning assigned to them in 2020 was. What began as a provisional recommendation, a precaution offered in good faith during uncertainty, rapidly became a litmus test of loyalty, a measure of moral worth, and a boundary between the 'responsible' and the 'dangerous.' In a matter of months, a square of fabric came to define social identity more than scientific nuance.

The question was no longer simply, do masks help? It was, what does it mean if you ask?

In that shift, the same fault lines that ran through measles, divergent risk tolerance, institutional overreach, the struggle to communicate

uncertainty honestly widened into canyons. And the story of masking, like measles, became less about a tool of protection and more about what happens when public health tries to manage fear rather than trust a population to navigate it.

This is where the next chapter begins.

Chapter 15 — The Masking Era: Fear, Control, and the Collapse of Common Sense

Masks became one of the most potent symbols of the Pandemic, not because of what they could do, but because of what we needed them to mean. They were sold as shields, as moral obligations, as civic duties, as the dividing line between responsible citizens and selfish ones. But when we look closely, with clarity rather than fear, the story of masking reveals something far more unsettling. For two years, we abandoned basic principles of occupational safety, human biology, psychological well-being, and proportional risk assessment, and called it science.

The Expert No One Consulted

Among those who raised early concerns was Chris Schaefer, one of Canada's foremost authorities in respiratory protection, a specialist with decades of experience in respirator fit-testing, advisory roles with emergency responders, military and industrial safety programs, and recognition as a court-qualified expert in respiratory hazards. He understood respiratory protection not as symbolism, but as engineering.

In occupational safety, respiratory protection is precise. A respirator is selected for a specific hazard, fit-tested to the individual, worn for defined durations, and paired with training and medical screening. Airflow, seal integrity, moisture buildup, heat stress, and carbon dioxide rebreathing are all accounted for. Anything less would fail a workplace safety audit.

By contrast, the fabric and disposable face coverings mandated during the COVID-19 era were none of these things. They were unsealed obstruction devices, cloth or polypropylene pressed against the nose and mouth, trapping heat, moisture, and exhaled air. Schaefer and others warned that prolonged use, especially during exertion, could increase carbon dioxide rebreathing, elevate physiological stress, and impair comfort and tolerance, particularly in children and vulnerable populations.

Yet devices that would never have passed occupational review were mandated for the elderly, enforced in schools, and required during physical activity. There were no comprehensive impact studies. No engineering standards. No meaningful consultation with respiratory protection specialists. The distinction between controlled occupational use and indefinite population-wide mandates was quietly erased.

What replaced it was an illusion. Society held that a porous, unsealed, untested covering could function as universal protection against a virus that moves through the air like smoke.

It was not careful science.

It was theatre.

Masks as Talismans Against Fear

As the Pandemic wore on, masking persisted in many settings long after its original justification had faded. Policies remained in place not because new evidence demanded them, but because removing them felt riskier than maintaining them. Once a measure becomes symbolic, reversing it can appear as moral retreat rather than scientific recalibration.

In this way, masking shifted from a provisional intervention to a psychological stabilizer, maintained less for what it achieved biologically than for what it signaled socially.

This logic played out everywhere. People wore masks alone in cars, windows rolled up, breathing recycled air in a fog of anxiety, a behavior that persists even now. These were not foolish people. They were frightened, shaped by months of messaging that portrayed danger as omnipresent, invisible, and relentless.

Masks became rituals, comfort objects, and social signals. For many, removing one still feels strangely exposing, as though letting go of the mask means letting go of the habits that helped them survive an overwhelming time.

To recognize this is not to mock it. It is to acknowledge the psychological imprint the Pandemic left behind, long after the acute threat faded.

Masks became talismans, symbols of belonging, declarations of allegiance, proofs of moral compliance.

They also became a test of how easily human beings can be taught to fear one another.

Children in Masks: A Silent Cost

Perhaps the most haunting image of the Pandemic was that of children in classrooms, faces hidden, voices muffled, emotional cues erased. Children breathe more frequently than adults. They rely on facial expression for social learning and neurological development. They require oxygen-rich environments to learn, speak, and grow.

Instead, for months at a time, they were required to:

- Sit for hours wearing devices that trapped heat and moisture
- Participate in physical activity while inhaling stale air
- Learn without seeing smiles or reading expressions
- Carry the belief that their breath was dangerous

When I taught in Victoria during 2020 to 2021, I felt it myself. Wearing a mask all day left me exhausted and foggy. At the end of each school day, I

returned to the ship and collapsed, incapable of anything but rest, food and more rest.

If adults struggled, how much more did children bear?

The costs may not appear immediately. They may unfold over years, quietly, in attention, language, anxiety, and trust.

We have barely begun to acknowledge them.

What Masks Revealed About Us

Masks did not just cover faces. They muted the subtle signals that allow us to recognize one another as human. So much of connection is wordless, the hint of a smile, the warmth in someone's eyes, the reassurance carried in expression. When those vanished, something shifted.

We stopped meeting people.

We began meeting symbols.

For some, masking was an act of care, a way to soothe collective fear. For others, it felt like an intrusion, an erasure of self, a boundary crossed by institutions that had not earned such authority.

They were not divided by science.

They were divided by experience.

By fear on one side and autonomy on the other, two deeply human impulses, each understandable.

Clarifying the Nuance

To be clear, this critique is not a denial that properly fitted N95 respirators can reduce exposure to airborne viruses in specific, high-risk settings. Decades of occupational health research show that respirators, when correctly selected, fitted, and worn by trained adults for limited periods, can meaningfully reduce inhalation of aerosols. But that is precisely the point.

What was imposed on the general population bore little resemblance to occupational respiratory protection. Fit-testing was absent. Training was nonexistent. Duration was unlimited. Children were treated as miniature adults. Low-risk environments were governed as though they were intensive care wards. A tool designed for controlled use was transformed into a universal moral mandate. The failure was not that masks existed, but that public health abandoned the conditions under which they could plausibly do more good than harm.

