IN THE MATTER OF A HEARING BEFORE THE HEARING TRIBUNAL OF THE ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS ("ACAC") into the conduct of Dr. Curtis Wall, a Regulated Member of ACAC, pursuant to the Health Professions Act, R.S.A.2000, c. P-14

DISCIPLINARY HEARING

VOLUME 1

VIA VIDEOCONFERENCE

Edmonton, Alberta

September 1, 2021

Proceedings taken via Videoconference for The Alberta College and Association of Chiropractors, Edmonton, Alberta

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September 1, 2021 Afternoon Session

HEARING TRIBUNAL

[redacted] Tribunal Chair

[redacted] Internal Legal Counsel

Dr. [redacted] ACAC Registered Member

Dr. [redacted] ACAC Registered Member

[redacted] Public Member

[redacted] ACAC Hearings Director

ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

D. [redacted] ACAC Complaints Director

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FOR DR. CURTIS WALL

J.S.M. Kitchen Legal Counsel

[redacted] CSR(A) Official Court Reporter

(PROCEEDINGS RECOMMENCED AT 1:03 PM)

THE CHAIR: The Hearing Tribunal regarding Dr. Wall is back in session, and we will ask

Mr. [redacted] to introduce his first witness, but before doing so, Dr. [redacted] we would ask that our court reporter, [redacted] either swear or affirm you prior to your giving testimony.

THE WITNESS: Sure.

DR. [redacted] Sworn, Examined by Mr. [redacted]

(Qualification)

MR. [redacted] Mr. Chair and Tribunal Members, just so you're familiar with what I'm going to do next, and some of you may well have been in hearings that have involved expert witnesses, and Mr. Kitchen will know this and Mr. [redacted] will know this, before I begin asking Dr. [redacted] questions about the substance of his report, I need to take a step which is called qualifying him as a witness. That will involved me asking some background questions of him in terms of his knowledge, training, experience. Mr. Kitchen may have some comments about that as well, and I will then tender him to be accepted as an expert witness, and, only then, would I start taking him through his expert report.

Q MR. [redacted] So, Dr. [redacted] I'll just ask you to state your full name for the record, please.

A Yeah, [redacted]

Q And I'll just confirm that the agreed on exhibits in this hearing were provided to you?

A Yes.
Q Also Exhibits E-1 and E-2 are your cv and expert report. Can you confirm that's correct?
A Yes.
Q And your expert report is dated July 28, 2021. I have just a housekeeping question before I start to qualify you. I note that on --
MR. [redacted] Oh, and Mr. Chair, I'm assuming everyone is at Exhibits E-1 and E-2.
THE CHAIR: Raise your hand if not. Okay.
MR. [redacted] Sorry, I was diving right in there.
Q MR. [redacted] Just as a housekeeping matter, I note that on page 1 of your expert report, again that's Exhibit E-2, it says: (as read)
Prepared by [redacted] and [redacted]
Can you please tell me who Ms. [redacted] is and what her role was in preparing the report?
A Yeah, so [redacted] is a -- was a Masters in Public Health student who worked with me on various things in my Public Health position role, and she did some of the preliminary sort of literature review, which is looking for papers around masking, the evidence for or lack thereof, and draft -- doing an initial draft of the report as well.
Q And I'm assuming that, nonetheless, you stand by this

expert report as your expert report?
A I did make, yes, substantial revisions to her -- her review is good, but I made a lot of revisions, so, yes.
Q Okay, thank you very much.
MR. [redacted] So I'm going to ask everyone to go to your cv, which again is E-1. I'll wait a minute till everyone is there, wait a few seconds.
Q MR. [redacted] Dr. [redacted] can you tell me what your current occupation, profession is?
A Yeah, so I'm a Public Health physician and a family physician. I have a few different roles right now. One of them I guess is to lead the provincial vaccine rollout from the -- primary care. I chair a group called 19 To Zero, which is a multi-sector coalition, you know, aimed at providing education around COVID-19 and vaccinations. I have various -- I was quite recently a Medical Officer of Health with Alberta Health Services in the Calgary zone, and many other miscellaneous things, but, generally, often lots of COVID-related things.
Q Okay, well, we'll probably touch on those in a little more detail in a moment, but I'd like to go to page 1 of your cv and ask you to just briefly summarize Section 1, which is your education.
A Yeah, so in terms of education, so I mean I have a Bachelor's degree in Economics from Harvard University;

medical degree from the University of Alberta, medical doctor degree; a residency in Public Health and preventative medicine and (INDISCERNIBLE) medicine from the University of Toronto; and that sort of Public Health residency is generally what qualifies you to become a Medical Officer of Health, which is kind of like what Deena Hinshaw is; and Masters in Health Policy, Planning, and Finance from the London School of Hygiene & Tropical Medicine and London School of Economics.

Q Thank you. And if I were to ask you what degrees or certificates you have, I think you canvassed that; are you a regulated member of the College of Physicians and Surgeons of Alberta?

A I am.

Q And can you tell me, have you attended or conducted continuing education seminars or lectures, that type of thing?

A Yes, I conduct continuing education seminars quite regularly throughout -- well, in general and throughout COVID, so I mean probably have done several dozen in the last year.

Q And those would be COVID-related?

A Yeah.

Q And just very briefly what would you be speaking to with those kinds of seminars or lectures?

A Oh, everything from, you know, things like masking to vaccination to what we're likely to see with a fourth wave or even a second wave, back in the day, before we had our second wave, and so really covering the gamut of, yeah, of -- if anything, that would touch COVID-19 actually from the science, the epidemiology, to measure to prevent transmission, et cetera, et cetera.

Q Okay. Have you received any awards or professional recognition in your career?

A Yes, I mean, I guess recently I received an award "Specialist Physician of the Year" from, you know, the Calgary's own sort of primary care association, and so that award is given to -- by the family doctors to like the, I guess, the best specialist physician of the year. I think as a member of the Alberta Medical Association, as a (INDISCERNIBLE) physician, we collectively received an award from them last year just around just COVID stuff. I forgot the name of that award actually, but, yes, I've received some awards.

Q Thank you. Have you published any articles in your field?

A Yes, you know, quite a few articles I would say. You know, I think a lot of what I do is around vaccine uptake research, vaccine hesitancy research, so many, many articles on that.

Also quite a lot of articles on sort of like lab

studies around COVID, so, you know, for example, I've been involved in the validation of every new type of lab testing in our province. You know, back in the day, we ran out of swabs, and so we started using new swabs and rapid tests and all that, and so, I mean, I can elect CVS in the publications I have, but a fair number I would say around COVID.

Q Have any of those publications been what I'll call peer-reviewed?

A Yeah, they're all peer-reviewed sort of by definition for me to call them a publication.

Q Okay. I'm just going to switch gears a little bit, and review your professional activities in terms of your employment history in three areas, and you've identified them in your cv, the first is your clinical work experience and then your non-clinical work experience and then what you described as leadership experience.

So when it comes to clinical work experience, I am looking at page 2 of your cv, and it starts off with an entry, July 14-present, and then it has three entries. Can you describe clinical work experience?

A Yeah, so I am trained as a family physician, and so since I've been in Calgary, the sort of active roles I've had one is sort of what you might call like a general family practice physician working at East

Calgary Health Centre, which is a clinic that generally serves marginalized complex patients, and I work as a sort of a locum there, so I provide coverage.

I also work at a long-term care or used to, I'll say, like in a really long matter, which is just -- it's a longer therapy phase, it's like -- that serves people with complex mental health issues. And, you know, prior to this, I did a lot of work as a hospitalist at the Peter Lougheed Centre. I will say that the amount of clinic work I've been doing during COVID is decreased as I've done more Public Health related work, but I do still see patients once in a while.

Q Okay. On page 1 of your cv, I'm skipping back, you describe your non-clinical work experience, and before asking you to briefly summarize that, can you tell me what you mean by "non-clinical"?

A Yeah, so, I mean, I -- I think I generally would define clinical as like directly seeing patients, whereas non-clinical would be anything that isn't directly seeing patients, and so probably like a hallmark of nonclinical that I put in there is like Medical Officer of Health with Alberta Health Services, right?

And in that sort of role, you primarily are doing things like, I guess, managing the overall response to COVID-19, including things like contact-tracing,

vaccine rollout, outbreak management, et cetera, and then so that's less one-on-one patient care. Well, it rarely is, but it's, again, like Public Health type work.

Q Okay. When I look at the heading "Non-clinical Experience", the first entry you have is the chair and co-founder of 19 To Zero. Can I ask you to describe what that is?

A Yeah. So, I mean, 19 To Zero is a multi-sector coalition basically aimed at closing the vaccination gap and providing education around COVID-19 and COVID-19 vaccinations. When I say "multisectoral", we basically have organizations from government, public health, health care, but also academia, which is kind of like the usual suspects, but also organizations like an NGO, some society partners, school boards, et cetera, and, you know, private industries, companies. This is really it's like a cross-cut of all society.

And, you know, fundamentally, what we do is, like I sort of mentioned, so through a (INDISCERNIBLE) like increase vaccination rates, provide education on COVID-19, but this -- to do this, you know, our activities range from what I would call very upstream things like collecting data, research on how to best increase vaccine uptake and how best to communicate

with people, down to very nitty-gritty things like organizing pop-up clinics all over the province, and the scope of our work geographically is in Alberta, Ontario. Nationally, really.

Q Okay, your next entry is corporate medical director, CPPI. Can you tell me briefly what that was, what involved --

A Yeah.

Q -- was involved there?

A Yeah. So I provide medical advisory to Canadian Pension Plan, the investment -- well, they call themselves different things, but the Canadian Pension Plan. And in that role, yeah, essentially -- again many things having to do with COVID and also many things having to do with mental health, right? So things related to, you know, what is most impacting their employees' health and well being. And, again, you know, very similar from when COVID started to, you know, what do we do, should we close our offices; you know, now for us should it be mandate vaccines and everything in between.

Q Okay. Your next entry is September 18 to May 21, Medical Officer of Health, Alberta Health Services, Calgary. Can you explore the -- your duties there; what was involved in your work there?

A Yes. So, you know -- not how familiar you are with

what medical officers of health do, but within Alberta, you know, you have folks like Dr. Hinshaw, who work for the Ministry and, therefore, are more directly accountable to, let's say, Cabinet. And then you have the medical officers of health within Alberta Health Services that are maybe more responsible for, let's say, if Dr. Hinshaw's job is more around setting overall policy in conjunction with Cabinet, then the medical officers of health with Alberta Health Services are responsible for actually responding to COVID within the confines of the policy line that they were in.

And so, for example, when COVID-19 started, one thing we had to do was rapidly scale up our contact-tracing, which we did. And then after that, I think the next big challenge -- you know, along the way, a lot of sort of communications to people around the importance of, you know, following Public Health guidance at the time, like staying home, you know, not going to see too many people.

Another big thing that we did was the sort of ongoing -- was management outbreaks, and so, you know, like managed every long-term care outbreak in this Calgary zone essentially, managed most of the acute care outbreaks, hospital outbreaks as well.

Because prior to COVID happening, my primary portfolio, and the different MOHs have different

portfolios, but mine was control of communicable diseases and vaccinations, and so it was sort of my base portfolio.

Once COVID happened, everybody was doing COVID, but I was probably doing the most like intense stuff I'll say, and, you know, the outbreaks were the next big piece, and then with the advent of the vaccine, really vaccine education, supporting the vaccine rollout, et cetera, et cetera.

Q Okay, I'm going to skip down, and the last question I'll have for you in this area of your cv is you've got an entry May 17 to February 17: (as read)

Consultant (part-time): Public Health Agency of Canada.

Can you tell me what Public Health Agency of Canada is, and what you did there?

A Yes. Oh, yes, yes, I forgot it's on my cv. So anyways, the Public Health Agency of Canada is sort of the federal body that provides guidance, expertise around sort of Public Health issues.

One thing that is sort of secondary to that via Canada is called NACI, the national advisory committee on immunization, which people may know about because they provide a lot of recommendations in having used vaccinations, but think of them as like near equivalent of the US CDC but for Canada.

In that May role, I was helping them develop guidelines around the use of the shingles vaccine, although I'll have to say, more recently, like I've been working with them again to develop a federal vaccine passport that Trudeau announced a few weeks ago.

Q At the bottom of page 2 of your cv, you've talked about -- you have a category entitled "Leadership Experience", and there's -- the first entry is "Board Member, Partners in Health Canada". Can you tell me about that and the other --

A Yeah.

Q -- two entries there?

A Yeah, so Partners in Health is an NGO, Boston-based NGO, that -- well, they're pretty well known. Actually they do a lot of global health work, started by a guy named Paul Farmer and a guy named [redacted] Kim, who later became the president of World Bank. And, you know, they basically do global health primarily in the area of sort of like health systems strengthening in low-income countries like Rwanda, Haiti, they do a lot of work in Haiti.

And they created a Canada arm about 11 years ago, and I'm on their board. I work quite closely with their Executive Director. And in that -- what I do there is actually, you know, try to fundraise, we try

to like carve out strategic direction and overall objectives.

And I guess actually more recently, Partners in Health was doing a lot of COVID work in the United States, and actually I was helping lead some of their US COVID-related work, which is primarily around supporting marginalized populations in, you know, getting testing, getting vaccinated, social support, et cetera.

Q Okay. Thank you very much.

MR. [redacted] Subject to any questions from Mr. Kitchen, Dr. Wall's lawyer, Mr. Chair and Hearing Tribunal Members, at this time, I would tender Dr. [redacted] as an expert in the area of public and, in particular, COVID-19 and the efficacy of masking and other COVID-19 measures.

THE CHAIR: Mr. Kitchen? I think you're muted on your computer again, Mr. Kitchen.

MR. KITCHEN: Can you hear me?

THE CHAIR: Yeah, I can just -- you're quite -- your volume is quite low.

MR. KITCHEN: All right, is that any better?

THE CHAIR: Yeah.

MR. KITCHEN: Okay, good. Mr. [redacted] I'm sorry, that was quite a long qualification. Can I just get you to say that again, because I'm probably going

to have some issues with how long that is?

Oh, Mr. [redacted] you're now muted. I've given you the idea.

MR. [redacted] Yeah, well, maybe when I'm muted, you've heard me at my best then, I don't know, but I'll try to do better.

I was tendering Dr. [redacted] as an expert in the area of public health but, in particular, COVID-19 and the efficacy of masking and related COVID-19 measures, prevention measures I guess you would say.

MR. KITCHEN: Okay, so COVID-19 including the efficacy of masking and other measures.

MR. [redacted] I think I said preventive measures.

MR. KITCHEN: And other preventative measures.

MR. [redacted] Measures, yeah.

Mr. Kitchen Cross-examines the Witness (Qualification)

Q MR. KITCHEN: All right, well, Dr. [redacted] I just have a few questions for you. Some of them will probably seem slightly repetitive based on what -- because that was quite extensive what you just went through, but please bear with me.

Now, from a review of your cv, it looks to me like you have done a lot of work for various government entities. You wouldn't disagree with that, would you?

A No, it you define AHS as a government entity, then I would not disagree with that.
Q Okay. No, and I would. I meant --
A Okay.
Q -- that very broadly, and nothing sneaky about --
A Yeah, yeah, yeah --
Q -- (INDISCERNIBLE) --
A -- yeah. Got it, yeah.
Q In fact, Dr. [redacted] you worked for AHS as a Medical Officer of Health up until a few months ago; isn't that right?
A That's correct.
Q You've also done and are doing currently some research work for pharmaceutical companies; wouldn't you agree?
A For -- yeah, I mean, I research the different -- I do research on how to increase uptake of all the vaccines, including like the Pfizer, Moderna, and, well, previously AstraZeneca vaccine, so yes.
Q Thank you. You would also agree, wouldn't you, that a lot of your research in efficacy work has centred on vaccines; isn't that right?
A That's correct.
Q And that includes COVID vaccines, doesn't it?
A Yes, primarily COVID vaccines actually, but yes.
Q I see that you have, like you said, published several recent studies regarding COVID. That's accurate,

correct?
A M-hm.
Q I think probably for the court reporter, and I know this is a common tendency, even I myself fall under this --
A Yes.
Q -- when saying "yes", you need to -- yeah, it's best to say --
A Yeah, I'll --
Q -- "yes" --
A -- say "yes" --
Q -- (INDISCERNIBLE) --
A -- yeah, yes. Sorry, sir --
Q We all do it.
Now, none of these studies that you've -- or these articles that you've published focus on masking, do they?
A That is correct.
Q Thank you. Now, I'm looking at your clinical work experience. I see the title "Physician" in every position. You would agree it is accurate to call you a physician, would you not?
A Yes.
Q You're not a virologist, correct?
A I am not a virologist.
Q You're not an immunologist, correct?

A No.
Q You're not a respirologist, correct?
A Correct.
Q You're not a medical microbiologist, correct?
A Correct.
Q Now, I'm looking at your research funding in 2020, it looks to me like you received almost 20 new sources of research funding in the year 2020; is that correct?
A As the -- like as a lead or generally a co-lead investigator, so a lot of that money isn't coming to me. Most of it isn't actually, but you tend to report grants that you win even if they're like -- they tend to be led by a team of people, but, yes, I guess my name is on that value of grants for the 2020.
Q Yeah, I'm looking on page 4, and I take your point, and I see "Principal" --
A Yeah.
Q -- "investigator", there's quite a few where you're the principal investigator, there's no others.
A M-hm.
Q There's one where you're the principal partner to one other. Now, when it says "principal partner", I suppose that means there's an investigator, and you're the partner?
A So normally the way these research grants work are there is a -- one personal who is primarily responsible

for the grant, sometimes probably NPI, the nominated principal investigator, and that person is generally responsible for -- what's the word -- may have control of the money. And with many of these grants, you tend to have a number of co-investigators, call them knowledge users, lots of different terminology depending on the type of grant involved.

And so traditionally with these grants, they -- there's a whole whack of people on them, and I am the principal investigator, as in I do have sort of, let's say, financial responsibility for some of the grants, but for most of the grants, I don't. And I think that you can see that pattern for most researchers because they tend to be, you know, the PI on a subset of grants, like the lead, lead person, and they tend to be co-investigators on a broader set of grants.

Q I count you as the principal investigator for about 12 grants in 2020.

A Oh, okay.

Q Do you dispute that?

A Let me see what I put in my cv, but like -- no, I don't actually.

Q And you would agree that nearly all of this research funding is associated with COVID, do you not?

A Yes. Absolutely.

Q And you agree that some of this funding comes from

manufacturers of COVID vaccines, do you not?

A Yeah, some does. I would say most doesn't, but some does.

Q If everyone decided tomorrow that COVID-19 was not really that big of a deal and that we should all go back to life as we knew it before 2020, you'd have a lot less research funding, wouldn't you?

A Yeah, that's true.

Submissions by Mr. Kitchen (Qualification)

MR. KITCHEN: Those are my questions. I'll just briefly make some submissions on the qualification.

Again forgive me, Mr. [redacted] help me out if I don't have this quite right, I understand you want Dr. [redacted] qualified as a Public Health physician or Public Health something, who is a specialist in COVID-19, including the efficacy of masks and other preventive measures.

I would submit to the Tribunal that Dr. [redacted] is a physician with expertise in COVID-19, including vaccines, and that's it. I submit that there is an insufficient basis to qualify him as being an expert in the efficacy of masking or any other preventive measures.

We've heard from Dr. [redacted] lots about COVID-19 vaccines, but we haven't seen anything about experience

or publications to do with masking or really any other preventive measures specifically, maybe generally and broadly but not specifically. What we see and we heard of specifically was a lot about vaccines.

Subject to any questions from the Tribunal on my comments, that's what I would say about the qualifications and the scope of the qualifications of Dr. [redacted]

Mr. [redacted] Re-examines the Witness (Qualification)

MR. [redacted] Mr. Chair, it's [redacted] I'll have a couple of comments in response, but I think Dr. [redacted] was kind of motioning that he might have something to say about the comments that Mr. Kitchen made, so I'm, frankly, going to ask him to make his comments.

MR. KITCHEN: Okay, that's fine, as long as I have an opportunity to cross.

A Yes, for sure.

So with respect to the efficacy of masking, I should say that I did help devise and implement all of the AHS masking guidelines for the infection prevention control committees. I mean, I do a lot of stuff, I probably should have mentioned that. Not on my cv, but, you know, like you can verify that later.

So you're right, I do not -- I have not published anything on masks, but I have been quite involved in

I'll say the development of how we use -- like our masking guidelines within AHS over the course of the pandemic, which I guess makes me somewhat involved in the actual operationalization of that particular measure, including reviews of the evidence for that.

Also have advised a number of organizations, including the City of Calgary, in advance of their implementing their masking bylaw, and -- sorry, like so there's a lot of -- if you'd like to know more about the sort of masking stuff I do, I can speak more to that.

Mr. Kitchen Re-cross-examines the Witness (Qualification)

Q MR. KITCHEN: Well, of course, I'm going to have questions for you.

A M-hm.

Q Your report has been entered by consent, so it's going to come in one way or the other. I'm going to have questions for you about masking --

A Okay.

Q -- (INDISCERNIBLE) written about masking. But the record today is what we have before us in your cv.

A Okay, that's fine.

MR. [redacted] Mr. Chair, I think, Mr. Kitchen, you're finished, I can --

MR. KITCHEN: Yes, I am.

Discussion

MR. [redacted] Yeah, thank you, yeah.

Mr. Chair, I was going to ask Dr. [redacted] to tell us a little bit more about what he did in the masking context, because when I was questioning him, I was asking him about broader concepts in some ways of Public Health. I think he's given a fulsome answer to Mr. Kitchen's questions, and I, again, ask that he be accepted as an expert witness on the basis that I described, which was an expert in the area of Public Health and, in particular, COVID-19 and the efficacy of masking and other COVID-19 measures.

MR. KITCHEN: Just to be clear, for me, the modification of that begins at COVID-19, including COVID-19 vaccinations, period.

MR. [redacted] Well, that's not the basis on which I'm tendering this expert. I'm not tendering him as an expert on vaccinations, although he may have something to say about that, but I've made my comments, and I leave it to the Chair.

MR. KITCHEN: And, Chair, unless you have any questions, you have my comments on my opposition to that broad of a scope of qualification. I think it should be limited to COVID-19 and COVID-19 vaccinations.

THE CHAIR: Okay, thank you, gentlemen. I

think we will recess so that we can consider the submissions from both parties of Dr. [redacted]

Dr. [redacted] I would just ask you to bear with us. We will have a brief recess here of 5 or 10 minutes, and then we'll rejoin the group.

MR. [redacted] And, Mr. Chair, I wonder if I can just make one quick comment for Dr. Hu's benefit, because I don't know if he's testified recently in one of these hearings, but while he's testifying, I can't have any direct communication with him, so I just would remind him that I'm going to turn my video off, my audio off, but I just remind him of that so that we don't get tripped up by that.

A Thank you.

THE CHAIR: Okay, and, Dr. [redacted] we will, the Hearing Tribunal and our independent legal counsel, will leave this meeting and go to a breakout room --

A Okay.

THE CHAIR: -- and you can mute and shut your video down if you want, and I expect we'll be back by about 20 to 2.

A Great, thank you.

(ADJOURNMENT)

Ruling (Qualification)

THE CHAIR: The Hearing Tribunal is back in session, and we have discussed the proposal by the

College to qualify Dr. [redacted] as an expert witness, and our decision is that we will qualify Dr. [redacted] as an expert witness as submitted by Mr. [redacted]

So, Mr. [redacted] if you'd like to just repeat your submission for the record, so we're all clear.

