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 6

VIA VIDEOCONFERENCE

Edmonton, Alberta

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

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November 20, 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

[redacted] ACAC Legal Counsel

FOR DR. CURTIS WALL

J.S.M. Kitchen Legal Counsel

[redacted] CSR(A) Official Court Reporter

(PROCEEDINGS RECOMMENCED AT 12:46 PM)

THE CHAIR: Mr. Kitchen, the floor is yours.

MR. KITCHEN: All right, Dr. [redacted] first

thing is we're going to have you sworn in by Madam Court Reporter, [redacted] so she's going to do that, and then we'll switch over to me asking you questions.

THE WITNESS: Okay.

[redacted] Sworn, Examined by Mr. Kitchen

MR. KITCHEN: So, Chair, Mr. [redacted] and I have agreed we're going to consent to the qualification for Dr. [redacted] However, I know Mr. [redacted] has a couple comments, so what I'm going to do is I'm going to put the qualification forward, and then Mr. [redacted] can give comments, and if there's anything I need to say in reply, then I'll do that.

So, Mr. Chair, the -- Dr. Wall tenders Dr. [redacted] as an expert in the area of respirology and, in particular, COVID-19 and the efficacy of masking and related measures.

Now, I'll turn it over to Mr. [redacted] who I think wants to just make some comments on that.

MR. [redacted] Mr. Chair -- thank you, Mr. Kitchen -- Mr. Chair, as I've discussed with Mr. Kitchen, I just want to, again, emphasize the Complaints Director's view that you can accept evidence in whatever manner you see fit, but that the Complaints Director's position is with respect to these expert witnesses that the focus of this case is regulatory compliance and not the efficacy of masking, and you

should place appropriate weight on the evidence of this expert. Thank you, Mr. Kitchen.

MR. KITCHEN: Thank you.

THE CHAIR: Okay, thank you both. We're okay to proceed then, Mr. Kitchen?

MR. KITCHEN: Unless you have any objections to the qualification that I've provided for you.

THE CHAIR: I heard comments; I didn't hear any objections, so --

MR. KITCHEN: Okay.

THE CHAIR: -- let's proceed.

Q MR. KITCHEN: Okay, all right. Well, Dr. [redacted] let's start with, do you practice here in Alberta?

A I do.

Q And where?

A My main clinical practice is in Medicine Hat, and then I do mainly consultancy work in Calgary.

Q And what does your clinical practice in Medicine Hat consist of?

A It is an outpatient community respirology practice in my own office, as well as interpreting and managing my own pulmonary function lab there, as well as seeing patients in hospital at the Medicine Hat Regional Hospital for internal medicine, critical care, and respirology.

I should mention I also have a satellite clinic in Brooks, which is a small city near Medicine Hat as well, with an associate pulmonary function lab there as well, and I spend a few days per month there as well.

Q Can you tell us what's a pulmonary lab?

A They -- well, basically we do pulmonary function testing, which is a series of breathing tests. Some people here may have done it, where you sit in a glass booth and you blow through a tube at the instruction of a respiratory therapist to see if you have chronic lung disease such as asthma or COPD or other lung disease, as well as doing things like teaching on how to use inhalers and also other tests such as methacholine challenge test and arterial blood gases.

Q So you're familiar with doing what I'm going to call breathing testing?

A Correct, I think the -- the respiratory therapist does most of the hands-on teaching and testing, but I'm the medical director, so I run it, yes.

Q Okay, thank you. And how much of your practice would you say is at the hospital as opposed to at your clinic?

A I would estimate 20 to 30 percent at the hospital and the rest in my office.

Q And can you give us an idea of the type of things you do at the hospital?

A So I am part of the call schedule for general internal medicine, as well as doing respirology consults as well, so we see everything. Basically, the family doctor or the hospitalist would consult internal medicine for any complicated case of heart, lung, or any body system disease, as well as managing patients in the intensive care unit, and we would see patients in the emergency room at the request of the emergency physician for a consultation and ward consultations as well.

Q So would you, just to give me an idea of this, would you be confined to simply reading charts and talking to doctors, or would you actually go into the room where the patient is?

A Yes, we would always go to examine the patient as well and get a full history, so it would be a full assessment of the patient, reviewing the chart of course as well, but examining and talking to the patients and then formulating our opinions and advice. Occasionally, I do procedures as well and -- or interventions to help the patient or to diagnose disease in patients.

Q Thank you. So would you refer to what you do, what you just described, as direct patient care; would that be a fair assessment?

A That is correct.

Q I just want to ask you a few questions about your impartiality. Dr. [redacted] do you know Dr. Curtis Wall personally?

A No, I've never met him.

Q Do you have any personal interest or personal stake in the outcome of this case?

A I do not.

Q Do you have any financial interest or stake in the outcome of this case?

A No, I do not.

Q Do you understand your duty to provide this Tribunal with your expert knowledge and opinions in an objective manner?

A Yes.

Q Thank you. Dr. [redacted] are there different types of health care settings?

A Yes.

Q Is there a big difference between, let's say, the hospital in Medicine Hat and your clinic?

A Yes, that is correct.

Q Is there a big difference between a hospital setting and a chiropractor's office?

A I would say so.

Q Based on your knowledge and the type of work you do at the hospital, would you say the type of the work you do is quite different than what a chiropractor does in a

chiropractic office?

A Yes, I would think so.

Q In a setting like the hospital in Medicine Hat, are a large number of the people there symptomatic?

A Generally, yes, that is usually one of the requirements of being hospitalized.

Q In a setting like a hospital, do nurses and doctors regularly interact with people that possibly have an infectious illness?

A Yes, potentially.

Q In settings like hospitals, are they designed to receive symptomatic patients potentially ill with infectious illnesses?

A Yes, absolutely.

Q What would you say are some of the big differences between a hospital setting and a setting like a chiropractic office?

A Well, I would think the acuity, patients are -- tend to be quite sick, sick enough certainly to go to the hospital and sometimes be admitted. They're symptomatic. There are lots of interventions that are offered to patients, some of them quite invasive.

And basically, generally, I think the biggest difference would be the degree of acuity of sickness of a patient as it would merit them coming to the hospital and usually being admitted to the hospital.

Q Thank you. Now, I'm going to move into your report. In the second paragraph of your report, you state how ridiculous it would have been to mandate the entire public wear masks during past outbreaks of respiratory infections, such as H1N1 and SARS. Now, the first question I have for you on that is are those infections viral-based or bacterial-based?

A Both of them are viral-based.

Q And you said H1N1 was in 2009 and SARS was in 2003; that's correct, right?

A Yes, I actually, of course, took part in the medical care during those time periods as well.

Q Well, that was my next question, so you were practicing medicine during both of those?

A Well, in 2003, I was in medical school, and then in 2009, I was in my full practice at that time.

Q Okay.

A But in both cases, I had clinical exposures, of course, to them.

Q Right. Besides those, are there any other historical viral outbreaks that you've had experience dealing with?

