SCIENCE FOR WHOM?

Manufacturing social consent for government policies through the control of science production in New Zealand during the COVID-19 pandemic.

J.R. BRUNING

SCIENCE = SOCIAL PROCESSES

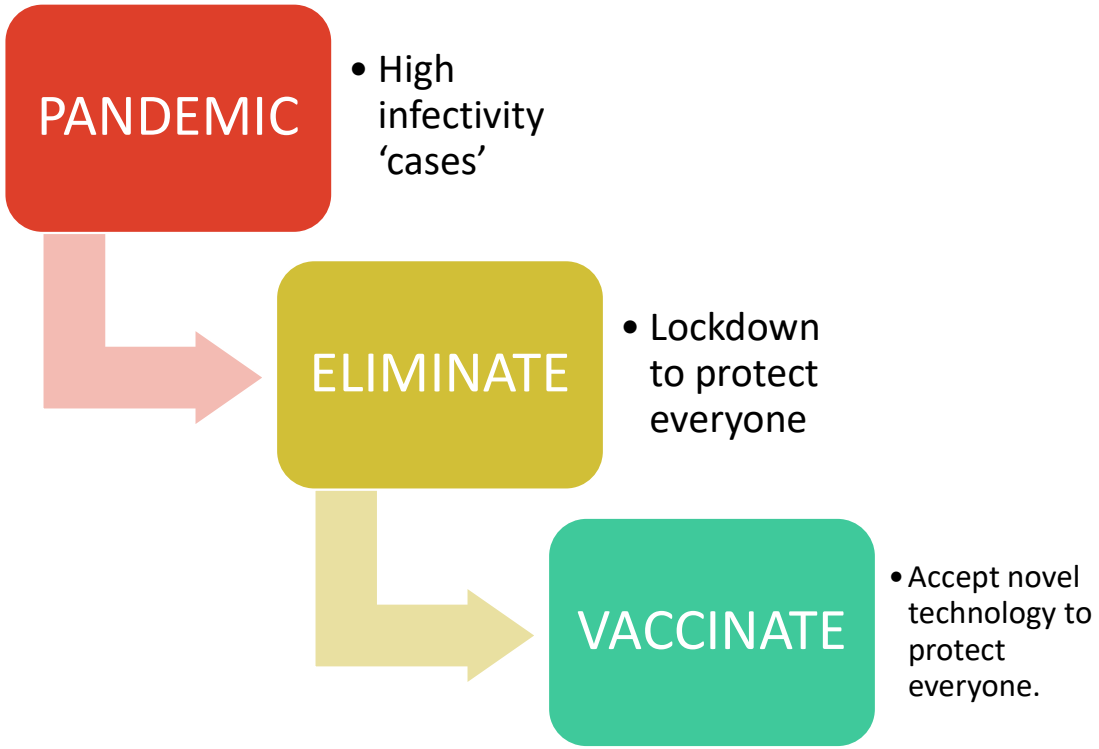
- Public interest rift – science in policy should be 'at arm's length' from vested interests

- Uncomfortable knowledge: Knowledge, which, if revealed, presented a danger to institutions because it such knowledge could potentially undermine institutional principles, arrangements and goals. (Rayner 2012)

Who funds the science

- Sets the scope
- Declares the values

STEPWISE STRATEGY



MISREPRESENTATION

1. PANDEMIC

Expectation: Event where general population at risk of death

- No! From 2009 – the definition of pandemic status altered to a *high infection/transmission* rate (not high death rate).

2. FATALITY

Expectation: Imperial College/WHO high case fatality / death risk

- Narrow risk group! From Feb/Mar 2020 known that only elderly & infirm, those with multiple health conditions at highest risk. Meaningful discussion of age stratified risk, and clarification that most were not at risk of hospitalisation and death, did not occur.

3. ELIMINATE

Expectation: New cases can be stopped with strict measures.

- No evidence! Coronaviruses are highly transmissible and mutate frequently. Believing new cases could be eliminated was a novel theory. Pharmaceutical and non-pharmaceutical measures to achieve elimination was a new theory.

4. RCTs ONLY

Expectation: Randomised control trial essential to approve drugs.

- Incorrect. Cochrane Institute in 2013 confirmed observational trials equally suitable. New drugs require strict RCT processes as toxicity is unknown. Generic/re-purposed drugs and nutrients with a long history of safe use do not require RCTs as their toxicity is known.

