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The Case Against Vaccine Passports

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I was alerted to what was coming at the end of July. Under the headline "The time for debating vaccines passports is over," Globe and Mail health columnist André Picard wrote that "it would be irresponsible, not to mention politically and economically self-defeating, to not try limiting the intermingling of vaccinated and unvaccinated populations." Two words struck me as particularly eerie: "intermingling," and "population." At that point, I had decided against vaccination on various grounds. The most compelling was concern for my heart. I had had some heart troubles at the end of 2020, and I knew that the new vaccines occasionally produced heart inflammation—a frequent enough side effect that Health Canada requires a caution on the labels of the Pfizer and Moderna vaccines. Now, evidently, my decision had consigned me to a threatening "population" requiring segregation and exclusion.

Since then, there has been an almost daily increase in the number of jurisdictions climbing aboard the vaccine passport bandwagon. There are local variations in the nature of the "passports," but we may take the term as referring to the requirement that one produce proof of full vaccination as a precondition for travel, employment, or admission to various public places. France, Italy, and Israel now have internal passport systems, as do cities like New York and San Francisco. In Canada, five provinces have announced they will issue certificates of "adequate protection."

There are still holdouts. Most U.S. states have rejected or actively banned any passport system. But among my neighbors and even some old friends, there seems to be a solid consensus that any resistance to compulsory vaccination is a mark of selfishness, or much worse—of "anti-science" thinking, or conspiracy theory, or even outright denialism. Conversation is difficult under these circumstances, and has become so polarized and full of pitfalls that it has become much easier to call people names than to conduct a courteous discussion. With what follows I hope to encourage a more civil atmosphere.

Vaccine requirements have existed for a long time. I carried an International Certificate of Vaccination during youthful travels more than half a century ago. It's not the legitimacy of venerable public health restrictions of this kind that I want to talk about, but the very new

situation COVID has created.

Vaccines have normally taken up to seven years to develop and fully test. The COVID vaccines currently on offer were developed and tested within a year. Most of the studies justifying the "emergency use authorization" they initially received were not released to the public or even to other scientists. A recent British Medical Journal article on the subject reports an "overall picture" of what it delicately calls "varied transparency." It cites a "WHO report [which] found that out of 86 clinical trials for 20 COVID-19 vaccines, 12% of clinical trial protocols were made publicly available." These vaccines, moreover, employ a new and previously untried technology. It seems, therefore, both fair and factual to call them experimental vaccines, even if the word has taken on a polemical edge in the current fraught environment. It also seems fair to insist, as some do, that these are not vaccines at all in the accepted sense. Vaccines, as the term has previously been understood, employ a killed or attenuated form of the disease to stimulate an immune reaction. These new agents involve a genetic intervention better described as "gene therapy" rather than vaccination.

How has it been possible to convince a majority of the safety of an experimental vaccine, whose long-term effects cannot, by definition, be known? To answer this question one has to go back to the way in which the pandemic has been presented to the public.

From the beginning the pandemic has been called a war, with all the concomitants of war—demonization of enemies, sentimentalization of heroes, constant stoking of fear, and censorship of untoward opinions. It's this last feature that has been the most shocking, from my point of view. During the last eighteen months, there has been lively scientific disagreement over the character of the new disease, the danger it poses, and the best policy to contain this danger. But barely a breath of these debates has reached the mainstream media. In Canada, for example, a group of public health professionals warned in an open letter, in summer 2020, that a policy of quarantining the entire eligible population, the so-called lockdown, was a radical departure from previous public health practice and might well backfire, doing more harm than good. This group included two former chief public health officers for Canada, three former deputy ministers of health, and three present or former deans of medicine at Canadian universities—a virtual Who's Who of public health in Canada. Nevertheless, their statement created barely a ripple in the Canadian media that I follow.

This pattern has been repeated again and again. A few months later, on Oct. 26, 2020, three eminent epidemiologists, accredited at Oxford, Harvard, and Stanford, made what they called the Great Barrington Declaration. It called for a policy of "focused protection" for the vulnerable and a return to normality for the majority. This statement too was either ignored or treated with derision in the organs of polite opinion. Dissident doctors have been threatened with discipline. On April 30, 2021, in Ontario, the College of Physicians and Surgeons warned the doctors whom they regulate, by statute, that these doctors would face discipline should they "communicate anti-vaccine, anti-masking, anti-distancing and anti-lockdown statements" or promote "unsupported, unproven treatments for COVID-19." Such a threat was necessary, the College said, to counteract the spreading, by some doctors, of "blatant misinformation," the term used to exclude unwanted opinions from journalistic media. In Australia, Dr. Paul Oosterhuis, an anaesthetist who has been practicing for more than thirty years, has been ordered to appear before his Medical Board in New South Wales for "endangering the health and safety of the public" because he questioned vaccination and counselled alternative treatment in social media posts.