A Not major ones that I can think of, to my knowledge, directly.

Q Now, forgive my ignorance, I can't help but notice that SARS must have something to do with what's going on

now, because the virus that causes COVID-19 is SARS-CoV-2. Can you just briefly tell me is there -- well, let me ask you this: Is there a relation between SARS in 2003 and COVID-19?

A Correct, yes. They're both made by a similar family type, shall we say, of the virus. SARS just means severe acute respiratory syndrome, so it described usually the type of illness a patient could get being exposed to the Coronavirus. Now, these viruses, of course, are related to each other then, they do share a lot of similar properties, but they are different viruses. I suppose, as an analogy, you could say those species, and then you have different types of dogs.

Q Okay, thank you. Now, you said back then that there was no, quote, controversy about masks. What do you mean by that?

A Well, I just meant that in terms of our approach to public health at that time was radically different. There was no thought of having universal mandatory masking. The most -- even in the hospital setting, we didn't have continuous masking. We had masking for patients at risk in isolated rooms, which we always would have but just I would say of a higher volume, but there was no question of having mandatory masking in the community setting or in any public setting, either indoors or outdoors. It wasn't even contemplated.

Q And in your opinion, was that the correct approach to take back then?
A Yes, I believe so.
Q And do you think back then that not mandating masking was an unsafe thing to do for patients and for health care workers?
A No, I mean -- you're asking is -- because we didn't mandate masks in our universal setting, was that unsafe for the --
Q Yeah --
A -- patients?
Q -- that's what I'm asking.
A Yeah, yeah. So, no, I don't think -- I think we did the right -- I think the public health authorities did the right thing at that time, it just had masking in very limited settings, which was what was always applied in the past anyways -- or in the past in terms of modern medicine.
Q Why do you think it is that there was no attempt to implement or impose mandatory masking back then?
A Well, I don't think anyone can say with certainty. There are multi-factorial reasons. One, I don't think at that time or as I say even now there was any firm evidence that that would work. Applications to general population would be problematic to say the very least, and it would be, at that time, probably considered a

great infringement upon people's ability to do their day-to-day activities. And it was also, I would say -- I believe the health authorities would not have made an impact upon reducing transmission.

Q In your opinion, has anything changed since then to make mandatory universal masking more scientific now than it was back then?

A No, I can't think, from a scientific perspective, why it is more advantageous now than then.

Q And why do you think now, this time, for the first time, we've done this mandatory universal masking in response to a respiratory virus?

A Well, again, I think it's multi-factorial, and I can't say with certainty. I can only think that our situation is different from a social and political aspect, which has led to this in terms of causing mass paranoia and fear and panic. And with, you know, communications and everything being so much more instantaneous now, I think that has led to these reactions.

Q Would you consider what you just said to be sociopolitical reasons?

A Correct.

Q So not scientific reasons?

A Correct.

Q Now, you were there back then; was there less fear back

then?

A I think there was less global fear that led -- that prevented this domino effect, yes, partially because of not -- the lack of social media, the lack of all these things we're doing right now. I mean, obviously, there's the internet, and there was online communications and telecommunications, but not anywhere to the extent that we have now.

Q You discussed in the third paragraph of your report that: (as read)

> Despite decades of mask wearing in the operating theatre, in many studies looking at whether masking prevented infection in that type of health care setting, the evidence does not support the conclusion that masks are effective at preventing transmission in a setting like the operating room.

Now, do you find it surprising that Dr. [redacted] has so confidently claimed that these same masks are now highly effective at preventing the transmission of COVID in health care settings?

A Yes, I would disagree with that assessment.

Q Is there anything fundamentally different about COVID as compared to past respiratory infections that make it likely for masks to work now against COVID even though they did not work in the past against other respiratory

infections?

A No, I don't think so. Many of the studies that myself and he posted cited literature in the past, which is how you build up on scientific knowledge; you base your theories and evidence on previous evidence.

Q In order for masks to work now, would there have to be something fundamentally different about COVID?

A Well, just the virus itself would have to behave in an entirely different manner, I would think, and be an entirely different size. But, no, with regards to what the virus is currently, there would be no substantial difference.

Q Speaking of size, is SARS-CoV-2, the virus, is it larger in size than past viral respiratory infections like SARS or H1N1?

A I don't think so. I don't know the exact size off my memory, but viruses generally are of the order -- a different size compared to bacteria. So I think that -- I think I gave it in my report the size of the SARS virus, it was I think 100 microns, but I could be off by a decimal point or two. I just can't remember that.

Q Well, you have here, it's 0.1 micron.

A Oh, then that's the correct answer.

Q Okay, and then, in brackets, you say about a hundred times smaller than a bacteria.

A That would be correct, yes.
Q Help us understand, us nonmedical people, what is a micron?
A Well, a micron is microscopic so you can't see it unless it's under a microscope, and even smaller than that, not even a regular microscope. So I imagine most of the audience here had to use a regular microscope at some point in their schooling, high school or university. You would have to go up to the next order, which is an electron microscope, to probably see these viroids. So we're talking about a magnification of 100,000 to a million times to even see a dot, for example.
Q Is electron microscopes what they use to be able to see things like RNA and DNA?
A Yeah, I'm not even sure they can see that, but they could see bacteria, and they could see some viruses. They're those kind of microscopes that fill up the entire room basically in the old days. Maybe they're smaller now, but I used to work, when I was doing my training, on an electron microscope, and it filled up the entire room, and, yeah, it required a lot of power. It was like one of those super computers you would think of in the old days.
Q So just to try and get an idea of the size of the SARS-CoV-2 virus, is it similar to a really large

molecule?

A It's very small molecule. Like a virus would be the size of an mRNA or a DNA, for example, so it would be extremely small. Probably one of the smallest forms of life forms possible.

Q So would it be smaller than, for example, a protein?

A Yes, I think it would be generally smaller than a protein.

Q Now, SARS-CoV-2, this tiny little molecule-sized virus, is it only transmitted through like large water droplets, or is it also transmitted through what's called aerosols?

A Well, I think in the early days, they thought it was more droplets, because that would be the typical nature of this infection, but I think there's more and more convincing evidence that aerosolized is possible and also a common route of transmission as well. The exact degree in terms of which one is more I don't think has been sorted out, but I think it is universally recognized now that it can be transmitted in both methods.

Q And can you just explain for us what's the difference between these large droplets and aerosols?

A Well, large droplets are, as the name implies, say you cough or you speak or sing or shout, you can spew droplets. Sometimes you see them, like if they're very

big, and they kind of go to a front trajectory, I would say, in layman's terms, almost similar to a shotgun, for example, it sprays out. So it's a very brief interaction, and whatever it hits, it potentially could attach to that and infect, and then it's gone. So if you were too far away, for example, then it probably wouldn't reach you.

Aerosolized means that it is suspended in air, and it could stay there for minutes to hours, and it would float. So think of it as a floating cloud, for example. And if some living thing got in the way of it, it could potentially could attach to that living organism.