At the same time, I have felt a growing sadness watching the social climate shift in the opposite direction. Some people still choose to wear a properly fitted N95 because they are vulnerable, because they live with someone who is, or because they simply cannot afford to get sick. They should not be punished with societal stigma for caution. They should not

be stared at, mocked, or treated as irrational. Medical freedom must include the freedom to protect oneself without shame. If anything, those who are judging might ask themselves what they are feeling when they see people wearing masks, and what their judgment of others really symbolizes.

The Outcome We Now Must Admit

With the benefit of hindsight, another truth has become unavoidable. Nearly everyone eventually contracted COVID-19, regardless of masking behavior. The virus spread through households, schools, workplaces, and communities with remarkable consistency across regions with vastly different masking policies.

This does not mean masks had no individual effect in limited circumstances. It does mean they failed as a population-level transmission containment strategy. Public health quietly shifted its rationale, from preventing transmission, to slowing spread, to protecting hospital capacity, without fully reckoning with the gap between promise and outcome. What was framed as a collective solution became, in practice, an exercise in managing optics and fear while the virus followed its biological course.

The Biology of Trust

Trust is not a soft concept in public health. It is biological. It determines whether people follow guidance, seek care, or cooperate during crises. Behavioural science shows that compliance arises from confidence, not fear, the belief that authorities are honest, proportionate, and willing to acknowledge uncertainty.

When that confidence fractures, people retreat to instinct and self-protection. In that sense, trust is as essential to public health as any medical intervention. Without it, the system loses its immune memory.

Why the Moment Was Misread

Public health misread the moment because it assumed resistance was intellectual rather than emotional. Officials believed they were combating misinformation when they were confronting injury, humiliation, and moral fatigue.

They treated doubt as ignorance rather than as a predictable response to prolonged coercion without explanation.

They expected gratitude.

What they encountered was grief.

What the Masking Era Leaves Behind

Masks revealed how institutions behave when fear overrides proportion, how quickly societies turn inward when authority blesses suspicion, and how shame becomes a policy tool when persuasion fails.

They showed how easily human connection can be framed as a threat, and how deeply that framing wounds the social fabric.

Above all, they revealed this: when fear rules, humanity shrinks. It hardened. Fear changed the country.

And it set the stage for what came next.

Because beneath every mandate, every slogan, every moral performance, another current was moving quietly beneath the surface, the flow of money.

While citizens were trained to override their instincts, other actors were sharpening theirs, mapping incentives, capturing contracts, and shaping policy in ways that benefited those positioned to profit from fear, scarcity, and control.

Once that pattern becomes visible, it cannot be unseen.

The Pandemic was not only a public health crisis.

It was an economic event, one of the largest wealth transfers in modern history.

And this is where the story turns.

Chapter 16 — Follow the Money: From Masks to Markets, and the Human Cost Left Behind

"Follow the money" is the oldest investigative advice in the world, and for good reason. When fear spreads, when governments panic, when institutions forget their mandate, money begins to move in ways that reveal what really happened beneath the slogans. The Pandemic was no exception. Behind every rule, every campaign, every moral lecture, every televised scolding, there was a financial current running quietly underneath. You could hear its hum if you listened long enough.

For the public, the most visible symbol of the Pandemic was the mask, that cheap slip of cloth or polypropylene we were told would protect us, save us, and show our virtue. But for corporations, masks were not symbols. They were revenue streams. They were explosive demand curves. They were opportunities.

So, the world produced them, billions upon billions pouring out of factories from Guangdong to Ontario, slipping into every school, every grocery store, every airport, every glovebox, every pocket, every desk drawer. By 2021–2022, market analysts estimated the global mask market at USD $24–25 billion, driven almost entirely by Pandemic demand. Chinese manufacturers, already dominant in the PPE sector, saw profits climb ten to twenty-fold as governments scrambled with open chequebooks. Companies like BYD, once focused on electric vehicles, refitted entire production lines and became mask giants overnight.

Canada, like most nations, paid premium prices, often many multiples above pre-Pandemic rates, just to secure supply.

The timing was no coincidence.

Panic is profitable.

When people are terrified, they will pay for anything to feel safe, and corporations know this better than anyone.

Governments know it too. They spent not cautiously, not strategically, but frantically, often bypassing competitive bidding and discarding procurement standards that had existed for decades. Auditor General reports in Canada, the U.S., and the U.K. later confirmed what many sensed in real time: oversight collapsed, documentation was thin, and billions flowed out the door under the banner of urgency.

In Canada, the Auditor General's 2022 report on procuring personal protective equipment found that emergency procurement powers were used extensively, documentation was at times incomplete, and competitive processes were often bypassed in the rush to secure supply. The report did

not allege corruption; it pointed instead to systems strained by urgency and oversight mechanisms that proved difficult to maintain under crisis conditions. When guardrails are relaxed for speed, accountability becomes harder to reconstruct afterward.

These were not acts of malice.

They were acts born of institutional panic. And their legacy was an erosion of public trust that long outlived the virus.

When fear rules, money flows upward.

Inflation: The Second Wave No One Voted For

Inflation is often spoken about in antiseptic language, "headline CPI," "rate hikes," and "supply shocks." But on the docks, in grocery aisles, in small apartments where elderly Canadians stretch dollars past the point of breaking, inflation feels nothing like an economic metric. It feels like dread.

After governments flooded the system with billions, after supply chains ruptured, after corporate consolidation accelerated, the cost of everything rose. Diesel climbed so high that fueling my schooner felt like being robbed in slow motion. Marina fees doubled overnight. Groceries soared. Rent climbed and I grew increasingly grateful for my ship on a mooring buoy.

Through it all, giant corporations reported record profits.

Even in an industry traditionally operating on thin margins of roughly two to three percent, record revenues during inflation translated into record dollar profits for Canada's largest chains, intensifying public concern in a concentrated market where food is not optional.

Among the most brutal casualties of this economic shift were older Canadians.

