Canadian Covid Care Alliance
Alliance canadienne pour la prévention et prise-en-charge de la covid
CCCA

Website: www.canadiancovidcarealliance.org
E-mail: info.canadiancovidcarealliance.org

Open Letter 6 February 2023

To: Alex Himelfarb, Ph.D.

The Council of Canadian Academies
180 Elgin Street, Suite 1401
Ottawa
Ontario K2P 2K3

Re: CCA publication: Fault Lines - Expert Panel on the Socioeconomic Impacts of Science and Health Misinformation

Dear Dr. Himelfarb:

We in the Scientific and Medical Advisory Committee (SMAC) of the Canadian Covid Care Alliance (CCCA) have read with interest your aforementioned report.[1] Here, we raise many issues that we found with our review of this document. In particular, we take issue with the characterization or lack thereof of what constitutes as misinformation, the disregard for legitimate concerns associated with the government handling of the COVID-19 pandemic, and erroneous modeling and conclusions presented in Chapter 4. Several of our other concerns have already been highlighted in a recent Financial Post article that also offers an accurate critique of this CCA report.[2]

Competencies and Conflicts of Interest

At the CCCA, as professional volunteers, we are dedicated to carefully reviewing the scientific literature in a balanced and evidence-based manner, independently of government or corporate funding. Consequently, we are taken aback by the defamatory insinuation in your document that our organization is a spreader of misinformation as portrayed in Figure 6.2 on page 118 in your report. The 36 members of the SMAC, which is primarily constituted with biomedical researchers and medical health professionals, have been meeting weekly and communicating daily for over two years to carefully review the scientific literature, and data from public health authorities across Canada and other countries that have similarly adopted unprecedented military-grade COVID-19 medical countermeasures in lock-step on their populace. Our ranks include many with expertise in immunology, virology, infectious diseases, pharmaceuticals, data analytics and biochemistry. Our publications and videos have been developed to educate and inform Canadians. They have been produced to serve the common good to permit informed decision making based on high quality scientific evidence and biomedical ethics that preserves human dignity and civil liberties.

As a body of concerned health care providers and scientists, we had sent a letter on September 30, 2022 by ground post and email to the current Director of Health Canada, the Honourable Jean-Yves Duclos, MP Minister of Health.[3] We have not received a response from the Minister or Health Canada for over four months now. We surmise that the Government of Canada is reluctant to discuss their "so-called" approval of the COVID-19 mRNA vaccines, especially since it negotiated their purchase (a total of ~ 10 doses per habitant) months in advance of any Health

[1] https://cca-reports.ca/reports/the-socioeconomic-impacts-of-health-and-science-misinformation/
[2] https://financialpost.com/opinion/cca-panel-offers-post-truth-misinformation-opinion?_ga=2
[3] https://www.canadiancovidcarealliance.org/wp-content/uploads/2022/10/22SE30_Oldfield-Letter-to-Duclos.pdf

Canada formal approval for these products.[4] This also included major financial commitments to their future domestic production with Moderna in Canada after their initial failure for their procurement from CanSino Biologics in China. It is reasonable to assume that such financial conflicts of interest and intense politicization of the COVID-19 enterprise has grossly stifled open scientific debate in good faith amidst state-sponsored information control.

In view of your government funding from Innovation, Science and Economic Development (ISED) Canada, we question the neutrality of the formed panel of 13 experts that were the primary contributors to your report. We note that the panel, based on their biographies, seem to have limited knowledge in the areas of virology, immunology and vaccines. This is crucial for understanding the benefits and risks of vaccines and other measures that were taken during the COVID-19 pandemic. Consequently, your panel does not appear to be in a position to distinguish between fact and speculation with a thorough understanding of the scientific literature with respect to the COVID-19 pandemic and the solutions that have been offered. They do not appear to be able to critically appraise the data and duly consider the weaknesses and limitations of published studies. For example, Professor Timothy Caulfield on your panel has only an undergraduate degree in science, and while he may have a good grounding on legal and ethical matters, from his numerous postings in social media and publications, it is evident that he has failed to recognize the misinformation or deficiencies in many statements issued from unelected public health officials that have regretfully influenced political decision making. He has publicly stated that he has no interest in debating with scientists with contrarian views.[5] He continues to ignore even recent calls for discourse with Dr. Byram Bridle, who is a member of the CCCA SMAC.