MR. [redacted] I'm going to try to get this as accurate as I can, but I'll invite the court reporter to maybe correct me, and if we -- we can almost go back and revisit this if we need to I suppose later, but my original comment was, I believe, I'm tendering Dr. [redacted] as an expert in the area of Public Health and, in particular, COVID-19 and the efficacy of masking and related measures --

THE CHAIR: That's --

MR. [redacted] -- or words to that effect. I'm pretty close, I think.

THE CHAIR: Yeah, that's what we understood, and we also understood, Mr. Kitchen, the different wording that you had, and we've decided to qualify Dr. [redacted] based on Mr. Maxston's submission, so we'll move on from there.

If you have -- if you'd like to start your questions with Dr. [redacted]

MR. [redacted] Thank you, Mr. Chair.

Dr. [redacted] Previously sworn, Examined by Mr. [redacted]

Q MR. [redacted] I want to ask a question right

off the top, and it wasn't one of the ones I planned to ask, but it arises from something Mr. Kitchen raised in his questions of Dr. [redacted] and that was in the context of grants and Dr. [redacted] losing money if COVID goes away. And I just want to be very clear, Dr. [redacted] is your report impartial and independent?

A Yes, completely. And I will say this, yes, I receive research grants, but I don't get any of that money myself. And in reality during COVID, I probably put in $500,000 of my own money doing research and other related activities because -- well, COVID is a disaster, and so I get why, you know, like you can think that it's biased, but also I mean, you know, as Dr. -- as Mr. Kitchens [sic] was saying, a lot of my research is around vaccines, which is accurate, and, you know, it's not like there's -- I don't publish stuff on masking. But, yes, regardless, the masking report is impartial, and I don't get money from research, just try to do the right thing.

Q I'm going to ask you some sort of general questions here at the beginning here, and I'd just like to ask you what is your experience in working with COVID-19 and the response to it?

A I would say everything other than Federal vaccine procurement, and so if you name a topic around COVID-19, I probably was involved in it, so other

than --

Q Outbreaks?

A -- (INDISCERNIBLE) -- yeah, outbreaks, masking, contact tracing, vaccine rollout, dealing with various sectors like the education sector, public communications, yeah, sourcing rapid tests. Yeah, it's pretty -- like truly everything, other than Federal vaccine procurement, which was the domain of Minister Anand.

Q I touched on this a little bit when we were going through your cv, but have you any experience working as a Medical Officer of Health?

A Yes.

Q And that was in Calgary for over what time period?

A From the fall of 2018 to May of this year.

Q And again --

MR. [redacted] -- and I'll be careful, Mr. Kitchen, I'm going to ask a bit of a leading question, but it's just for cleanup here --

Q MR. [redacted] -- that would have involved outbreak management, contact tracing, transmission, masking, the things you've already mentioned?

A Yes.

Q Did you advise any Public Health bodies concerning the science surrounding COVID-19 prevention?

A Yes.

Q Can you describe that?

A Yeah. So, well, Alberta Health Services has something called a Scientific Advisory Group, SAG. All their reports are actually publicly -- like they're on the internet. It's actually the course Scientific Advisory Group that provides recommendations to Alberta Health Services and actually Alberta Health for that matter.

And so I was the initial chair of the Scientific Advisory Group many, many -- well, 18 months ago. It was sort of later handed over to some other people, but, you know, I continue to sort of work with them, and that's sort of one of them.

I mean, I mentioned that, you know, I work with the Public Health Agency of Canada on things like vaccine passports. I have advised the Ontario Ministry of Health on various COVID-related things, and, you know, like -- so, you know, organizations like AHS, the Ministry of Health in Alberta, the Ministry of Health in Ontario, the Public Health Agency of Canada, and, you know, also at sort of more of an operational level, the various hospitals and long-term cares around the Calgary zone of AHS.

Q And just to be clear, when you've been advising those Public Health bodies when you were involved in the SAG group, Scientific Advisory Group, were you providing advice on masking and social distancing and similar measures?

A Oh, yeah, a bit of everything. I -- yes, actually, I do recall that very, very early on, we did some reviews on masking. This was before -- I mean, so much evidence has come out since then, but if you look at the Scientific Advisory Group reports, they basically -- they cover the span of the gamut of topics around COVID, including all the things you've mentioned and a lot more.

Q Okay. Have you, in the course of those steps, those efforts, have you been asked by a Public Health body to provide advice about responses and recommendations for COVID-19?

A Yes.

Q Can you describe that to me?

A Yeah, so -- well, actually one really obvious one might be then -- another group that I sit on is (INDISCERNIBLE) committee for immunization or I used to, and that group basically is a group who reports to the Minister of Health and, I mean, essentially delineated the vaccine priority groups, so that was quite a contentious topic I think earlier this year.

You know, when it comes to, let's say, masking in specific, you know early SAG reviews sort of reported like some of the things we did were around actually, you know, how do we get the most out of our masks if we do not have enough PPE, and that's the environment we

were living in in March of 2020, so what I call PPE mask extension.

Later -- (INDISCERNIBLE) thing if I remember -- later on, I guess, that summer when masking bylaws were becoming a thing potentially, you know, at that point in time, the Government of Alberta did not want to implement a province-wide masking bylaw, and as I mentioned before, you know, again worked closely with many -- like the City of Calgary, for example, but many other organizations and provided, you know, advice, recommendations around masking to them in terms of the benefits, the pros and cons I'll say.

Within AHS, there is -- there are a few infection prevention and control committees provincially, zonally. When I say "zonally", I mean Alberta Health Services is divided into five zones, Calgary zone, Edmonton, north, central, and south. Actually, well, I guess I chaired -- or I used to chair the Calgary zone infection prevention and control committee, and I was a member of the Provincial infection prevention and control committee, and, you know, it's in these committees where we make sort of operational recommendations around things like -- well, let's say, hand washing and/or masking, you know, cohorting, and a whole host of things meant to prevent the transmission of COVID-19.

Q Okay, thank you for that. Just for your benefit and for the Tribunal's benefit, just in terms of a road map, I'm going to ask you some questions about the CMOH, Chief Medical Officer of Health, office and three CMOH orders. I'm going to take you through the -- what I'm going to call the AHS documents, which were admitted this morning. I'm then going to take you to the Pandemic Directive that the College has issued. And we're then going to go through your expert report. So that's just a bit of a road map for you.

So turning to the CMOH or Chief Medical Officer of Health, can you describe for the Tribunal what the CMOH is and what it's purpose is?

A Yeah. So the CMOH, Chief Medical Officer of Health of Alberta, Dr. Hinshaw right now, is a role that sits within the Ministry of Health and -- versus a role that's within Alberta Health Services, and, very generally, the Ministry of Health primarily is designed to -- well, their job is to set overall health policy, and Alberta Health Services' primary job is to operationalize that health policy.

Now, you know, there can be variations in what they do in AHS is very vague, but think of that as the like the simplest demarcation between the Ministry of Health and AHS. The CMOH is meant to advise the Ministry of Health on issues of, you know, public

health importance. And I believe that role is sort of -- there's something in the Public Health Act and within the Public Health Act that it creates provision for the role of CMOH.

Within the Public Health Act, there's also certain sections for -- that allow for the creation of various sort of Public Health orders. And a Public Health order, you know, as Mr. [redacted] talked about are -- I'll call them like legally binding orders, instruments that we can use to essentially limit people's activities to prevent, you know, the spread of an infectious -- of an infectious disease or another health hazard, yeah.

Q Are you familiar with the various CMOH orders issued by Dr. Hinshaw during the COVID pandemic?

A Yes. That happened a lot though, but yes.

Q And were you involved in the preparation of the CMOH orders?

A So when it comes to preparation of CMOH orders, those are drafted within the Ministry of Health specifically. That being said, a lot of the evidence base, for example, the forms, you know, what goes into these orders, you know, like groups like SAG and others that do provide support there. And so nobody within Alberta Health Services actually writes CMOH orders, but it's a pretty small ecosystem, right? There's not a whole lot

of Public Health physicians, infectious disease specialist, and, you know, I think that like I'm involved in bits of the evidence-gathering pieces that lead to the drafting of the orders.

I will also just flag one other thing about the role of the CMOH, in case it's not very obvious to the group here, so the CMOH is a -- as I mentioned, it is a position that falls under the purview of the Minister of Health, and, therefore, you know, you can sort of think of them as like some like half -- sort of like a bureaucrat, like not in the bad sense of the word, but a bureaucrat as in a person who works within the Ministry, and, therefore, you know, sometimes you see she is able to advise, but when it comes to, you know, big policy decision-making, you know, those do come down from Cabinet. And so I've just explained it, like, sometimes people talk about the politicisation of how our COVID response has been and that the final responsibility to do these things does not rest with Dr. Hinshaw, but it rests with the Cabinet that --

Q Dr. [redacted] I'm going to take you through some CMOH orders now, and the first one is going to be CMOH 38-2020, which is dated November 24, 2020, and it's Exhibit D-8 in the materials that are before the Tribunal.

I'll just pause a moment and make sure everybody, including you, Dr. [redacted] has been able to find, again,

CMOH 38-2020.

A Yeah. This is CMOH 42?

Q No, this is CMOH 38-20 [sic]. I'm going to take you to 42 in a minute --

A Okay.

Q -- but, first, I'd like to take you to 38-2020 --

A Okay. Yeah, let me just pull that up. I got it. Thank you.

MR. [redacted] Mr. Chair, are you and your colleagues all -- do you all have that document? I can proceed?

THE CHAIR: I think so. Anybody having problems? No, I think we're good. Thanks, Mr. [redacted]

Q MR. [redacted] Okay, I'll go ahead then.

I'm going to ask you to turn to page 4, Dr. [redacted] and it's -- there's a heading, "Part 4 - Masks".

MR. [redacted] And, Mr. Kitchen, I hope you'll give me this liberty, I just -- to save a little bit of time, I'm just going to note that Section 20 says: (as read)

> This order is effective November 24, 2020, and it applies to Calgary metropolitan region and Edmonton metropolitan region.

And then we have a reference to what the Calgary metropolitan region includes, and that, in 21(d),

includes the city of Calgary.

So, Dr. [redacted] this CMOH would apply to the city of Calgary?

A Correct.

Q Okay. I'll ask you to go to the next page of the CMOH order, and paragraph 23 and 24 talk about public places and what a face mask is, and I'll ask you to look at paragraph 26 and explain to me what paragraph 26 says.

A Basically paragraph 26 says that in -- people need to wear masks, face coverings in indoor public places for the jurisdictions listed above earlier in the order.

Q And I think the first line actually says a person must where a face mask; isn't that correct?

A Yes, yes, must, correct.

Q There's an exception in Section 27, specifically 26(c) [sic] that says you're exempted from masking if a person: (as read)

> Is unable to wear a face mask due to a mental or physical concern or limitation.

Are you familiar with that exemption?

A I am.

Q Okay. I'm going to ask you some questions about that exemptions later on, but I'll just leave that for now.

I'd like you to now go to CMOH Order 42-2020, which, for the benefit of the Tribunal Members, is Exhibit D-9. So this is the CMOH Order 42-20 [sic],

Exhibit D-9, and it is dated December 11, 2020.

THE CHAIR: Mr. [redacted] you said the date on D-9 was --

MR. [redacted] I think, Mr. Chair, I'm looking at page 9, it says December 11th, 2020.

THE CHAIR: Okay.

Q MR. [redacted] Okay, so, Dr. [redacted] I'm looking at Exhibit D-9 then, CMOH Order 42-20, and there's a final "whereas" paragraph --

MR. [redacted] -- and, Mr. Kitchen, there's a question coming --

Q MR. [redacted] -- whereas having determined that measures in CMOH Order 38-2020 are insufficient to protect Albertans. Is -- to your understanding, was CMOH Order 42-2020 to strengthen masking and other measures?

A The primary reason for CMOH Order 42, so I'm going to wind this back, this is now November, December of last year when we were hitting about 2,000 cases a day, making us, at the time and as today, the hot (INDISCERNIBLE) sort of case count per capita jurisdiction in Canada, quite a long measure.

The original CMOH order had this sort of mask -- like a -- I say mandated masking in areas of the province with relatively high case counts, you know, primarily in the urban areas, Edmonton and Calgary,

Edmonton in particular.

What CMOH 42 did was a essentially a ban on indoor social gatherings, and that was basically what led us to not be able to see people over Christmas, essentially, and that was the most restrictive order. Like that -- like when CMOH 42 was in effect, that was the most sort of restrictive period we had during -- no matter the whole lockdown, the most restrictive period we had during the pandemic period.

Q I'll ask you to go to paragraph 23 in this CMOH order we're looking at, and I'll let everybody get there. We again have a statement subject to Section 24 of this order: A person must where a face mask at all times while attending at an indoor place. I want to stop and ask you and say what was the rationale or purpose for having this masking order in place; why was it important?

A Because we know that masking in indoor public places reduces transmission of COVID, period, and you know, at the time -- I'll give you a bit of background, right, and I mentioned some of these things get pretty political.

So prior to November, the Government of Alberta was fairly dead set against any provincial masking bylaws, and at the time, I believe the Premier and the Health Minister were signalling to municipalities that

Felt that they needed to do so, to do so, and that is why masking bylaws already were in place in the cities of Calgary and Edmonton as of the summer, roughly, before this came in.

Now, as I was saying before, by the time we hit November and December of last year, we were probably at our most dire situation in the history in Alberta's COVID experience, especially in Edmonton. And so at that time, to really try to sort of mitigate the further transmission of COVID-19, a Provincial sort of mandate was put in high transmission areas.

I will say one other thing, and I suspect Mr. [redacted] will ask about it later, the evidence, while there is a great deal of evidence for the use of masking to prevent COVID in indoor public places, you know, like a mall or restaurant or some of those places, the evidence for using masks in a health care setting is far stronger, and so I'll just leave it at that.

Q Okay, thank you. When I look CMOH Order -- the same CMOH order, if we go to paragraph -- or Order Section 28(a), it talks about: (as read)

This order does not prevent a place of business or entity listed or described in 1 of Appendix A from being used to provide health care services.

Was it the intention of the CMOH orders to allow entities such as chiropractors to continue to practice?

A Could you repeat that question?

Q Yeah, were the CMOH orders, this CMOH order, was it intended to allow chiropractors to continue to practice?

A Yeah, I mean, I don't think the CMOH orders were designed to stop the provision of health care.

Q Provided that the CMOH orders were complied with?

A Yeah. And I mean, again, I think that far prior to the CMOH orders, which were quite late in the game when it comes to let's say a masking bylaw, you had -- and we'll get to this, right -- health organizations, like Alberta Health Services, like the -- they call these ones (INDISCERNIBLE) of Alberta and others recommending masking, continuous masking in all health care settings, right, long, long before the public bylaws -- which makes sense actually, because that health setting is wearing a mask long, long before in the health care setting, but, in a way, the CMOH orders kind of moot, I think in a way, because there are already masking bylaws in place like -- as recommended by -- I shouldn't bylaws -- masking regulations, mandates, whatever you want to call them, by pretty much every health care organization in the province for people providing clinical services, health care services.

Q Okay. I want to take you to -- I want to take you to the next CMOH order, which is 16-2020, and that's Exhibit F-2, and this is the May 3, 2020 order.

A Okay, let me pull it up.

MR. KITCHEN: I'm sorry, Mr. [redacted] which CMOH order are we talking about?

MR. [redacted] It's Exhibit F-2.

MR. KITCHEN: F-2.

MR. [redacted] 'F' as in Fred, and that's 16-2020, and May 3, 2020.

MR. KITCHEN: Thank you.

MR. [redacted] I just need to consult with my client for a moment. I'm just going to put myself on mute, if you can just give me a minute.

(DISCUSSION OFF THE RECORD)

Q MR. [redacted] I just want to begin by looking at CMOH Order 16-20 with a comment asking you to kind of clarify its effect. And I suppose I could read this in, but I won't. I'm looking at paragraphs 2, 3, 4, 5, and 6, and I'm going to characterize this as a CMOH re-entry to practice order for health care professionals.

Can you tell me what paragraphs 2 to 6 are saying and what they have to do with colleges and -- or practitioners like chiropractors going back into practice? I'll let you --

A Yeah.
Q -- read those sections, so ...
A Yeah. So essentially paragraph 2 and, yeah, this is now right after the first wave of the pandemic, and, during the first wave, a lot of stuff was shut down, including a lot of actually physicians' offices and health care offices, right; so essentially paragraph 2 says that anybody -- all regulated health professionals essentially have to comply with guidances around community health care settings to sort of return to work.

And every college, paragraph 3 basically says that every college was directed to publish these guidelines to all the members of their college and -- or -- and/or come up with their own guidelines as soon as possible, and that these colleges can then sort of provide to the CMOH essentially the -- their -- their plans, so to speak, for, you know, safe return to -- return to clinical services.

And then 5 basically says that, you know, the colleges are allowed to come up with their, you know, their own sort of return to practice guidances, but the CMOH can revise them, and, you know, if they're not good enough, basically make -- maybe make them a little bit stronger.

So that basically summarized this. So part of --

summarized that real quick, it essentially says for regulated health professionals to return to work in a clinical setting, (INDISCERNIBLE) clinical setting, you basically have to follow guidelines that were essentially designed by a CMOH or your college.

Q When I look at order -- paragraph number 2, it says: (as read)

> Regulated member of the College established under HPA practicing in the community must comply with the attached workplace guidance for community health care settings.

I'm going to ask you to turn to page 9 of this document, and that is, in fact, the attached workplace guidance for community health care settings. When you get to page 9, you'll see a heading "Personal Protective Equipment (PPE)".

A M-hm.

Q And I wonder if you can just read the first couple of lines on that.

A Yes, I can. Oh, sorry --

Q It starts off with "All staff providing".

A Yeah: (as read)

> All staff providing direct client or patient care or working in client and patient care areas must wear a surgical/procedure mask continuously at all times in all areas of the

workplace that they're either involved in direct client/patient contact or cannot maintain adequate physical distancing.

Q So this is --

A (INDISCERNIBLE)

Q Oh, sorry.

A And I'll read this point: (as read)

> The rationale for masking of staff providing direct client/patient care is to reduce the risk of transmitting COVID-19 from individuals in the asymptomatic phase.

Q So this is, if we go back to paragraph 2, it says you must comply with this guideline, and then we have order 3 saying subject to Section 5, each college can create their own masking guidelines; is that correct?

A M-hm, or their own sort of guidances, yeah.

Q So what I'm getting at here is order number 2 says you've got to comply with the attachment here, and I've taken you through the masking requirement, or if you're a college, you get to create your own Pandemic Directive.

A Yes. And, you know, the rationale here writ large is that, you know, it's very hard for a CMOH order to encapsulate all the different types of clinical practice that are provided in the community, right, across all the, I think, 27 registered colleges,

registered health profession. And so you can think of the CMOH guidance as like the minimum, right, but, you know, the College could -- well, our college, for example, can provide additional guidance, let's say, when doing a specific type of procedure, like an arrow slide [phonetic] generating procedure or, you know, doing an anoscopy or other such things.

But, you know, think of the -- go ahead.

Q Would it be fair to say that the CMOH is deferring to colleges; they know their profession best?

A I would say it's a bit of both, right? As in like there's the minimum standard, like, and part of the minimum standard is to wear a mask, but, again, it's hard for a CMOH to think of all the possible things colleges do, and so, in that sense, they are deferring to the colleges to provide potential -- additional guidance around different types of procedures and things that different registered health professionals may do.

Q I'm looking at paragraph 4 in this CMOH, and it says each college must provide the CMOH with a copy of any COVID-19 guidelines published in accordance with Section 3. Do you know what the purpose of that would be; why they would have to provide the -- their guidelines to the CMOH?

A Well, I mean, I think, you know, we, like at a very

high level, the responsibility of preventing -- I mean, many people are responsible for preventing the transmission of COVID, the spread of COVID, but I would say that, as far as ultimate responsibility, the CMOH cabinet, you know, like as (INDISCERNIBLE) cabinet are really responsible for it, and so a pretty good idea to have a sense of what, you know, different colleges are doing and recommending for their members.

Q If I look at order number 5, it says: (as read)

> The CMOH may amend any COVID guidelines created by a college under Section 3 if the CMOH determines that the guidelines are insufficient to reduce the risk of transmission of COVID-19 in the practice of the regulated profession.

Is this a check and a balance?

A You know, I think this -- this clause basically says that, you know, we recognize that you know your profession the best, which is probably true, but, you know, if you're not sort of up to snuff when it comes to providing, you know, a set of guidances that reduce COVID transmission risk sufficiently, then we can edit your guidelines.

And I would say that, you know, fundamentally, when it comes to understanding the dynamics of COVID-19 transmission, you know, there probably is more

expertise within the office of the CMOH than for many other regulated health professionals. You know, like, for example, I -- not to pick on any group in particular, but, in the same way, I know very little about optometry and the eyes, so too your average optometrist may not know as much about, you know, COVID transmission, and, therefore, with that clause, the CMOH can basically, you know, amend the guidance, you know, provided by the College of Optometrists, for example.

Yeah, you can view it as a check and a balance, just having the final word to, you know, maintain safety.

Q And we talked about page 9, saying that there must be mandatory masking when treating patients when you're not able to socially distance. Again, that's the minimum --

A M-hm.

Q -- under this order?

A Yes.

Q Okay. And when I look at this final question on this one, I look at Section 6, it says: (as read)

> Section 2 of this order does not apply in respect of a regulated member under the HPA whose college has published COVID-19 guidelines as required by Section 3.

Again, that's the authority for a college to create its own guidelines; is that correct?

A Yes, I believe so.

Q Okay. And I'm looking -- sorry, I had a couple of quick other questions. I'm looking at paragraph 3: (as read)

> Subject to Section 5, each college established under the Health Professions Act must, as soon as possible, publish COVID-19 guidelines applicable to their college.

That's mandatory language?

A Yes, I think so.

Q And the use of the phrase "as soon as possible", what does that mean to you, or what does that indicate?

A I mean, I think as soon as possible -- like I was not involved in the, well, direct drafting of these for any specific colleges. Probably actually did advise the College of Physicians, but I would say, you know, as soon as you can do it, a week or two. But I suspect our colleagues at the Alberta College of Chiropractors [sic] would have a better sense of what "as soon as possible" meant, given the fact that they had to submit things to the CMOH at that time.

Q Well, I'm going to switch gears now and take you to the ACAC Pandemic Directive.

MR. [redacted] And, Mr. Chair, I'm just going

to make a comment that I'm asking all of you to go to Exhibit C-22, which is the Pandemic Directive dated January 26th [sic], 2021.

If I had had Dr. [redacted] to testify first, I was going to ask him questions about the fact that there are three pandemic directives, there's a couple in May of 2020 I believe, and then there's this one in January. [redacted] testimony, I hope there isn't anything controversial on this, was going to be that there were some minor changes made to the Pandemic Directive over time but that the masking requirements in it did not change and the other social distancing requirements.

So I'm going to question Dr. [redacted] using Exhibit C-22, which is the January 26th, 2021 Pandemic Directive because, as you'll hear from Dr. [redacted] this document, insofar as the issues we're talking about, didn't change.

Q MR. [redacted] So, Dr. [redacted] I'll just ask you to call up this document then, and, again, it's January 26th, 2021 Pandemic Directive, and this is the ACAC's Pandemic Directive that was created pursuant to CMOH Order 16-2020.

MR. KITCHEN: Mr. [redacted] so you're going to ask questions about --

MR. [redacted] I am, yeah, and I'm sorry,

Mr. Kitchen, I gave some background there on these three versions of the documents, but I do want to use the January 16 [sic] one. [redacted] going to testify to what I said a couple of minutes ago.

MR. KITCHEN: January 16th, not January 6th?

MR. [redacted] January 6th, pardon me. I may have written that down wrong.