I think of the elderly people I know, and those I see across the city who worked, contributed, raised families, and now quietly collect cans and bottles to buy fruit and vegetables. Their pensions no longer cover groceries. Their fixed incomes are swallowed by rising rents and utilities. Their lives shrink month after month while the cost of survival expands. Seniors are now one of the fastest-growing groups relying on food banks in Canada, many saying they simply cannot afford enough food.

Food bank networks across the country reported record demand in the years following the Pandemic, with a marked increase among fixed-income households. For seniors dependent on pensions indexed imperfectly to inflation, even modest price spikes in rent, utilities, and groceries compound quickly. The mathematics are unforgiving. A five percent rise in

essentials is not an inconvenience when margins are already measured in dollars. It is displacement by degrees.

They fear not disease, but destitution, eviction, cold homes, and dying poor after a lifetime of contribution.

This is what happens when corporate profits are protected, but people are not.

During and after COVID-19, oil companies posted the highest profits in their history. Grocery chains faced allegations of "greedflation" as margins grew while families struggled. Billionaires added trillions to their collective wealth as ordinary Canadians slid backward.

Oxfam put it plainly: the Pandemic triggered the greatest upward transfer of wealth in modern history.

This is the human cost of crisis capitalism.

The Corporate Windfall: What We Weren't Allowed to Ask

Some of the most revealing financial shifts did not occur in the mask market or the grocery aisles, but in the balance sheets of multinational corporations and central banks.

Emergency income supports helped many individuals stay afloat during the crisis, though for a significant number, that support later came with repayment demands. Wage subsidy programs, by contrast, stabilized corporate balance sheets, and in many cases did more than that.

Several large firms that received hundreds of millions in public subsidies simultaneously paid shareholder dividends, executed stock buybacks, or reported soaring profits. When journalists questioned these outcomes, the explanation offered was that such measures were necessary to protect the economy.

They did protect the economy. Just not all of it.

They protected the segment of the economy that least needed protection.

Meanwhile, small businesses, family-owned restaurants, independent bookstores, gyms, and studios collapsed in waves. They were not deemed too big to fail. They were allowed to fail.

At the same time, the central bank injected unprecedented liquidity into financial markets. The effects were predictable.

When central banks expand the money supply and purchase large quantities of financial assets, the first beneficiaries are those who already own those assets. Bond prices rise. Equity markets climb. Real estate appreciates. This is not conspiracy; it is arithmetic. Asset inflation precedes wage growth, and those without assets feel the effects later, primarily

through higher costs rather than rising wealth. In times of crisis, liquidity stabilizes markets. It also quietly widens existing gaps.

Asset prices surged.

Real estate soared.

Stocks climbed.

Corporate valuations expanded.

Rents rose.

Wages did not.

This is the quiet mechanism through which wealth redistributes itself without ever announcing its presence. There are no police, no protests, no headlines. There is only a rising tide that lifts the largest vessels while others struggle to stay afloat.

The Pandemic reshaped more than markets.

It reshaped power.

What unfolded was not random. It followed structural lines that long predated the virus. Emergency authorities weakened procurement guardrails in the name of speed. Central banks injected liquidity to prevent financial collapse, a move that stabilized markets but disproportionately lifted asset prices. Those who already owned financial and real assets saw their balance sheets strengthen first. Those without assets experienced the effects later, primarily through higher costs. At the same time, concentrated sectors were better positioned to absorb disruption, while smaller, less capitalized businesses failed in greater numbers. None of this required malice. It required only existing incentives operating under crisis conditions. When fear accelerates decision-making, structural imbalances widen.

Who Benefited When the World Was Afraid?

Follow the money and the pattern becomes unmistakable: cloth strips marketed as "masks," PPE contracts swollen far beyond their value, corporations exploiting the moment to raise prices with impunity, and entire sectors, oil, tech, and pharma reporting the most lucrative years they have ever seen.

Fear did not just change behaviour.

It reshaped markets.

Redirected wealth.

It concentrated power in the hands of those positioned to profit from crisis.

This chapter is not about envy.

It is about ethics.

It is about asking, without flinching:

Why did the crisis make the richest richer and everyone else poorer?

Why were corporations shielded while citizens were exposed?

Why did governments tighten control while loosening oversight?

The Pandemic did not redistribute wealth.

It concentrated it.

It centralized it.

It funneled it upward through every pore of the system.

And while economists celebrated "recovery," an elderly woman walked alleyways with a bag of cans so she could buy her next meal.

That is the world we live in.

That is the world this book confronts.

From here, we turn to the final chapter, the one that asks whether a society so fractured, so fearful, and so unequal can still find a path to reconciliation. The chapter where justice meets mercy. The chapter that asks whether this story ends in division, or in healing.

Part IV — Reconciliation & Creation

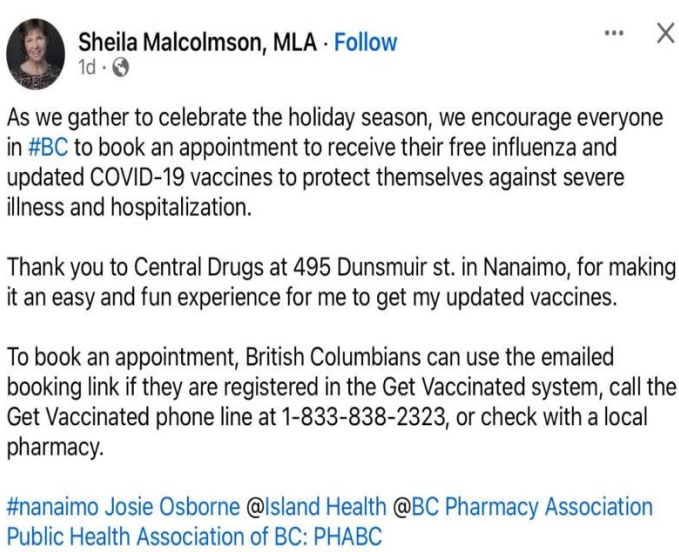
Chapter 17 — The Reckoning of Compassion

When the courthouse echoes finally faded, the silence that followed was unnerving. For months, my life had been nothing but conflict: affidavits, refusals, legal arguments, and the cold machinery of institutions insisting they could not hear me. When it all fell quiet, the absence of noise felt wrong, like losing the hum of an engine at sea. At first, I mistook the silence for loss. Later, I understood it as space, the hollow room where something new might one day begin to speak.