Defining Misinformation

The very issue of defining what is misinformation versus fact is not addressed in your report. We are worried that this report can readily be weaponized by those in power to silence dissent and suppress truth, as the history of authoritarian regimes reminds us. It would appear that in the overzealous efforts to quash any debate against the dogmatic and apparently infallible assertions established by certain "health experts," the legitimate concerns of thousands of scientists and medical doctors about the inadequate clinical testing and efficacy, sub-standard manufacturing and distribution, as well as risks of experimental genetic COVID-19 vaccine prototypes have been highly censored and ignored. Such adherence to political dogma over scientific fact was exemplified in the case of 60,000 scientists and health professionals who signed the Great Barrington Declaration expressing "grave concerns about the damaging physical and mental health impacts of the prevailing COVID-19 policies," and whose concerns were unjustly silenced and dismissed.[6] In addition to the COVID-19 vaccinations, this declaration was critical of other measures, which included lockdowns with arbitrary school/workplace closures, and quarantining of presumptive PCR screen-positive yet otherwise healthy 'asymptomatic' individuals.

To brush off in broad-stroke information that does not align with the Public Health Agency of Canada (PHAC) narrative as misinformation does not serve the public interest. While in Canada, PHAC still advocates the COVID-19 vaccination of babies as young as 6 months old, the public health authorities in other countries such as Australia, Denmark, Finland, Norway, Sweden and the United Kingdom, do not call for, and in some instances, do not offer the same vaccines to those under 12 years of age. Even the National Advisory Committee on Immunization (NACI) in Canada has recommended that vaccination of children under 5 years of age should be discretionary.[7] Moreover, the

[4] https://www.canada.ca/en/public-services-procurement/news/2020/09/government-of-canada-signs-new-agreements-to-secure-additional-vaccine-candidate-and-treatment-for-covid-19.html

[5] https://vancouversun.com/opinion/columnists/ian-mulgrew-science-proves-to-be-messy-on-the-fly

[6] https://gbdeclaration.org/view-signatures/

[7] https://www.canada.ca/en/public-health/services/immunization/national-advisory-committee-on-immunization-naci/guidance-covid-19-vaccine-booster-doses-initial-considerations-2023.html

adenoviral DNA-based vaccines have become suspended for use in most developed countries due to higher risks of adverse clotting events. This was after authorities vouched for their safety while also promoting their mixed use with modified mRNA/lipid nanoparticles from different manufactures, irrespective of variations in dosage, product constituents and transfection mechanism, without any supporting evidence as to the safety or efficacy of such practice.

Notably, in reviewing the same or similar data as Health Canada, foreign health authorities have come to essentially the same scientific conclusions as the CCCA stated in the social media post that you have branded as "misinformation" in Figure 6.2 of your report. Several key foreign health authorities have determined that the safety and efficacy profile of COVID-19 vaccines is not sufficient to justify the continued vaccination of young children. Several of these countries, such as Australia, Denmark and the United Kingdom, are also no longer recommending booster vaccine shots for those under 40 and even 50 years of age. Yet instead of seriously examining this evidence, your report dismissively labels such analysis as misinformation.

Canada largely adopted a "quarantine until vaccination" model of public health that was riddled with absurdities and contradictions, fear-mongering, social disruptions, school/business closures, unprecedented wealth transfer, travel restrictions, and ultimately worsened physical and mental health outcomes disproportionately impacting the poor, marginalized, and children/young adults. For instance, collateral damage (*e.g.,* deaths of despair) includes a 135% surge in opioid-related deaths in Ontario alone during the first 6 months of 2020 as compared to 2019 that impacted mainly young adult males equivalent to an additional 17,843 quality-adjust life years lost.[8] None of these extraordinary public health decisions with documented harms appear to have received serious consideration in your report.

Importance of Scientific Debate

Scientific discourse and debate are critical to ensure the effectiveness and safety of the drugs, vaccines and other health practices that we submit to our community. This is especially the case for mandated and liability-free injectables. These were aggressively promoted to all healthy individuals as safe 'prophylactic agents' that were the only way to end the pandemic, irrespective of individual health concerns, even for previously infected and recovered individuals (*i.e*., those with natural immunity) and at early stages of pregnancy and fetal development. Without such discourse, the harmful effects of originally approved products like thalidomide, diethylstilbesterol, Vioxx and OxyContin, and the 1976 swine flu vaccine would not have come to light and been withdrawn from the market. Even now, government vaccine adverse events reporting systems such as the US FDA's VAERS,[9] European Medicines Agency's EudraVigilance and the World Health Organization's VigiAccess have tabulated more injuries, disabilities and deaths attributed to COVID-19 vaccines in the last two years than all of more than 80 other vaccines combined in the last 30 years. Not all vaccines are equivalent or necessarily promote health due to *non-specific, poorly understood and unintended adverse effects* rarely measured in clinical trials as documented, for example, in the five-fold higher infant mortality of diphtheria-tetanus-pertussis (DPT) vaccinated as compared to not yet DPT vaccinated infants in Guinea-Bissau that could be modulated by use of an oral polio vaccine.[10]