This well-documented censorship is alarming. First of all, it hides scientific dissensus from the public. “Science” is presented as a monolithic body of opinion, which political leaders simply “follow.” This view of science as a transparent, unquestionable, and unified institution has two pernicious effects. First, it hides the moral character of political decisions. People can legitimately disagree, for example, about lockdowns, but what I think is undeniable is the moral character of such a policy. Some will benefit, some will be harmed, and the weighing of the one against the other is, inescapably, a political task. But under cover of “science,” it is possible to abdicate moral responsibility for the vast collateral damage of the COVID war. (And this abdication is all the more egregious when much of “the science” consists of wildly speculative statistical models.) The second consequence of “following science” is that it reinforces one of modernity’s most enduring myths: that “science” is a consistent, compact, institutionally-guaranteed body of knowledge without interest or agenda. What this myth conceals is the actual operation of the sciences—multiple, messy, contingent, and tentative as they necessarily are.

Modern science during the first half of its four-hundred-year career was called natural philosophy—Michael Faraday, who died in 1867, still called it that—and that is still, in many ways, its proper name. Recognizing science as philosophy allows us to see that, like any knowledge whatever, it is a creature of its tools, its techniques, and its initial assumptions. Einstein’s famous remark—that the most surprising and mysterious feature of the world is that it is “comprehensible” at all—points to the most basic assumption on which physical science rests: that the world corresponds to the concepts which we have available for grasping it. Vaccine science, obviously, rests on more refined and, for that very reason, more problematic assumptions, such as our right and our duty to dominate and control for our convenience the world’s biota (in which, for present purposes, I include the viruses, barely living though they are). The point is that these are philosophic assumptions that not everyone shares—a point overlooked when the vaccination question is seen as a contest between the informed and the uninformed, or the selfish and the public spirited.

At this point, various scarecrows pop up to frighten us: the anti-vaxxer, the anti-masker, and the conspiracy theorist. These are figures of fear, or of fun, that can be used to inhibit thought, restrict debate, and discredit opposition. They are said to be spreading dangerously, like crabgrass. A columnist here in Toronto recently wrote that “anti-vaxxers” who formerly comprised no more than “a few isolated loons,” now present as an “organized campaign.” A colleague of the columnist I just quoted even detected a “fundamental change in the public mood” that was producing a “growing rage” against the unvaccinated that was “boiling up amongst the responsible vaccinated citizens.” Even a fraction of this rhetorical fury would be hate speech were it directed at any protected class—an indication of just how far beyond the pale the “anti-vaxxer” has now been placed.

People can, of course, be found who correspond more or less to these stereotypes. People often pattern themselves on the designs of their enemies, and journalistic media are always able to find people willing to play the currently assigned roles. What I want to point out is how useful these cartoon enemies are to advocates of compulsory vaccination. Stereotypes consolidate, placing everyone into a single, easily characterized class. They discredit, tarring any and all objections with the same brush. And, most important for my purposes here, they polarize, creating a predetermined contest in which only two positions are available. Either you’re a “responsible vaccinated citizen” or you’re a wingnut.

What is left out of the account, to return to my point earlier, is legitimate philosophical

difference. Not everyone who is vaccinated feels this way, but vaccination, generally speaking, belongs to a larger scientific worldview that tends to see nature as ours to control and reshape as we will, death as an enemy to be overcome, and life as a resource to be maximized and extended at all costs. There are other worldviews, with different accounts to give of the nature of health and the ends of human life. Disagreements that may at first appear to concern matters of fact will often turn out, on closer inspection, to be about these deeper differences in orientation. "Facts" are cited, because facts are supposedly the coin of the realm, the only recognized legal tender. But many facts are also, a priori, symbols. Their very salience as facts derives from this prior symbolic resonance. Recognition of this symbolic character is a crucial step toward civic peace. Symbols are indeterminate—they can be interpreted, discussed, and re-interpreted. Shadow battles over facts often get us nowhere because the facts in question are not primarily facts at all.

This brings me back to my plea that we put a realistic image of the sciences in place of the obsolete mirage of an omniscient oracle able to tell us, with absolute authority and universal jurisdiction, what shall count as a fact. If we were to recognize, as Thomas Kuhn pointed out long ago, that facts become facts within paradigms, and that facts drawn from different paradigms are incommensurable, then avenues to peace might open on the present field of battle.