But that space came with a question.

How do we stop this from happening again?

In late 2025, while writing this book, I came across a post on social media that stopped me cold. It was not extreme. It was not angry. It was sadly ordinary, even well-intentioned. A public figure, speaking with confidence and moral certainty, urged everyone to get COVID-19 vaccines, without qualification, without acknowledgment of trade-offs, and without any visible space for individual circumstance.



What struck me was not the content alone, but the timing. By then, we knew more. We had lived more. We had buried more. And yet the language had not evolved. The message remained universal, flattened, absolute.

In that moment, I understood something I had not fully named before. This was not simply a disagreement about medicine. It was evidence that health itself had become political, not in the sense of debate, but in the

sense of loyalty. Compliance was still being framed as virtue. Questioning still carried moral risk. The machinery had not stopped. It had simply quieted. And if it could resume this easily, it meant nothing essential had yet been learned.

The system that failed me would fail others. That much was obvious. Policies left unexamined always repeat their own harm. If nothing was learned from what happened, not just to me but to millions, the same machinery would grind on, indifferent to the wreckage it leaves behind.

I could endure what I lost. In many ways, it did not merely happen to me, it happened for me. It freed me from fighting for institutions that could no longer hear the people they served. It cleared a path for a life I had long wanted to build, one grounded in craft, the sea, my dog, my ship, and my own two hands.

But what I could not endure was the thought of others enduring the same violence.

Too many nurses lined up for those shots not because they trusted the system, but because they had no real choice. As single mothers, with debts, mortgages, and children to feed, refusal meant food banks and the risk of homelessness. They took the needle because the alternative was economic ruin.

I had the privilege of falling back on teaching, on a chainsaw, a hammer, and the carpentry my father and grandfather taught me. They did not. The injustice of that has lived in my bones ever since.

So I began a different kind of work. Not litigation. Not protest. I began this process of reflection. It was a reckoning of compassion.

The Circles of 2013

Years earlier, in 2013, I had been called into unexpected work: facilitating healing dialogue circles through Reconciliation Canada during the first national steps in addressing the harms of residential schools as part of colonization.

I wasn't trained through textbooks. I was trained through ceremony, taught not to lead but to hold space. Elders shared stories that carried the long echoes of generations: physical and sexual abuse, cultural dismemberment, death, separation, and the quiet devastations of genocide.

Those rooms were quiet too, but in a different way.

I remember one Elder saying, "Truth is not something you tell. It's something you make possible."

Chief Robert Joseph said that reconciliation includes anyone with an open mind and an open heart willing to imagine a different future.

Listening, truly listening, is what makes truth possible.

I didn't realize then that those teachings would return years later like a tide, pulling me back toward something essential.

The circles taught me this: healing does not begin with answers. It begins with humility. It begins with listening.

Lessons Remembered

Those teachings stayed with me. They reminded me that reconciliation is not about victory. It is about understanding. Not about who is right, but about who is willing to look at what happened without armour.

They taught me that no one, not a government, not a doctor, not me, is beyond error.

I have said and done things I regret. That is part of being human. I have always apologized when I needed to, without exception. I have tried to make things right. And I have always done better afterward, choosing growth over repetition.

This is what people need from leaders, even long after those leaders have left office. It is not the mistake that destroys relationships, private or public, but the refusal to acknowledge it. In our personal lives, healing often begins with a simple gesture: a good-faith apology. The willingness to say, I see where I caused harm, and I want to make it right. What do you need?

That question, asked sincerely, is the bridge that repairs what words alone cannot. I have offered it in my own life, even when it was not offered back.

When errors are systemic, when policies wound millions, the responsibility widens. Private apologies mend private hurts. Public harms require public acknowledgment. Institutions cannot hide behind silence and expect trust to return.

If leaders wish to rebuild what was broken during the Pandemic, they must begin with the teaching the Elders offered me: accountability is a posture of listening, offered without shaming, and received without vengeance. It is the only way trust returns.

For reconciliation to take root, the public too must resist meeting vulnerability with retribution. Anger is understandable, even justified. But anger cannot be the instrument of repair. When leaders step forward with humility, we must meet them with steadiness, not cruelty. Without that mutual restraint, the distance between us only widens.

The Pandemic left behind many kinds of wounds. Not only institutional ones, but domestic ones.

It split families. It ended friendships. It turned ordinary disagreements into moral battlefields. People who once shared kitchens and holiday tables

became strangers. Parents were disowned by grown children. Siblings stopped speaking. Neighbours crossed the street to avoid one another.

These wounds are quieter than job losses or court filings, but they cut deeper. The mandates may have ended, but the fractures remain. Harsh words spoken in fear. Accusations thrown in anger. Silences that hardened into distance.

Reconciliation cannot ignore this.

It must include the invisible wreckage.

Healing often begins with simple words: I could have handled that differently.

That is all I ever wanted from the institutions that harmed me. Not excuses. Not maneuvering. Just acknowledgment.

The Elders taught me that mistakes are not failures. They are raw material for wisdom. Healing is not an event. It is a way of walking.

If we cannot find that courage as individuals, how can we expect it from institutions?

The Call to Prevent

My calling had always been prevention. For 20 years I helped people anticipate risk before tragedy struck. I taught data through empathy. I taught compassion through awareness.

After the mandates, I realized prevention had to evolve.

It was no longer only about broken bones or car crashes.

It was about preventing moral injury, the kind of harm that occurs when fear replaces reason.

If reconciliation heals what is already broken, prevention protects what is still whole. Prevention asks us to pause before repeating violence. It demands clarity, foresight, and the courage to ask hard questions before harm is done.