The application of the Bradford-Hill tenets for establishing causality from mere association in observational data has been largely satisfied based on several measures at this stage. This includes *consistency* of adverse events reported

[8] Gomes, T., Kitchen, S.A., Murray, R. (2021) Measuring the burden of opioid-related mortality in Ontario, Canada, during the COVID-19 pandemic. JAMA Netw. Open. 4(5):e2112865. doi: 10.1001/jamanetworkopen.2021.12865

[9] https://www.openvaers.com/

[10] Mogensen, S.W., Andersen, A., Rodrigues, A., Benn, C.S., Aaby, P. (2017) The introduction of dipththeria-tetanus-pertussis and oral polio vaccine among young infants in an urban African community: A natural experiment. EBioMedicine. 17:192-198. doi: 10.1016/j.ebiom.2017.01.041

in different regions as a function of vaccination/booster rates, *temporality* of adverse events recorded within hours/days/weeks of injection, and *biological gradient* with worse clinical outcomes (*e.g*., myocarditis and myopericarditis) attributed to more frequent injections and/or use of greater mRNA dosage products. Also, *plausibility/coherence* was satisfied based on the many mechanisms of harm, including autoimmune response against uncontrolled non-self/viral spike protein expression, and *experiment* from review of the expanding COVID-19 scientific literature. For instance, the highly inflammatory nature of cationic lipids utilized as adjuvants/carriers/stabilizers of modified mRNA products acted to ensure their widespread distribution well beyond the site of injection throughout the body as confirmed in pre-clinical mouse studies published after the start of the mass vaccination campaign.[11]

Misinformation in Promotion of Vaccination

The primary culprits in the promotion of misinformation have been the public health agencies who have been parroted by mainstream media, which derive a significant portion of their operating funds from government and pharmaceutical company grants and advertising. Additionally, active collusion among global media/technology companies and their corporate and philanthropic partners to "combat harmful vaccine disinformation" in late 2020 prior to the COVID-19 vaccines roll-out is a matter of the public record (*i.e.,* Trusted News Initiative). Information control, behavioral modification strategies (*i.e*., nudge units) and changing word meanings (*i.e.,* redefining vaccines, pandemics, herd immunity) have been cynically altered to obfuscate and confuse the populace, including a denial of the efficacy of natural infection-derived immunity. Many of the methods attributed to the spread of misinformation in your report have in fact been practiced by public health agencies, government officials, and regulatory colleges for physicians and other health professionals. For example, until the last year, anyone that was tested PCR positive with SARS-CoV-2, despite a false-positive rate up to 90% due to the high thermal cycle numbers typically used for diagnosis, was counted as a COVID-19 case in hospitalization, ICU admissions and death statistics. This included individuals that had been vaccinated, but acquired COVID-19 within 2- to 3-weeks of their inoculation being classified as unvaccinated for statistical purposes. Last year, public health authorities and hospitals finally admitted that they had significantly over counted hospital admission for COVID-19 by not differentiating admissions "for COVID-19" from admissions "with COVID-19."

Many out-spoken, credible scientists and medical doctors that have raised such concerns have been effectively threatened, muzzled, censored and subjected to public ridicule with the prospects of losing their livelihoods. This injustice has been experienced once again by Dr. Patrick Provost on the SMAC, with a second four-month suspension without pay from the University of Laval for merely stating what is supported in the peer-reviewed, scientific literature.[12] Your report only further contributes to magnifying efforts to silence and discourage those that are knowledgeable on these matters to speak up and protect the Canadian public from fraud, malfeasance and corruption.