Q And these large droplets, you described how they come out and kind of like a shotgun, how far do they tend to go typically?

A Well, I don't think anyone knows for sure. The regulations say 2 metres in Canada because they figured that that would be roughly the safest distance to stay apart, but that's far from universal. Every country has their own rules.

I think the references for this date all the way back to research from the 1930s, so I don't think anyone knows for sure. It obviously depends upon the intensity of the cough or the sneeze or whatever propellant propelled the droplets. It's entirely

dependent on that. Just like if you shoot something with a rifle or whatever, it depends on how much pressure is applied.

Q So we'll pick a number, let's call it 3 metres; if COVID was only transmitted through large droplets, and we all stayed 3 metres apart all the time, do you think that would actually work to stop the transmission of the virus?

A Theoretically, if that was true, that it only transmitted 3 metres, and the only way of transmission was through large droplets, and every organism or human being could stay more than 3 metres apart for an appropriate length of time, and there's no aerosolization, then theoretically, in a perfect world, that would be possible. But in my opinion, in a practical sense, that would be impossible, so short of isolating everyone, you know, like completely.

Q So is the reason these 2 metre distancing rules don't work is it because of the aerosolization?

A I believe that's a large part of it, not the only part. I believe that 2 metres or any distance that you enforce -- that by mandated is unenforceable in a practical sense, because everyone at some point inadvertently or under circumstances where they allow exceptions are put in very closer. Just, for example, being packed in airplanes, despite being lined up 2

metres apart before boarding the plane.

Q Right. Is there any logical or scientific reason to think that masks are significantly more effective at preventing the transmission of COVID in a health care setting than in the general community?

A I don't think, from a scientific point of view, necessarily, because the masks are the same and the virus are the same theoretically, if you're talking about mask for mask.

The applications of the rules may be more vigorous in the hospital and under certain circumstances may be beneficial, but they would be, in my opinion, impossible to enforce and to make perfect in a community or a general population setting.

Q In your experience, is there any sort of significant difference in efficacy between nonmedical cloth masks or the medical blue procedural masks?

A Well, yes, they're quite different, and I would say the blue ones for certain things are certainly better than the cloth masks.

Q Are the blue procedural masks, are they better at stopping the large droplets than the cloth masks?

A They would be -- I think they would be superior at stopping anything compared to -- relatively compared to the cloth mask. I'm not saying that they're effective against viral transmission, but if you compare, of

course, a disposable medical grade blue mask to, well, a nonstandardized cloth mask, I would have to say they would be superior in every way for stopping things.

Q So the procedural blue masks, they would stop more aerosols?

A Well, they're not aerosols, but they potentially would stop more droplets, yes.

Q Oh, okay. So with aerosols, is there much difference between the two?

A I don't think so, because aerosols would then just, as I say, it's like a cloud, so unless you seal any mask airtight, it's just going to seep around the masks.

Q Is that what you see in your work; do you observe that; do you observe the aerosols coming out of the blue masks?

A Well, you can't observe it if it's invisible; you have to theorize that that's what's happening. They have done studies I think looking in terms of within the lab where you can see it, because they can trace the gases and see that it's clearly going around the masks. One experiment you can do is just if you see people vaping or that sort of thing through a mask, and you can see it going around it, so -- or the other way around.

Q Would you say the idea that these blue surgical masks are effective at preventing the transmission of COVID, would you say that's a scientific theory or a

scientific fact?
A I'd say that's a theory that has been debated and disputed, yes. Not a fact.
Q On the second page of your report, you mention a randomised control trial on the effectiveness of masks regarding COVID that was conducted in Denmark --
A Correct.
Q -- for short, it's called the DANMASK-19 study. Can you just tell me briefly about some of the findings of this study?
A Well, it was a study in a public setting looking at masks and seeing if it would reduce rates of COVID, and the findings were negative, meaning it didn't significantly show a reduction in COVID infection.

The significance of this study -- I mean, every study has problems -- is that it is the only randomised control trial looking specifically at COVID. Every other piece of evidence so far is based on either previous literature pre-COVID or else based on observational data. So the only randomised control study, which is considered -- generally considered the highest form of research, looking specifically at this issue during the COVID pandemic so far is a negative study for showing benefits with wearing a mask.
Q Now, you've said that randomised control trials are, you said, the highest -- of the highest value, is that

what you said?

A Yes. Well, they are the -- they're generally accepted as the most difficult studies to set up. Generally, if you start a medical treatment or something like that, and you want it to be approved, you have to have a randomised control trial -- or more than one usually, but you have to have randomised control trials to prove that it is better than the alternative, which is usually whatever was done before, or a placebo.

This is the study that can -- randomised control studies are those that can show causation. Observational studies can show correlation, but they generally cannot conclude that it causes it, for example.

Q Okay, so to go back to what you're saying, you said generally these randomised control trials are what's required for a new product or intervention, so I guess this mandatory universal masking was imposed without any randomised control trials that demonstrate that it's a good idea?

A Correct. I believe Dr. [redacted] also said the same thing, but then he mentioned because you wouldn't -- the analogy he put up of not testing someone without a parachute.

Q Yeah, what's the likelihood of surviving jumping out of an airplane without a parachute?

A Well, I guess it depends how high the plane is, but I would say, under normal circumstances, zero.

Q Right, okay. And what's the likelihood of surviving COVID if you contract it?

A Well, taking the general population, it would be more than 99 percent.

Q Taking the population of health care workers, would that number go up?

A It has more to do with health, age, and risk factors, so on the whole, in general, no, it would stay the same, over 99 percent survival rate.

Q And forgive me, I know this question is obvious, but what's the difference between 0 and 99?

A I think infinity, if you argue that way, mathematically, but obviously quite extreme opposite ends of each other.

Q It's not really a fair assessment to compare jumping out of a plane with a parachute with COVID, is it?

A I think not. May I just take a 1-minute pause?

MR. KITCHEN: Yeah, you know what, Chair, can we take just a little bit of a break; is that all right? Maybe until 1:30. Mr. [redacted]

A I just need 2 minutes, but whatever you ...

THE CHAIR: That's fine. I was just going to ask, Mr. [redacted] you're okay?

MR. [redacted] Yes, I'm fine, thank you.

THE CHAIR: Okay, we'll reconvene at 1:30.

MR. KITCHEN: Thank you.

(ADJOURNMENT)

THE CHAIR: Okay, Mr. Kitchen, I believe we're all back, so please continue.

MR. KITCHEN: Thank you.

Q MR. KITCHEN: Now, Dr. [redacted] before the break, you were talking a little bit about randomised control trials versus observational evidence. Now, observational evidence does have some value; is that right?

A Correct, lots of studies are observational studies, far more than randomised control trials, I would say.

Q But just to properly contextualize this, observational evidence has some value but less than randomised control trials?