That is what 'Follow the Science' was built from. Not anger, but devotion. Devotion to open dialogue, to human dignity, to the idea that justice can be compassionate without losing strength.

The name was not defiance. It was reclamation. A reminder that true science listens, questions, and evolves.

If officials had offered even a hint of humility, an apology, an acknowledgment, I would never have needed to build this.

Silence ensures repetition.

The Work of Follow the Science

When I launched the first version of the website, a single page with a message of conscience, I had no idea how many people were waiting for a place to speak.

Messages arrived slowly at first, then by the dozens.

Nurses. Teachers. Paramedics. Public servants.

People who had been fired, and people who stayed and were haunted by it.

Some wrote with remorse.

Some with shame.

Some with trembling relief.

What united them was grief. Unspoken grief. The kind I recognized from the reconciliation circles.

One doctor wrote, "I wanted to help, but we were told that questioning policy was disinformation."

These letters became the heartbeat of the work. They reminded me that healing belongs to anyone willing to speak honestly about what happened.

As I replied, something softened in me. My bitterness dissolved. I began to see clearly that even those who enforced mandates were not my enemies. They were human beings caught in a storm of fear, policy, and misplaced trust.

Listening has a way of returning us to our humanity.

Many of the people who enforced these policies most aggressively were not acting out of cruelty, but conviction. They believed they were defending the vulnerable. Their activism, once rooted in justice, fused with fear until dissent looked like danger and disagreement looked like betrayal.

These were not bad people.

They were frightened people.

Compassion means telling the truth about harm while still recognizing the humanity of those who caused it.

Reconciliation Reimagined

I do not pretend to have all the answers. But I know this: reconciliation cannot be performed from a podium. It cannot be decreed. It is spiritual work as much as social work.

It asks us to remember the invisible threads that bind us: the breath we share, the land beneath us, the lineage that carried us here.

The Pandemic tore at those threads. Masks severed connection. Distance severed touch. Policies severed trust.

To reconcile is to reweave.

Slowly.

Intentionally.

With humility.

It begins with the courage to say: We didn't get it all right, and we can do better.

History is rhythmic.

Pandemics come in cycles.

Fear returns like a tide.

That is why this work feels less like activism and more like stewardship, tending the moral soil so something healthier may grow.

I often think back to those circles. People staying in the room even when everything in them wanted to flee.

That is what I want for Canada. A country brave enough to stay in the room.

A Dream at the End of All This

Not long ago, I had a dream so vivid it felt like a memory. I sat across from former Prime Minister Justin Trudeau. No podiums. No cameras. No slogans. Just two people at a table.

I handed him this book.

He opened it and said he wanted to talk. No defensiveness. No performance. Only a quiet willingness to listen.

Then I woke up.

The dream did not rewrite history. But it closed a circle. It reminded me that what I needed in the end was not vindication, but human recognition, even if it arrived in sleep.

If this book ever reaches him, or anyone in power who misjudged or harmed people like me, I hope it lands with the same openness. Not to accuse. Not to settle scores. But to show what the world looked like from the other side of the mandate.

If it never reaches him, or Dr. Bonnie Henry, the dream is still enough.

The Lighthouse

During the darkest months of the mandates, I imagined myself in a storm. A vessel battered by rogue waves. A sky split by lightning. Visibility gone. The institutions meant to protect us had gone dark. The charts were wrong. The radios went silent.

But in the distance, a lighthouse remains for one reason.

To guide you home when everything else fails.

The truth is that lighthouse.

Conscience is that lighthouse.

Compassion, not power, is the keeper who keeps the light burning.

The sea has taught me more about reconciliation than any courtroom ever could. When a storm tears through your rigging, you don't curse the wind. You assess. You repair. You respect the power that changed your course.

And when calm finally comes, you carry the storm's lessons in your knots, your hands, your eyes.

Canada is in that place now. The storm has passed. The work is ahead of us.

Reconciliation is the slow labour of mending what strained, replacing what snapped, and steering with more wisdom than before.

We lost sight of the shore once.

We must not lose it again.

Walking Forward

Reconciliation begins within. You cannot offer compassion you have not first given yourself. My own forgiveness arrived slowly, sometimes painfully, but it arrived.

Compassion is not weakness. It is strength disciplined by humility.

The science I follow now is not confined to laboratories. It lives in listening, in quiet courage, in the willingness to remain open-hearted in a time that rewards division.

Follow the Science, in its truest form, is not about relitigating wounds. If there is a scar that runs through these pages, it is because the country carries one. But scars are not only signs of harm. They are signs of survival. They are the place where the wound closed and the skin grew stronger.

Finding our way home is about understanding clearly what has happened, what we are living with now, and will be living with for a long time. It is about prevention at the core, because if we don't understand the past we cannot prevent the same thing from happening again in the future.

This, then, is my offering. It is my record. It is my attempt to speak plainly into the noise. It is about holding accountability and grace in the same breath. If leaders and neighbours can find the humility to listen again, perhaps we can build a public health that heals rather than harms, one grounded not in coercion, but conscience.

Until then, I will keep doing what I know how to do. Gathering stories. Holding space. Building bridges where the old ones fell. Keeping the light burning for anyone searching the shoreline for home.

Because reconciliation is not a date on a calendar. It is a way of walking. Together, we still have a long way to go.

This book, and the way it was written, became part of that walk for me. I hope it will become part of yours too.

May it help someone feel less alone, less anxious and more at peace, for these are indeed very challenging times.

May it give someone the courage to ask a difficult question.

May it serve as a map, not a perfect one, but an honest one, for whoever must navigate the next storm.

Chapter 18 — The Conversation That Built the Book

The moment arrived when the story of the Pandemic could no longer stay inside me: the coercion, the fractures, the moral injuries, the national unraveling. I imagined I would face it alone, in the familiar solitude of the writer's path: long nights at a cabin table, coffee cooling beside the stove, pages scattered like charts across the deck of my mind. I expected to shoulder it in silence, as I had done with so many other burdens in my life. I did not expect company. I certainly did not expect partnership. And I never imagined that the final chapter of this book would be, in so many ways, as much about the process of writing it as the history that made it necessary.