MISREPRESENTATION

5. WHO IS VACCINATED?

Expectation: only those at risk of COVID-19

- No! In June 2020 March 2021 a all-of-New Zealand staged roll-out plan was locked in place, with the 'remainder of the population' designated to be vaccinated from July 2021. Mandates would be set in place to drive vaccination.

6. EQUITY

Expectation: Equity of vaccination for all - will protect all

- No! COVID-19 risk differed by age and morbidity status, up to a thousandfold. The elderly & infirm, and those with multiple health conditions were at greatest risk of waning & breakthrough, vaccine failure. Safe early treatments tailored to individual needs (symptomologies) were suppressed in the first months of the pandemic.

7. VACCINE

Expectation: Live attenuated virus, localised, prevents transmission.

- No! The biologic drug (BNT162b2) comprised single-stranded messenger RNA (mRNA) which coded for full-length, codon-optimised, pre-fusion stabilised conformation variant (K986P and V987P) of the SARS-CoV-2 spike (S) glycoproteins (the antigen). Efficacy based on lesser symptoms 7 & 14 days post 2nd dose than placebo group.

ULTIMATE AUTHORITY

- Department of Prime Minister & Cabinet (Ardern)
- Minister for COVID-19 (Hipkins to Jun 2022 then Verrall)
- Minister of Health (Hipkins to July 2020, then Little)
- Assoc. Minister of Health (Verrall)
- Director General of Health (Bloomfield)
- Attorney General (Parker)
- Minister for Economic Development (MBIE) (Parker)

- Mandates roll-out as per policy - Minister for COVID-19 Response.

MARCH 2021 ROLL-OUT: EMBEDDED MANDATES

March 2021. 50,000 border & MIQ workers & household contacts.

Feb-May 2021. 480,000 frontline workers and people living in high-risk settings

May 2021. 1.7 million. Priority 'higher risk' populations.

July 2021. 2 million people. Remainder population.

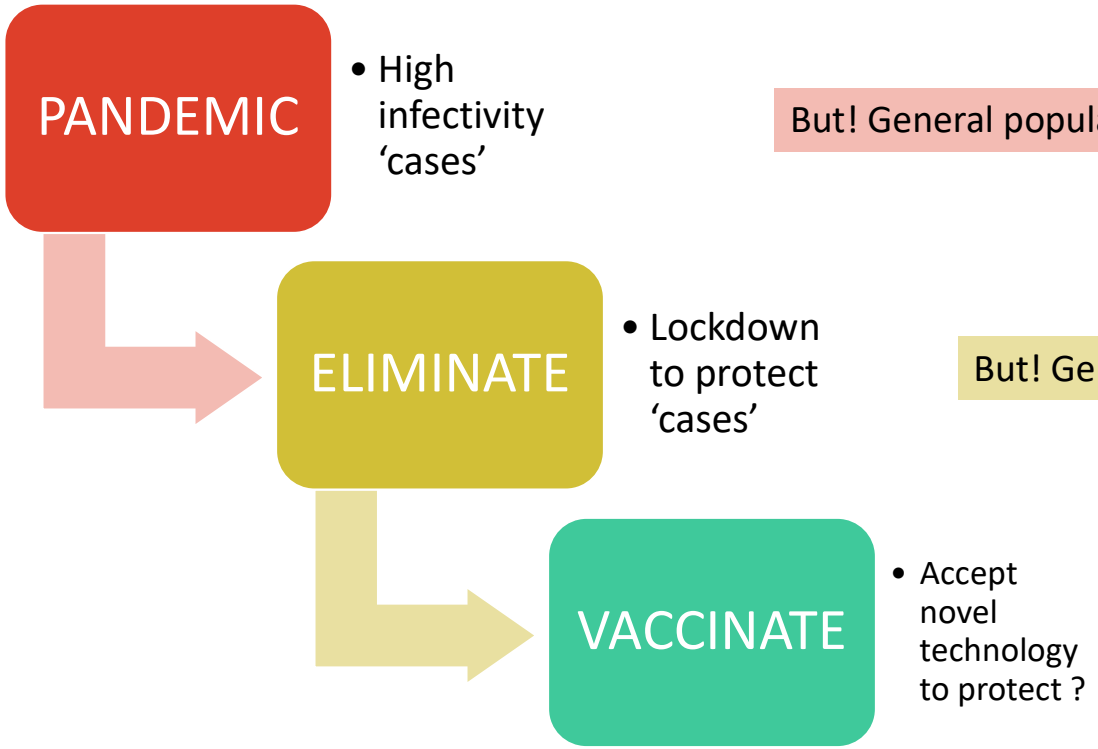
RISK-BENEFIT RATIO

Age group ?
Health/disease status ?