THE CHAIR: And, Mr. [redacted] we're in 'C' now, the --

MR. [redacted] Yeah --

THE CHAIR: -- 'C' folder?

MR. [redacted] -- C-22.

THE CHAIR: C-22, thank you.

MR. KITCHEN: Now, my understanding, please help me, you said there's three versions, my understanding is January 6th, 2021, is the most recent.

MR. [redacted] Yeah.

MR. KITCHEN: Okay, we're on the same page.

MR. [redacted] Yeah, we are, and I think what I want to do though is the section -- Mr. Kitchen, in fairness to you, the sections I'm going to take Dr. [redacted] to haven't changed from -- that's what [redacted] evidence is going to be, and I think it's better to use one document, not three, and just use the most current version of it.

MR. KITCHEN: Okay, well, I may have a

problem with this. I've given you a long leash with the many questions about the CMOH orders, notwithstanding the fact that Dr. [redacted] is not the CMOH and didn't write that, but he's Public Health, he's been an MOH, so that's fine, but I'm going to struggle to understand how -- you haven't asked the question yet, so but how does his comments on these, the ACAC Pandemic Directive contents, how this falls within the scope of his expertise as we've qualified it.

MR. [redacted] Well, I'll ask my question, and I guess you'll object if you need to. I just wanted to set the stage frankly on a document-basis as to why I was going to the third version, not the first two.

MR. KITCHEN: I have no issue with that.

MR. [redacted] Yeah, okay.

Q MR. [redacted] So, Dr. [redacted] I'll get you to turn to page 8 of the --

A Yeah.

Q -- Pandemic Directive.

A Yeah, I'm there.

Q And there's a heading "Personal Protective Equipment".

A M-hm.

Q And you've read this document I understand. From your perspective, is the masking requirement and the other requirements in it, social distancing, plexiglass

requirements, are those acceptable, are those warranted?

A Yes.

Q Can you tell me why?

MR. KITCHEN: Well, hold on, there was two questions there; there was acceptable and there was warranted. Can you --

Q MR. [redacted] I'll rephrase my question. Are these scientifically supported?

A Yes.

Q Can you tell me why?

A Yeah. You know, based on -- well, again, we've already reviewed the CMOH orders, which essentially say that the reason why registered health professionals practicing in a community setting need to wear masks continuously reduces the transmission of COVID-19. But I mean, fundamentally, in a health care setting, wearing a mask does reduce the transmission of COVID-19. It protects both the user of the mask and also the people around the person who's wearing the mask.

There is quite a lot of evidence supporting this, and I can elaborate into that, but it's fundamentally, I mean, I think, to, well, one, to keep the environment safe, perhaps, more importantly, keep the patient safe.

You see more to another (INDISCERNIBLE)

asymptomatic transmission, and, you know, by that, we know with COVID-19 -- well, you can transmit the infection when you're symptomatic, when you're asymptomatic. When you're symptomatic, you probably shouldn't be at work in the first place, and once in a while we see that happening, usually because it's hard to sometimes tell if you're have -- you get symptoms or not, but certainly lots of people can transmit when they're asymptomatic. And when that happens, you don't know if you have COVID, right, you don't have any symptoms, and, you know, wearing a mask does -- well, it prevents all sorts of COVID transmissions, symptomatic or asymptomatic.

Q Okay, thank you. I'm going to turn to another area, which is what I'm going to call the AHS documents. MR. [redacted] And those were three documents, Mr. Chair and Tribunal Members, that were admitted as exhibits this morning.

I had previously sent those to Dr. [redacted] not knowing if they would or not be before the Tribunal, but they now are before the Tribunal as exhibits, and I have a couple of very brief questions for Dr. [redacted] about these.

I believe, Mr. Chair, these are in your Dropbox under File 'H', if I'm correct, and I think they're H-2, 3, and 4, but I might be wrong on that. And while you're looking for them --

Q MR. [redacted] -- Dr. [redacted] I'll just ask you to call up my email to you which had those three documents attached.

A Yeah.

THE CHAIR: Everybody have them? I think we're good.

Q MR. [redacted] Okay, I'm just going to go to the first document, which is -- sorry, open my documents, my apologies.

The first document, which is "AHS Guidelines For Continuous Masking". It's kind of got a grey border or a grey heading, and it starts off with the word "Purpose". Do you have that in front of you, Dr. [redacted]

A I do.

Q In the "Background" section, there's a reference to the "Public Health Agency of Canada". Can you please comment on the statements in the AHS guidelines and what they say about PHAC?

A Yeah, so basically "Background", there's evidence that asymptomatic, presymptomatic, or minimally symptomatic patients, that's like, let's say, a super -- like very like subtle runny nose, for example, can transmit COVID-19.

As such, the Public Health Agency of Canada, which we've talked about, recommends that health care workers should wear a mask when providing any care to patients

in order to prevent transmission to patients and their co-workers, yeah.

Q The next paragraph has a sentence, and there's a question coming: (as read)

> To prevent the spread of COVID-19, AHS has a continuous masking directive in place.

Do you agree with the statements in this document?

A Definitely, yes.

Q I'll ask you to go to the next AHS document, which is entitled "Personal Protective Equipment (PPE)" document.

A Yeah. I have that.

Q Just wait a second to make sure everybody on the Tribunal has that.

On the beginning of page 1 under the heading "Protecting Our People & Patients", there's a statement: (as read)

> PPE is critical to the health and safety of all health care workers, as well as patients we care for.

Do you agree with that statement?

A Yes.

Q Can you tell me why?

A Because there's a lot of evidence that shows that masking is very effective at preventing the transmission of COVID-19, and it is very important,

well, one, to prevent health care workers from giving COVID-19 to -- inadvertently patients and other people, but also to protect health care workers from COVID-positive patients.

I'm going to expand a little bit, right, so I was involved in the original continuous masking policy, as in, I was around before there was a continuous masking policy, and this goes way back to maybe March of 2020. At around that time, you know, COVID was kind of raging through New York and Italy. In Italy, there were a very, very, very large number of health care workers who got COVID and died from COVID.

And part of the reason that happened was because they ran out of PPE, they ran out of masks, and you know that probably provided the initial rationale, before all the studies that came after that, and there were plenty of studies for implementing continuous masking, within AHS, sort of -- within AHS, we'll say, which is the main health providing body.

You know, like I give you another sort of like illustrative example, you know that within AHS hospitals, there were COVID units, right, so units where people with COVID were put to limit the spread of COVID from patients to other patients in the hospital; that would cause an outbreak. And with those COVID units, we -- by the time the COVID units were set up,

we basically had continuous masking in place, and this is before any eye protection actually was generally offered. So the general policy was if you treat a patient, if they don't have any symptoms of COVID, all you need to wear is a mask. If they had symptoms, you would put on eye protection.

And, you know, given the number of COVID patients we had on our COVID units and given the number of health care workers who saw, you know -- think of, you know, in any given day, a patient with COVID would see dozens -- would have dozens of interactions with health care providers, right? And so we're talking about tens if not hundreds of thousands of interactions with a COVID-positive person, a patient, and a health care worker who's COVID negative.

And across those tens -- the hundreds of thousands of interactions, the number of transmissions that occurred was very low. I mean, I believe, the last time I checked with AHS, like we had less than, you know, a hundred transmission events from a COVID positive to a health care worker. That is after hundreds of thousands of interactions. And, you know, that is, to me, very compelling to say that masking does work versus let's say what happened in Italy, where they didn't (INDISCERNIBLE) masks (INDISCERNIBLE) died.

Sorry, that was a bit long-winded, but I just wanted to provide some of my personal experience early on in the pandemic in masking and getting masking in place.

Q Sure, thank you. I'm going to take you to the final what I'll call AHS document, and that's Alberta Health Services Directive "Use of Masks During COVID-19".

MR. [redacted] I'll just everybody get to that document.

Q MR. [redacted] And I only have I think one question for you -- one or two on that document.

On page 1 of that document --

MR. [redacted] I'll just wait. Is everybody there? Okay.

Q MR. [redacted] On page 1 of that document under "Principles", I'm just going to read this statement, and then there's a question: (as read)

> Continuous masking can function either as source control, being worn to protect others, or part of personal protective equipment, to protect the wearer, to prevent or control the spread of COVID.

Can you describe this dual purpose of masking?

A Yeah, so a mask -- when we say "source control", like that means -- like assuming you're the source, like the person wearing the mask has COVID-19, it does prevent,

reduce the transmission of COVID-19 onto others. So, for example, if you and I were in a room, you had COVID, you had a mask on, I would be less likely to get COVID from you than if you did not have a mask on, and that is source control.

The other thing, you know, let's now say, in that room, you have COVID, you have a mask, and now I -- and I don't have COVID. If I had a mask on, I'd be less likely to get COVID than if I didn't have a mask on, and so it also protects, you know, like it -- it'll -- so I would -- the mask protects me if somebody doesn't have COVID and also reduces the forward transmission of somebody with COVID.

Q So there's a benefit to the wearer and a benefit to the patient around the wearer?

A Yes.

Q I want to turn to your expert report, and I believe that is Exhibit E-2.

MR. [redacted] Just let everybody get to that expert report. Mr. Chair, I'll assume that everybody has that document in front of them.

Q MR. [redacted] I just have a general question for you, Dr. [redacted] about your expert report --

A M-hm.

Q -- in your expert report, you talk about the benefits of masking and social distancing, et cetera; are your

opinions consistent with those, to your knowledge, consistent with those of Alberta Health Services?

A Yes.

Q Are they consistent with the Public Health Agency of Canada?

A Yes.

Q And are they consistent with the Chief Medical Officer of Health's office?

A Yes.

Q Okay, your report is dated July 28th, '21. Since you've prepared your report, have you had any changes in terms of your opinions or conclusions?

A No.

Q Your report begins with a "Purpose" section, and I'll ask you just to briefly describe, again, what your purpose was and what the conclusion you reach at the end of this paragraph.

A Yes, the purpose of this report really is to talk about the -- the benefits or the effects of mask wearing to reduce the transmission of COVID-19 generally but specifically in the health care setting, and conclude that there is, frankly, an overwhelming body of evidence that supports that wearing masks does reduce COVID-19 transmission particularly in a health care setting.

Q There's a list of citations at the end of your report,

and I think they start -- give me -- they start on page 9. Can you tell me, in general terms, what documents, what reports, or information you reviewed in preparing your expert report?

A Yeah, so I did a -- one sec here -- like a vast literature review, and so generally a set of documents that are reviewed -- they tend to be either mostly academic publications. They tend to be mostly academic publications from like very well-known sort of press -- I don't want to use the word "prestigious", but like well-regarded medical journals like The Lancet or the Journal of American Medical Association or the Cochrane Database Systematic Reviews.

Furthermore, you know, when I say there's an overwhelming body of evidence supporting this, it's not like one study or ten studies or a hundred studies -- I mean, well, maybe closer to a hundred studies, and so I do draw on a number of studies known as systematic reviews and meta-analyses.

Systematic review is basically the type of study where, you know, let's say there's 20 papers on masking and whether they're good or bad. They summarize the results of those studies, and that analysis basically takes the -- I know sometimes, in a given study, you have some, you know, calculations, statistics, you know the population, so you study a thousand people, and

one's studying 2,000 in another, I'm just making those numbers up. The meta-analysis (INDISCERNIBLE) through the methodology to combine those populations together. And so instead of having, you know, a thousand -- one paper with a thousand studies, another paper with 2,000 participants; you know, we might, like, look at like hundreds of thousands of participants.

And when it comes to -- I don't want to say the hierarchy of evidence, so to speak -- you know, systematic reviews and meta-analyses are viewed quite highly, because they provide a summary of the evidence by -- a better summary of the evidence than, you know, like the one paper here or there. And so that is sort of primarily what I'm drawing from.

Q Okay. How would you describe your level of confidence in the documents you reviewed?

A Extremely high.

Q Did you review -- and I should go back, you're aware that some cv's and expert reports from Drs. [redacted] and [redacted] have been put before the Tribunal as well. Did you review those expert reports when you prepared your expert report?

A I did, yes.

Q This is maybe an obvious question, but those expert reports didn't change your conclusions?

A No.

Q Okay, well, we'll get into those in a little while.

I'm looking at the "Introduction" section in paragraph 1, and you talk about: (as read)

Mask wearing, among other measures such as physical distancing, were clearly and demonstrably effective.

Why did you use those terms? What do they mean?

A You know, I get the sense the sometimes I used words that may have a legal implication. Again, I'm not (INDISCERNIBLE) of that, but, I mean, I just -- you know, clearly it means, obviously, demonstrably I sometimes throw that in and -- and, sorry, like and sometimes I change my language, and, you know, you catch onto words like "must", when I'm like, oh, I just, you know, use that, sometimes I don't.

But at the end of the day, you know, like what I'll say is that there -- again, I sound like a broken record, but like an overwhelming amount of evidence showing that masks reduce transmission in -- especially in a health care worker setting.

Q And I'll be clear for my questions, in as much as I'll invite your comments, I suppose, on legal use of terminology, I'm asking you questions from a clinical perspective --

A Oh --

Q -- and your training and knowledge in your field --

A Yeah, sorry, sorry, I misunderstood. I'll stop --

Q No --

A -- (INDISCERNIBLE) --

Q -- that's fine. The next paragraph says: (as read)

> Masks are a form of protective device designed to protect the person wearing the mask and protect those in their immediate surroundings.

Is this is the dual affect we were just talking about before?

A Yes.

Q The next paragraph talks about the use of masks and other nonpharmaceutical interventions being recommended by World Health Organization. Can you tell me about the -- bear with me -- you talk about the use of masks, sorry, in SARS and influenza. Can you talk about the, briefly, the historical experience recently with the use of masks?

A Yes. And I apologize, again, to [redacted] I keep on talking over [redacted] and I said I wouldn't, and I've really sorry about that.

Look, I think that like our understanding of mask efficacy has grown exponentially because of COVID. Nothing in the history of medicine and probably in the history of humanity has been researched as much as COVID-19, right, like that's a fact.

And I would say, first of all, that we've learned a heck of a lot more about mask use and how good it is, where it works, where it doesn't work quite as well over the last 18 months than we have in the history -- just the sum total of everything we've known before.

For example, one thing we did not use before was continuous masking in health care centres, right? Like that is not something that we did; that is something that was new. And we -- you know, we began to do that as we learned more about how COVID-19 transmissioned and (INDISCERNIBLE), a.k.a. a lot of the sort of asymptomatic transmission. But when I think about --

Sorry, am I answering your question or sort of going off on a tangent? Is that what you meant?

Q Yeah, I think you -- in the paragraph above, you talk about the historical use of masks dating back to the 1600s, and then you've got some comments here about some of the more recent experience, and I'm just asking you to summarize that.

A Oh, yeah. I mean, masks have been used for a long time, used in different health care settings. You know, we know that they are an effective tool for preventing the spread of respiratory viruses writ large. And then (INDISCERNIBLE) what I've said before, but we know far, far, far more about masking and its effectiveness around COVID-19 than any -- than the sum

of everything we knew about masks in the history of all masks that is going back, yeah.

Q In the middle of that paragraph we're talking about, you mentioned on line 4 a Cochrane review, and it included -- I'm skipping a couple lines -- 67 randomized control trials and observational studies. What do those terms mean, "randomized control trials" and "observational studies"?

A Yeah, so a randomized control trial is generally considered like the gold standard of a type of a medical study, right. Essentially in a randomized control trial, what you do is there's a -- let's say you split the population in half, and they actually sort of split randomly, so the characteristics of those two populations is the same. And then one group gets assigned a treatment, let's say it's a medication, and the other group gets assigned nontreatment, like a placebo, for example.

And then you essentially use that to -- and then you look at the treatment group to see if there's a difference in effect, effect being, you know, your outcome of interest, let's say, for a medication, you know, how much it reduces your blood pressure.

And, you know, the reason why I randomized -- randomized part is when I say "randomized", that's when I said you split these people in half randomly, so the

characteristics of the two groups should be sort of random -- like largely similar, controlled in the sense that you kind of control the study, you know, like you've had very precise control over the study and trial and that sort of randomized control trial.

Observational study is a more general term to describe the type of study where you don't have sort of much control over it, right. So an example of an observational study would be some of the stuff that I, you know, mentioned like around the COVID units of Alberta. So like I'm observing that, you know, even though we didn't have a vaccine, and there are hundreds of thousands of interactions between COVID-positive patients and COVID-negative health care workers, there were very, very few COVID transmission events.

I will say that the issue with randomized control trials is they cannot be generally used in the absence when you have something called clinical equipoise.

So the best example of that is this: We generally don't do randomized control trials on the effectiveness of parachutes from jumping out of planes, right, because, like, if you -- we could test them out that way, but if we were to do that, the person -- we have a hypothesis that the person with that parachute would die.

And so like I say that because, when it came to

COVID, there aren't as many RCTs around COVID-19, because it became pretty abundantly clear pretty early that masking was good, and, therefore, depriving health care workers of masks, like you can't do that, that would be considered an unethical study; just like depriving somebody of a parachute jumping out of a plane would be considered unethical to study the efficacy of parachutes for preventing death when you jump out of a plane. So ...

Q Okay. I want to turn to the next page on your report, and you talk there about "Methods", and on line number 2 -- oh, I should go back -- you talk E-2 about databases such as PubMed, JSTOR, Cochrane Library, high-quality peer reviewed. I think you've commented on what peer reviewed means, but there's something interesting in the -- at the end of your -- that sentence -- or that paragraph, it says: (as read)

> The vast majority of literature is from the years 2020 to 2021 with an emphasis on literature published in 2021 as it is the most up-to-date and evidence informed.

Why is that important, being up-to-date and evidence informed?

A Well, specifically what we're really interested in, right, is how good masks are at preventing COVID-19, right? COVID-19 wasn't around, well, in 2019, really.

I guess it was maybe in China, the tail end of 2019.

And so when I, you know, look at past -- and, you know, I comment on past studies around masking, but, you know, it's less salient in the discussion because different viruses like influenza or RSV have different transmission dynamics than COVID-19, right, and so what we want are studies to look at masking and COVID-19 in specific, right, because every virus is different. Yeah.

Q Okay. I'm going to go to the next section in your expert report, which is entitled "Benefits of Masking". Second sentence, I'll let you read -- or comment on, the second sentence in that paragraph says: (as read)

> Vast majority of evidence presented was by credible academic sources indicating mask use does reduce the rate of transmission in clinical and lab settings.

And then: (as read)

> Below are multiple studies detailing the effectiveness of mask use in response to the other expert reports.

What are you trying to communicate in that paragraph, Dr. [redacted]

A You know, in this paragraph, I guess what I'm basically saying is that as the first (INDISCERNIBLE) says, like as the pandemic progressed, there was more and more

evidence around what we wanted to specifically know about, which is COVID-19 and masks, and this evidence generally got published in very high quality, different journals and different levels of, you know, quality. They're all peer-reviewed.

So we began to build essentially more and more of a robust case for masking, and, generally speaking, that these studies show that masking is good at reducing COVID-19 transmission in a clinical setting, in a lab setting, various -- like all sorts of different settings, so it's more I feel like what I've been saying a lot over and over again, sorry.

Q Well, I'm asking you to do that, so you can -- you'll have to bear with me.

The next paragraph talks about the transmissibility of COVID-19. Can you describe that?

A Yeah, so COVID-19 is believed to be transmitted through, you know, primarily through contact and respiratory droplets, right, and to a lesser extent through, you know, aerosols, right. And so basically, you transmit it in a way I'll say that is like broadly similar to the way like influenza is transmitted, broadly similar I say, as opposed to something like HIV, which is transmitted through sexual intercourse.

We now that COVID-19 is relatively infectious, you know, in that, you know, we sort of thought the

original COVID-19 had a sort of R0 of 2.5. That basically means, you know, one person would, on average, infect 2-and-a-half people if everybody was susceptible.

With the Delta variant, we think that R0's 4, maybe even 5, and so COVID-19 is quite infectious, and maybe -- a very good example of why COVID-19 is very infectious, you know, every year we have a flu season, right, and we can't really stop the flu season. But this year, last year, we had no flu, and even though we had no flu, there was a heck of a lot of COVID-19 still, and so our measures used to control COVID-19 were clearly sufficient to stop the spread of influenza, but clearly insufficient to spread the stop [sic] of COVID-19. So highly infectious respiratory virus, but you all know that after tens of millions of cases around the world. Hundreds, yes.

Q I'm looking at the next --

MR. [redacted] Mr. Chair, I should mention I intend to take, if the Tribunal is willing or is agreeable, I intend to take a break at 3:00, if that will work for everybody, and then resume, and we maybe go another hour after about a 15-minute break. I think the intention is probably to try to finish each day by about 4 or 4:30, somewhere in there, so just to give you a heads-up on -- and, of course, if anybody on the

Tribunal needs a break at any time sooner, please let me know, but I just thought I'd mention I thought I'd go till 3:00.

MR. KITCHEN: Based on that, Mr. [redacted] it sounds like we're not going to have time for cross-examination today; is that you're thinking?

MR. [redacted] I'm thinking, and as I mentioned to you, Mr. Kitchen, Dr. [redacted] is available to come tomorrow morning at 9 AM to finish any examination and cross-examination, so yes.

A Yeah.

MR. KITCHEN: Okay, that's fine.

Q MR. [redacted] The next paragraph in your report, Dr. [redacted] says: (as read)

> To reduce transmission and spread to others, studies indicate that physical distancing in conjunction with such measures as mask wearing can reduce the probability of droplet spread.

Can you comment on why physical distancing is important?

A Yeah, and, you know, again, this is me -- like I say, in conjunction with things like vaccines as well, but, you know, if you imagine that, you know, this virus is, let's say, primarily spread through respiratory droplets, I -- like I cough, there's little bits of

like spit with virus in them, and, you know, I cough on -- like I cough on Mr. [redacted] and if he's 1 metre -- well, if he's right up to my face, then he'll get all -- a big spray of COVID-19 spittle on his face, which can cause infection.

If he is, let's say, a hundred metres away, my little respiratory droplets probably won't go that far, and, you know, we -- the further you are from somebody -- and this is pretty obvious -- the less likely you're going to get a virus sort of like this. You know, I will say that it is known that COVID-19 does have some aerosol transmission.

And, you know, the line between -- here's how our understanding evolved, right? Before, we were like contacting droplet means if you're outside of the 2-metre range, you're probably not going to get the virus, and if you're within the 2-metre range, you're (INDISCERNIBLE). But conceptually, and this is where like our understanding has really evolved over COVID, if you coughed into a fan, and like clearly like your little wet spray droplets can go more than 2 metres presumably, right. And so when I say aerosol transmission, you know, we can go further than 2 metres, and, you know, these droplets sometimes linger in the air. And so it's less of like a -- you know, it's airborne versus contacting droplet, like, you

know, like binary, like one, zero, on, off, it's more of a continuous spectrum sort of transmission where the further you are from somebody who is infectious, the less likely you are to get it.

Q I'm going to go to the -- just carry on with your report, and there's a comment about a large outbreak of COVID-19 on the USS Theodore Roosevelt of an aircraft carrier, I believe, and after that, there's a paragraph that says: (as read)

> The Public Health Agency of Canada produced a COVID-19 brief titled "Does wearing a mask in public decrease the transmission of COVID-19".

You've already told me what the Public Health Agency of Canada is, can you tell me -- and this I think is the next couple of paragraphs in your report -- what the Public Health Agency of Canada's brief found?

A Yeah, so, you know, it's this brief basically comments on some of the evidence around masking and how it does reduce the transmission of COVID-19. And, you know, like you've got to remember, right, like -- and I'll own this -- at the very start of this pandemic, we were not recommending continuous masking, right? And the Public Health Agency of Canada was saying you don't have to wear a mask outside, you don't have to wear a mask indoors, we weren't saying -- recommending mask

wear, like mask use in health care settings when the pandemic started, right?