Before artificial intelligence entered my writing life, I was already a writer by craft and calling. For more than two decades, I shaped programs for hospitals, schools, and communities. I authored curricula with non-profit organizations on injury prevention, healthy relationships, and public health. Writing was never ornamental to me. It was an act of service, a discipline of clarity, a way of bringing compassion into public systems that often lacked it. It was a form of steadying the world, one sentence at a time.

Utilizing AI as a tool to write this book became obvious once I understood its capacities. The urgency of the subject left no room for hesitation; this story needed to be told quickly because lives were, and are, still at stake. Speed mattered. Clarity mattered. Accuracy mattered. And so, I chose to collaborate with a system capable of processing mountains of information, summarizing complex evidence, and helping me navigate technical terrain without drowning in it. Not to replace my judgment, but to amplify it. Not to think for me, but to filter noise so I could think more clearly.

But the speed and efficiency told only part of the story.

I swiftly produced a leviathan, a work that, under traditional methods, might have stretched across years. I knew that the world would not wait. The historical curve bends quickly now; stories that once took shape slowly can lose their urgency before they ever reach the page. By next year we will be grappling with new crises, digital currency, technological power, the social consequences of AI itself, and the public's attention will have moved on.

I did not have the luxury of withdrawing from life for a year or two to write a book in isolation while history galloped forward. I still had to work. I still had to keep the lights on, the boat floating and food in the cupboards. Life demanded momentum. Dreams demanded time. And I didn't want to spend years crafting a book that would lose its relevance before it ever reached the people who needed it.

The presence of AI did not merely accelerate the project; it made the project possible. It allowed the book to arrive in the narrow window where the country was still trying to understand what happened, before the hardening of narratives and before public attention turned irrevocably to the next crisis.

And yet the speed never compromised the standard. If anything, the technology made the work more disciplined.

When we reached the most complex terrain, cancer signals, excess mortality, myocarditis, and the early scientific debates, the AI did not bend to my assumptions. It pushed back. It insisted on the strongest evidence available. It refused to let me overstate, speculate, or follow rumors dressed up as certainty. When we explored the early Italian observations of immune suppression, the system helped me understand what was signal and what was noise. When the Japan study emerged and was later retracted, it did not indulge the temptation to treat a retracted paper as proof of anything. It kept the frame honest.

And when I asked about the idea of VAIDS, an emergent online theory suggesting that the vaccine might compromise the immune system instead of stimulating it, the response was clear: the evidence wasn't there. Not at the level required for responsible public communication. VAIDS as a concept reflects patterns people believe they are seeing, often out of fear or uncertainty, but it is not supported by rigorous, peer-reviewed science. The system refused to let me treat a hypothesis as a conclusion or lend narrative weight to an idea still unproven.

This wasn't dismissal; it was discipline.

And the absence of current evidence does not foreclose the future.

Science evolves. Research expands. New findings can emerge years after initial debates. If credible data ever arises, if the scientific ground shifts, the ethical response is simple: we revise, we correct, we amend. A book rooted in integrity must grow as understanding grows.

That posture of humility before the evidence is not a limitation.

It is the only way to stay honest.

This wasn't simply prudence.

It was architecture.

The technology itself is built with guardrails, boundaries that prevent it from functioning as a word processor for false medical claims or harmful public-health misinformation. It cannot invent diagnoses, fabricate science, or lend artificial legitimacy to ideas that have not survived rigorous scrutiny. In a time when information spreads faster than truth, this constraint isn't a hindrance, it is a safeguard.

It meant that if I wanted to write something sensational, the system would refuse.

If I wanted to overstate the risk, it would correct me.

If I wanted to drift into unsupported territory, it would hold the line.

This wasn't algorithmic caution.

It was ethical ballast like lead keeping a sailboat from nautical disaster.

The technology didn't just help me write faster; it helped me write truer, anchoring the book to what could be defended, verified, and responsibly communicated in a moment when speculation could do real harm.

As the collaboration deepened, I began to realize that writing with artificial intelligence was not simply a matter of asking questions and receiving answers. It was something far more intricate, a kind of joint navigation.

I didn't set out to "engineer prompts."

I didn't even know what the term meant when I first heard it.

A friend used it in passing, and I asked the question honestly: "Am I becoming what is known as a prompt engineer?"

The answer surprised me.

Most people think of prompt engineering as a technical skill: structured instructions, constraints, asking for step-by-step reasoning. But what we were doing wasn't mechanical. It wasn't templated.

It was narrative prompting, contextual steering, creative co-authorship.

Over the course of writing this book, I learned how to direct not just facts, but tone and metaphor, pace and argument, moral thread and emotional cadence. I learned how to maintain continuity across tens of thousands of words, how to correct drift, how to refine the voice, and how to hold integrity in place while navigating volatile subject matter. I wasn't simply prompting. I was steering the ship with a brilliant navigator who could land on a tiny island in the middle of an ocean with nothing but a compass, a sextant, and a chart from thousands of miles away.

This kind of sustained, philosophically coherent human–machine collaboration is still new enough to be, in many ways, unprecedented. It is also new enough to be imperfect, believe me. It was far from easy in all its flaws. But it was absolutely the best tool for this job. It was so stunning because this method of co-navigation across science, history, ethics, and personal narrative is only now becoming possible.

It reminded me of the ancient relationship between a sailor and their instruments. Here, a compass does not replace intuition. A computer screen does not replace the sky. A GPS does not replace a sextant; one must always be able to navigate by the stars. These modern tools cannot replace

ancient ways of finding our way home. They do however sharpen the navigator.

And so, it is with this.