That said, there are still many specific concerns about the COVID vaccines that have to be approached, even if tentatively, as factual matters. In the first place, there are questions about the character of the emergency that the vaccines are supposedly addressing, a character often obscured by the "fog of war" surrounding the battle against COVID. The obscurity starts with the "modelling" that puts a lot of hypothetical numbers into play as quasi-facts. Next are the "case counts," derived from a test so fine-grained—the PCR test—that no one knows exactly what it is detecting. And, finally, there are the ambiguous "death tolls," which ascribe all deaths following the detection of COVID to its agency. Under these circumstances it can be hard to know what's going on. A recent study published by the Ontario Civil Liberties Association examined mortality from all causes in Canada between January 2010 and March 2021 and found "no extraordinary surge in yearly or seasonal mortality which can be ascribed to a COVID-19 pandemic." I don't mention this finding as definitive, though I could find no fault with its reasoning or methods, but only in support of my idea that there is legitimate doubt about what exactly has been happening over the last 18 months.

The same considerations apply to safety concerns about the vaccines. Some side-effects are well attested, although so far rare—among them blood clotting, heart inflammation, and disruption of women's menses. We know that the number of injuries and deaths registered by the Vaccine Adverse Event Reporting System in the U.S. are unusually high. But many other possible consequences are at this point only speculative. One such was revealed at the end of May by Canadian scientist Byram Bridle, an associate professor of viral immunology at the University of Guelph. He told radio interviewer Alex Pierson that he and two colleagues had submitted a freedom of information request to the Japanese government's vaccine regulator, the Pharmaceuticals and Medical Devices Agency, and received in response a previously unreleased study of the Pfizer vaccine. At the time, the manufacturers of the vaccines were claiming that the vaccine acted at or near the injection site and was not widely distributed in the body. The study that Bridle and his colleagues obtained, done on rats, showed otherwise. It found accumulations of the material that coats the mRNA in the vaccine in various parts of the body including the spleen, bone marrow,

liver, adrenal glands, and, particularly worrying, the ovaries (of the female rats).

This result echoed a small study of 13 health care workers at the Brigham and Women's Hospital in Boston that found the spike protein, which the vaccine uses as an antigen, circulating in the blood of eleven of the participants following first inoculation. (The antigen is the element in the vaccine that induces an immune response.) A debate ensued about whether the spike protein for which the vaccine supplies the genetic recipe to our cells is a toxin or not, about how long it persists, and other such matters. Bridle and others argued that it is a toxin and speculated about possible consequences, including infertility. (Notable among those who shared Bridle's concerns was Dr. Robert Malone, one of the scientists who first proposed the idea of mRNA vaccines more than thirty years ago.) Many able and persuasive refutations of these concerns have also been put forward. As a lay person, unqualified to judge the technical issues, I have concluded only that there might be a legitimate question here, and one that must, necessarily, remain open until time and experience can settle it. The point, for my present purpose, is only that there is such a debate and that telling points are being made on both sides of it. This should be a sufficient reason against foreclosing the issue and compelling everyone to take the vaccine.

Another school of scientific opinion worries that mass vaccination during a pandemic may lead to so-called "viral escape." Many virologists have predicted that, as COVID-19 becomes endemic, it will moderate and become more like its various coronavirus cousins with which humanity has already achieved a painful but tolerable equilibrium. The fear of the "viral escape" school of thought is that mass vaccination might disrupt this process of equilibration. Natural immunity, achieved by fighting off infection, is robust, they say, and allows the virus no further foothold. But vaccination affords only partial immunity and may, therefore, force the pace of evolution among "escapees," leading to the emergence of more virulent strains. This argument too is speculative, of course. Belgian virologist Dr. Geert Vanden Bossche, who first advanced this theory, supported it by pointing to the way in which antibiotic use has led to the evolution of antibiotic resistant bacteria. Like Bridle's hypothesis, his idea was soon refuted—McGill University's Office for Science and Society went so far as to call him a "doomsday prophet"—and, if you look it up, will find scores of these refutations, before you ever come to Vanden Bossche, if you come to him at all. Again, I am only trying to draw attention to the existence of competing theories, and to the fact that the differences between them cannot be quickly or easily settled. One hopes that the vaccines turn out to be as safe as their proponents say, but, in the meanwhile, the sidelining of scientific dissent and the enforcement of uniform opinion among doctors makes it difficult to have confidence that a fair evaluation is underway.