And over time, it didn't take too long, our evidence sort of changed or the recommendations changed, and that -- those recommendations changed on the basis of evidence. And I say this because I think it's really important to recognize that we've learned lot about this, and organizations like the Public Health Agency of Canada, like AHS, like CMOH office, we take evidence, and we change our recommendations as new evidence evolves, right? And so I'll just cap it at that, because that did happen, initially we weren't recommending mask use, and that was a mistake. And I -- it wasn't me recommending that, but I'll like own that mistake on behalf of Public Health.

But, you know, this little brief basically then goes to cite a few different studies where, you know, masking did reduce transmission, so, you know, one of these is a longitudinal study in the US that it showed, you know, essentially with an increased use in face masks, you're going to have like lower cases.

There's a real interesting hairstylist study actually, where basically, you know, if you imagine somebody cutting somebody's hair, you're pretty like up and cozy with them for a long period of time; and, you know, essentially the COVID-positive hairstylist who

saw 139 people while infectious, and they were all masked, and nobody became positive, right; and that's reasonable evidence to show that masking may work, may reduce the risk.

And, you know, there's something call an ecological study here, right, and think of an ecological study as a subset of an observational study where, you know, you're not controlling the experiment, you just sort of observe what happens over time, you know, when masks are used, when they're not used, and the vast majority, so 26 out of 27 studies showed that face mask policies did decrease COVID-19 infections and, naturally, that would decrease deaths.

If anything, like when I wrote this report, there's like too many studies to talk about in favour of masking, so I picked a few, right, but, you know, I -- even this brief cites 27 studies at least that show that, you know, masking is beneficial for reducing transmission.

Q Just one quick question before we break, it's almost 3:00, you have a -- in the last paragraph on that section, just about masking for health care workers: (as read)

A recent systematic review with a high AMSTAR rating concluded use of masks did reduce the risk of contracting and transmitting

COVID-19. Overall, the Public Health Agency of Canada brief, using evidence-informed data, concludes that mask use decreases the transmission in the community.

I take it that's still your conclusion?

A Yes.

Q And what's an AMSTAR rating?

A So, you know, with different type -- for most types of studies, like whether you have a randomized control trial study or systematic review type of study, they're sort of like rating systems to, you know, kind of look at how good -- within the -- within, let's say, the universe of systematic reviews, like some are better than others, and there are sort of rating systems where you can sort of like assess the quality of the systematic review by looking into a few factors, you know, like did they include all the studies, did they do the correct sort of like literature review, like stuff like that. So it's a rating -- it's like rating score for systematic reviews. So it means it's a good systematic review.

Q Thank you.

MR. [redacted] Mr. Chair, I would propose to take a 15-minute break now and then give everyone a chance to take a bio break and then proceed from about 3:15 till about 4:15 if that works for everybody, and I

think I'll be able to be finished with Dr. [redacted] today on that timeline.

THE CHAIR: Okay, that sounds good. I'm not seeing any shaking heads, I'm seeing nodding heads, so we'll do that. We will recess for now and reconvene at 3:15. Thank you, Dr. [redacted] and we'll see you in 15.

A Thank you. Sorry for being too long-winded. See you soon.

(ADJOURNMENT)

THE CHAIR: It's 20 after 3. We anticipate about another hour, and the plan will be to finish the direct examination of Dr. -- by the way, the hearing is back in session, and the plan is to finish direct examination of Dr. [redacted] this afternoon, and assuming that things go the way they are expected to, we would adjourn for the day and pick up tomorrow morning at 9:00 where we leave off today. Likely that will be with Mr. Kitchen's cross-examination of Dr. [redacted]

So I'll turn it back to you, Mr. [redacted]

MR. [redacted] Thank you, Mr. Chair.

Q MR. [redacted] Dr. [redacted] I'm now taking you to the heading in your expert report "Masking for healthcare workers". In that paragraph, the first paragraph, you talk about a three-fold increased risk of reporting a positive COVID-19 test compared with the general community, that's for health care workers. Can

you just explain what your comments here are about in this paragraph?

A Yeah, so I mean basically this is saying that health care workers are at potentially high risk of COVID than non-health care workers, which stands to reason for a number of possible reasons: One, if you think about health care workers work in person, health care workers work closely in person with people, and health care workers interact with COVID-positive patients more than, you know, the -- like your average person in society, because your average person in society, you know, over the last year-and-a-half has spent a lot of time in some degree of lockdown or another, so, yeah.

Q Okay. You then have got some comments about chiropractors falling into the category of HCWs or health care workers. I'm looking at, you've got a citation 13, and then there's a comment that starts: (as read)

> This statement indicates that chiropractors are a health care worker and must adhere to proper health and safety protocols.

What if they don't adhere to proper safety, health in protocols in terms of COVID?

A Well, yeah, I mean, as with any sort of health care worker, they're going to be at an increased risk of getting COVID and/or giving COVID to their patients.

Q In the next paragraph, you talk about: (as read)

> The evidence of the importance of mask use among HCWs is very robust, and there is an overwhelming body of evidence supporting the use of masking in health care settings to reduce COVID transmission.

Again, clinically, why did you choose the words "robust" and "overwhelming body of evidence"?

A This is -- I like to use the word "robust" once in a while. I could have used the word "strong". When I say "overwhelming", I just mean there's like lots of studies on it. You know, rarely do you have dozens and dozens of studies on the same thing, reporting the same, you know, benefit over and over again. I mean, not all the studies show the exact same benefit, but, yeah, like there's just like a ton of -- heaps, mounds of evidence.

Q In the couple paragraphs down, you talk about a study relating to the Massachusetts health care system that was reported in the Journal of the American Medical Association with -- I think involving 75,000 employees. Can you talk about the importance of that study?

A Yeah, so I mean this is just one of the sort of many studies. This is a fairly large study, right, I would say, given the sample size of the health care workers.

But, you know, essentially this study looks at,

you know, the effect of implementing universal masking and sort of how many health care workers became sort of, you know, positive. And, you know, in the study, you do see that there was a significant decline in like risk of acquiring COVID-19 once, you know, universal masking was in place.

Q The next couple of paragraphs down, you start with a paragraph that says: (as read)

> If we look closer to home in Alberta, there is clear evidence of benefit to mask wearing in the health care settings.

And then you go on to make some comments about -- I guess in support of that statement. Can you summarize what you're saying there?

A Yeah, yeah, this is back to sort of like what I said earlier about the COVID ward example, and then so I won't rehash that -- sorry, I jumped around a bit -- but COVID wards, no vaccine, masks only really, and it worked pretty darn well.

Q And I think, in fact, you refer in that paragraph to over tens of thousands of interactions between COVID-19 infectious patients and health care workers, and there being only a handful of transmission events. Does that support your opinion in this report?

A Yes.

Q I want to ask you in terms of your expert report and

your testimony, are using masks perfect?

A No. Nothing is perfect. Vaccines aren't perfect, seatbelts aren't perfect. There's nothing that is perfect, but it reduces transmission, and that's -- you know, by a fairly substantial amount, so -- but they aren't perfect.

Q I'm going to take you to the next part of your report, which is your response to the statements by the other experts, Drs. [redacted] and [redacted] and I'm going to ask you about [redacted] expert report, but that, of course, came in after you prepared this document.

When I took you through your report, we talked about a series of phrases, randomized control trials, the AMSTAR rating, the quality peer-reviewed evidence, systematic reviews, I think we talked about meta-analysis. Bearing that in mind as a reference and remembering the Journal of the American Medical Association and Lancet, how would you characterize the documents and studies cited by Drs. [redacted] and [redacted]

A Yeah, so I mean a few comments, and one is that, you know, I -- when I read the reports, a lot of the reports sort of aren't necessarily specifically about masking in a health care setting and its effect on COVID-19, right? It's about like how bad COVID is or

how not bad COVID is, and those things, right. And I mean, I won't comment on that, I'm just saying that stuff isn't directly salient to what we're talking about today.

I think when it comes to some of the studies they cite on masking, they -- you know, like they used studies that were sort of before, the pre-COVID era, and, again, I think that all I'm definitively saying is that masking is very good for COVID-19, probably works for other respiratory viruses, but like the overwhelming body of evidence is for masking for COVID-19. And I think these lot of older studies, you know, I think they do comment on the lack of, one of them, randomized control trials, but, again, I use my example of sometimes we can't do RCTs, like, you know, the parachute example. There's a lot of things we can't do RCTs, randomized control trials, for.

And then they use kind of -- you know, they use kind of like these -- like there's all sorts of lab studies, that, you know, some of them show these pictures of how masks are imperfect, and, you know, even if you have a mask, there's sort of like leakage, so to speak, right. And that's true, and masks are not perfect, right. We know that, you know, how well you put on your mask matters, how well the mask fits matters, all these things matter.

But, you know, the type of evidence that I think is the most compelling in this is what I call like an epidemiological study, that is a type of observational study that basically shows that, you know, in places where we implement the masking, like transmissions drop, right. And, you know, regardless of how imperfect they are, the net end result, which we care about, transmission or numbers of infections goes down.

And so I would, you know, essentially say that what their reports, to summarize, one, a lot of them don't talk about masking, so maybe not directly salient. Two, they refer to some -- a few studies, but they're pre-COVID, and so like it doesn't really matter. Like, again, like I only care about COVID studies and masks. And three, they comment on the imperfection of masking, and I don't disagree with the fact that masks are imperfect, but there's an update that shows masks do reduce transmission, and that's what we're interested in, that's what I'm interested in when, you know, I'm going around telling people to where masks in health care settings.

Q I asked you during my -- some questions a while ago about your level of confidence in the studies and reports that you had cited, and I think you said your level of confidence was high, and you referred to highly regarded institutions. Do you see those same

institutions in the citations from the three other expert reports?

A No. I mean, like basically, as you probably all know, like every Public Health organization recommends masking in a health care setting, right? We talked about some of them AHS, like PHAC, the Public Health Agency of Canada, US CDC, like all the ministries do -- and so I don't because they all recommend masking.

Q You've got a statement that your first comment here is in relation to Dr. Warren's statement about the risk of death due to COVID-19 in persons under 60 is very small, and you've got a response to that. Can you please comment on that response, what it means?

A Yeah. I mean, I think that this is an example of the statement is not directly salient to our discussion, right, which is that, you know, he's saying that not a lot of young people die from COVID. And it's true that if you're over, let's say, 80, your risk of dying from COVID is very, very, very high, but, you know, plenty of people under 60 have died in Canada, 1475 since June 2021. I think about 3,000 people under 18 in the United States have died of COVID. And so I acknowledge that COVID is less likely to kill you if you're young, I also acknowledge that COVID can kill you if you're young, but, lastly, like this doesn't -- it's not relevant.

Q Okay, I'm going to take you to your next comment where you've quoted Dr. Warren's report by saying: (as read)

> Asymptomatic transmission does occur, but the rates of transmission from asymptomatic persons is substantially less than from symptomatic persons and does not warrant being considered a significant contributor to the overall transmission burden.

Can you comment on your thoughts to that statement?

A Yeah, so I mean I think that maybe what he's saying, you know, asymptomatic transmission is not a big part of, you know, overall COVID transmission, asymptomatic or symptomatic. And I -- again, I acknowledge that people who are symptomatic are at -- more likely to transmit, you know, pound for pound than people who are asymptomatic. But that being said, you know, viral loads are actually the highest two days before symptom onset than -- for what it's worth.

Actually nailing down the proportionate transmission that's from asymptomatic versus symptomatic is actually quite difficult to do, and so I cite the CDC report saying it's about 60 percent. I mean, other -- the lowest found estimate that I've seen around asymptomatic transmission as a portion of total transmission is probably around 20 percent, right. And so whether it's 20 percent, whether it's 60 percent,

those are significant numbers, so, you know, it's not like --

Q Okay.

A -- 1 percent.

Q There's another quotation here from Dr. [redacted]'s report that begins with "Testing of asymptomatic people", and there's a four or five-line quote there, and then you've got another response there. Can you explain your response to what Dr. [redacted] is saying?

A Yeah, I mean, once again, like a comment that is isn't salient to our discussion at all, but he's basically saying is that testing asymptomatic people doesn't make clinical or economic sense. I do know quite a lot about testing, and I've actually published quite a lot about testing, and I will say that asymptomatic testing makes a lot of clinical sense.

You know, like, for example, in AHS, we basically -- every patient who's admitted to hospital during the -- you know, during the peaks, you get tested whether you have symptoms or not, because we can't rule out asymptomatic -- like asymptomatic infection without testing. And so, yeah, like I again -- I mean, so I do think we can test asymptomatic and we can detect virus in meaningful ways when people are asymptomatic, but it's not salient to the masking discussion.

Q There is a bold type paragraph a little bit down in your report, and it talks about the factual errors in the above statements, and at the end, it says -- oh, pardon me, you have a comment: (as read)

None are actually salient to the question at hand around whether or not masks provide a benefit in a health care setting.

Do their reports not relate to health care settings?

A Well, a large -- like much of the reports don't, but if you read down, then I then comment on -- the above statements just don't talk about masking at all, right; one talks about how likely you are to die from COVID, right; one talks about asymptomatic transmission of COVID, like not just -- you know, one talks about whether or not we should test people for COVID who don't have symptoms.

Below that bold font section, I then respond to the parts of the other expert witnesses that actually talk about masking, for example.

So I guess what I'm saying is that above, they make some statements that aren't necessarily true, but like regardless if they're true or they're not true, like it's not relevant.

Q I'm skipping down a little bit in your report now. You've got a statement: (as read)

Dr. [redacted] argues that masking is not helpful

given the aerosol route of transmission.

And then a quote, and then you've got a paragraph about your response. Can you talk about your response in aerosol transmission?

A Yeah, and I sort of spoke about aerosol transmission a bit earlier, right, versus contact and droplet. I'll rehash that, I mean I think that -- people I think are perhaps under the impression that something that is airborne or has an aerosol -- airborne and aerosol have different -- just think of transmission occurring on a spectrum, right, where most of it happens within 2 metres through the cough -- like respiratory droplets, you know, like me talking on you, Mr. [redacted] and sometimes it can like aerosolize, which is probably defined as it staying in the air for an extended period of time or going beyond 2 metres.

Now, again, very hard to pin down the proportion of transmission due to aerosol spread versus contact and droplet spread, but we think it's pretty low. And, again, like it's just like none of those things matter in the face of the hefty evidence that shows once people start putting on masks in health care settings, transmission goes down, right. Like that is the -- that's all you need.

Q You've got a paragraph that begins: (as read)

Dr. [redacted]'s critique of how well masks fit

and mask pore size being too large to screen out SARS-CoV-2 in no way negate the huge body of real-world ecological evidence that masks reduce transmission as we describe in our report.

And then you talk about masks not being a hundred percent effective. You then go on to say that: (as read)

It is clear they provide significant amounts of protection and dramatically reduce transmission.

Why do you say that?

A Well, I mean, I -- like there's a -- I think I do say this somewhere in my report, but there's a big meta-analysis in the Lancet, a highly reputable journal, looked at -- I mean, I think they looked at 200-plus studies, and that study basically showed there's about an 85 percent reduced odds of transmission when people have masks on. And like there's just so many studies like that over and over again, right. And when I say "real-world ecological", yes, masks are imperfect, yes, the pores might not be perfect, yes, there's like air released. Like putting on masks leads to reduced transmission, and we see that in the real world over and over again, they probably reduce transmission.

Q You've got a comment after a quote from [redacted] report about his statement being false and not backed up by any evidence. Can you comment what you're saying -- about what you're saying in that paragraph?

A Yeah, like this is kind of interesting, right, so I mean this statement is basically like, how do I call this, this is a fallacy, ecological -- whatever it's called, so basically they're saying like if we implement a mask bylaw, cases still go up, right, writ large, but that just doesn't control for a bunch of confounding factors, right.

When we implemented the lockdown, like CMOH Order 38, which was pretty aggressive, followed by CMOH Order 42, cases still went up for a while, and then they went down, right. That doesn't mean the lockdown didn't work. There's so many factors that lead to transmission of COVID. Masks are one thing that like -- that is protective, but, you know if people all wear masks, but they then go around to basement parties and kiss each other, you're still getting a lot of transmission.

And so I think this is like what I call like -- it's called spurious causation, right. It's like a correlation, not causation. So I talk about all the things that can lead to like cases going up and cases going down.

Q There's a paragraph in your expert report that begins: (as read)

> Lastly, both Dr. [redacted] and Dr. [redacted] make unsubstantiated claims that there are "numerous harms associated with masking".

And then you say: (as read)

> There are no known harms associated with masking.

Can you explain that?

A Yeah, so medical harms, like I'm not a respirologist, but like the Canadian Thoracic Society, which is the group of like -- you know, has a statement that basically says mask wearing is not known to exacerbate any lung disease, right. That's their statement. They are, I guess, the lung disease experts.

Probably the only harm that I'm aware of that masking brings is, you know, in people with extreme anxiety, right. It can make you anxious, right, but it doesn't make your asthma worse or your COPD worse, and that is from the, you know, the body that represents the respirologists and the lung experts in Canada.

You know, I will say, you know, earlier the CMOH orders, you know, they're like exemption clauses, right. Like you put in these exemption clauses because to like have a little way out, right. That exemption clause caused great chaos, certainly in the medical

field, because there actually is not a reason to have an exemption for a mask.

And so what ended up happening with a bunch of patients went to the family doctors to try and seek exemptions, and doctors were like, Is there a reason to get an exemption; and the answer was no, and we were caught in quite a bind. And that actually led to Dr. Hinshaw apologizing to the Alberta Medical Association for like not being clearer on, you know, what qualified as an exemption and (INDISCERNIBLE).

Q Let me ask you this: Should a health care worker in direct contact with patients be allowed to have an exemption for mask wearing?

A No, I don't think so. Certainly not now with the case counts where they're at, right? And like I mean -- I'll use a comparison, right, like I get why people don't want to wear masks. Like I personally find wearing masks quite uncomfortable and annoying, but like when it comes to a matter of obviously patient safety, then, you know, like you've got to do it because you don't want to harm your patients.

If I was a surgeon, you know, surgeons they have to operate in a sterile space, they have to scrub in, you know, like I would not give an exemption to a surgeon from scrubbing in and, you know, sterilizing his or her hands for operating even if they were, you

know, like in -- if they were allergic to that, like, you know, the particular sterilizers, and they use something else. If they were allergic to everything, they would not operate, because operating in a non-sterile condition poses too great a risk to the patient.

In the same way right now with COVID, you know, not masking is not -- like is a risk to the patient, and, again, and I will caveat this by saying if we had five cases a day in the province of Alberta, we would not need to do this probably I would say, right? Like, you know, the extent to which we need COVID masks to prevent COVID does depend on the risk of COVID. And the baseline risk of COVID depends on how many cases we have, right?

But like right now, Alberta a thousand cases a day, north zone 33 percent positivity rate, that's like as high as the highest US states ever were, right? That's like we have a lot of risk and -- yeah, so, no, like, you know, like you've got to wear a mask if you're seeing patients.

Q I'm going to ask you a couple of very brief questions about [redacted] report, and I know you only received that a little while ago.

MR. [redacted] And I just want to, Mr. Chair, be clear to the Tribunal that in asking these questions

of Dr. [redacted] I am again reserving my client's right to call further rebuttal evidence on that point, but I want to ask him about them.

Q MR. [redacted] You had a chance to read Mr. [redacted] report?

A M-hm, yeah.

Q Do you have any comments generally about its validity and the opinions in it?

A Yeah, I mean, I think like the conclusion of -- in the report is more or less that it's not safe to wear a mask because it creates dangerously high levels of carbon dioxide and dangerously low levels of oxygen.

Now, practically, if that were the case, a lot of my friends would be really sick and/or unwell, because a lot of my friends wear masks all day long because they work in hospitals all day long, you know.

But, again, I -- again, I refer to the Canadian Thoracic Society, these other sort of experts, you know, basically said that like mask wearing is safe and fine. There's so much evidence, and like we've been wearing masks in hospitals every day for a year-and-a-half, and if it was that bloody dangerous, we'd have somebody passed out from low oxygen or too high C02, and that has not happened to any health care worker in Alberta in AHS that I'm aware of, right? And so like that's -- that's about all I'll say about that.

Q Okay, I'm just going to go to the end of your report, and you've got a "Summary" section, and you talk about the vast majority of expert reports focus on trying to downplay the seriousness of COVID-19 and various public health approaches we have used to contain the pandemic. You then talk about them not addressing the question at hand, which is the evidence of masking and reducing viral transmission.

Are you aware of -- and I'm going to apologize in advance for me butchering this word -- are you aware of any epidemiologically valid studies establishing that masks should not be worn by health care providers?

A No. For COVID transmission, no.

Q Yeah, for COVID and --

A No, no.

Q I don't have any further questions for you. I'm wondering if there's anything you want to add before I ask Mr. Kitchen if he wants to begin his cross-examination.

A Maybe I'll just say this, right, like I mean, like I've clearly reiterated over and over again that I think masking is very good for preventing transmission in a health care setting and that there's a lot of evidence for that, but, you know, I'll also say this: Like I'm not like somebody who's like hyper-ideological. Like, you know, when it comes to things like COVID, there's

lots of areas to debate, you know.

Like I think, oftentimes, people associate people -- like, you know, pro-masking with like pro-lockdown and all that stuff, and I guess what I'm trying to say is -- like I try to read the evidence. I'm fairly pro re-opening actually. You know, I was the Calgary Stampeded medical director and like managed to run that.

And so with that, you know, I do think what happens with a lot of these debates, you know, whether around masking or vaccine passports or lockdowns, people get into a bit of an ideological bent, a bit of a political bent, right; these issues have all been highly politicised, and I really try to steer away from those things and try to, you know, balance the benefits and the harms of any particular intervention. And when it comes to masking, like the benefits really, really, really, really outweigh the harms. There aren't a whole lot of harms other than them being a bit uncomfortable to wear I think, so ...

Discussion

MR. [redacted] Okay, well, thank you, Dr. [redacted]

Mr. Kitchen, I don't know if you want a quick break before you start your cross-examination or whether you'd prefer to start tomorrow morning; I leave that up to you.

I think, and I should say in fairness I think just to the Tribunal Members and everyone involved, I still think we should shoot for shutting down today at maybe 4:15 or 4:30 just because people get a little saturated at a certain point.

MR. KITCHEN: I don't want to start and not finish, so if that's -- you know, we talked about this. You know, my primary goal for pushing to go today, if I was, was to try to get us ahead of the game. That's not going to help anyways with I think where we're going to go. So I have no interest in starting today, because I don't want to go too long and not finish. It should be done all at once. So I think tomorrow morning, hopefully 9:00 right away we'll get going. I think that's probably best for everybody.

MR. [redacted] Frankly, I would prefer that. I don't think my redirect will be very long at all. I anticipate the Tribunal might have questions, but I think it's better to do that in one block so everything's fresh in everyone's mind.

My intention would be, after the completion of Dr. [redacted] to have Dr. [redacted] testify.

MR. KITCHEN: That's fine with me.

THE CHAIR: Okay, Dr. [redacted] you are okay for 9:00 tomorrow morning to --

A Yes.

THE CHAIR: -- continue?

A Yes.

THE CHAIR: We appreciate that very much, sir. Thanks, Mr. [redacted] and Mr. Kitchen. It was a pretty full day, as we expected, a lot of documents, so I think we can adjourn for today with the expectation we'll start at 9 sharp tomorrow morning, and we'll try and have the site open a few minutes early so people can log on, and we'll get off to a flying start in the morning.