A Correct, generally speaking, the gold standard to try to find causation would be to do a randomised control trial. Observational trials often can lead to randomised control trials if there is enough correlation.

Q Well, I'm going to ask you some questions about your observations, and you mention this in your report, I'm going to ask you first about some international observations. From what you've seen, has the transmission of COVID noticeably decreased in

jurisdictions with mandatory masking, let's say, California as compared to jurisdictions with no mandatory masking like Florida or Texas?

A No, they have not decreased.

Q Now, bear with me, but has the transmission of COVID noticeably increased in jurisdictions like Florida or Texas with no mandate as compared to jurisdictions with a mandate?

A Not necessarily, no. I don't think they have any correlation honestly.

Q Now, Dr. [redacted] has stated that every country that has imposed masking as a mandate has experienced decreased transmission of COVID; do you agree with him?

A Well, no, I think that's patently false because we have higher rates now than ever, so -- in some places.

Q Are you aware of any academic literature that would support his claim?

A None that could support it conclusively.

Q Now, I want to ask you about closer to home, but Alberta and your practice in Medicine Hat, and you state in the third page of your report that you have seen patients who have contracted COVID despite diligently wearing a mask as directed by the mandates. Can you tell me any more about that?

A Well, in general, yes, I think everyone has made a sincere effort to just obey the law, because that's

kind of the nature of our civil society, but almost all the patients that I've seen have been respectful of the laws and the rules, and they have contracted COVID.

Q Do you have any patients that generally don't wear a mask?

A For various reasons, I do, yes.

Q Do you see any difference between the two as far as contracting COVID?

A I don't, no, not in my personal experience.

Q And some of your patients that wear a mask, are they themselves health care workers?

A Some of them directly are my patients, or some are -- just happen to be health care workers that I have known to have contracted COVID, but some are directly under my care.

Q You mean like the health care workers that you work with?

A Correct, yes, I know some of them, they aren't necessarily my patients, but I know they've contracted COVID because they chose to make it public, for example, or it became public, one way or the other.

Q Okay. Now, Dr. [redacted] has said that despite hundreds of thousands of interactions between Alberta health care workers and patients with COVID, he says transmissions have been very, very, very low, likely less than 100. Based on your experiences and observations, is Dr. Hu's

statement likely to be true?

A I think it would be more than 100. I think there may be a degree of less than, say, in the community because of various factors, not just -- not primarily masking that may reduce the incidents to some extent, but I don't see that as being supported by evidence.

Q If we had to put a number on it, how many would you -- how many transmissions of COVID between patient and health care worker do you think has happened in Medicine Hat?

A Well, we're not a big facility, first of all, but I would say, I'm just estimating here, I would say in the hundreds.

Q Hundreds just in Medicine Hat?

A Yeah.

Q (INDISCERNIBLE)

A Over the last two years though, that's --

Q Right, but Dr. [redacted] has said that it's less than 100 for the whole province.

A Well, I don't think that's true.

Q Now, I want to ask you about the general community. From your perspective as a clinical respirologist in Medicine Hat, has mandatory masking noticeably reduced the transmission of COVID in the general community in Medicine Hat?

A No. Medicine Hat, up until the very first mandate,

was -- some people may or may not know -- the last major jurisdiction in Alberta to enforce the mask mandate. They did it very reluctantly in terms of all the other -- compared to the other City councils, and their numbers, up until that date, had faired much better than Calgary or Edmonton, for example, whereby they imposed mask mandates very early on, independent of the Provincial guidelines.

Q So I just want to make sure I understand you then, and you tell me whether or not it's correlation or causation, but you're saying that, with mandatory masking, cases actually seemed to go up after the mandatory masking?

A Well, that would be a correlation. That was what was observed. It can't be disputed because that simply is what was observed. Whether that is due to the mandates or not is debatable, of course.

Q Right. But you haven't seen any correlation of cases going down with mask mandates, have you?

A No firm correlation. I think the virus itself has cyclical natures, just like any other typical virus, so it will peak and ebb throughout the seasons and throughout the year, but due to many, many circumstances, I don't think masking has any impact on that.

Q Is a peak and a wave sort of the same thing?

A Yes, correct.
Q And how many peaks or waves of the virus have we had so far?
A I believe we're in the fourth one they say in Alberta anyways.
Q And for how many of those waves has mandatory masking been in place?
A In terms of the Alberta rules, I believe it was instituted December 8 -- or announced on December 8th, 2020, which is I believe during the second wave.
Q So is there any data to suggest that the third wave and fourth wave were decreased because of masking?
A No, because their waves were much higher than the very first wave when there was no mandatory masking at all, provincially or by city.
Q So the cyclical nature of the virus is going on unabated by universal widespread masking?
A Correct, I think it's independent of that. I don't think it has made any impact on viral transmission.
Q So you wouldn't say there's even any correlation, let alone causation?
A Correct.
MR. [redacted] Just while you gather your thoughts, I just want to express a bit of a concern that some of the questions have some preambles to them and the question at the end; I'm a little concerned

that there's a bit of a leading question pattern here. I wonder if I can just ask you to think about that maybe when you're asking your questions. I'm not going to formally object, but I've just seen a -- I think a little bit of that that causes me a little concern.

MR. KITCHEN: Sure, I'll slow down and ask some more questions so that we're not leading anywhere.

Q MR. KITCHEN: Dr. [redacted] do you think enough evidence has accumulated over the last year-and-a-half to allow us to reasonably know, one way or the other, whether the Public Health restrictions have been effective regarding COVID?

A No, I think it's highly debatable to now.

Q So mindful of my learned friend's comments, it's highly debatable, so you're saying -- I want to make sure I understand -- is there enough evidence to say that the restrictions definitely don't work?

A No, I don't think anyone can say that either with certainty. I say that is debatable that you can say that these restrictions have had a meaningful impact. If you go by case numbers itself, in terms of the volume of COVID cases, in some jurisdictions, we have seen the highest rates ever despite vaccinations, restrictions, et cetera. So if you go by results, you could argue that they've had no impact because you have more cases than ever.

Q And just to be clear, there is not enough evidence to definitely say they do work?
A Correct, yes, there's -- I would agree with that statement completely. There is no definite evidence that they do work as they were intended, and that the point is really debatable at this point.
Q Based on a preponderance of evidence, if you had to choose between the restrictions are generally working or the restrictions are generally not working, which would you say is the case?
A Well, I said previously, given the -- many jurisdictions having the highest cases ever since the pandemic began, over almost two years now, I would say that they generally are not working.
Q You said the word "debatable"; is there a debate currently ongoing about the effectiveness of these measures?
A I think, to some extent, there is a debate. I believe currently the debate has been more leaning to one side than the other in terms of the ability to debate, but anything in the scientific realm should be debatable and argued reasonably.
Q Do you think the Alberta Public Health authorities are open to debate?
A Based on what I can see so far of their actions, no, I do not think they are open to debate.