Risk of hospitalisation &/or death:

- COVID-19 *vs*
- Genetic vaccine

CASE FOCUS – CHASING INFECTION



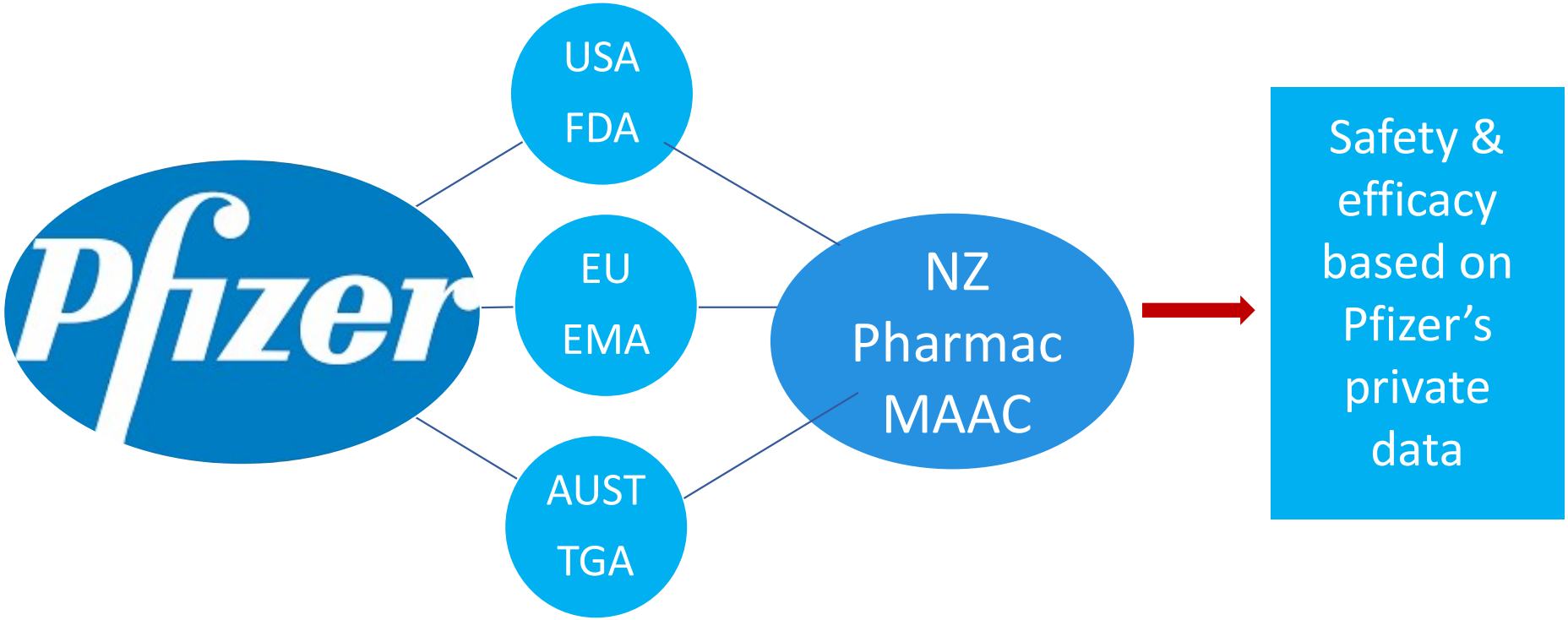
But! General population not at risk

But! General population not at risk

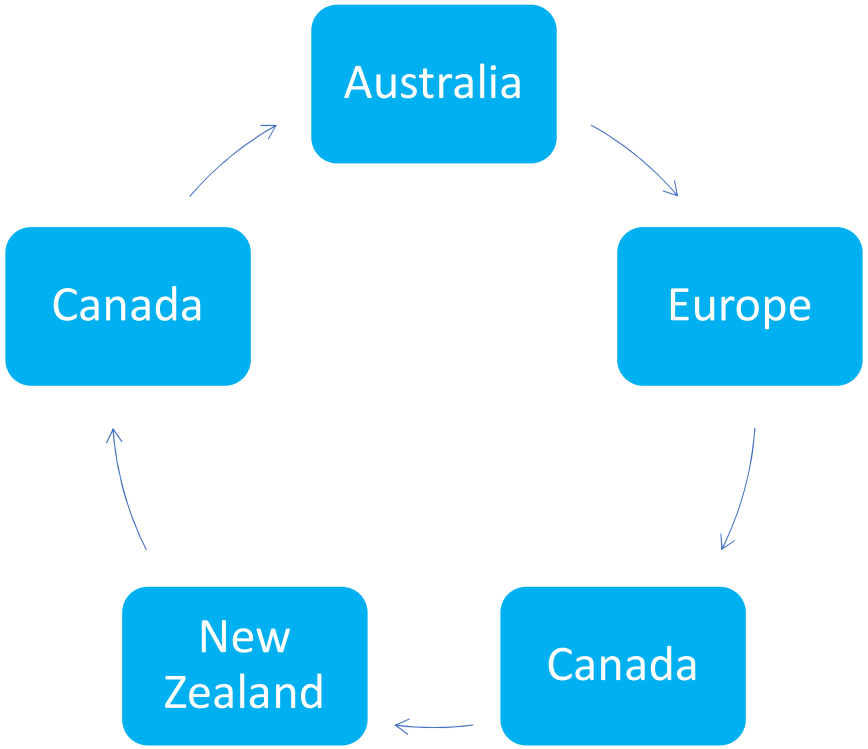
But! General population not at risk of virus. Required to submit to vaccination to return to normal.

New tech could have severe adverse reaction 1/100.