Your report produced with funding from ISED Canada appears to follow a trend of other government agency sponsored initiatives designed to counteract vaccine hesitancy. For example, Dr. Donald Redelmeier at the Sunnybrook Health Sciences Centre was another recipient of a $50,000 NSERC grant to "Encourage Vaccine Confidence in Canada." In a poorly performed and easily criticized study that received broad media coverage, he and his team recently reported in the American Journal of Medicine that vaccine hesitancy correlated with increased risks

[11] Ndeupen, S., Qin, Z., Jacobsen, S., Bouteau, A., Estanbouli, H., Igyrárto, B.Z., (2021) The mRNA-LNP platform's lipid nanoparticle component used in preclinical vaccine studies is highly flammatory. Science 24(12):103479. doi: 10.1016/j.isci.2021.103479

[12] https://www.theepochtimes.com/laval-university-professor-suspended-for-vaccine-criticism-faces-new-disciplinary-threat_4734126.html

of traffic crashes in Ontario.[13] This same investigator also reported that low fruit consumption linked with increased risk of traffic fatalities in the US.[14]

In a recent publication coauthored by Dr. Teresa Tam, the Chief Public Health Officer of Canada, it was claimed that without government COVID-19 policies, including pushing the COVID-19 vaccines, there would have been up to 800,000 COVID-19 deaths in Canada.[15] This incredulous outcome corresponds to a higher per capita death rate than for all Canadian lives that were lost in World War I, the 1918 influenza pandemic, and World War II combined. Such modelling was based on an infection fatality rate (IFR) for COVID-19 in the general population of 1 in 100, which is off by at least one order of magnitude. Even at a 1% IFR, taking into account the size of the Canadian population, this amounts to 380,000 people. Despite the wide publicity in news outlets for the ridiculous conclusions of this publication in the PHAC journal CCDR, we did not observe any criticism from Professor Caulfield in his crusade to expose "misinformation" for this article. In fact, real-world data from global seroprevalence studies indicate a median IFR of 0.034% for those under 60 years old with the largest burden of COVID-19 carried by the elderly and frail in nursing homes as evident early in the pandemic.[16] In fact, the COVID-19 pandemic is likely a mere reflection of a growing pandemic of obesity, poor nutrition/lifestyle, metabolic syndrome and chronic disease burden/comorbidities (*e.g.*, type 2 diabetes, cardiovascular disease, frailty, *etc.*) in most developed countries whose populations are also more vulnerable to seasonal respiratory infections.[17] Regrettably, draconian public health policies advocated for COVID-19 have only exacerbated existing health inequities and ultimately failed to protect those greatest at risk, while shifting the socioeconomic burden indiscriminately to the population as a whole.

Your own report in Chapter 4 suggests that "misinformation" has resulted in 2,800 extra deaths due to COVID-19 from vaccine hesitancy. In the first year of the COVID-19 pandemic in Canada, there were 14,642 deaths recorded with COVID-19 before the availability of vaccines. There have been about 14,580 and 20,344 additional deaths in 2021 and in 2022, respectively, associated with COVID-19. Thus, despite the prevalence of less virulent Omicron variants of SARS-CoV-2 and about 87% of the population with two or more vaccinations during 2022, the number of COVID-19-related deaths were 39% higher than in 2020. Studies, including those conducted by Public Health Ontario,[18] indicated that close to half of all of these fatalities were not from COVID-19 itself, but rather from other comorbidities. Consequently, there does not seem to be any correlation with vaccination and the reduction of COVID-19-related deaths. This is in keeping with the published results of the 6-month, phase III clinical studies originally conducted with these vaccines, which showed higher death numbers in the vaccinated cohort.[19]

In addition, your modeling does not take into account any of the deaths that may have occurred from COVID-19-vaccine induced injury. For example, in the US VAERS, there have been over 33,900 deaths in the US alone allegedly linked to the COVID-19 vaccines,[9] and even as fewer than 2% of vaccine injuries are believed to be recorded in the

---

13 Redelmeier, D.A., Wang, J., Thiruchelvam, D. (2023) COVID vaccine hesitancy and risk of a traffic crash. Am. J. Med. 136:153-162. https://doi.org/10.1016/j.amjmed.2022.11.002

14 Wang, J., Redelmeier, D.A. (2023) Vaccine hesitancy and traffic deaths: Ecological analyses. J. Gen. Intern. Med. doi: 10.1007/s11606-022-08008-z

15 https://www.canada.ca/en/public-health/services/reports-publications/canada-communicable-disease-report-ccdr/monthly-issue/2022-48/issue-7-8-july-august-2022/counterfactuals-effects-vaccination-public-health-measures-covid-19-cases-canada.html

16 Pezzullo, A.M., Axfors, C., G-Contropoulos-Ioannidis, D., Apostolatos, A., Ionnidis, J.P.A. (2023) Age-stratified infection fatality rate of COVID-19 in the non-elderly population. Environ. Res. 216(Pt 3):114655. doi: 10.1016/j.envres.2022.114655.