Q Do you find that strange?
A I do. Normally, the scientific community should be open to debate and arguments and to see both sides of the situation before making profound measures that impact basically the entire population.
Q Do you think the decisions that Alberta Health Services or the CMOH are making, do you think they're entirely informed by science?
A I do not think they have considered all the evidence in science that is available or looked at both sides of the situation, so the short answer to that being, no, I don't.
Q Do you think there's anything nonscientific that's influencing these decisions?
A Well, I think there's always an element of a bit of fear and the tendency, it appears, from this organization to err on one side rather than the other. I think there's also, to some extent, a kind of a domino effect from what is happening around the world, so that every jurisdiction has to feel like they're following everyone else's, and it's reached a point where it's very hard to go against the grain, as it were. But there have been some countries that have successfully done that, and I think I put a point in my report to that effect as well.
Q And would you say that impact, is that a scientific

impact?

A Sorry, can you clarify that?

Q You said there's the domino effect of feeling like you have to follow what other jurisdictions are doing; is that effect a scientific effect?

A No, I think that's mainly a social political effect.

Q Dr. [redacted] has repeatedly stated that the evidence supporting the effectiveness of masks is, quote, overwhelming. Do you think that's a scientifically accurate statement?

A Well, I disagree with that statement is I think the best I can say. I think that there is not overwhelming evidence. I think it is still highly debatable at this point, and there have been studies in the past for and against his position.

Q Dr. [redacted] has also said that there's heaps and mounds of evidence supporting the effectiveness of masks.

A I would not say --

Q Do you -- I was just going to ask you, do think the statement is an exaggeration?

A I disagree with the statement.

Q Would you say he's -- you merely disagree with him, or would you say he's exaggerating?

A Well, I don't think what he said is true. I don't think there are heaps and mounds. Although heaps and mounds is a very subjective description, so maybe, in

his mind, heaps and mounds are -- is different from what I think of heaps and mounds.

Q Dr. [redacted] said masks are an effective tool for preventing the spread of respiratory viruses writ large. In your opinion, is this a medically sound statement?

A Again, I would disagree with that, based on the studies in the past, looking specifically at viral transmission, masks have not been proven to be beneficial in that sense. And from a structural point of view, I don't see how they could be, given the sizes of viruses versus the pores of masks.

Q And forgive me if this seems redundant, but then Dr. [redacted] goes on to say in the last page of his report that: (as read)

> The efficacy of masking on disease transmission is beyond doubt.

Do you agree with that statement?

A I do not.

Q Let me ask you a different question: Do you think that statement is even reasonable?

A Well, personally, I don't think it's reasonable. As I mentioned before, science is open to debate, and so this is I think still a very debatable point. And there has been some research looking into this long before COVID, and the results have been mixed at best. So to say that this is definitely one way or the other

is not right.

Q Do you think there are some things about science or medicine that really aren't debatable because we know what the answer is?

A Yes, but very few things.

Q Okay. So does it surprise you then that Dr. [redacted] is so confident that he's absolutely right about the efficacy of masks?

A Well, really I can't speak for Dr. [redacted] or his intention, I presume they're honourable, but I think, as I say, in any scientific debate, especially on a question as this, that potentially it could affect civil society to such a broad extent, I think it should be open to debate, and I don't think that there is firm evidence saying conclusively that masking worked or that they justify the measures that have been in place.

Q Now, of course, to Dr. Hu's credit, he specifically said masks aren't perfect, nothing's perfect, masks aren't perfect.

A Correct.

Q Are you -- would you say that masks don't work at all ever?

A It -- no, I think that it depends on what the purpose of the mask is and the conditions that they're used. In some very limited settings, they might be useful to some extent. Even in the days, as I mentioned, the

previous pandemics that I was experiencing, we didn't have these universal rules in the community of populations, but we certainly had limited settings in isolated rooms, in negative pressure rooms, and different types of masks and different procedures for wearing the masks.

So -- but the original purpose of wearing masks, supporting my OR research -- or in the studies that looked at it in the operating room, it's not for viral transmission protection but really to prevent transmission of very large things like blood and saliva and things like that.

Q So some masks could work sometimes for some things?

A Correct, yes.

Q But when it comes to COVID, from your observations, are the masks working to stop the transmission of COVID?

A No, and if we go completely by result-based assessment, then I think that definitely you can say, no, it has not been successful in that way.

Q Now, I want to go back to this issue of causation and correlation, because I think this is probably pretty important.

Dr. [redacted] stated in his testimony that a very, very, very large number of health care workers in Italy contracted and died from COVID early on. He concluded that part of the reason that happened was because the

Italian health care workers ran out of masks. Now, in your opinion, is there a causal link between masking and what happened to the Italian health care workers, or is that only correlation?

A Well, that would be, at best, correlation. I think even if you clarified that with Dr. [redacted] he would agree with that if he's a clinician and a researcher because that's -- that's not a randomised control study, and that's not -- there are other factors at play, so you can always say, at best, that there's a -- there may be a correlation.

Q So there's no scientific basis to attribute causation to that?

A Correct.

Q Dr. [redacted] in his testimony described the lockdown restrictions imposed last December -- which we've already talked about, that's the first time universal masking was in place all across the province -- he stated that cases went up after that November, December lockdown, but then eventually later, the cases went down. He then concluded that the lockdown caused the cases to eventually go down, and that the initial rise in cases was only correlated with the lockdown. Do you agree with Dr. Hu's analysis?

A No, I don't think you can have one or the other. You have to say, at best, there may be a correlation. As I

mentioned too before, I believe that the virus is cyclical.

And if -- and I remember that first lockdown quite clearly in my mind, because I kept track of it, and for personal reasons, I just remember it, but the Government announced -- well, Medicine Hat was the last city that announced a mandatory mask, of all the major cities in Alberta, on December the 4th, and then four days later, the Premier announced a lockdown on -- a masking and general restrictions on December the 8th, but to be effective that weekend, so it would be a few days to give people some time to prepare for that.

Even though he instituted that, at that time, the cases for that time period had reached the highest it had seen at that time. It continued to reach -- go up slightly for the first few days, but then it peaked, and then after that, it steadily started to go down. I mean, you can look into the statistics for this; you yourself can easily prove that.

Now, obviously even by their own words, they said that it would take two -- at least two weeks or more before any of these measures would take -- would have any benefit. So the fact that it peaked already and started to come down two or three days after they announced the general lockdown shows that those restrictions had nothing to do with the cases going

down, but I believe just due to the cyclical nature and the natural path -- pathogenicity of the virus, so -- and then we've seen that since with subsequent waves from what I can see.

Q So did Dr. [redacted] make a mistake when --

A Dr. Hu's entitled to his opinion. I don't know, I can't speak to what he says. I can only tell you what I believe, and I disagree with his assessment.

Q Okay. He was very clear on this, because I asked him his position.

Is conflating causation and correlation, is that a pretty big mistake?