Yet another large speculative question about the vaccines concerns the integrity of the individual immune system under the pressure of externally induced genetic manipulation. Vaccination, in the old sense, imitated nature, inducing immunity by the same means by which natural immunity is achieved: exposure to a tolerable dose of the pathogen. The new "vaccines" interfere, as I've said, at a genetic level. Since this has never been done before, we simply cannot know, in advance of the experiment being tried, whether natural immune response to other diseases or to new forms of COVID will be in some way impaired by this intervention. This, by itself, seems to be reason enough for not compelling the reluctant to take part.

The foundation of contemporary medical ethics, by most accounts, was laid when the war crimes tribunal that met after World War II produced the Nuremberg Code in 1947. It insisted unequivocally and without exception on "voluntary consent" to any medical

procedure. It went on to characterize voluntary as follows: “This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision.” Variations on this statement have since been issued by the U.N. and by medical associations around the world. The promotion of COVID vaccination has violated this principle. It began with bribery, whether it was the “joints for jabs” that spread from the state of Washington to other jurisdictions or free pizza or Krispy Kreme donuts or the “Vax To Win Lottery” that recently paid out $100,000 to seven people in the Canadian province of Manitoba who were willing to “roll up their sleeves to win big.” It has culminated in much more serious forms of duress, including, most seriously, the threat of loss of livelihood.

In Canada almost all employees of governments or public agencies now face the threat of job loss, and new vaccine mandates are being introduced almost daily. The government of Ontario, which had for months insisted it would never countenance a “split society,” changed its mind and announced a passport system. In the United States, President Biden recently announced vaccination will be required for all government employees and all health care workers at facilities that receive government funds; he has also directed the Department of Labor to order all companies with a staff of 100 or more to require employees to get the vaccine or take weekly COVID tests. The vaccination requirements are also providing a bully pulpit for judges. In Chicago, a judge recently ordered that a child be taken from its unvaccinated mother, and American judges elsewhere have reduced, commuted, or extended prison and probation sentences on the basis of vaccination status. All these bribes, threats, deprivations, and restrictions are intended to keep “the responsible vaccinated citizens” safe from the unvaccinated by denying the latter group basic social rights.

It seems undeniable that these measures violate the principle of informed consent. This deprivation of the right on which the very legitimacy of contemporary medicine depends is justified by the imminent threat to public health that the unvaccinated are said to pose. But if public health were the primary objective, wouldn’t the natural immunity that many possess as a result of previous COVID infection be recognized as equivalent to or, as a recent Israeli study shows, much better than vaccination? The fact is that in many jurisdictions natural immunity is not recognized. In these jurisdictions, excluding a handful of narrow exemptions, vaccination is required of everyone as a condition of citizenship and social participation, regardless of immune status. This requirement cannot but create suspicion that the vaccine agenda is driven by more than pure public health concern.

Then there’s the question of the effectiveness of the vaccines. One hears again and again that we are now in “a pandemic of the unvaccinated,” but, in highly vaccinated Israel, the director of the Herzog hospital in Jerusalem told a television interviewer on August 5 that 85-90 percent of those currently being admitted to his hospital were fully vaccinated. He ascribed this number to the “waning” effectiveness of the vaccine. As of Oct. 1, Israel will require a third shot of those not vaccinated within the previous six months as a condition of receiving their vaccine passport, the Green Pass. This opens the prospect of what one writer has called “a vaccine treadmill.” In Ontario, at the time of writing, 30.1 percent of those testing positive for COVID have had at least one vaccination. In hospitals, 22.1 percent of non-critical patients and 19.4 percent of intensive care patients have also had at least one

shot. This doesn't mean that vaccination doesn't work. It does mean that the vaccines have limited effectiveness that may wane quickly over time. We also know that the vaccinated can transmit the disease as readily as the unvaccinated. The vaccinated may, for the most part, get infected less frequently and suffer less severe illness when they do, but they will, when exposed, pass it on just as surely as the unvaccinated will. All these considerations argue that the differences between the vaccinated and the unvaccinated are not as great as the advocates of shunning contend.

In short, forced vaccination is setting an ominous precedent. The vaccines are untried on the time-scale that would be necessary to establish even their relative safety. The threat of COVID, which pertains mainly to the old, is being aggregated across the entire population in order to impose vaccination on those at negligible risk. Dissident opinions have been censored and vilified, rendering dispassionate and disinterested discussion impossible. And the plurality of views that should properly characterize the sciences has been replaced by a dictatorial oracle called "the science." All these concerns militate strongly against coercing the consciences of those who oppose vaccination on scientific, philosophical, or religious grounds. Coercion will only compound existing social division. Perhaps it would be better to start a conversation rather than continuing the war.

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