17 Stefan, N., Birkenfeld, A.L., Schulze, M.B. (2021) Global pandemics interconnected – obesity, impaired metabolic health and COVID-19. Nat. Rev. Endocrinol. 17:135–149. https://doi.org/10.1038/s41574-020-00462-1

18 https://data.ontario.ca/en/dataset?groups=2019-novel-coronavirus

19 Thomas, S.J., Moreira, E.D., Kitchin, N., *et al.* (2021) Safety and efficacy of the BNT162b2 mRNA COVID-19 vaccine through 6 months. N. Engl. J. Med. 385:1761-1773. doi: 10.1056/NEJMoa2110345

VAERS.[20] Furthermore, COVID-19 vaccine compliance is estimated to be lower in the US population at around 79% with two or more inoculations with the vaccines as compared to about 87% in Canada. With lower vaccination rates in the US than Canada, the vaccine injury rates per capita would also be lower. Furthermore, unlike Canada, the Astra-Zeneca COVID-19 vaccine was not approved by the US FDA. Ignoring the differences in vaccination rates, but accounting for the differences in sizes in the US and Canadian populations, there would be equivalent to around 3,900 death reports in VAERS for Canada. While all the deaths recorded in VAERS are not necessarily caused by the COVID-19 vaccines, it is reasonable to multiply this number by at least 10-times to get a better sense of the actual deaths due to COVID-19 vaccines due to known underreporting to VAERS. Thus, the total number of COVID-19 vaccine deaths in Canada may be comparable to those from COVID-19 alone.

Due to death misclassification given incentives to overreport incidental COVID-19 cases, whilst underreporting vaccine-associated serious adverse events, the only bias-free approach to assess the long-term impact of public health policies, including mass vaccinations, is via assessment of age-stratified excess mortalities, disabilities and birth rates across different countries as a function of the primary series/booster injection rate in the population. In 2022, the all-cause mortality rate was higher than that in 2021, which itself was higher than in 2020, indicating that the measures put in place by our government may not have had an overall positive impact on the crisis, but rather may have worsened it more than the sole virus itself without any measures. Such a review has not, to our knowledge, been undertaken by any public health agency or authority in Canada in spite of the alarming rise in excess mortality in Canada and other highly vaccinated countries around the world following the rollout of the mass vaccination campaigns.

Despite public health authority claims that the COVID-19 vaccines prevented SARS-CoV-2 transmission, hospitalization, and/or severity of COVID-19 in those that did get the disease, these claims were not in fact tested or demonstrated in any controlled phase III clinical trials as primary or secondary endpoints. Additionally, the original public health officials' claims that the short-lasting mRNA vaccines remained near the injection site without widespread/uncontrolled distribution and rare side-effects (less than 1:100,000) are largely debunked now. There are also alarming concerns with repeated booster injections connected to immune tolerance and immune imprinting on top of the other serious thrombotic, cardiac, and neurological complications that increase in risk with further injections.

The instigation of masking was also claimed to reduce the transmission of COVID-19, even though there were no studies from influenza pandemics to support this assertion, and this has also been conclusively demonstrated for COVID-19 by a recent Cochrane study,[21] where even N95 masks failed to show a significant reduction in SARS-CoV-2 transmission.[22] Nearly all coercive workplace mandates were based on the false premise that after an initial primary series of vaccinations, they ensured workplace safety and transmission reduction (*i.e.,* societal benefit), which was unfounded and not demonstrable as evidenced with the large Omicron waves of SARS-CoV-2 infections in late 2021 and early 2022.

Going Forward

The inability of the COVID-19 vaccines to maintain immunity against SARS-CoV-2 even after four inoculations within an 18-month period demonstrates their clear failure. Fortunately, the reduced virulence of the recent Omicron

[20] Lazarus, R., Klompas, M. (2011) Harvard Pilgrim Study - Lazarus Final Report 2011 | PDF | Electronic Health Record | Adverse Effect. Grant Final Report ID R18 HS 017045

[21] https://www.cochrane.org/CD006207/ARI_do-physical-measures-such-hand-washing-or-wearing-masks-stop-or-slow-down-spread-respiratory-viruses

[22] The 2023 Cochrane review concludes that "RCTs did not show a clear reduction in respiratory viral infection with the use of medical/surgical masks." This statement according to paragraph 2 on page 4 of Fault Lines should now be considered misinformation according to the definition made in Section 1.2.

variants of SARS-CoV-2, and the acquisition of natural immunity by greater than 85% of the population following their viral infection has brought the threat level of this pandemic markedly down, contrary to the pronouncements of our health authorities. This clearly obliviates the need to vaccinate the vast majority of our healthy population, including infants and children, using obsolete, unnecessary, unsafe and ultimately negatively-efficacious genetic mRNA inoculants falsely marketed as effective vaccines where one is never fully immunized.