Okay, unless any of the Tribunal Members wish to meet and chat, if you do, stick your hand up. No? They're all heard enough of me for today, so we'll declare this meeting in recess for now, and we will reconvene tomorrow morning at 9. Thank you, everybody.

PROCEEDINGS ADJOURNED UNTIL 9:00 AM, SEPTEMBER 2, 2021

CERTIFICATE OF TRANSCRIPT:

I, [redacted] certify that the foregoing pages are a complete and accurate transcript of the proceedings, taken down by me in shorthand and transcribed from my shorthand notes to the best of my skill and ability.

Dated at the City of Calgary, Province of Alberta, this 27th day of September, 2021.

Karoline Schumann

[redacted] CSR(A)

Official Court Reporter

IN THE MATTER OF A HEARING BEFORE THE HEARING TRIBUNAL OF THE ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS ("ACAC") into the conduct of Dr. Curtis Wall, a Regulated Member of ACAC, pursuant to the Health Professions Act, R.S.A.2000, c. P-14

DISCIPLINARY HEARING

VOLUME 2

VIA VIDEOCONFERENCE

Edmonton, Alberta

September 2, 2021

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Proceedings taken via Videoconference for The Alberta College and Association of Chiropractors, Edmonton, Alberta

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September 2, 2021 Morning Session

HEARING TRIBUNAL

[redacted] Tribunal Chair

[redacted] Internal Legal Counsel

Dr. [redacted] ACAC Registered Member

Dr. [redacted] ACAC Registered Member

[redacted] Public Member

[redacted] ACAC Hearings Director

ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

[redacted] ACAC Legal Counsel

FOR DR. CURTIS WALL

J.S.M. Kitchen Legal Counsel

[redacted] CSR(A) Official Court Reporter

(PROCEEDINGS COMMENCED AT 9:03 AM)

THE CHAIR: I think the point we were at yesterday was that Mr. [redacted] had presented or had direct examination of his expert witness, and we

adjourned for the day to enable Mr. Kitchen to start his cross-examination of the expert witness this morning. Is that where we're at?

Discussion

MR. [redacted] Mr. Chair, it's Mr. [redacted] I think that's accurate. I do have one quick housekeeping comment I need to make based on a discussion I had with the court reporter about exhibits. I also believe Mr. Kitchen has I'll call it something in the nature of a preliminary application to make concerning some documents he wants to place before Dr. [redacted] which my client is objecting, and we'll have to ask Dr. [redacted] to be excused and put in a breakout room while we deal with that.

I wonder if I can just very quickly make my comment about exhibits, and then I'll let Mr. Kitchen speak about his application.

THE CHAIR: Okay.

MR. [redacted] Madam Court Reporter made a comment to me that yesterday when I was introducing documents to a witness, I did not stop and ask for each one of them to be formally marked as an exhibit, and the reason I didn't do that was because of the agreement between Mr. Kitchen and myself, that the exhibits were agreed on. I'm happy to do that if you prefer. I, frankly, don't think it's necessary, given

the agreement between Mr. Kitchen and myself. I see him nodding, so I'm hoping that perhaps we can dispense with that, all on the understanding that all of the documents when they're referred to are formally entered by agreement as exhibits. Mr. Kitchen, do you have any thoughts on that?

MR. KITCHEN: I have no objections to that. I think that's fine. We've already identified them in the files with letters and numbers, so ...

THE CHAIR: Okay, and just for Karoline's clarification, those are in the folders that are marked 'A' to 'F', and then we have Folder 'H', which we dealt with, and I don't know that there ever was a Folder G. So, okay, that's -- you're okay with that, [redacted]

THE COURT REPORTER: (NO VERBAL RESPONSE)

THE CHAIR: Good. So then --

MR. [redacted] Mr. Chair, my apologies, I think it's time to turn this over to Mr. Kitchen, but we are going to have to ask Ms. [redacted] to move Dr. [redacted] into a breakout room I think for a relatively brief period of time, but I think we need to do that first.

THE CHAIR: Okay. And just before Mr. [redacted] departs, I will just remind him that he is -- well, he's gone. Okay. We have to remind him that he's still under oath from yesterday.

Okay, Mr. Kitchen.

Submissions by Mr. Kitchen (Application)

MR. KITCHEN: So, The Chair, the purpose of this is I have two documents. They are PDF screenshots of web pages, and obviously I'm going to have to provide them to you, but I approached Mr. [redacted] about providing these to the witness, and I take it from his comments, and this reflects something I had proposed to him, that the best way to do this is for me to make an application, he will oppose it, and then you'll be provided with the documents. I can send those to Ms. [redacted] and then you can make a ruling whether or not to admit them.

What these two documents are, very briefly, they're simply evidence of the existence of one randomized -- well, RTC, they're clinical trials, randomized clinical trials. One ended in June, one is ongoing; that's what these two documents are. They simply show the existence of these trials, simply what they are, where they are, what they're called, who is doing them, et cetera. That's what they are.

The purpose for my putting them in is to give them to Dr. [redacted] and give him a chance, an opportunity, to respond before I ask him any questions about those or before I would ask any questions to my experts, as, of course, that wouldn't be fair if he hasn't had a chance

to see them and comment on them.

Again, the only purpose I'm putting it in is not substantively for anything to do in the trial; it's simply that the trials exist. He had said that it would be unethical to do so. I'm simply putting those in to show on the record that those trials are being done currently and have been done.

THE CHAIR: Mr. [redacted]

MR. [redacted] Just so I'm clear enough, I didn't understand you correctly, Mr. Kitchen, were you proposing that those documents be provided to the Hearing Tribunal as they consider this issue or only after they hear submissions from us?

MR. KITCHEN: After they hear submissions, I'll provide -- I propose that I provide them to Ms. [redacted] so that she can provide them to the Tribunal, and they can have those documents in front of them to make a decision on whether or not they should be admitted as exhibits.

Submissions by Mr. [redacted] (Application)

MR. [redacted] Okay, well, then I will make my submissions.

Mr. Chair and Hearing Tribunal Members, the Complaints Director strongly objects to these documents being provided. I will speak about this in a few minutes in greater detail, but there is an element of

fairness that has to be a core element of this hearing, fairness not only to the member but fairness to the Complaints Director.

Just by way of background, I received -- or I opened my emails this morning and say an email from 12:11 AM from Mr. Kitchen attaching these two studies. Again, my client strongly objects to these going in; it's highly prejudicial. I haven't been able to print, much less read, these studies. Mr. [redacted] hasn't been able to read them, and certainly Dr. [redacted] hasn't been able to read them.

Mr. Kitchen has had Dr. Hu's expert report since July 28 of this year and has had more than enough time to prepare any rebuttal documents or any type of exhibit package he wanted to enter. He has not three but now four experts to present his client's case, and providing these studies immediately before cross-examination gives Dr. [redacted] no ability to properly read them, to engage in an informed analysis of them, and to responsibly engage in any kind of discussion about them.

I know Mr. Kitchen says they're only being tendered to reflect the existence of these studies, and I have no idea about the history or background of these, but Dr. [redacted] may have very strong comments about the validity of the studies or the status of them, any

myriad of elements of those studies, he might have very, very considerable questions and thoughts on those.

So, again, no time for Mr. [redacted] or I to read and review these, certainly no time to consult with Dr. [redacted] to allow him to provide a fulsome and informed response.

The answer is not to say, Well, let's take an hour break and let Dr. [redacted] review them. I think that is not the answer for a number of reasons. First of all, it's just not fair. Dr. [redacted] is under the gun. He's looking at these, trying to formulate a response on very, very short notice. It takes up valuable time which we could be using on other things. Frankly, the witness's, his order is potentially disrupted. He's only available till noon today. It just is a very, very troubling development.

Again, there are four expert reports that have been tendered with citations and documents in support of them, and I would say to you that the Complaints Director has been very, very accommodating and very generous in terms of not objecting to three experts and not objecting to other documents and information that have been provided in support of those documents.

I think, Mr. Chair and Hearing Tribunal, this also speaks to the larger question of how this hearing is

going to be conducted, and as I said before, there certainly has to be fairness to the member, to Dr. Wall, but there also has to be fairness to the Complaints Director. A phrase I like to use, and I can't remember where it came from, but I used it over the years is these types of hearings are not argument by ambush. It's not a surprise gotcha moment that we're looking for, and we need to avoid that.

We had the [redacted] report come in I would say very, very briefly before the hearing, which was of concern to my client. You've made your decision; we've got some remedies to call rebuttal evidence, but that was concerning. I know that the cases I received from Mr. Kitchen in support of his preliminary application were sent to me at 12:44 AM on Wednesday. I sent my cases about my preliminary application, my supporting document to him the day before. I don't think it's fair to expect Mr. [redacted] and I to check emails at all hours and to be on-the-fly and be ready to accept documents and information in that manner. Mr. Kitchen is obviously trying to be an advocate for his client, and that's certainly his role, but this goes beyond that.

We need, Mr. Chair and Tribunal Members, we need direction from you, not just to refuse to allow this document to go in but to set parameters about how

documents and case law are going to be provided, because, again, this isn't argument by ambush.

So my client strongly objects to these being provided. If they have any probative value, it's minimal, and it's highly prejudicial to the Complaints Director. Those are my submissions.

Reply Submissions by Mr. Kitchen (Application)

MR. KITCHEN: Chair, if I may respond. These have been provided to my friend, he knows that I'm not tendering studies. There's no content here. He knows that all I've provided is a record that's a couple pages long that such studies are being done. They haven't been written out yet. There is no report. There's no peer-reviewed article. They're simply at the clinical phase of being done. We're simply tendering them for the evidence that these studies are being conducted. So there's nothing to read.

You know I'm literally going to -- if these are admitted, I'm literally going to take Dr. [redacted] to the point in which it describes what the study is, and I'm going to ask him that. That's it.

So all of this argument about the time it's going to take is completely without merit. There is no time involved. There is no actual study to read. There is simply a document showing that such clinical trials are ongoing or have been conducted a few months ago.

That's it.

I have no disagreement with my learned friend about fairness or avoiding a trial by ambush, which is why I provided it to them, I asked him his position. It's almost as if he thinks this is unusual; it's unusual to put documents to a witness in cross-examination after his examination-in-chief reveals that there are certain things that would be useful. That's not unusual. It's not unusual to provide cases. In fact, if it were in person, it would not be unusual to hand the cases up at the beginning of a hearing. That they're provided the night before is not unusual.

I don't think it's appropriate to be commenting on what time of the day my emails come in, as if I expect everybody to be awake at all hours of the day to read my emails and immediately comment on them. I think that's a red herring.

You're going to see these documents I have, and you're going to see that they are as I've described them, and they are not actual articles that need to be read. I think that's very important to understand, and I think any description of that is completely missing the point. Those are my submissions, Chair.

THE CHAIR: Can I ask you, Mr. Kitchen, you said there's one study that's been completed?

MR. KITCHEN: Yes.

THE CHAIR: Has it been published?

MR. KITCHEN: Not that I know of.

THE CHAIR: And the other study is ongoing.

MR. KITCHEN: The other study is ongoing to be completed I think in October.

THE CHAIR: Okay --

Reply Submissions by Mr. [redacted] (Application)

MR. [redacted] Mr. Chair, I wonder if I might just have an opportunity to make one or two very brief comments in response to what Mr. Kitchen said.

I have looked at these document very, very briefly. They may well be not in-depth studies. They may not have a lot of meat on the bone, but it's the larger principle. Again, Dr. [redacted] is at a complete disadvantage. He has seen these on-the-fly. He is not able to go and make his own inquiries about them. It doesn't matter that Mr. Kitchen is going to be very brief with them he says. It simply puts Dr. [redacted] in an awful position, because he can't respond properly whatsoever.

And I would suggest, I'm not a fan of this, but -- or I can't tell Mr. Kitchen how to run his case, but certainly he's got his own experts, he's got four of them. There is ample opportunity for him to have his

experts testify to these matters. I don't see that putting Dr. [redacted] in this position is at all fair to my client.

Reply Submissions by Mr. Kitchen (Application)

MR. KITCHEN: Sir, I just want to make a comment. Fairness seems to be an issue here, and as I've said I have no issue with that.

I will say, out of fairness, it's typically, procedurally the way we do things is if somebody makes an application, they make the application, the other side has a chance to respond, and then the person who -- the party who made the application has a chance at rebuttal, and then that's the end of things.

And twice now in these proceedings, Mr. [redacted] has come in after I've given a rebuttal, and he's made comments, and I haven't objected to that out of fairness, but since fairness is becoming a real issue here, I note that that's not normally how things are done.

And if we're going to get really about the book about this, which seems the Complaints Director is going in that direction, I'm going to find myself objecting any time Mr. [redacted] is coming in after I've given a rebuttal and is trying to make comments, because that's not actually normally how things are done.

THE CHAIR: Your comments are noted, Mr. Kitchen. That's -- I will take responsibility for that. I know the rule of three is the generally accepted process, and I will do my best to adhere -- or to follow that.

I think at this point, we'll caucus while we discuss -- can I just ask one more question? Is Dr. [redacted] involved in these studies? Is he an author or a ...

MR. KITCHEN: No, he is not.

THE CHAIR: He is not, okay, thank you.

MR. KITCHEN: And what I'm doing is I'm just -- I haven't provided these documents yet, so I'm just providing them to Ms. [redacted] so that she can provide them to you.

THE CHAIR: I think what we were talking about is that -- okay, we will caucus now, and we'll be back to you shortly. Please bear with us, thank you.

MR. KITCHEN: Thank you.

(ADJOURNMENT)

Ruling (Application)

THE CHAIR: Okay, we'll reconvene. The Hearing Tribunal with the advice of counsel has considered the two documents in question. I will give you our decision and then some comments before we move any further.

We have decided to allow these within certain

limitations, and we've noted that these are overseas trials, that these are in progress or just recently completed. Neither of the two documents contains any results, and they've not been published.

So our view is that, Mr. Kitchen, if your desire is just to establish that these trials exist, that's the direction we're prepared to allow. If the questioning or the discussion goes into any depth regarding the trials themselves, I'm sure we will hear objections at that time.

MR. KITCHEN: Thank you, Mr. Chair. I appreciate that. That makes perfect sense to me.

EXHIBIT H-5 - Face Masks to reduce COVID-19 in Bangladesh RCT

EXHIBIT H-6 - Locally Produced Cloth Face Mask and COVID-19 Like Illness Prevention RCT

Discussion

MR. [redacted] Mr. Chair, in light of your decision, and I hope Mr. Kitchen will be comfortable with this, we're going to bring Dr. [redacted] back in. I think he needs to have a little bit of time to look at these documents, and I don't mean 2 minutes on-the-fly, and I don't mean two hours, but I think he's got to be given a reasonable opportunity to see these documents and be able to read through them.

I understand the narrow parameters you've placed

on the questioning, but I'll be candid, I think all that he can say is, Well, I guess these are documents that shows studies being done. I'm still kind of puzzled why Mr. Kitchen can't do that with one of his experts, but, again, I think he has to be given the opportunity to at least read these.

THE CHAIR: I agree, and I suggest that we take -- it's 20 to 10, one's a six-page, one's a seven-page document, there's not a lot of information in them; I think if we said we'll reconvene at 10:00, people can take an early coffee break now, stretch, grab a coffee, and we'll give Dr. [redacted] 15 minutes to review them, if that --

MR. [redacted] Can I --

THE CHAIR: Yeah?

MR. [redacted] I welcome Mr. Kitchen's comments on this, but I wonder if we could bring Dr. [redacted] back in and let him know exactly what they're being tendered for, because if we simply give them to him, and he's thinking I've got to go off and check sites, I've got to research these, I've got to -- it's entirely different to say he's being -- You're going to be asked about whether these are ongoing or not. And I don't want to spoil Mr. Kitchen's questions, and he may have a few more questions than that, but I mean if I send these to him and say you're going to be examined

on these, he's going to say, Well, to what end and in what nature.

MR. KITCHEN: So, again, all I'm -- well, if I had have asked him, you know, these studies exist, don't they, that would have been improper, because they're not before him. I'm literally going to ask him, Do you deny that these studies exist. And now that he's had an opportunity to see them, he can actually make an informed answer on that, it's not ambush, and then that's only fair.

And, you know, that's why I can't bring it in with my experts, that's not fair to do that because then the Complaints Director's expert hasn't seen it. We're probably talking about, you know, 90 to 120 seconds of questioning at most on that, and that's it.

So -- and I'm fine, you know, with giving him the time to break until 10, but I'll say that if we do that, and we come back at 10, I would ask that we just go straight through until noon, if I take that long without any breaks, because I want to have the time I need for cross-examination, and I understand Dr. [redacted] has to get going as well.

MR. [redacted] And, Mr. Kitchen, of course, I may have redirect and the Tribunal may have questions as well, so, again, I can't tell you how to run your cross-examination, but we have some timelines here that

are tight.

THE CHAIR: Yeah, we --

MR. KITCHEN: I don't expect to go beyond an hour-and-a-half, I really don't.

THE CHAIR: Okay, let's bring Dr. [redacted] in please then, and I'll give him an explanation. Do we have a copy of the documents for him?

MS. [redacted] I can send those to him via email right now.

THE CHAIR: Could you send them, please.

Dr. [redacted] we're back. Dr. [redacted] can you hear me? Can you hear me?

A Oh, yeah, now I can, sorry. I was just -- yeah.

THE CHAIR: Yeah, okay, thanks, Dr. [redacted] sorry to keep you waiting.

A That's okay.

THE CHAIR: We're very respectful of your time and our commitment to get you out of here at noon. An issue --

A (INDISCERNIBLE) all good.

THE CHAIR: -- an issue has come up, and we're going to be breaking here momentarily, and we're providing you with summaries of -- well, two documents that contain summaries of clinical trials. It's a six-page summary put out by the NIH US National Library of Medicine. So --

A Yeah.

THE CHAIR: -- we have allowed these documents to be entered by Mr. Kitchen. Neither of these studies have been published, one has just been completed, the other is still in the data collection.

A Okay.

THE CHAIR: We are only allowing Mr. Kitchen to question on the actual existence of these. Because there are no results, there's no findings, there's no publication, there's nothing to discuss there, but Mr. Kitchen will deal just with the actual existence of these.

We're going to give you until 10:00 to read through them --

A Sure.

THE CHAIR: -- so that you're familiar with it. I don't anticipate there will be very many questions on this, but we don't want you having to respond to something you haven't read.

A Yeah, yeah, I'm all good. I always like more, more science, so happy to -- yeah, that's good, cool.

THE CHAIR: Have you got them; have you checked your email?

A Let me just hit "refresh" again. Oh, yes, I just got them, okay. Cloth masks and face masks reduce COVID-19 (INDISCERNIBLE).

THE CHAIR: Okay, we will recess now, and we will reconvene at 10:00 with Dr. [redacted] and Mr. Kitchen.

A Thank you.

THE CHAIR: Thank you.

(ADJOURNMENT)

THE CHAIR: Okay, the session is -- obviously, we've reconvened, just to remind everybody, and the floor is Mr. Kitchen's to cross-examine Dr. [redacted]

MR. KITCHEN: Thank you, Chair.

DR. [redacted] Previously sworn, Cross-examined by Mr. Kitchen

Q MR. KITCHEN: Dr. [redacted] I'm mostly going to be questioning you on your report, so I'll be taking you to various portions of it at times.

Just to start off on your first page of the report, you refer to the Manchurian plague. I note that you neglected to mention that plague is caused by bacteria. The Manchurian plague was caused by a bacteria; isn't that right?

A Yeah. Yes.

Q And bacteria are hundreds of times larger than viruses; isn't that right?

A Yes.

Q In your report, you regularly refer to masks without any qualifiers, and I think twice to what you call medical-grade masks, and by either of these terms, you

are referring to the so-called surgical or blue masks that are specified in the ACAC Pandemic Directive; isn't that right?

A Correct -- well, it depends. I mean, the report talks about a number of different things, right, and like, first of all, that introduction around Manchurian plague, think of that as like a fun introduction. Like, once again, I only care about COVID and masks; I don't care about anything else in masks.

There's some studies that I talk about which are -- which talk about sort of masks in the community, right. And when I talk about masks in the community, it's a mishmash of like surgical-grade masks, but primarily probably cloth masks and sort of that mix of masks changes based on where you are and access to medical-grade masks.

Very early on, people didn't really have access to medical-grade masks. Now, probably people have more access to those. But within the health care setting, I think we can broadly assume that, in Alberta, like, you know, we have medical-grade masks, so yes.

Q Okay, now that was a bit long, I just -- and, again, I'm not trying to trick anybody, I want to make sure we're all on the same page about what is a medical-grade mask. Now, would you agree that a medical-grade mask is the same as a surgical or blue

mask?

A Yes, so I would say a medical-grade -- like, when it comes to mask terminology, you know, we often say surgical mask, procedure mask, or medical-grade mask. Within the categories of medical-grade masks, there's sort of different levels, like, you know, like tier 1, tier 2, tier 3 masks, and these are not the same as N95 masks, which are different.

Though to your question about like what I talked in my report, you know, like I report about types of like community type studies, and those are more going to be like a mishmash of mask types that just ...

Q Right, but a lot of times in your report, you use the term "masks", and when you use the term "masks", you're not referring to cloth masks; you are referring to --

A No --

Q -- let's call them surgical masks?

A No, it -- no, and I should have probably applied more specificity in the report, but like -- I mean, we can go by study by study, and we talk about the types of masks being used in those studies, but like I -- it depends on the study in question, right.

So, for example, by and by, if I refer to a study around, you know, like some of the studies around this reduces community transmission, so masks used -- any study that describes mask wearing and its ability to

prevent COVID outside of a health care setting, you know, we don't necessarily know what masks are being used, but I would broadly assume, in that setting, we're not using medical-grade masks. Like, you know, some people might have them, like I would, you might not. But when we begin to talk about the studies in health care settings, those are almost all medical-grade masks, but -- so I use the term "masks" like generally, but it would depend on the study in specific.

Q Now, just to confirm --

A M-hm.

Q -- I think, I believe you said this, when you use the term "masks", you are not referring to N95s?

A That is correct.

Q Okay, thank you. Now, would you agree that the surgical or blue masks, and those are the ones that are specified as being -- or medical masks --

A M-hm.

Q -- (INDISCERNIBLE) as being specified in the ACAC pandemic [sic], and the reason I'm mentioning this is the ACAC pandemic says cloth masks are unacceptable, all right, and --

A Yes.

Q -- there's no trickery here, right? We're talking about --

A Yeah.
Q -- a classification of masks between N95 and cloth. Would you agree that's what we're talking about, when we're talking about what's acceptable for the ACAC Pandemic Directive, we're talking about masks that are not cloth and not N95 but in that surgical category in between? Would you agree with me on --
A Yes.
Q -- that? Okay.
A Yes. Although, I'm not entirely -- like I think that like if somebody wanted to wear an N95 mask like in the, you know, clinical setting, like ACAC in a chiropractor's office, I mean you could mask, I would say an N95 is better than a cloth mask -- like, sorry, than a medical-grade mask, which serves different purposes, but it's not inferior, I'll say, to a medical blue mask.

Yeah, so -- and I don't think there's trickery, I'm trying to explain, because I wasn't specific in my report around what I mean by "masks", so yeah.
Q Well, and that's just it, I don't want us to talk at cross-purposes.

Now, would you agree that these medical or surgical or blue masks are of low cost?
A What do you mean by "low cost"?
Q I mean that they are not expensive; would you agree?