A I believe so --

MR. [redacted] I'm sorry, I'm going to have to comment again. I think you can ask your client where he disagrees and why he disagrees, but that kind of a question sort of presumes a response.

Q MR. KITCHEN: Dr. [redacted] when it comes to medicine and science, is it really important to not conflate correlation and causation?

A Correct, the two do not always end up agreeing. Correlation may be helpful to stimulate further research and hypotheses, but the causation may turn out to be something completely different.

Q Do you see any causal link, causal link between the lockdown measures like mandatory masking and the COVID

numbers, be it cases, ICUs, or deaths; do you see any causation between these lockdown measures like masking and those COVID number?

A No, I don't see any conclusive evidence of that, and I don't think anyone can say conclusively that the lockdowns or these restrictions caused lower cases.

Q But that's what -- isn't that what Public Health says?

A Well, I can't speak for what Public Health says. I can observe what I see and what the numbers are like in the world and in our province throughout all this.

Q But you said, you know, I can't see how anyone could say this, and yet isn't just about everybody saying it?

A I can only speak to myself and my own conscience and the evidence that is presented to me that is available to everyone else. I can't speak for anyone else. I would say it's universal, but I agree that there are -- I think the majority of people do believe, at least at this point, that these restrictions have had some impact, but, again, I believe that is probably due a lot to social political reasons as well.

Q Maybe you can't answer this and you tell me if you can't, but why do you think it is that we are making Public Health decisions based on social and political concerns and not scientific concerns?

A Well, I think like everything else in civilization, we're human beings, so we don't just deal with facts,

we deal with emotions too, and we deal with -- right now we're dealing with fear and panic and paranoia, et cetera, and I believe that each and every government is trying to respond in, they think, the best way to deal with that.

Q To deal with the fear?

A Correct, and to maintain, perhaps in their eyes, a civil order and control perhaps, but that is my opinion.

Q Well, and that's what you're here to give us.

Do you think the term "anti-mask" is pejorative?

A Correct, I do.

Q Do you think it is fair and accurate to label someone as an anti-masker if they are opposed to mandatory masking but not voluntary masking?

A I believe that is pejorative in that case, yes.

Q Do you think people should be free to mask if they want to?

A Well, yes, in general, that I think was always an option in the past in -- many jurisdictions did that; for example, Japan, a lot of people wear masks for other reasons, but, yes, I believe it should be a free choice.

Q What does the phrase "informed consent" mean to you?

A Well, it generally means that you tell the patient what can happen -- the procedure that you plan to do, the

risks and benefits of it, the evidence for or against it, and then they make a decision after being informed of all relative and important features about the decision; they make a decision whether to go for it or against it, and without any coercion or duress.

Q Do you think informed consent is obtained if only the benefits are discussed but not the risks?

A Correct -- no, correct, I -- yes, you're -- I do not think informed consent is obtained in that case. You have to give the risks and benefits and all the important salient features about whatever that decision is before informed consent is obtained.

Q When it comes to masks, would you say that there are both potential benefits and potential risks?

A Yes, I would.

Q So do you think mandatory masking is consistent with informed consent?

A No, because there is no consent being sought. It is just a rule being imposed. So by definition, that is the complete opposite of informed consent.

Q What does the phrase, "First, do no harm" mean to you?

A That's one of the tenets of any physician, primum non nocere in Latin, that we are taught, first, do no harm, and the principle is whatever we suggest, we always have to keep in mind that whatever we do, not cause harm to the patient.

Q Do you think mandatory masking is consistent with, first, do no harm?
A I do not.
MR. KITCHEN: Mr. [redacted] just to give you an idea. I'm probably only about 20 minutes from being done; 30 minutes at the very most. Yeah, I'm going to say probably 20 minutes or less.
Q MR. KITCHEN: All right, Dr. [redacted] with that, I'm going to move into asking you some questions about the harms of masking as you've discussed them in your report.
A Okay.
Q You state near the bottom of the second page of your report that wearing a mask is, quote, not harmless. You go on to discuss how humans are designed to breathe. Now, can you tell me, as a respirologist, how are humans designed to breathe?
A Well, I can certainly tell you as a respirologist, but I think anyone can tell, without respirology training, that we're meant to breathe as we are, unobstructed, freely through our mouth and nose, ideally good air of course, clean air.
Q So even if we're breathing unobstructed, if we're breathing bad air, what happens?
A Well, then we have to -- then, as I mention in the report, in certain circumstances, we have to, of

course -- we can use protective measures if the benefits outweigh the drawbacks of that.

So if you're -- obviously, if you were exposed to mustard gas or something like that in World War I, then you would have to wear a special gas mask to prevent that. It would obstruct your breathing, and no one, I think, would argue with that, but, for that temporary purpose, that would be beneficial.

Q So given the choice between access to -- or decreased access to oxygen and breathing mustard gas, which is the better choice?

A Well, breathing the lower oxygen as long as it can still sustain life for the shortest period of time possible.

Q And forgive me, but is that because mustard gas is so dangerous?

A Correct, I believe it is deadly in many cases.

Q If you're exposed to mustard gas, is your rate of survivability less than 99 percent?

A I don't have the exact numbers, but I certainly wouldn't want to be exposed to mustard gas under any circumstances. Even the survivors have damage in terms of pneumonitis and other chronic health problems too.

Q So we would never do a randomised control trial with mustard gas?

A Not during these days. Maybe during World War I, they

might have, but, no, we wouldn't.

Q It's kind of like the parachute example?

A Correct.

Q Now, the types of masks that are mandated for COVID, how do those types of masks interfere with the normal breathing process as you've described it?

A Well, it could be something from very mild to very significant, depending on the type of mask, how it is worn, how much it has changed, et cetera, and also their condition of the patient -- or the person who wears the mask. If they have chronic lung disease, they may be impacted more severely than others.

I can tell you just from personal -- I mentioned, I run a pulmonary function lab, and just as kind of a personal inquiry, I had some healthy testing whereby just wearing a mask versus not wearing a mask and doing a pulmonary function test, and these are completely healthy people. The lung functioning drops about 15 to 20 percent. So it does play an impact, in my opinion.

Obviously, that's just my own anecdotal kind of evidence, but I believe that any reasonable person would agree that wearing anything that covers the mouth and nose would, at least to some degree, obstruct your airways and breathing. Whether it's clinically significant or not is debatable though.

Q So this reduction in lung function, that's across the

board, the same for everybody?
A Well, it's rough -- because everyone's going to be slightly different, but, yeah, in a healthy individual, it seems to me, from what I've seen, roughly 15 to 20 percent.
Q But help me understand, is that really significant or not really?
A It won't be noticeable if you're sitting still, doing light stuff, but if you're exerting yourself or exercising, you could definitely notice a difference, and if you have some sort of lung health problem -- other health problems, it would probably be much more noticeable.
Q So do you find it surprising that some people seem to tolerate wearing these masks more than others?
A No because everyone has different lungs, shall we say, and also everyone in the public wears masks differently and the types of masks, so everyone will have a different response.
Q You mentioned in your report self-contamination due to moisture retention. Can you just describe, what is this self-contamination due to moisture retention?
A Well, it's just simply when you breathe, of course, you're breathing moist air, there's water in it, et cetera, water vapour, and anything that it hits will condense. I mean, you see that so when you wear

scarves or anything to cover your face.