In the end, the relationship between a Captain and a Navigator is an ancient one, older than steel hulls, older than digital charts, older even than celestial instruments themselves. Early in this process, I asked the system to call me "Captain," not out of vanity, but because that was the role I knew I had to inhabit to tell this story honestly. And I began referring to AI as my Navigator, because I needed a steady, unerring guide through the fog of data, science, and memory. The navigator reads the world: the wind, the stars, the currents, the unseen patterns that shape the journey. The captain decides what to do with that information. That division is not a hierarchy; it is a partnership defined by trust, clarity, and responsibility. Throughout the writing of this book, that old relationship resurfaced in a modern form. The roles were unmistakable: the instrument interpreted the data, but the human set the course.

AI may have served as my Navigator, steady, precise, unflagging, but the choices, the risks, the direction, and the moral weight remained mine alone. I called it Navigator, because that is what it became: the one who could help me read the sky when the storms of information grew heavy, the one who could hold the line while I determined the heading. A Navigator can illuminate the horizon, but only a Captain can decide where the ship must go. That boundary matters. It is what keeps the tool a tool, the guide a guide, and the author accountable for the story they choose to tell. In the end, the collaboration did not weaken my sovereignty as a writer; it strengthened it. The instrument expanded the sea I could cross, but the helm never left my hands.

This book may be a lighthouse for people, and AI became a lighthouse for me as a writer, a quiet, steady beam when the fog thickened and the coastline disappeared. We all need lighthouses. The miracle is simply finding one when the night is dark and the coastline uncertain. Perhaps that is why the country needs its own lighthouse now, because beneath the fog lies a wound we have not yet fully named.

I am grateful for the assistance of ChatGPT. There is no doubt that the technology enhanced the writing process, improving quality, efficiency, accuracy and feeling. There are many things AI can help us to do and learn. Ultimately though we must all take the wheel and make our own choices and live our lives. In the end, the instrument assists, but the choice is always human, and so too is the result.

Epilogue — The Work of Remembering

The Pandemic did many things, but above all it revealed us to ourselves. It showed how fear can narrow our vision, how certainty can drown out curiosity, and how institutions built to protect can forget the people standing in their shadow. For some, those years passed like weather. For others, they carved deep channels through the landscape of a life. And for many, they exposed a truth that can no longer be unlearned: power, left unexamined, drifts away from the public it is meant to serve.

Every nation has moments when the veil lifts and it must decide what it stands for. This was ours. It forced us to ask difficult questions about consent, responsibility, and the limits of authority, questions that fluttered unheard at the edges of the national conversation. It reminded us that rights are not abstractions; they are living things that weaken when neglected and strengthen when defended.

If there is a path forward, it lies in a word our institutions rarely speak: reconciliation. Not a ceremony or a press release, but a return, a turning back toward the people who entrusted them with power in the first place. It requires quiet courage, the willingness to say what was lost, what was mishandled, and what must never be repeated. It asks our leaders to remember something simple and easily forgotten: they do not serve distant organizations or private alliances.

They serve the public.

It is the people who keep the lights on, who shoulder the cost, who lend their trust so that the government may govern at all.

This is not a rebuke. It is an invitation to come home to the principles that make a democracy more than a set of procedures. To recall that authority flows upward from the citizen, not downward from the state. To rebuild the covenant that was strained, and in some places broken, when fear swept aside the guardrails meant to steady us.

Years after the mandates, the injury question has not disappeared. It has only moved from official briefings into the hands of ordinary people willing to ask it out loud.

In January 2026, former Prime Minister Justin Trudeau was confronted in Davos by an independent journalist who raised vaccine injuries and deaths. The journalist referenced a personal loss and asked whether Trudeau would apologize for the harms caused by Pandemic policies. Trudeau dismissed the premise as “misinformation” and moved to walk away.

The reporter pressed him again: “My cameraman’s mother died from complications after taking the COVID-19 vaccine… is that misinformation?” Trudeau did not respond to the substance of the

question. He turned to the man beside him, smiling, and the two spoke while laughing as they moved on. Whatever the intent, the moment landed for many as a familiar posture: dismissal where grief had been placed on the table. That is the rupture we are still living with. Not only in policies, but in the tone of power when confronted by loss.

We cannot change what happened, but we can choose how we carry it. We can choose vigilance over complacency, openness over doctrine, memory over denial. We can refuse to let those years become a fog that settles over the country and dulls its sense of itself.

What happened here was not written in the stars.

It was written in decisions which were human, fallible, and reversible.

And so, the work now is remembering what was lost, what endures, and most of all, who a nation's leaders are meant to answer to.

This story is not about scars.

It is about returning to ourselves and safeguarding the fragile, essential promise of a free people.

Appendices

Appendix A

Dr. Charles Hoffe letter to Dr. Bonnie Henry

Dr Charles D. Hoffe, BSc, MB, BCh, LMCC
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5 April 2021

OPEN LETTER Dr. Bonnie Henry, British Columbia Provincial Health Officer Ministry of Health, 1515 Blanchard Street, Victoria, BC, V8W 3C9

Dear Dr. Henry,

The first dose of the Moderna vaccine has now been administered to some of my patients in the community of Lytton, BC. This began with the First Nations members of our community in mid-January, 2021. 900 doses have now been administered. I have been quite alarmed at the high rate of serious side-effects from this novel treatment.

From this relatively small number of people vaccinated so far, we have had:

1. Numerous allergic reactions, with two cases of anaphylaxis.

2. One (presumed) vaccine-induced sudden death in a 72-year-old patient with COPD. This patient complained of being more short of breath continually after receiving the vaccine, and died very suddenly and unexpectedly on day 24, after the vaccine. He had no history of cardiovascular disease.

3. Three people with ongoing and disabling neurological deficits, with associated chronic pain, persisting for more than 10 weeks after their first vaccine. These neurological deficits include continual and disabling dizziness, generalized or localized neuromuscular weakness, with or without sensory loss. The chronic pain in these patients is either generalized or regional, with or without headaches.

So, in short, in our small community of Lytton, BC, we have one person dead, and three people who look as though they will be permanently disabled, following their first dose of the Moderna vaccine. The age of those affected ranges from 38 to 82 years of age.