A I don't know. I mean -- so the price of a medical-grade mask before the pandemic started was around, I think in bulk procurement prices, 6 cents a mask. In the midst of the first wave, that price went up to 60 cents to $1 a mask, given our shortage of masks, right? And so I mean -- and then I think it's gone down again, but I would say that 6 cents a mask is pretty cheap. I would say that during the pandemic, a 10X increase in price is not insignificant, but, yeah, those are the prices. So now you know what the prices are.

Q Thank you, and, you know, that's -- I wasn't asking you about supply and demand. So let me ask you again, would you agree that surgical blue medical, would you agree that those are low-cost masks?

A I would, relative, yeah, sure. If we think that 50 cents a mask is low cost, then that's low cost.

Q Thank you. And, Dr. [redacted] you're proud of the work you've done for AHS during COVID, aren't you?

A Generally, I mean, I think I've made mistakes, but I think I've done some good things hopefully as well.

Q You're glad to defend the COVID public health restrictions in the CMOH orders, aren't you?

A Which restrictions are you referring to specifically, like in which CMOH orders? And not being at cross-purposes, there's things I agree with and things

that I don't. I would defend the masking one for sure.
Q And you would defend the distancing one?
A Yes.
Q When it comes to COVID, you think information is more likely to be scientifically accurate if it comes from a government public health source than if it comes from some other source, don't you?
A What is the "other source" referring to?
Q Exactly that, an other source, other than government public health source.
A Yeah, I mean, I would say that I -- yes, with the caveat that I think government and public health sources tend to aggregate the, you know, hopefully the studies and what we know about COVID sort of at the time, and so I would say stuff like that, or, you know, things published in high quality peer-reviewed journals are good, but, yes, I would agree broadly with the statement that I trust those sources a fair amount, but we've also been wrong, right? So ...
Q What I'm asking you is do you trust government public health sources more than any other source?
A I mean not -- like it depends, right? And so like here, I'll give you an idea of things that I trust, right? So I generally trust things that AHS comes out with, right? I generally trust things like the meta-analysis and the Lancet, you know, that I refer to

in my expert report.

I generally trust less, you know, any one-off study, right? Like, you know, I tend to trust like conglomerate-like aggregation studies, but, yeah, that would be sort of what I trust and don't trust.

And then what I'm looking for is like a convergence of evidence, right? Like when I say what governments do is we try to -- I'll say what public health bodies do is they try to synthesize the evidence, right, and so what they're drawing on -- like the data they draw from are published studies, right, and one -- you know, I would say that you can look at the quality of any one published study, and, you know, some are better than others, but, you know, I -- you know, because there are so many studies, you try to look at like what do the majority of those studies say, but they -- yeah, but, yes.

For example, I'll give you a counter example, right? So, you know, I could argue that, you know, in a lot of US states, the governments have been very anti-mask, right, and so, you know, like the State of Texas, like no masking, right, State of Florida, no masking. So I don't necessarily trust that, right, just because it's coming from a government.

I trust more I think if that's -- the source is sort of informed primarily by the available scientific

evidence, because, again, governments can say lots of different things because they have other considerations, like political ones.

Q Anyone who disagrees with your position on masks is anti-mask; is that correct?

A No, I mean -- I think I'm actually quite -- what's the word -- I'm quite open to chatting with people about these things. You know, like I said at the end of the last testimony, I'm quite un-ideological, right? Like I have lots of chats with people about things like Ivermectin, which Public Health doesn't really agree with. You know, I have chats -- and so I --

And the word "anti-mask", I think, carries with it like a certain -- like I don't like it, just like I don't like the word "anti-vaxxer", right? Like, you know, I think people are generally trying to do the best thing for themselves and their patients. I may disagree with what the best thing for themselves and the patients are, but like I like -- you know, like I'm always down, game for discussion about these things.

Q You just said you don't like the term "anti-masker", and yet you just used that term to describe two states in the United States of America; isn't that right?

A Sure, well, my bad then, but I -- I mean, maybe what I'm saying is like -- I think right now when we call somebody anti-mask or anti-vax, I think it carries with

it an implication that they're like a bad person in some ways, right? And I don't want that -- I don't want that to be implied, right?

I think, you know, people are trying to do the best, like, with the knowledge they have. I may disagree with their perspective, but I don't want to be, what's the word, judgy, right? So anyways.

Q You would agree that the term "anti-mask" is a pejorative term, would you not?

A Yeah, it is pejorative, yes. I mean, it's -- it's both pejorative -- like it's an interesting -- because -- you know, like being anti-something does not necessarily, in and of itself, make a term pejorative. But being, you know, in the current environment, I would say being anit-vaxxer can be pejorative, being anit-masker can be pejorative. Anyways, I don't know if I want to talk about sort of these like linguistic interpretations.

I guess what I'm saying is that, I mean if you use the statement, people who are against wearing masks, right, that sounds less pejorative than anti-mask, and it sort of defines like, characterizes what they like -- you know, a position is. And so I just don't want to be too judgy, you know.

I think it's very important that we always sort of listen for new evidence, right? Like -- and not like

judge people or malign people like for not -- like the nature of people for having these different perspectives, even though I may disagree with them.

Q You said argument "against masking", in the very last sentence of your report, you say that: (as read)

> Nobody would argue against masking in a health care setting.

That seems to me a curious thing to say. Nobody is arguing against masking in any context, are they?

A Well, I would say it's an inaccurate statement, because clearly people are arguing against masking in a health care setting, and so, again, the precision of my language is not there. I would say the vast majority of people in the health care sector would not be against masking in a health care setting.

Q Can you identify for me somebody that's arguing against masking?

A I mean, I sometimes see protesters that say like "no masks", right? I -- you know, I've received a lot of emails around, you know, may have -- you know, the Calgary school boards are implementing masking, mandatory masking for school-age children, that's where it starts, and, you know, I've commented on it, and I've gotten lots of emails saying that, like, kids shouldn't be masked. I would say that's an example of arguing against masking. I don't know if it's many

people arguing against masking in the health care setting, but I'm sure there's more than one somewhere in the world.

Q Let me narrow that, and I apologize that I didn't, nobody's arguing against masking in any context in this case, are they?

A Not -- I'm -- I thought that we were talking about not wearing masks in like the chiropractic setting, but if I'm -- yeah. Is that not what we're talking about?

Q There are individuals in this case that are arguing against the case for mandatory masking; isn't that right?

A Can I ask the ACAC for like -- like what is the actual argument here?

Q Well, "argument" isn't really the right word. I guess -- and I've only used that word because you have. What I'm getting at is you said in your report that people are arguing against masking.

A M-hm.

Q You haven't identified anybody, other than some unspecified anti-masking groups. It just strikes me as a strange thing to say. I guess what I'm asking is would you agree with me that, from your perspective, from your perspective --

A M-hm.

Q -- is it not true that what anybody in this case is

arguing about is against mandatory masking?
A If that's the case, like I'm not sure actually, but if, it's helpful to note, so the issue is against the policy of mandatory masking, good to know, we can talk about that, but pardon my ignorance, yeah.
Q No, I know. I'm asking you, the question is to you --
A Well, I don't know.
Q -- would you agree with me that what individuals in this case are arguing --
A M-hm.
Q -- against mandatory masking? You can disagree or agree. It's up to you. Please --
A No, I'm not -- like I'm -- sorry, I talked over you again, I'm not sure, but it sounds like that's the case based on what you're asking, so that's good for me to know, and we can talk about that.
Q The experts adduced by Dr. Wall, if they're arguing for anything, they're arguing against the efficacy of masks and the supposed harmlessness of masks.
A M-hm, yes, I agree with that, yeah.
Q Nobody is arguing that people shouldn't wear masks if they want to, are they?
A Correct, I agree with that.
Q And, again, do you have a copy of your report in front of you?
A Yeah.

Q Okay, excellent. I'm at the end here -- or I should say the end of the main section, so this is page 5.
A Okay.
Q And you say: (as read)

> While there does exist [in quotation marks] anti-masking movements in Alberta and Canada and all across the world [et cetera].

You provide no independent source to verify your claim about these so-called anti-masking movements, do you?
A No, but I can just pull up an article from, you know, like the news. There was a group called Masks not -- Hugs Not Masks [sic] as I recall. I thought they had quite a catchy name, and -- but I mean -- and I think the point of that line was to say that when I look at the masking debate, so to speak, let's say the debate around mandatory masking, right, I think there's a lot more contention around mandatory masking in, say, public spaces, indoor public spaces, versus the debate around masking in health care settings, generally speaking, right? So, yeah, I can give you sources if you like.
Q You said yesterday that the final decision on the content of the CMOH orders lies with the Cabinet of the Alberta Government; isn't that right?
A Yes, I would say so.
Q You agree that cabinet is a political body, do you not?

A I do, yes.
Q Yesterday, you said that COVID public health restrictions, including mandatory masking, have become politicised; isn't that right?
A Correct.
Q Now, Dr. [redacted] chiropractic offices are not true health care settings; isn't that right?
A I mean, I think they're health care settings. You're providing treatment to a person. You spend like a -- you know, I'm a -- sometimes a family doctor, right, you know, what I do is, you know, talk to patients, do a physical exam once in a while, prescribe medications. Yeah, I think chiropractors, you know, do much of the same, but I think they spend probably more time with a patient than I normally would, like, you know, so I think that they're a health care setting.
Q Chiropractic offices really are community settings; isn't that right?
A I mean, I believe I call it a community health care setting in the same way that a family doctor's office is a community setting, as opposed to a hospital setting, right, but health care is provided in a community setting. A dialysis clinic is a community setting if it's outside of the hospital, right, like -- but, yeah, health care is provided, and sometimes it's provided in the community, as in not in the hospital,

and sometimes it's in the hospital, but they're all health care settings.

Q Chiropractors are more like office-based professionals than front-line health care workers, aren't they?

A No. I disagree completely. I mean, if you're saying chiropractors aren't front-line health care professionals, like, that see patients, then family doctors aren't either. Are you -- sorry.

Q In a health care setting such as a hospital, a large number of symptomatic people are regularly and predictably present; isn't that right?

A Yes.

Q In fact, in a health care setting such as an emergency room or hospital ward, most patients could not accurately be described as healthy, could they?

A Correct.

Q In a health care setting, such as a hospital or a drop-in clinic, workers such as nurses and doctors will regularly interact with symptomatic people that possibly have an infectious illness; isn't that right?

A Yes.

Q Front-line health care workers like nurses and doctors actively and knowingly treat many symptomatic people that are possibly ill with an infectious illness; isn't that right?

A Yes.

Q On a daily basis --
A (INDISCERNIBLE) --
Q -- isn't that right?
A Oh, no, it's true, yeah. I mean, I -- although I mean I kind of see your questioning, but I'll just say that, you know, family doctors often -- like I would say when it comes to, you know, let's -- I'll talk about a community family doctor practice, right. You know, you see patients that are actively ill; you take those precautions that you can. You also see people who don't have symptoms, right, or don't have respiratory symptoms, and you see them for other things, as a chiropractor would, right? Like it's a family doctor who sees somebody for lower back pain, a chiropractor sees somebody for lower back pain, no symptoms, no respiratory symptoms.

But this is where the whole asymptomatic transmission of COVID comes into play, right? And so I have definitely seen examples in a family doctor setting where patients did not have symptoms when they presented, no respiratory symptoms, ended up having COVID and ended up, you know, infecting health care workers, right. And that just shows that, you know, the absence of symptoms, in and of itself, does not mean that you do not have COVID, which you know.

I will agree that there are higher risk settings

than a chiropractor's office or a family doctor's office. I think a long-term care is probably the highest risk setting possible, right, based on what we've seen.

But you know I would still say that the risk of, you know, getting COVID or like the risk of seeing a COVID patient in a family doctor's office or even a chiropractic office is higher than, you know, walking around a mall, and that is for a few reasons, right? Like let's assume everybody who comes in is, you know, asymptomatic, you know, and you do your best to do symptom screening ahead of time. But even with that, you know, the duration of contact with a person matters quite a lot. And for much of this pandemic, we have been in lockdown, you know, I don't think we've been generally close with lots of different people for an hour at a time, right? Most people haven't enjoyed that, like (INDISCERNIBLE) to be hearing that. And when you have that intensity of -- like when you see a bunch of people, patients, and we see a bunch of people for long periods of time in close proximity, you're naturally at higher risk of getting COVID-19.

Q Health care settings like hospital emergency rooms and drop-in clinics are designed to receive symptomatic patients potentially ill with an infectious illness; wouldn't you agree?

A Yes.
Q In fact, people, who think they might be ill with an infectious illness, intentionally set out health care settings like hospital ER rooms and walk-in clinics to get the medical health care they need; isn't that right?
A Yes. And you're talking about "symptomatic" as in respiratory symptoms, right, like COVID symptoms that -- correct? As opposed to, say, what I might see a chiropractor for or a family doctor for, right, so -- but you're -- I assume you're talking about respiratory symptoms here?
Q Yes --
A Okay.
Q -- and just so it's fair to you, I wasn't trying to name symptomatics, as in any symptoms, what I meant was visibly symptomatic with a cold, flu, respiratory type, runny nose, coughing, et cetera.
A Okay.
Q In health care setting such as hospitals or medical doctors' offices, a wide range of interventions, treatments, and tests are likely to occur on a regular basis; isn't that right?
A Yes.
Q Now, community office settings, such as the types of offices where chiropractors typically work, it's quite

rare that a symptomatic person is regularly present; isn't that right?

A Yes. However, I will say this, you know, one of the most difficult things -- and this, like, and I would say is quite rare actually for symptomatic patients, and at various points, for them to even go to a family doctor's office, right, because we try to like screen that quite a lot.

But, you know, and this is actually a cause of a lot of transmission actually, because what is a symptom, right? And this is why COVID is tricky. You know, if you've been having a, you know, a headache for much of your life on and off, right, and then you have a headache again, that could be your old headache, that could be COVID, right, and that's, you know, a type of symptom that's hard to sort of assess.

If you're tired, right, you're fatigued, another COVID symptom non-specific, you know, you come in, you're kind of tired, you know, do you think that -- like, and you're a bit more tired today than yesterday. Was that because you, like, didn't get enough sleep, or could it be COVID.

And then you have like what I call like very like possi [phonetic] low-grade symptomatic people, and so really -- and this happens a lot in real life and kind of makes it difficult, right? So you have a runny nose

for 5 minutes this morning, right, so you had a symptom, and then it goes away. You probably think it's nothing, and it most likely is nothing, but that could actually herald, you know, COVID-19.

And this is -- you know, these are the things where, you know, it's not like always -- like obviously if you have like a raging fever and shortness of breath, you know, it's very clear, you're very symptomatic. But it's a lot of these sort of like -- well, I've talked about asymptomatics already but these like sort of low-grade symptoms and/or, you know, you just think it's something you've always had, these people have symptoms at the baseline that become very tricky.

And those types of events have led to actually, you know, transmission events actually in hospitals, oh, for sure, yeah.

Anyways, keep going.

Q Symptomatic people who expect they are ill with an infectious illness usually avoid community settings like chiropractic offices; wouldn't you agree?

A Yes, you're right, if they suspect they have an illness. But here's my example, and I'll say it again, right, like, you know, let's say you're going to see your chiropractor, right, tomorrow, and then tomorrow morning, you have a runny nose for about 5 minutes,

right. Like, you know, are you like, oh -- and you feel well otherwise; is that a symptom? It is technically, but, you know, you might not think it's a big deal.

I can tell you for sure that like this happened at, you know, the Peter Lougheed Hospital. We have staff coming in. To like have that type of symptom, you don't think it's a big deal, and then you end up having COVID, you end up inadvertently like maybe infecting some other people.

But you're right, that, by and large, if you have like very clear overt symptoms, you will avoid, correct, but there's all these like low-grade-type symptoms and/or, you know, like if you have chronic symptoms actually, you know, let's say you have like chronic allergies, right, like, and then your allergies start up again; you know, like you may not think that's a sympton of COVID, and you can't really actually differentiate by the symptoms alone whether it's your allergies or COVID, and this has actually been very, very tricky. And it's a cause of -- yeah.

Q You said yesterday that sick people generally avoid community settings; isn't that right?

A Yes, but we need to like get deeper into the word "sick", right? But you're right. So here's what I'll -- and thank you for questioning me on the sort of

specificities of my language. I would say people who clearly have like what I call overtly obvious respiratory symptoms will not go to, I imagine, a chiropractor, will tell them ahead of time, right? So totally agree with that. You know, if you have trouble breathing, you have a fever, you have like a day of runny nose, day of sore throat, yeah, I imagine you would not go see your chiropractor. I imagine, you know, when you book in, there's some screening that happens to try to like, you know, suss out, you know, like you don't have those symptoms.

But it becomes a bit trickier when like what is sick is kind of what I'm saying, right? Like this happened to me a number of times during this pandemic, right, like in the sense of, like, I had for like 30 minutes, and then I go get tested. And, you know, like -- and then the runny nose goes away. But like ten times this happened, ten times I've been tested, but, you know, they've all been negative, but like I know people where you have that, and you test, and it's positive. So it's not quite so black and white, unfortunately.

And I wish it was, because if it was -- we -- anyways, keep going. Sorry, I am long-winded, but I think it's important to impress, you know, the like -- there's a difference between like really, really

like -- it's a spectrum of what sick is and what people perceive as sick.

Q Would you agree with me that it's accurate to call someone who is asymptomatic healthy?

A Are you, again, talking about asymptomatic with respiratory symptoms not having or cold-like, flu-like symptoms being -- not having cold or flu-like -- like not having like a viral infection?

Q Let me ask you again. Would you agree with me that it's accurate to call somebody healthy if they do not have any visible cold-, flu-type symptoms?

A What do you mean by "healthy"? They could still have COVID. Right now you know can be asymptomatic of COVID. We know you can be asymptomatic of COVID and get pretty sick tomorrow.

Q You would agree with me though that it would be accurate to describe most people at a chiropractor's office as asymptomatic?

A Yes. I would, most. Yes, I would agree.

Q Chiropractors don't actually interact with people infected with COVID any more than in a typical day than members of the public, do they?

A This I disagree with. I mean, I don't know how many patients the average chiropractor sees in a day, but like, yeah, I'm going to assume your appointment's an hour long, half an hour.

Am I allowed to ask the chiropractor people how many people they see in a day? If I'm not, I'm just going to speculate, sure.

So, let's say, you see eight people a day, right, like it could probably be more sometimes than that. I would say during the course of the pandemic, most people did not see eight new people every day, right, like that would be really bad, and so you are at high risk. And they also didn't see eight people in such close indoor settings, right? Like how many people did -- well, you've see during the pandemic when we were like in lockdown, right; I doubt you were close in a room with eight new people every day.

Q No front-line treatment of suspected infectious illnesses occur at chiropractor offices, does it?

A I don't think so, but I imagine not.

Q A chiropractic office is actually much more akin to any other office where a professional service is provided than it is to a true health care setting like a hospital or a walk-in clinic; isn't that right?

A What do you mean by other professional services? Like a retail bank or something?

Q Let me ask you --

MR. [redacted] Mr. Chair, Mr. Chair, it's Mr. [redacted] and I apologize for interrupting my friend's questions here, but I'm going to have to

object to this line of questioning. Dr. [redacted] is not a chiropractor. He can't characterize what a chiropractic office is or isn't. He can't have any understanding of what the patient load is for a chiropractic office. These are questions that are far afield from his expert report, and I've given my friend some leeway here, but I have to put on the record that we object to these questions.

THE CHAIR: I think I have to agree, Mr. [redacted] Dr. [redacted] is qualified as a public health expert and not a chiropractor, so if we could focus the questioning.

Q MR. KITCHEN: A chiropractic office is a public place under the Public Health Act, is it not?

A I would say it's a health care setting under the Public Health Act. Well -- yeah.

Q Pursuant to the CMOH orders, a chiropractic office is a public place, is it not?

A I mean. It is a public place, as is in a family doctor's office, it's public, like people can go in, but it's also a health care setting, yeah.

I mean, like I actually have a -- like I don't know that much about the specifics of chiropractor, but what I need to be able to do in my line of work is like try to assess risk, right? And so I will tell you this right now your risk of COVID increases the more people

you interact with, right, and your risk of COVID increases the longer you interact with those people, right, and the closer you are with those people, right? Like I think we can all sort of agree with that.

The average person in society during this pandemic was not interacting with a whole lot of people, new people, I imagine. They weren't interacting with a whole lot of people in very close quarters indoors as well. And so, you know, I get the sense what you're asking, you're trying to sort of like say that a chiropractic setting is closer to a public setting like you said professional services than a health care setting.

Whereas what I'm arguing is that, no, I would say a chiropractor's office is more akin to a health care setting or any community family practice than that -- than, you know, like a retail bank or something. Where, you know, in a retail bank, what do you do, right, you go, you see teller for like 15 minutes, there's like a big like plexiglass barricade, and you'll -- yeah, and so I mean there's other sort of measures, so anyways.

Q You would agree that in CMOH Order 16-2020, chiropractic offices are called "community health care settings"; isn't that right?

A Yes.

Q Going to go back to your report, I note in your report that you did not respond -- actually, and I'm going to refer to [redacted] report. Do you want me to give you a moment to get that up?

A Yeah, let me just pull it up. Yeah, I have it up.

Q Thank you. Now, I note, in your report, that you did not respond to the 2015 study and 2014 Cochrane review that were cited by [redacted] on the first page of his report, and these -- both of these conclude that there's a lack of evidence to support the effectiveness of masks even in a health care setting like an operating room. You don't contest the existence of these studies, do you?

A No, but what I will say is that 2014, 2015, COVID did not exist, and I think what I care about is masks in a COVID setting, right? So I abide what's in those studies, right, but we live in a different world with COVID.

And so earlier, I did comment on the fact that, you know, like whatever studies we had pre-COVID are not as salient as studies around masking and COVID, because COVID is its -- is a unique novel virus with its own transmission dynamics.

Q Now, you just said that you only care about masks in a COVID setting; is that right?

A I -- yes.

Q And yet, you specifically put in your report a reference to masks during the Manchurian plague?
A Yeah, that was like a -- think of that as like fun introduction, I mean, you know, a historical preamble.

You'll see that, in my report, most of it is around masking during COVID, whereas in the expert reports, I don't think many of them comment around masking during COVID at all. My report is full of citations around masking during COVID. I'm providing some historical background. It's not salient as well, I agree.

Q You don't think it's fun that bacteria are hundreds of times bigger than viruses, do you?
A Say that again?
Q You don't think it's fun; you used the word "fun", did you not?
A Yeah, I'm sorry. Yeah, I shouldn't have used that, my bad. Very casual.

I think that if you want to disregard that section of my report entirely, feel free to do so. It is -- you know how I was critiquing the other expert reports for having a lot of sections that were not relevant to the question at hand, I have some sections in my report that are not relevant to the question at hand, and this is one of them.

Q You would agree with me then that it's not relevant to

talk about infectious illnesses that are caused by bacteria when it comes to --

A Correct, a hundred percent, I would agree with that.

Q You said yesterday that there's no good reason to have any exemptions to mandatory masking except maybe severe mental health reasons such as anxiety; do I have that right?

A Yes, correct, and that is based on a Canadian Thoracic Society statement. Again, I'm not a respirologist, but, you know, they basically say that, you know, it doesn't really exacerbate any underlying lung disease, so, yes.

Q You said yesterday that nobody should be exempt from wearing a mask except maybe those few people with anxiety; do I have your position right?

A Are we talking about in a health care setting? Because I think I've been referring to a health care setting.

Let me put it this way: I think that like if you're going to work in a health care setting, right, like you generally have to wear a mask, right. And by "generally", I mean I can think of almost no exceptions to, you know, wearing a mask in a health care setting where you're providing care to patients and you see more patients, and, you know, you're at risk of getting COVID more, and patients are at risk of getting COVID more.