The only way to determine whether or not the current government is being candid with the Canadian people is to have open public dialogues to discuss the science behind the federal and provincial governments' handling of the COVID-19 pandemic. While various forms of misinformation abound in social media with regards to COVID-19 vaccines and other treatments, there is also much confusion and downright misinformation emanating from public health authorities and self-proclaimed "trusted" media. Only by active promotion of discourse on controversial public health policies can the general public be properly served and make informed decisions about the best course of actions in confronting the COVID-19 pandemic and future health emergencies. No individual or organization can claim to "own the science." The condescending approach of 'health experts' to assume the public cannot make informed decisions based on reliable information following a personal evaluation of the purported benefits and risks of a medical intervention is a complete reversal of the principles of evidence-based medicine and biomedical ethics. The application of the scientific method is an effective strategy to uncover the truth. Knowledge is ever changing as more data accumulates, and people must recognize and acknowledge when they were wrong and when there exists considerable uncertainty based on poor quality evidence. It is essential to continuously, transparently, and carefully assess the scientific evidence in order to ensure that serious public health policy errors laid to bare by the COVID-19 pandemic are not repeated again in the future.

In closing, we would ask you and other members of your task force to reconsider the lack of accuracy in the modeling and conclusions stated in your report concerning the impact of "vaccine hesitancy" on the alleged unnecessary deaths and costs of hospitalization and other economic outcomes. All Canadians will benefit from accurate modeling and truthful public discourse, taking into account all of the data and evidence available, not coloured by political motivations. We would also ask for a public retraction of the inaccurate and defamatory labelling in your report of the CCCA's "stop the shots" campaign as misinformation.

Respectfully submitted by:

Dr. Byram W. Bridle, MSc, PhD, Associate Professor of Viral Immunology, Department of Pathobiology, University of Guelph

Dr. Philip Britz-McKibbin, PhD, Professor, Department of Chemistry and Chemical Biology, McMaster University

Dr. Claudia Chaufan, MD, PhD, Associate Professor, Health Policy and Global Health, York University

Dr. L. Maria Gutschi, BSc Pharm, Pharm D, Pharmacy Consultant, ex-Scientific Officer

Dr. John Hardie, BDS, MSc, PhD, FRCDC, Oral pathologist (retired), former Head of the Department of Dentistry at the Vancouver General Hospital

Dr. York Hsiang, MB, MHSc, FRCSC, Professor Emeritus of Surgery, University of British Columbia

Dr. Niel A. Karrow, MSc, PhD, Professor of Immunotoxicology, Department of Animal Biosciences, University of Guelph

Dr. Bonnie Mallard, MSc, PhD, Professor of Immunogenetics, Department of Pathobiology, University of Guelph

Dr. Kanji Nakatsu, PhD, Professor Emeritus, Department of Pharmacology, Queen's University

Dr. Susan Natsheh, MD, Pediatrician (retired), former Associated Professor, Dalhousie University

Dr. Philip R. Oldfield, DPhil, CSci, CChem, FRSC (UK) (retired)

Dr. Eric T. Payne, MD, FRCPC, Clinical Assistant Professor, Pediatrics, University of Calgary

Dr. Steven Pelech, PhD, Professor, Department of Medicine, University of British Columbia; President and Chief Scientific Officer, Kinexus Bioinformatics Corporation

Dr. Christopher Pinto, MD, Physician, Independent practice

Dr. Patrick Provost, PhD, Professor, Department of Microbiology, Infectious Diseases and Immunology, Faculty of Medicine, Université Laval

Dr. Denis Rancourt, PhD, Interdisciplinary research scientist, epidemiologist, former Professor, Physics, University of Ottawa

Dr. Wendi Roscoe, PhD, Professor, Department of Health Science, Fanshawe College

Dr. Christopher A. Shaw, PhD, Professor, Department of Ophthalmology, University of British Columbia

Dr. David J. Speicher, PhD, DTM, Assistant Professor of Biology and Health Sciences, Natural Sciences and Mathematics, Redeemer University

Dr. Lauraine Wagter-Lesperance, PhD, Senior Research Associate & Regulatory Affairs Manager High Immune Response Technology, University of Guelph