Pfizer clinical trial data - *collegiality*



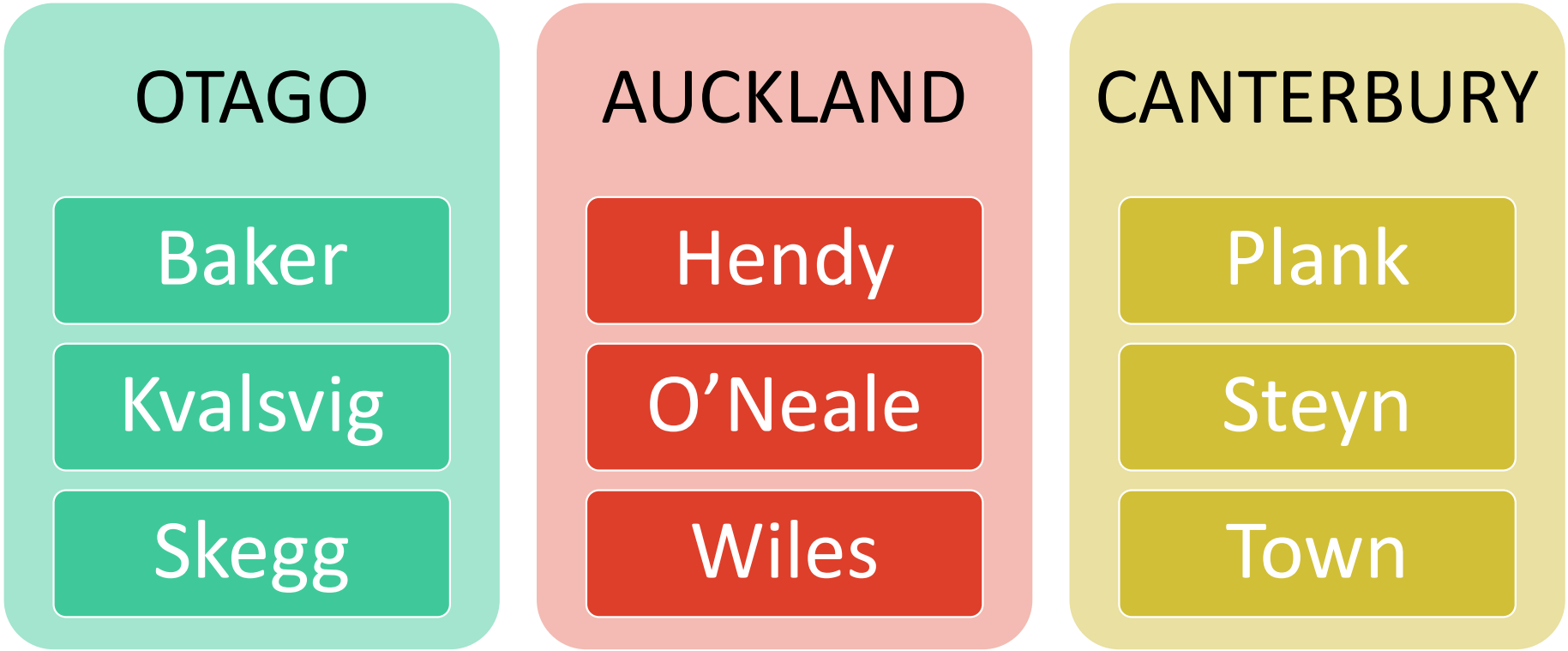
Regulatory round-a-bout



Published scientific & scholarly literature?

Never systematically reviewed for (safety & efficacy) signals

Vaccinate to Eliminate strategy



Vaccinate to Eliminate

- STRATEGIC PUBLIC HEALTH ADVISORY GROUP
- Covid-19 MODELLING AOTEAROA
- COVID-19 VACCINE TECHNICAL ADVISORY GROUP (CV-TAG)
- THERAPEUTICS TECHNICAL ADVISORY GROUP (Therapeutics-TAG)
- LONG COVID EXPERT ADVISORY GROUP
- COVID-19 TESTING TECHNICAL ADVISORY GROUP (CT-TAG)

PERMITTED

- Discussion of infectivity rates & case rates
- Examples of hospitalisation & death from COVID-19
- Surveillance & tracking
- Vaccine induced immunity
- Vaccination to 'reopen'

SUPRESSED

- Risk of hospitalisation and death from Delta & Omicron
- Waning & breakthrough following BNT162b2 injection
- Acknowledging (age & gender stratified) myocarditis risk
- Short term efficacy in comorbid groups at most risk of death

TABOO

- Changing case/infection fatality rate by age/health status
- Access to clinical trial data
- Methodological review of the published literature
- Short term efficacy endpoints for a mandated genetic vaccine
- Hospitalisation & death following vaccination

	SILENCING SCIENCE	TECHNIQUES OF CONTROL
1	PUBLIC HEALTH NORMS IGNORED	Ethical principles and processes to ensure that responses were proportionate to age-stratified risk and health status were discarded (risk-benefit analyses not undertaken).
2	TOR	Terms of reference limited exploratory research or reasoning by scientist cohorts.