So same thing with masks; if you wear a mask long enough, you're going to collect moisture there, and then that can, in turn, collect secretions, your own secretions, or things that are exposed at -- or contaminants around you, and then in the end, you're going to be breathing that in again. So that's what I mean by moisture contamination.

In fact, the appropriate way to wear a mask before all this began, in a health care setting is that we had to change our masks frequently. So, generally, I would change it, if I had to -- first of all, I wouldn't wear it any longer than I had to, but if you had to wear it for an extended period of time, you should probably change it every hour, and we're talking about disposable, you know, surgical-type masks.

But that's simply not happening in the public. You're having people wearing cloth masks or the same surgical mask over and over again and touching them, et cetera. So even the application of wearing them safely is not -- is not done. I would say in 99.9 percent of the population in a community setting.

Q And what would some of these contaminants be?

A Well, it would be whatever is in your saliva basically. So it could be bacteria, it could be viruses, and then whatever your breathe around you, could be particulate

matter, could be anything from just smoke, dust, vapours, allergens, could be viruses. I mean, if you were exposed to someone coughing with COVID or any other virus, it could go onto there, then you could have breathing it in theoretically.

Q Hold on. So, theoretically, wearing a mask could actually increase your chance of contracting COVID?

A Well, could increase your chance of getting any infection, if you don't wear -- if you don't change the masks and don't keep them clean, correct, yes.

Q Okay. In your practice or in the literature, either one, what are some of the harms that you have observed from continuous or prolonged mask wearing?

A Well, there's -- of course, there's psychological damage that could be done, both to patients, particularly in younger ones, kids for example. There are things like severe allergic reactions.

I had one patient, a health care worker in the hospital who couldn't wear a mask, because every time the patient wore the mask, there would be a very severe rash, and this is well-documented, she -- the patient had pictures to prove it, and despite wearing several types of masks of different material, they all produced the same results.

And then, of course, there's people -- my practice, of course, consists of mostly people who are

short of breath, so if they're extremely short of breath, of their oxygen, et cetera, they are severely impacted by wearing a mask.

Q Can you describe for me generally what lung disease is?

A Well, lung disease just means any disease that affects the lung, but the most common ones that I see would be chronic obstructive pulmonary disease, also known as COPD or emphysema, and asthma --

Q Okay.

A -- those would probably be the two commonest chronic lung disease seen in the community.

Q Are those people more negatively impacted by wearing a mask than people who don't have those conditions?

A Many of them are because their lung functions are already impaired to start off with.

Q So you have patients with asthma?

A I have many patients with asthma.

Q In your opinion, is asthma, you know, a valid medical basis for having an exemption from wearing a mask?

A In some circumstances, depending on the severity of the asthma or any lung disease, something that's very mild and if the patient can tolerate wearing a mask, then it may not be a problem that way, but other people are severely impacted.

I believe Dr. [redacted] mentioned the Canadian Thoracic Society saying that masks weren't harmful or were safe,

but if you look at the actual guidelines, and I have them in front of me, it's a very short statement by the way, and they reference old literature, for the most part, but even within their context, they do leave room for patients to remove masks if it causes them shortness of breath. So they recognized -- and in their own statement, they recognize that -- they say that wearing a mask will obstruct breathing to some extent, so ...

Q Well, Dr. [redacted] didn't give us the whole quote, but what he said twice was that he said that the Thoracic Society said that prolonged mask wearing does not exasperate any underlying lung condition. Is that what the Thoracic Society has said?

A Well, I have the argument here. This is quoting what they say exactly. What they say is quite -- a little bit different, they say: (as read)

> There is no evidence that wearing a mask/facial covering will lead to prolonged symptoms or a flare-up of an underlying lung condition.

They say there's no evidence; that's as far as they're willing to go. I personally believe that statement is still too strong, but that doesn't mean that there isn't any harm; it just says that from what they can see, there's no evidence.

However, in that same paragraph that I quote that statement, at the very beginning, they say: (as read)

> Breathing through a mask takes more effort, and this may vary depending on whether one is using a commercially produced mask, a mask made at home, or a simple cloth covering. For those with underlying lung diseases, the effort required may cause a feeling of shortness of breath while wearing the mask. In such situations, we recommend that individuals remove the face mask, and if symptoms do not immediately settle, they should follow the existing strategy for relief of acute symptoms.

MR. KITCHEN: Mr. [redacted] how do you feel about me providing you a copy of this statement and then asking to have it entered as an exhibit?

MR. [redacted] I don't think I have a problem with it, Mr. Kitchen, but I think, to the extent your client is expressing an opinion different than Dr. [redacted] the Tribunal is aware of that, and they're going to have to make their determination. So I don't think a great deal turns on it. Mr. [redacted] might have some different views on that, but he's shaking his head no. Frankly, if it will move us ahead, and you think you don't have to go through the document in

detail, I'm happy to have it sent over, but I think this is just another point the Tribunal is going to have to dissect and decide on, Mr. Kitchen.

MR. KITCHEN: Okay, so here's what I'll do, when we're done, I'm going to get a copy of this, it should be easy, because it's the Thoracic Society of Canada, I'll get a copy of it. I'll submit it to you, and then you can let me know if you consent on it being entered as an exhibit, and then we can provide it to the Tribunal.

MR. [redacted] I think, Mr. Kitchen, I'd be very reluctant to object to it being entered as an exhibit. Your client has read from it. Again, I think it's just something the Tribunal's going to have to digest, so I think you can send it to --

Mr. Nelson's [sic] nodding his head -- you can send it to Ms. [redacted] at some point, and it can be distributed to the Tribunal.

MR. KITCHEN: Thank you.

THE CHAIR: And to our reporter too.

MR. KITCHEN: I don't know where we're at for letters and numbers, so we'll figure that out after the fact.

EXHIBIT H-8 - Excerpt from the Canadian Thoracic Society guidelines (Document not Provided to be Marked)

Q MR. KITCHEN: So, Dr. [redacted] -- Dr. [redacted] I apologize -- I've got Dr. [redacted] in front of me here -- the Thoracic Society statement said there's no evidence for masking impacting underlying lung conditions. Do you disagree with that?

A Well, yes, I think there has been some evidence that it does potentially show potential harm, but my point was their statement was much more limited than what Dr. [redacted] was saying. They're saying, in their statement, they have found no evidence. That doesn't mean it's not there; it just means that they look -- and if you look at the reference, which I can certainly send you or you can find yourself, it's a very short statement. It's only I think two or three pages, and it has very few references. So it's not like they did an expansive literature review to look at this, nor, would I expect there'd be a lot of research into this. I think pre-COVID, it just made sense that wearing a mask when you have severe lung disease, unless you actually have to, was not something that would be done.