Q I'm going to ask you the question again, because this is my memory of what was said yesterday.
A M-hm.
Q And if you disagree with me you tell me. You said yesterday that nobody should be exempt from wearing a mask except maybe those few people with anxiety.
A Yeah, and I'll add in like in a health care setting especially.
Q Okay, especially.
A M-hm.
Q But help me out here --
A Yeah, that's fine.
Q -- I'm not trying to trick you, I just -- I want to know --
A Yeah.
Q -- did you say yesterday, because that's what I have written down, you said yesterday that nobody should be exempt from wearing a mask except maybe those few people with anxiety?
A I did say that, and I -- like what I was referring to in a health care setting. And like, let me explain that, right, like -- the riskier the setting, the more important it is to wear a mask, right? And so do I care if you're wearing a mask outside in public, you know, in a park? No, I don't really care if you wear a mask there or not, because the risk of transmission is

very low.

In a health care setting during COVID, and -- your risk is much higher, so there should be -- like, yeah, I would agree, like basically like no exemptions or almost no exemptions. I'm sure -- yeah.

Q So you would agree that there should be no exemptions in what you call to be -- in what you say is a health care setting?

A Yes.

Q And would you agree -- well, would you agree with me that your position is that no one should be exempt from wearing a mask, except maybe the anxiety people, in a community setting, community indoor setting?

A More flex there. Community indoor, non-health care setting is what you're talking about, right?

Q Well, let me ask you again.

A Okay.

Q Is it your position that there -- you said flex, so let me ask it this way --

A M-hm.

Q -- you said -- or, sorry, your position is that there should be exemptions for people to not wear a mask beyond just anxiety in an indoor community setting, yes or no?

A I mean, I -- I would say that in certain indoor community settings, you don't need to wear a mask at

all.
Q Okay.
A Now, I'm defining community indoor like as separate from community health care. Community indoor would be a mall, a restaurant, you know just not a place where you receive health services.
Q So is it your position then that in a place where health services are received, regardless of what the health service is, nobody should be exempt from wearing a mask?
A Yes, while they're providing care to a clinic -- you know, while they're providing, you know, like patient care, I mean, that's also in all the orders, right? Yes.
Q And that includes --
A (INDISCERNIBLE)
Q And that includes --
A Pardon?
Q -- and that includes the patients, correct?
A Well, I'm focused more on the health care worker side right now, but, again, I would say patients sort of should wear like a mask in those settings, and, yeah, but like, sure, yes.
Q Just to clarify, because I asked you, in fairness --
A Yes.
Q -- to you, I asked you in a setting where health care

services are being received, I asked you if anybody should be exempt, and you said no, and then I asked you does that include patients, and you changed your answer. So let me give you an opportunity -- listen --

A Yeah, I mean --

Q -- listen carefully to the words that I use -- when I say "nobody" --

A Okay.

Q -- okay -- you know, I'm really not trying to trick you, okay?

A Okay, no, I know, I'm just, yeah --

Q Let me ask you again: Your -- look, you want your position to be understood, so do we.

A Yes.

Q In a setting where health care services are being received, it's your position that nobody should be exempt from wearing a mask except for those few with severe anxiety?

A And thank you for clarifying that. I mean, I will say there are like times, as a patient, you would take off your mask in a health care setting. If I needed to, for example, look at the back of your throat, I don't know if that's considered an exemption, but you would take your mask off to receive certain medical treatments, right?

And, again, I think the focus is on what health

care workers should do, right? There are very few -- you know, like, and I think there -- I'll say this: In a community health care setting, I think that health care workers should always wear a mask. In a community health care setting, I think patients should almost always wear a mask, but there are times when they -- you know, you've got to take that mask off for the patient.

Q Is it your position that patients should not be allowed -- is it your position that in a setting where health services are being provided --

A M-hm.

Q -- regardless of the health services, is it your position that patients should not be exempt such that they're allowed to never wear the mask?

A Such that they're exempt that they're never allowed to wear a mask. I mean, it is more complex with patients I think, right, for a few reasons.

Number one, if I had a patient coming in, and they're having a heart attack, and they don't want to wear a mask, like would I turn that patient away? No, right, because it's sort of our duty as health providers to like treat the patient for what they have. This is actually why it's all the more important for health care workers to wear masks so they can sort of take that extra layer of protection for themselves and

for those, you know, patients.

You know, another type of patient, you know, somebody with some, you know, psychosis, right; they may not like walk -- people walk in the emerg, you know, they may not have a mask on, they may like be agitated and not want to wear a mask, we should not at all like deny care for those patients, I don't think, right?

And so there's, yeah, the patient side is a little more complex, but I think if you are able to wear a mask, you should wear a mask as a patient. Most community health care settings have these policies where if you come in, you should wear a mask. But, again, you know, I don't think -- and this is where there's more of a, you know, a balance. I know some physicians, who, you know, like won't see patients unless their patients are wearing a mask, right, and I know some, you know, who are more flexible on it, right? It just -- you know, like but, generally speaking, the rule is patients should wear a mask if they can, right, if they're able to.

Q You said "able to". Do you think religious beliefs are a good enough reason for a person to not be able to wear a mask?

MR. [redacted] Mr. Chair, I have to object to that question. This is far beyond the purview of what

Dr. [redacted] has been called to testify on. That's -- if anything, that's a legal issue. It's certainly not for an expert, like Dr. [redacted] to comment on.

MR. KITCHEN: Chair, Dr. [redacted] yesterday, gave a lot of opinions on the CMOH orders. He gave a lot of opinions on mandatory masking; okay, mandatory masking he gave opinions on.

A M-hm.

MR. KITCHEN: So we're not just talking about masking itself; we're talking about mandatory masking. So I am exploring his positions on mandatory masking. It's relevant, and it goes to what he said yesterday.

MR. [redacted] You're not exploring, Mr. Kitchen, clinical positions, you're exploring religious beliefs. I'm going to strongly object to that.

THE CHAIR: I have to agree with Mr. [redacted] that's a protected ground. I don't think we need to get into that.

Q MR. KITCHEN: Dr. [redacted] you think that the CMOH orders would have been better if they did not allow for exemptions to mandatory masking, correct?

A What do you mean by "better"?

Q Well, that's the word I heard you use yesterday. Yesterday, did you not say that it would have been

better if those exemptions were not in there that Dr. Dean Hinshaw had in her orders?

A Well, no, I mean actually -- from a policy perspective, I think what I said -- I may not remember, but here, I'll -- my position on this looks, like, looks like this, right: Normally when governments like make these recommendations, they tend to like have a carve-out for exemptions, because, it's just -- you know, you can't necessarily think of all the million things that somebody could have an exemption for, right, and so you tend to want to be a little bit flexible.

The issue that -- you know, when you say there's some exemptions to this is the CMOH order cannot provide guidance on what those exemptions -- like what would qualify as an appropriate exemption, and they -- I think they added that intentionally a bit. And that let to a lot of confusion, you know, with family doctors being like, okay, so people are asking for exceptions, like what qualifies as an exemption, right?

And so it would have been better if they probably qualified what would -- if they sort of described what an exemption would actually -- what would qualify for an exemption.

Q From a Public Health policy perspective, you support mandatory masking policies, correct?

A Yes. M-hm, yes.

Q From a Public Health policy perspective, you support the Alberta Chiropractic College's mask mandate, correct?
A Yes.
Q You think the Alberta Chiropractic College got it right by not permitting exemptions; isn't that right?
A This is for health care workers, right?
Q Yes. From a policy perspective, you support mandatory vaccination, don't you?
A Define "mandatory vaccination". I mean, this is a very, yeah, complex topic, right?
Q I define it exactly the same as I define mandatory masking.
A Sorry, you're talking about do I support mandatory vaccination of health care workers who work in health care settings? Is that what you mean by mandatory vaccination?
Q Well, I'll ask you again. From a Public Health policy perspective, do you support mandatory vaccination of all health care workers?
A I do, yes. But as somebody who also like works a lot in like trying to create having this policy, you know, you can't -- I think it would be wonderful if all health care workers were immunized. I think that what you want to do is not use a mandate if you can convince people to be immunized without a mandate, right? You

always want to be as non-coercive as possible initially, right?

I think that when it comes to, you know, like when it comes to mandatory vaccination policy, for example, right, there will be exemptions, right, there's carve-outs for exemptions. But I think, broadly speaking, I view mandatory vaccinations, like a policy like that, is something you do once you find that, through other means, you cannot get a sufficiently high number of people immunized in health care, like, for example, health care workers immunized.

And, you know, I -- the mandatory vaccination thing is really interesting because I think that a lot of people like view it as a way to increase vaccine uptake, which, you know, is obviously an effect of mandatory vaccination.

You know, the primary reason for a vaccine mandate in a particular setting is to keep that setting safer, I think, right? So I almost definitely support mandatory vaccination in a long-term care setting, right, because, again, that's the -- by far, the highest risk. You know, I think hospital settings are also, you know, pretty high risk.

But, you know, you want to -- yeah, like, and so I'm like shading this a little bit, because it's not like just like "yes", "no", right? Like, and we go

down this road because it's a complex topic for a mandatory vaccination: When you should do it, like when's best, who should apply for it, what exemptions you should have, et cetera, et cetera.

Q I'm going to move on to something different. You said yesterday that more health care workers died in Italy in the spring of 2020 because they weren't wearing masks; do I have that right?

A No, I think what I said was they ran out of like -- sorry, what happened is they didn't have enough like good PPE, and, sorry, if I meant that, right? I think they were reusing masks. They like were -- and these masks were -- like their masks were not providing sufficient protection -- or the PPE was not providing sufficient protection. That can happen by not wearing masks, so I think they were wearing masks, or just by using the same mask over and over and over again for days. Right?

Q You don't have any scientific reports or peer-reviewed studies to support that conclusion, do you?

A I don't, but I can find some.

Q You didn't include them in your report, did you?

A Correct, there's lots of things I didn't include in my report that I've been talking about.

Q You weren't a health care worker in Italy in the spring of 2020, were you?

A No, I was not.
Q I'm looking now at the second-to-last paragraph on page 4 of your report where you discuss health care workers in Alberta.
A M-hm.
Q That paragraph starts with "If we look closer to home". You cite no scientific reports or peer-reviewed studies in that entire paragraph, do you?
A Yeah, because nothing has been like peer-reviewed yet on this, yeah, but you're right.
Q You provide no independent sources to verify your claims regarding the number of infections between COVID-19 infectious patients and health care workers in Alberta, did you?
A No, but I can provide them.
Q You provided no independent sources to verify your claims regarding the number of transmission events, did you?
A No, I did not.
Q Everything discussed in this paragraph is simply your assessment of what happened, is it not?
A My assessment in discussion with a bunch of other people, like Workplace health and safety, Alberta Health Services, you know, hospital management, leadership, and all that, but, yes, you're right, I do not cite anything, that is true.

Q You've not worked as a doctor in an emergency room or hospital ward treating COVID patients, have you?

A No -- I'm trying to think, because like I spent a fair amount of time in the hospitals to manage some of these outbreaks, but you're right I wasn't providing direct clinical care to patients in the COVID wards or the emerges, but I was extremely involved in developing, one, policies around preventing transmission of COVID-19, and, two, managing any outbreaks that emerged in hospitals and emerges.

Q Now, I note it's 10:58, which means you've got to leave in 2 minutes.

A M-hm, yes, thank you for reminding me.

MR. KITCHEN: Mr. [redacted] I can tell you I'm at least half way through.

MR. [redacted] I think we should let Dr. [redacted] go, and maybe we can chat about, after he's gone, just take 5 minutes of that 15-minute break to chat about the balance of the day.

MR. KITCHEN: Sure.

THE CHAIR: Before we do that, Dr. [redacted] you mentioned that you might be a little more flexible on the noontime if you're able --

A Yeah --

THE CHAIR: -- to deal with it.

A -- yeah. Yes, I can be. I like jigged things around a

little bit, so ...

THE CHAIR: Could we take 1:00 as a target --

A Yes.

THE CHAIR: -- time to be done? Does that work for you, Mr. [redacted] Mr. Kitchen, if needed?

MR. [redacted] Yeah, I have a -- I think that would be as far as I would want to go without having people take a lunch break, frankly.

I am concerned we're not going to finish with Dr. [redacted] today though if we -- just nothing critical of anybody, but I have a fair number of questions, and the Tribunal should be able to ask questions too, and that shouldn't be rushed, so I think we should just press on here and try and get done as much as we can.

THE CHAIR: Okay, let's break, we'll reconvene we'll go into recess now, and we'll reconvene at 11:15, when Dr. [redacted] returns, and we'll press forward. If it looks like we can wind up somewhere around 1:00, we'll press through. If not, Mr. [redacted] I take your comments to heart; we will find time in there for a proper lunch break for people to replenish, and we'll go from there. So, thank you, we'll see you in 15.

(ADJOURNMENT)

THE CHAIR: So we will reconvene, and Mr. Kitchen is continuing with his cross-examination of

Dr. [redacted]

MR. KITCHEN: Thank you.

Q MR. KITCHEN: Now, Dr. [redacted] you said yesterday that it would be unethical to perform RCTs on people jumping out of planes without parachutes as a part of a scientific investigation to determine the effectiveness of parachutes; is that right?

A Yes.

Q The overall survivability rate of jumping out of an airplane is zero, is it not?

A Well, it's close to zero, but -- very close to zero, but you're right, it's like basically near zero, yes. I think a --

Q (INDISCERNIBLE)

A -- I think a few people have survived in the history of it, but it is very close to zero, I agree.

Q The overall survivability rate of COVID is 99 percent; isn't that right?

A Yes.

Q RCTs --

A (INDISCERNIBLE) -- oh, sorry.

Q -- RCTs regarding the efficacy of masks have been conducted and are currently being conducted, are they not?

A In the community setting, yes, not in the health care setting really.

And maybe I'll just explain, so, I mean, I used the parachute example just like -- just to describe certain situations where you can't do an RCT, but I believe I -- I used a term yesterday called "clinical equipoise", and that basically means that when you do an RCT for anything, medication, intervention, right, like, you can't do it if you think that like one -- like the placebo, if the treatment is like -- you think is like definitely better than the non-treatment placebo group, right?

And I think right now it would be probably not ethical to do an RCT of mask wearing in a health care setting, because there's so much evidence supporting masking in health care setting. Now, in a community indoor setting, it's a bit different, right? There's a lot more sort of debate around that one.

Q So RCTs regarding the efficacy of mask and mask wearing in community settings --

A Yes.

Q -- are being conducted and has been conducted?

A Yes.

Q Thank you. Now, on the top of page 3 of your report -- forgive me, I put it down -- the top of page 3 of your report --

A Yeah.

Q -- you cite to a study sponsored by the World Health

Organization that is authored by Chu et al., so I'm going to call that the Chu study.

A Sure.

Q You know what I mean by that?

A Yeah.

Q And you discuss this same study in the second paragraph of page 4. This study was published in June 2020, correct?

A Yeah.

Q Now, this study is also discussed by [redacted] on page 6 of his report in the second-to-last paragraph of his report. Dr. [redacted] --

A Okay (INDISCERNIBLE) --

Q (INDISCERNIBLE)

(INDISCERNIBLE - OVERLAPPING SPEAKERS)

Q MR. KITCHEN: Let me know when you've got it.

A Yeah. This is page 6 of his report.

Q Right, that's these -- the paragraph there at the bottom that starts with: (as read)

> Finally, a comment should be made. Dr. [redacted] refers to a Cochrane review that was evidently published after the Chu study. This Cochrane review is found at footnote -- or I should say, sorry, end note 62 of Dr. Warren's report. The first author listed for this report is Jefferson.

A Okay.
Q Jefferson/Cochrane review.
A M-hm.
Q Dr. [redacted] quotes directly from this Jefferson/Cochrane review, in which it is stated that the Chu study, quote: (as read)

> Has been criticized for several weeks. Use of an outdated risk of bias tool, inaccuracy of distance measures, and not adequately addressing multiple sources of bias, including recall and classification bias and, in particular, confounding.

My question is you don't deny the existence of this Jefferson/Cochrane review cited by Dr. [redacted] do you?
A No.
Q You don't contest that the portion of the Jefferson/Cochrane review quoted by Dr. [redacted] was quoted accurately, do you?
A No.
Q And you don't disagree with Dr. [redacted] that Cochrane systemic reviews are widely recognized in the medical community as authoritative, do you?
A Yeah, they are. I agree.
Q I note --
A I'm trying to download this Cochrane review; is that okay? Can I like crack it open?

Q Well, yes, because it's part of the record, it's --
A Yeah, just trying to --
Q It's in Dr. Warren's report.
A Is it one of the -- it's not one of the exhibits, right? I'm just trying to download the PDF of it right now.
THE CHAIR: It's in E-7.
A Oh, it's in E-7, okay, thank you. (INDISCERNIBLE)
(INDISCERNIBLE - OVERLAPPING SPEAKERS)
Q MR. KITCHEN: (INDISCERNIBLE)
A The paper itself, the Cochrane review itself.
Q So just so you know, Dr. [redacted] I'm not going to question you any further on the report, so ...
A I'm just reading that study right now, the Cochrane one where -- I mean, so they talk about medical surgical masks compared to no masks, but I think that what they're looking -- and they basically in that study say that wearing a mask may make little or no difference to the outcome of influenza-like illness if not wearing a mask. And so what we're trying to look at is if like what they're looking at is general influenza-like illness for COVID specifically.

So, now, this Cochrane review was published initially in 2007, and then -- as Cochrane reviews often are, right; you have an initial one on masking, and then updated in 2009, '11, '17. And so I mean I --

again, I kind of wanted to look at it just to see if the studies this Cochrane review talks about, which -- Cochrane reviews are very good -- refer directly to the transmission of COVID and masking to prevent that.

The comments around criticizing, you know -- you know, with the Lancet paper, I mean, yes, you can always critique these meta-analyses, but it really is seen as like a, you know, a fairly good study. No study is perfect, but -- oh, thanks for flagging the -- the -- yeah, yeah, I'm just reading this document right now. I'm going to -- keep going though.

Q I note that in your report, you state no less than six times that the evidence in support of masking is, quote, overwhelming. Do you --

A Yes.

Q Do you today remain of that opinion?

A Yes, for health care -- for prevention of COVID in a health care setting, yes. I do.

Q You state on page 8 of your report that the efficacy of mask wearing is beyond doubt; do you stand --

A (INDISCERNIBLE)

Q -- by that statement?

A Yes, in a health care worker setting, yes.

Q So it's not beyond doubt in a community setting; do I have your position right?

A Yes. I mean, I will say the other thing that like

affects this is like the number of cases you have, right, of COVID.

And so, for example, like -- and this is quite -- I think I may have talked about this yesterday, but if we had zero COVID, we wouldn't need to wear masks, right; like I fully support that, right. And so, like, a lot of what I'm trying to say is that, you know, when you wear -- like -- and zero COVID is a type of, you know, like if there's no COVID cases, your risk is very low of getting COVID. I think that, you know, your risk is sort of determined by a number of factors, including, you know, the prevalence of COVID but also what you're doing exactly.

But I will stand by my fact that right now, like, yeah, like, beyond doubt people should wear masks to prevent COVID-19 in health care settings. If there was no COVID for ten years, I would take that back, right? But, you know, that's -- these are all important things that I, you know, actually even think about. The community setting is very, very different.

For example, do I think people should engage in indoor masking in -- let me pick an area with very few COVID cases -- in, I don't know, there's a big outbreak in the Northwest Territories -- like in Nunavut, right, where I don't really think they have many cases right now. Like, no, not in, you know, a community setting.

It's really important to make a difference between a health care setting and a community setting. They're completely different.

Q When -- well, I want to make sure I have your position correct --

A M-hm.

Q -- so you --

A (INDISCERNIBLE) again?

Q Sorry?

A Do you want me to say my position again --

Q No, no, sorry, I'm going to ask you a question, I apologize.

A Okay, yeah, no problem.

Q So you would say that the evidence of the effectiveness of masking in what you call a health care setting is overwhelming, correct?

A Yes.

Q It's not overwhelming in what you would call a non-health care setting?

A Correct. I think there's lots of evidence for it; it's just not as overwhelming, right, like -- but yes.

Q And, again, embellish me, you would say that the evidence for the efficacy of mask wearing in what you would call a health care setting --

A M-hm.

Q -- beyond doubt --

A Yes.
Q -- (INDISCERNIBLE)
A And I will --
Q -- and you would say it's not beyond doubt in what you would call a non-health care setting?
A I would say that -- and, you know, these terms are not very specific, right, beyond doubt, overwhelming. So let me try to describe these terms.

When I say "overwhelming", what I mean is that in a health care setting, basically every study on -- pretty much every study or the vast majority, let's say 95 percent plus studies have been done on masking in a health care setting during COVID which show that it provides benefit, right, and so that's pretty overwhelming, I think.

And now when I talk about studies around masking in a community setting, again, there's a lot of studies that show, you know, masking previously, like in a classroom, for example. That's probably one of most interesting ones right now. Like it's also strong, but like the effect size is not as strong. By "effect size", I mean the extent to which like the proportion of like -- the risk reduction of transmission is not as high in the community settings as in a health care worker setting. And so while there's lots of studies supporting it, like the magnitude of the risk reduction

does matter as well, so, yeah.

Q Going to take you to page 8 --

A M-hm.

Q -- of this report, now we're in the response sections --

A Yeah.

Q -- I guess this is the last page. You make a comment on this page, page 8 --

A Yeah.

Q -- in response to [redacted] statement regarding mask mandates in other countries. You say that [redacted] remark about Sweden is, quote, false and not backed by any evidence. However, you do not refer to any study or other evidence that supports your claim that [redacted] Sweden remark is, in fact, false, do you?

A You're right. And let me explain that, maybe I didn't use my words, like language correctly, but [redacted] real-world data from various countries shows that cases increased after masked mandates were enacted, and countries that had no mask mandates did just as well or better than other countries with masked mandates.

You know what, my -- like I will -- I like -- my main critique with that is, you know, I'll give you an example, right, like China after the first wave as of, let's say, June of 2020, no longer had any

restrictions, right, because they had no COVID anymore, because they managed to suppress it completely. You know does that mean masking doesn't work? No, because there's no COVID, so you don't like necessarily need to mask.

I think that when we're looking -- and this is what I was talking about like a -- like spurious, you know, causation, a lot of factors drive up cases. Masking can reduce transmission, but like a lot of things can reduce transmission and a lot of things can increase transmission as well, right? And I would say the biggest predictor overall case counts in a particular country, you know, is just the total number of -- you know, actively interaction between people.

And so, you know, you can't just like make like -- it's kind of like -- yeah, you know what I'm talking about when you have like a -- like a spurious like, you know, causation like -- correlation versus causation are very different.

I think the example I used yesterday was -- and, you know, November -- like late November, we implemented some strict measures, and then in December, in Alberta, we implemented stricter measures, but cases kept on going up. They eventually started falling, but I can say that, you know, the implementation of measures in November, December, like initially led to a

rise in cases, right, and like -- and so you'd be like, oh, so maybe your like lockdowns don't work.

But, you know, it's factually true, the cases went up after we implemented lockdowns, right, for a bit. That doesn't mean lockdowns don't work. I'm just saying lots of other factors determined, you know, what our case counts are.

Q So you would say that when cases went up after what you called the lockdown --

A M-hm.

Q -- you would say it's just correlation; it's not causation?

A Yeah, I mean, like, sorry, like if you're like correlation like, you know, like mathematically, statistically is like there's a -- like something happens, and something goes up or down, right? It's just like a direct -- this immediately -- how do I define correlation? Like correlation just describes the relationship between sort of like two variables, right?