3	ELITE CONTROL	A handful of elites were senior authors on the majority of legitimate information
4	CLINICAL TRIALS & REGULATORY DATA	Excusive reliance on RCTs and regulatory data kept methodological reviews of the published literature to assess weight of new evidence, pathways of risk, at arm's length.
5	CLINICAL TRIAL SUPREMACY	This ensured new & novel medications would be authorised while off-patent (repurposed) drugs would not be authorised. Pharma corporation do not fund RCT's for off-patent drug.
6	RULES DECOUPLED	The production of laws forcing mandates was decoupled from emerging evidence in the published literature. This law rolled out in accord with the March 2021 roll-out plan. No feedback loops would alter the rollout programme, no safety signal was developed.
7	INSTITUTIONAL CAPTURE (SCIENCE)	20 years of clinical and 'applied' or siloed expertise has produced a dearth of interdisciplinary 'polymaths'. No-one with authority to challenge contradictions.
8	INSTITUTIONAL CAPTURE (COURTS & MEDIA)	Courts & media have traditionally struggled with complex ethical, scientific and socio-cultural issues. (E.g. Decisions conflated the technology with traditional vaccines.)

THANK YOU FOR LISTENING!

SCIENCE FOR WHOM?

Manufacturing social consent for government policies through the control of science production in New Zealand during the COVID-19 pandemic.

J.R. BRUNING

Member/trustee: PSGR.org.nz
Personal: TalkingRisk.NZ
Blog/writing: JRBruning.Substack.com


Permitted
Supressed
Taboo