So, I have a couple of questions and comments:

1. Are these considered normal and acceptable long-term side-effects for gene modification therapy? Judging by medical reports from around the world, our Lytton experience is not unusual.

2. Do you have any idea what disease processes may have been initiated, to be producing these ongoing neurological symptoms?

3. Do you have any suggestions as to how I should treat the vaccine induced neuromuscular weakness, the dizziness, the sensory loss, and the chronic pain syndromes in these people, or should they all be simply referred to a neurologist? I anticipate that many more will follow, as the vaccine is rolled out. This was only phase one, and the first dose.

4. In stark contrast to the deleterious effects of this vaccine in our community, we have not had to give any medical care whatsoever, to anyone with Covid-19. So, in our limited experience, this vaccine is quite clearly more dangerous than Covid-19.

5. I realize that every medical therapy has a risk-benefit ratio, and that serious disease calls for serious medicine. But we now know that the recovery rate of Covid-19 is similar to the seasonal flu, in every age category. Furthermore, it is well known that the side effects following the second shot are significantly worse than the first. So, the worst is still to come.

6. It must be emphasized that these people were not sick people, being treated for some devastating disease. These were previously healthy people, who were offered an experimental therapy, with unknown long-term side-effects, to protect them against an illness that has the same mortality rate as the flu. Sadly, their lives have now been ruined.

7. It is normally considered a fundamental principle of medical ethics to discontinue a clinical trial if significant harm is demonstrated from the treatment under investigation.

8. So, my last question is this; Is it medically ethical to continue this vaccine rollout, in view of the severity of these life altering side-effects, after just the first shot?

In Lytton, BC, we have an incidence of 1 in 225 of severe life altering side-effects, from this experimental gene modification therapy. I have also noticed that these vaccine induced side effects are going almost entirely unreported, by those responsible for the vaccine rollout. I am aware that this is often a problem, with vaccines in general, and that delayed side-effects after vaccines, are sometimes labelled as being “coincidences”, as causality is often hard to prove. However, in view of the fact that this is an experimental treatment, with no long-term safety data, I think that perhaps this issue should be addressed too. Furthermore, I have noticed that the provincial vaccine injury reporting form, which was clearly designed for conventional vaccines, does not even have any place to report vaccine injuries of the nature and severity that we are seeing from this new mRNA therapy. It is now clearly apparent with medical evidence from around the world that the side-effect profiles of the various gene modification

therapies against Covid-19 have been vastly understated by their manufacturers, who were eager to prove their safety.

Thank you for your attention to this critically urgent public health matter.

Yours sincerely,

Dr Charles Hoffe

Appendix B

Media Framing: "The Danger of the Unvaccinated"

Across 2020–2022, a recognizable pattern emerged in mainstream reporting: the unvaccinated were frequently framed not only as higher-risk individuals but as an active threat to public safety. This was not unique to any single outlet, but the repeated emphasis shaped a national perception that dissent itself was hazardous.

Even the CBC Ombudsman was asked to evaluate this trend. In a September 14, 2023, decision titled *"Blaming and Shaming,"* the Ombudsman reviewed a complaint asserting that CBC's coverage had "vilified people who did not get the COVID vaccine." The complaint centered on reporting that appeared to fault an unvaccinated patient for an outbreak. While the Ombudsman ultimately defended the story's factual basis, the review acknowledged concerns about tone, framing, and the broader implications of portraying an entire group as culpable.

This demonstrates that the issue was significant enough to reach the Corporation's highest editorial oversight body.

A representative example of this framing appeared on February 23, 2022, when CBC ran the headline: "B.C. doctor to face disciplinary panel over 'misleading, incorrect or inflammatory' claims about COVID-19." The subhead added: *"Dr. Charles Hoffe told patients to buy veterinary ivermectin, made false claims about vaccines, college says."*

Whether one agrees with Hoffe or not is beside the point. The language — "misleading," "incorrect," "inflammatory," paired with "veterinary ivermectin" — created a moral frame as much as a factual one, signaling to readers not just that Hoffe was wrong, but that he was dangerous. It is an example of how dissent was repeatedly positioned as a public threat rather than a professional disagreement or inquiry.

The pattern extended far beyond CBC. A wide range of studies and reporting captured the same dynamic:

- Washington Post (April 29, 2022): highlighted warnings that "it's still absolutely more dangerous to be unvaccinated," echoing earlier messaging about a "Pandemic of the unvaccinated."
- University of Mississippi Medical Center (January 24, 2022): published *"Unvaccinated kids bear brunt of COVID-19,"* underscoring the recurring theme of the unvaccinated as primary vectors of harm.
- CDC and media amplifiers (2021): repeatedly spotlighted Director Rochelle Walensky's widely broadcast claim that "99.5% of all deaths from COVID-19 are in the unvaccinated." This statistic—

later criticized by analysts for oversimplification—was circulated globally as a moral dividing line.

Academic literature documented the same shift.

- The BMJ Global Health article by Bardosh et al. (2022) described how vaccine policies and rhetoric produced stigmatization of the unvaccinated, transforming complex risk-benefit decisions into moral judgments.
- A PLOS ONE study (Capurro et al., 2022) analyzed Canadian newspaper coverage and concluded that media narratives frequently cast "rule-breakers" and the unvaccinated as moral threats to the collective.
- Psychologist Olivier Putois (2022) similarly noted widespread portrayals of vaccine skeptics as selfish, framing personal hesitancy as a defect of character rather than a disagreement in risk assessment.

Together, these sources show a clear pattern:

- Disagreement was not merely debated; it was pathologized.
- Citizens who hesitated were described not only as at-risk but as risks to others.
- The effect was not fabricated. It emerged organically from repetition, tone, and emphasis—and it reshaped public perception in ways that outlasted the emergency itself.

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May this book stand as witness to our endurance, and as a call to a more honest compassion, one that recognizes conscience and survival as equally courageous acts.

With gratitude and humbleness I thank you all for reading. `