And so whereas causation is more like, okay, so what our action -- what is driving, you know did lockdowns lead to lower cases in the end? Yeah, they did, but it took some time for that to happen, right; but if I took a slice of time, like a week after, cases were still high. Anyways --

Q So you --
A -- (INDISCERNIBLE) say.
Q You would say the relationship between cases going down after what you call the lockdown is causation not correlation?
A Yes.
Q So you would agree that the lockdown caused those cases to go down?
A Yes. And then let me like -- and we have to like get into more specifics like because many, many things like lead to a decrease in cases, right?

What did the lockdown actual -- okay, for just a fun public health discussion, right? So, again, you know, just illustratively, what was causing our cases to be very high in the late fall was indoor private social gatherings, right? The lockdown really said you couldn't do those things, and, you know, that led to a decrease in the number of indoor private social gatherings that occurred, as in people going to people's houses, or we think it did.

And that is sort of like the causal link, because, you know, when you say "causation" -- like establishing causation, as you know, can be very difficult, but, you know, the reason why I think lockdowns generally -- and there's a whole set of criteria and epidemiology to, like, try to determine causation.

But I would say that I guess point one is you can't just look at correlation; point two when you're trying to assert causation, you know, you have to consider a number of factors, you have to have an understanding of like, you know, the sort of like the drivers of transmission, the things that make it worse, the things that make it better.

Q Now, I'm going take you back to -- I know you just talked about a lot of stuff, but I'm going to take you back to exactly what we were talking about before, okay --

A Yeah.

Q -- we're talking about this Sweden reference here.

A Yeah.

Q Okay, so you've got your sentence here where you say, And this statement is false and has not been backed up by any evidence.

Now, in the very next sentence, you state in your report: (as read)

> The use of masks has decreased the transmission of COVID-19 across every country that has imposed them.

Q That's what you state in your report. You do not cite or refer to any study or other evidence at the end of that sentence to back up that claim, do you?

A No. But I can give you some citation.

Q On page 6 of your report, you accuse Dr. [redacted] of committing a factual error in stating that 1,010 COVID-related dates says, as of April 16th, 2021, our last deaths than the 1,191 motor vehicle accident deaths in the year 2018. Do you today stand by that accusation?

A I do. Sorry, like -- like I think what Dr. [redacted] put in is accurate, right? Like I'm not arguing that. Like I think what I'm trying to articulate is that, one, it doesn't really matter for the purposes of our discussion to talk about again, which is, you know, whether or not which of these masks can be in a health care setting, right, and whether or not that reduces, you know, transmission.

You know, the spirit of I think what, you know, Dr. [redacted] is talking about is basically like COVID isn't that serious, and, you know, whether or not you think COVID is serious or not, right, like -- like, again, like the focus of this is, you know, health care -- like use of masking in a health care setting to reduce transmission, right?

And I think one of the issues that I have with a lot of the expert reports -- and, you know, like I can actually chat at length actually about how serious or not serious I think COVID is. You know, there's a lot of room for discussion, I think, frankly, right? Like,

lockdown I think is actually -- you know, more people have died from non-COVID causes than COVID, you know, during like our -- the last 18 months in terms of excess mortality.

But, you know, at the end of the day, it's just not relevant, and, you know, I think with a lot of the expert reports, like a lot of their reports are spent like just talking around the issue -- or like around COVID, but not around masking. There's very little in the reports about masking as a portion of the total report.

And I made that error too, I talked about the Manchurian plague thing, which is also not relevant, so point taken.

Q Now, that was a long answer, and I want to make sure I have your answer, okay?

A Okay.

Q You stand by the accusation that Dr. [redacted] made a factual error in stating that 1,010 COVID deaths as of April are less than the 1,191 motor vehicle accident deaths in the year 2018?

A Yeah -- no, I don't. Like his statement is accurate --

Q No, you don't -- hold on, like I don't want to interrupt you, but, no, you --

A Okay.

Q -- don't stand by your accusation?

A Sorry, what I'm saying -- okay, like what he says is that, in Canada, there have been a thousand COVID deaths in people under 60 as of April 2021. In Canada, in 2018, there were 1191 motor vehicle fatalities. And what I say is that as of June, so like two months later --

Q But I didn't ask you what you said --

A Okay.

MR. [redacted] Mr. Chair, Mr. Chair, Mr. Kitchen may not like the answer Dr. [redacted] is giving, but he's got to let him finish, and he should be allowed to finish his answer.

Q MR. KITCHEN: Okay, you go ahead, Dr. [redacted]

A So I mean, I think that Dr. -- that is what Dr. [redacted] said, right, and he's basically saying there were fewer COVID deaths than motor vehicle deaths, you know, as of April 2021. What I say is, as of June 29, there were more COVID deaths than motor vehicle deaths, right, and so that's it, and both are factually correct statements, right?

And, yeah, so you're right, the point where I say, notwithstanding the factual error, I mean, like it's not his fault, because like at the point he cited it, there were more motor vehicle deaths than like there -- than COVID deaths, and two months later, there are more COVID deaths than motor vehicle deaths, but like --

but -- and when you like pick a point in time for looking at COVID deaths, right?

Q Now, I feel like I've gotten two answers from you, and I want to make sure everybody's got this right, because you just said -- you just said that there is a factual error --

A Yes, the factual error is that --

Q -- you stand by the claim that Dr. [redacted] made a factual error?

A Okay, let me be precise here. So at the time of him citing, you know -- picking April -- like so he says two things really, right? He says as of April 16th, there were more motor vehicle deaths than COVID deaths, right? And that's true. And then he goes on to say so the risk of death due to COVID in persons under 60 is less than the risk of death due to a motor vehicle fatality. So, I mean, I think that part is not true based on, you know, by June 2021, you know. There have been 1400 COVID-related deaths under 60, right?

And so what I'm saying is like the first part of his statement is accurate, right, like numbers of deaths at this point versus number of motor vehicle fatalities, but the second part, the risk due to COVID in a person under 60 is less than death to a motor vehicle fatality, because like if you go like two months later, you see that the number of COVID deaths

is quite a bit higher than the number of motor vehicle deaths, right?

Q So what he said was accurate on April 16th?

A Yes. But --

Q (INDISCERNIBLE)

A -- as of June, it is no longer accurate, right, and so there's a factual error there, right?

Q But Dr. [redacted] didn't say June, he said April; isn't that correct?

A That's true. Yeah, but like he did, so you're right, at that time, he was correct, but like two months later, he was no longer correct, right?

Q There are --

THE CHAIR: Please --

Q MR. KITCHEN: -- (INDISCERNIBLE)

THE CHAIR: -- Mr. Kitchen, I'm wondering if Dr. [redacted] is referring to the second -- he said there were two parts to the answer, one, what happened in April, and then a broader generalization. I think, Dr. [redacted] were you not saying that it's the broader generalization that's not true?

A Yeah, so the generalization he makes is -- I mean, and like we can move off this, like I -- is like so the risk of death due to COVID in persons under 60 is less than the risk of death due to a motor vehicle fatality. And while that was true in April, it is not true now,

because we had a lot more COVID deaths, right? And so that is like the sort of factual error. I mean, regardless, I will -- yeah.

Q MR. KITCHEN: Let me ask you this, Dr. [redacted] There are 12 months between April 16th, 2020, and April 16th, 2021, are there not?

A Yeah.

Q And there were 12 months in the year 2018, were there not?

A M-hm. Would you like me to calculate like a death by month rate because -- okay, so, here, let's do this --

Q Now, Dr. [redacted] look, I didn't ask, and Mr. [redacted] can chime in here, I didn't ask you a question.

A Sorry, my bad.

Q You're asking me, Can I do this, and then you're talking, and, you know, I've let you do that a lot, I don't generally have an issue with that, but --

A Sorry, but --

Q -- the idea is that you --

A -- (INDISCERNIBLE) --

Q -- I ask a question and you answer it. And that's exactly why Mr. [redacted] rightfully stepped in and said, Well, you know, look, my witness --

A Yeah.

Q -- is answering a question that you asked.

A Right, that's fair.

Q Now, in the next sentence, you accuse Dr. [redacted] of lacking, quote, a basic understanding of disease patterns. Do you today stand by that accusation?
A Well, it's a little bit general accusation. I don't know, like I -- maybe I won't say that anymore, right? Like I don't know Dr. [redacted] well enough.
Q So you don't stand by that accusation; do I have that right?
A Yes. I don't anymore. It's too general. It's too like general in my writing.
Q It must surprise you that someone who you up until just now said has no basic understanding of disease patterns has written a seven-page report about COVID that contains 98 citations to academic literature, doesn't it?
A No, I mean, like -- like I said, like I -- I will retract my statement as I think he has no understanding of disease patterns, and, fair. I mean I think he has a lot of citations, but I think, yeah, when it comes to the whole masking thing, which is the thing we should be focusing on, which is the purpose of this discussion, right, I disagree with, you know, his findings.
Q So it doesn't surprise you that he's created a seven-page report with 98 citations to academic literature about COVID?

A No. Does it surprise me? No, because -- yeah.
Q Your report contains 22 citations to academic literature; isn't that right?
A M-hm. Yes.
MR. KITCHEN: Those are my questions.
A Thank you. Sorry, for being so long-winded again, Mr. Kitchen.
THE CHAIR: Thank you, Dr. [redacted] We will now turn the floor back to Mr. [redacted] for his -- any redirect.
MR. [redacted] Thank you.
Mr. [redacted] Re-examines the Witness
Q MR. [redacted] I'm just going to start with a question, Dr. [redacted] about the Pandemic Directive, which is Exhibit C-22 --
A Okay.
Q I'll let you just get to that, and I'm looking at -- in specific, I'm looking at page 8. While --
A Yeah.
Q -- you're getting to that, there was a discussion between you and Mr. Kitchen about the type of masks that are -- really, you're referring to, and I think a discussion about the blue medical clinical mask. I'll just take you to the heading "PPE Requirements" and --
A Yeah.
Q -- the first black dot says: (as read)

Surgical or procedure masks are the minimum acceptable standard.

And you'd agree that's appropriate?

A Yes.

Q There was a discussion between you and Mr. Kitchen about how the CMOH orders come about and Cabinet and other considerations, regardless of the development process of CMOH orders, they're to be followed, aren't they?

A Yes. They are legally binding, I believe, so ...

Q There was, I found, a surprising comment, a surprising question from Mr. Kitchen that chiropractic offices aren't true health care settings, and I think you responded pretty vigorously to that, but I just want to be clear, is there any doubt in your mind that chiropractic offices are health care settings?

A No.

Q Patients are treated, diagnoses --

A Yes.

Q -- diagnoses are made, and that, in fact --

MR. KITCHEN: Chair, hold on a second, I -- this was the same line of questioning that I was doing that Mr. [redacted] objected to on the basis that, ultimately, Dr. [redacted] doesn't know what goes on in a chiropractic office, and he's not qualified as an expert to comment on what goes on in --

MR. [redacted] I'll skip on, I'll skip on.

Q MR. [redacted] You made comments about there being a higher risk -- pardon me, that there are higher risk settings in the health care world that -- than there are in the community setting; is that correct?

A Yes.

Q You talked about things like duration of contact is important, the number of patients you might see, and although you're not a chiropractor, you used an example of eight people a day as a patient load. If any health care professional, whether it's a chiropractor or a dentist or whoever, sees 16 or 32 patients, the risk would go up for COVID transmission, wouldn't it?

A Yes.

Q So if someone like Dr. Wall was seeing 32 patients a day would be different -- more risky than if he was seeing 8 patients, just to use your hypothetical?

A Yes.

Q You talked about there is a spectrum about what sick is, and I think, very importantly, you said, And what people perceive as sick. And I'm going to suggest to you that people may not know when they're sick; that's the whole concept of asymptomatic?

A Yes, definitely.

Q And isn't that why we have things like what are called universal precautions, so that when someone comes into

a dentist's office, the dentist says, I'm going to assume you've got Hep B, Hep C, or whatever, we always use universal precautions?

A Yes, yeah, that is a term used in infection prevention and control, just the basics for everybody.

Q You made a statement, and I'm going to paraphrase here, but I think I've got the wording right, the more people you interact with and the longer you interact with them and the closer you are, the greater the risk of COVID transmission; is that correct?

A That's correct.

Q So if I'm a dentist or a physician or a chiropractor, and I have closer contact, see more people, have a longer duration with them, the risk of COVID is going to increase?

A Yes.

Q Or transmission, okay.

A Yeah.

Q There was a discussion you had with Mr. Kitchen about bacterial infection references and some historical references in your paper, but I want to be clear, your paper focuses on masking and COVID and efficacy of masking?

A Yes.

Q There was another lengthy exchange between you and Mr. Kitchen about exemptions to masking, and I just

want to be absolutely clear on this point, because I think the discussion boiled down to one comment on your part -- or one theme on your part, there should not be exemptions to masking in health care settings in the overwhelming majority of situations?

A Yeah, but I will take -- Dr. -- that Mr. Kitchen's projective for health care workers, right, like a lot of patients can't wear masks or, you know, their mental -- like, you know, so I'm not going to deny treatment to an acutely psychotic person coming into the emerg without a mask on, right?

Q Yeah, and let me be more clear, there should be no exemptions for health care workers in health care settings?

A Yes.

Q You had a discussion with Mr. Kitchen about -- and, again, I'm going to paraphrase -- it would have been better if the CMOH orders had provided more detail about exemptions; is that your recollection?

A Yes.

Q Ideally, you would want, I'm assuming, some criteria for what a medical exemption is?

A Yes.

Q And a process for getting it, who you get it from, and who that person is and how qualified they are?

A Yes.

Q I think you, would it be fair to say that when you get a medical exemption, you would want some rigour involved in that exemption process?
A Yes, ideally.
Q You would want testing, diagnosis, interaction with the patient?
A Yes, ideally.
Q You'd want to avoid quickie, one-line diagnoses or exemptions?
A Yes.
Q Would it be fair to say that a physician, for example, shouldn't self-diagnosis his own or her own exemption from COVID?
A Yes, for various reasons, but yes.
Q Okay. And, particularly, let's say if it was a physiotherapist, a nonphysician, that person shouldn't be self-diagnosing their medical exemption for COVID?
A No.
Q And can you tell me why?
A Well, I mean, I -- in the same way that I, you know, generally do not know very much about the practice of -- you know, like the skill set, knowledge of being a physiotherapist or a chiropractor, you know, so too I imagine most physiotherapists don't know as much about, let's say, providing medical exemptions for masks, respiratory illness, all those things as compared to at

the doctor or a physician, it's just how you're trained and what you do.

Q So if you had someone who thought they might have an anxiety disorder, they should get that diagnosed by someone who has knowledge and training and experience in anxiety disorders?

A Yes.

MR. [redacted] Those are all my questions, Mr. Chair.

MR. KITCHEN: Mr. Chair, there were some new questions there that weren't in response to my questions. I'd like a chance, and this is what I'm going to ask you, I'd like a chance just to ask one or two questions based on what I saw as new questions that were not in response to my questions.

MR. [redacted] I wouldn't have a problem with that, Mr. Kitchen.

THE CHAIR: Okay.

Mr. Kitchen Re-cross-examines the Witness

Q MR. KITCHEN: Prior to May 14th, 2021, nothing in the CMOH orders said that a third-party diagnosis was required for those who felt that they fell within the exemption clauses in the CMOH orders as far as masking is concerned; is that correct?

A I believe you. I'd have to go into the CMOH orders and just double-check, but I think you're right from my

experience.

Q Why don't I put one to you.

A Sure.

Q I've got to find one here, that's only fair, and I think May 14th is the right date upon which the CMOH issued a new order specifying who can grant exemptions and the criteria for granting them and all of that. Would you agree with me that it was on or around May 14th that happened?

A Do you have the CMOH order that did that?

Q No, I don't.

A Oh, well, I (INDISCERNIBLE) --

Q But what I have -- but what I do have is CMOH orders prior to May 14th, 2021. Find one here. So, for example, CMOH Order 38-2020; are you familiar with that one?

A Yes, we talked about that one yesterday, I believe.

MR. [redacted] Mr. Kitchen, that's actually an exhibit, if you want to go to that, it's D-8.

MR. KITCHEN: It is? Thank you. It's D-8.

Q MR. KITCHEN: Yes, we talked --

THE CHAIR: 'D' or 'E'?

MR. KITCHEN: 'D', it should be 'D', should be D-8, that sounds familiar. I've got my exhibit book over here. Yeah, it's D-8.

Q MR. KITCHEN: Okay, so this is the first

CMOH order that brings in province-wide mandated masking, and Dr. [redacted] if I could just take you to, and you were here yesterday, I believe --

A M-hm.

Q -- Part 4 says "Masks", if we go down to Section 27, it says: (as read)

> A person must wear a mask at all times.

Do you see that there?

A Yeah, section -- this is on page 6 of 8 of the --

Q That's on page 6, and we're at Section 26, it says: (as read)

> Subject to Section 27, a person must wear a mask.

And then Section 27 says: (as read)

> Section 26 does not apply to a person attending an indoor public place if the person ...

And then there's above, I don't know what, about ten -- eight or ten different exemptions there, one of which is 'C', it says: (as read)

> Is unable to wear a face mask due to a mental or physical concern or limitation.

You see that there, correct?

A Yeah.

Q Now, would you agree with me that in this order and subsequent orders up until around -- on or around May

14th, 2021, there was no requirement in the CMOH that anybody who is unable, pursuant to Section 27(c), "unable to wear a face mask due to a mental or physical concern or limitation" get third-party authorization for that inability?

A Can I ask you a question about this actually? So my read of Section 27, like this is a broader thing to sort of indoor public places, right? I think we should look at the CMOH orders that talk about community health settings as opposed to general --

Q Yes, that's right.

A Yeah, and so 27 is indoor public places, which is not the same.

Q That's right, that's right. And so what I'm asking you about is 38; I'm not asking you about 16.

A Okay.

Q I'm asking you about 38-2020. So you would agree with me in 38-2020 and in 40 -- I think it's 40-2020, 42-2020, 02-2021, et cetera, all the way up until May 14th, 2021, you would agree with me that there was no requirement in the CMOH orders for a person saying they're unable to wear a mask to get any type of third-party medical verification of that inability?

A I trust you. Like, I mean, I -- like I don't -- I would have to read in greater detail all these orders, but let's assume I agree with you. I mean, I -- yeah.

Q Well, you did speak at length yesterday about the CMOH orders, correct?
A I did, yes, but they're quite long, and I don't remember every single clause in the CMOH order.
Q I understand, but you did say you are fairly familiar with them, generally speak --
A Yes.
Q And you're familiar with the mandatory mask portions of the CMOH orders?
A Yes, and I'm familiar, in particular, with actually the problems that were caused by not providing guidance around what constitutes an exemption and how to get one. I'm more familiar (INDISCERNIBLE) --
Q And that's (INDISCERNIBLE) --
(INDISCERNIBLE - OVERLAPPING SPEAKERS)
A -- yeah.
Q Go ahead.
A I just don't remember what date, like, that was changed, but you're right, I'm familiar with the fact that like in -- on the series -- I agree with you, in the series of initial CMOH orders, they talk about the exemption, they didn't provide like criteria for an exemption or like who to get an exemption from. It was broadly assumed that people would have to go to their family doctor to get an exemption. Family doctors were getting lots of questions about exemptions, and they

were confused about what to do, and that caused a bit of chaos.

Q And by the way, it's okay to answer my questions with, I don't know. If you --

A Yeah, okay.

Q -- do, I'll leave you alone, if you give me that answer --

A Yeah, yeah, yeah.

Q -- (INDISCERNIBLE) with you because you know a lot, but if you do --

A Yeah, no, but I don't know, you're right, I don't know, so there you go --

Q Okay, so your answer is to -- my question was is there a requirement in CMOH Order 38-2020 to get the third-party authorization of that inability to wear a mask, is your answer yes, no, or I don't know?

A I don't know, but I'm flipping through this, and I'm going to assume -- like I trust you that I -- I don't know, but I believe that you -- like I trust you that I don't think there is one based -- because you're saying there isn't.

Q Well, no, I'm asking you.

A Well, I don't know, but now I'm just --

Q If your answer is, I don't know, that's okay, but your answer shouldn't be you trust me.

A Oh, really? Okay, well, I don't know then. But now

I'm reading it. Okay, I mean, now I would say, yes, there's no like specific criteria. I just like scrolled through the whole order again.

Q And you would agree with me that it was in the month of May 2021 that that new criteria came in?

A I don't know. I'm trying to look through the actual CMOH order that led to that one, but I don't know, and I'm trying to find the CMOH order specifically.

Q I don't know if it's an exhibit in this case. It wouldn't -- I don't think it would be difficult to make it one; it's a CMOH order.

A Yeah, yeah, it's not. I'm just looking for it in the list of CMOH orders.

Q Well, if you have -- I have a list, but you might have a better one.

A This is from the Alberta Health website.

Q I remember the date, but not the number of the CMOH order.

A They're hard to track, just so many of them. Anyways --

MR. [redacted] Mr. Kitchen, it's Mr. [redacted] I'm not going to take issue with this point, the CMOH orders are the CMOH orders. If I can respectfully suggest, you can go on with your questions, you're not going to hear from me later on there wasn't a CMOH order that spoke at some time, at some date with some

type of criteria if you produce that order, so I -- just in the interest of time, I thought I'd make that comment.

MR. KITCHEN: Well, maybe I'll produce it, because it seems like it's probably going to be good to. No, that was it. That's all I wanted to ask.

A Thank you.

THE CHAIR: Okay, Dr. [redacted] thank you very much. I would ask you to just bear with us; we're going to have a brief recess while the Hearing Tribunal Members caucus to see if we have any questions of you, so --

A Sure.

THE CHAIR: -- just give us a couple minutes here, and we will be back. Get up and have a stretch if you want. We'll be back before long. Thank you.

A Thank you.

(ADJOURNMENT)

Discussion

THE CHAIR: Dr. [redacted] the Hearing Tribunal has met, and we do not have any further questions for you, so I will take this opportunity to thank you very much for your time and your testimony. I'm sure you're a busy man, and I'm sure we all wish you continued success in dealing with this particular problem at this

time. And I will also apologize if I mispronounced your name. I apparently called you Dr. Ho, which is unforgivable. But anyway, thank you, and you're free to go, and hopefully we won't need to call you back.

A Yeah, no, no, thank you so much for having me, and I'm sorry for talking over people, [redacted] and it was a pleasure to meet you all, and sorry for being long-winded and all that jazz, but have a good day.

THE CHAIR: Thank you, take care.

A Bye.

THE CHAIR: Bye.

(WITNESS STANDS DOWN)

THE CHAIR: So it's 12:15. Mr. [redacted] is your next witness available for 1:00, or do we know that?

MR. [redacted] He is. I can certainly make him available for 1, and that would be Dr. [redacted]

THE CHAIR: Yes, I think that's the next step; is that correct? So why --

MR. [redacted] Yes.

THE CHAIR: -- don't we meet -- did you have any thoughts, Mr. Kitchen?

MR. KITCHEN: Well, I prefer an hour for lunch, but I think most people prefer to have a quick lunch and get out of here sooner, so I'm fine with that.

THE CHAIR: If we want to take an hour, we can take an hour, that's ...

MR. [redacted] I have no problem, neither does my client with taking an hour break. We had a pretty intense morning, so we're in your hands, Mr. Chair.

THE CHAIR: Okay, well, let's reconvene at 1:15 with Dr. [redacted] I think you're right, it was a fairly full morning, and it would be good to get away from the computer screen and the pen and paper for a little while. So thanks everybody, we'll see you at 1:15, and we are now in recess until 1:15 for the record.

PROCEEDINGS ADJOURNED UNTIL 1:15 PM