Q All right, so in your opinion, as a respirologist, are there medically valid reasons for exemptions from being required to wear a mask?

A Absolutely.

MR. KITCHEN: I think I'm just about there. Just give me a second.

Q MR. KITCHEN: Dr. [redacted] I'm just going to ask you one more question -- and I'll give my learned friend a chance to object, because he might -- there's been a particular word used by both you and Dr. [redacted] and others, but, particularly, you and Dr. [redacted] that I have found very interesting, and that word is the word "politicised". Dr. [redacted] has said that the masking issue is politicised, and you have said the same thing, but I'm not sure that we've really heard an explanation of what the heck that means. When you say that the mask issue is politicised, what do you mean by that?

A I mean, I think that the decisions on masking have not been made based on the medical literature, medical debate, or medical judgments mainly, but has been based on what is happening with human interactions in society and with the governments currently, and is made based on a lot of emotional and nonmedical reasons.

Q Do you find that surprising?

A I actually don't. I think that in times when people are calling for crisis or certainly the pandemic has probably been the largest crisis we've ever dealt with in a long time and certainly in terms of magnitude extending around the globe, there's very little else to compare within recent history, that when something like that happens, and we are dealing with raw emotions, especially when we're dealing with fear, paranoia, and

power, so we are dealing with, you know, the very features of politics.

Q You said "power", so do you think power is part of what's influencing the decisions on mandatory masking?

A I believe --

MR. [redacted] Mr. Kitchen, I think I'll object to that. I think your last question was debatable, I didn't object to it, but we're now -- "power", you tell me what that means, I think that one's just a little too far. I would -- politicisation, correct, Dr. [redacted] weighed in on that, but I think it might just be a little too far.

Q MR. KITCHEN: Dr. [redacted] you're aware that every health professional regulatory body has imposed mandatory masking on their members; is that your understanding?

A Well, more or less indirectly. I believe the Government, that has done that, and then the regulatory bodies have approved of it or have been either explicitly or tacitly agreeing to it; they're certainly not opposed to it.

Q Right, and my learned friend can stop me here, but that's actually I think a fair description of what happened with the College. We had a lot of evidence from -- the College said, Well, when we constituted the mask mandate, we had to because Dr. Deena Hinshaw said

that in order for our members to practice, we had to have a mask mandate. So I think what you've just said is not controversial.

Last question I'll ask you on this, you said you didn't find it surprising; do you find it strange?

A About the masking pandemic worldwide or restrictions in general?

Q Do you find it strange that politics is influencing decisions on whether people wear masks or not?

A I disagree with those things profoundly, but I don't find it strange that politics has done that, because it has endeavoured to do that sort of thing throughout history. I myself have fled from a communist country, so I know what these things are.

MR. KITCHEN: Those are all my questions.

THE CHAIR: Okay, Mr. [redacted] did you want a moment before you start? It's 2:30, and we've been going for just about two hours, why don't we take a 10-minute break.

MR. [redacted] Mr. Chair, I have a question for Mr. Kitchen before I begin my cross-examination, and I think it's something that Dr. [redacted] shouldn't be present to hear, there's no magic in it, but it's about my cross-examination. I'd like to ask him a question on the record. Can we just take 5 minutes, if Ms. [redacted] can put Dr. [redacted] into a break-out room and

then break for -- I think it's good idea to have a break. I won't be terribly long, but I think if we can just deal with that one matter now, I'd like to do that.

THE CHAIR: Okay, so we will move Dr. [redacted] into a break-out room, and then you can put your question on the record.

And so, Dr. [redacted] we're going to transfer you to a break-out room so you won't be participating in the hearing, and we have a matter that we need to deal with without your presence, and then we're going to take a short break, then you can come back and have Mr. [redacted] conduct his cross-examination.

A Okay, that's fine, thank you.

THE CHAIR: Okay, thank you.

Discussion

MR. [redacted] So, Mr. Chair and Mr. Kitchen, you know, pre-virtual hearings, when I was going to do a cross-examination of a witness, and I wanted them to look at a document, I'd walk across to my friend and I'd give him the document, and I'd say, Do you want to take a look at this. The document that I have that I can potentially give to Mr. Kitchen and to you, but I don't know if it's necessary, and that's why I raise it, is the CPSA's COVID re-opening practice document, and it essentially says -- and I'm happy to send it as

a courtesy, in any event, to Mr. Kitchen -- that masks are required for physicians, and I'm going to ask Dr. [redacted] Are you aware of masking requirements for your profession last year, are you aware of the AHS mandate. I don't have to put that document in, unless my friend's going to object and say, Oh, no, no, I take issue with whether there were masking requirements for the CPSA, that kind of thing.

So I don't want to sandbag my friend, I don't want to sandbag the witness, but I don't know if I need to send this document or not.

MR. KITCHEN: I have no issue. I mean, I don't have it. I mean, Dr. [redacted] and I essentially established that fact, so --

MR. [redacted] That's why I think it may not be necessary. Some of the tail end of your questions, Mr. Kitchen, were you're aware of imposing these. So I think my question will be to Dr. [redacted] You're aware of your profession having one of these and requirements.

So if we can go on that basis, then I don't think I need to provide this document to Mr. Kitchen, but I didn't want to surprise him, of course.

MR. KITCHEN: No, I appreciate that.

THE CHAIR: Okay, just before we break, Mr. [redacted] how long do you anticipate your cross will be?

MR. [redacted] I'm hoping 20 minutes.

THE CHAIR: Okay, then let's take a shorter rather than a longer break; let's just break for 10 minutes and come back at, I don't know, 20 to 3, and then maybe we can wrap up around 3. So a 10-minute break for now, and we'll see you in 10.

(ADJOURNMENT)

THE CHAIR: Okay, it's Mr. [redacted]'s turn for cross-examination of Dr. [redacted] and just I'll mention it now so I don't forget, we would like to caucus with the Hearing Tribunal after Dr. [redacted] has finished the cross-examination to see whether or not the Panel has any questions of him.

Mr. [redacted]

Mr. [redacted] Cross-examines the Witness

Q MR. [redacted] Good afternoon, Dr. [redacted]

A Good afternoon, Mr. [redacted]

Q I'm going to take you through three or four questions relating to the things you just talked about with my friend, Mr. Kitchen.

I think you made a comment -- I think there was a question, rather, from Mr. Kitchen, when it comes to mandatory masks, are there potential risks and potential benefits, and I think your answer was one word "yes". Would you agree with me that Alberta Health Services and the Chief Medical Officer of Health

and Health Canada, and the College of Chiropractors in terms of its Pandemic Directive, which you've seen, they're erring on the side of potential benefits?

A Yes, I agree that that is their intent.

Q We talked a little bit -- or you and Mr. Kitchen, rather, talked a little bit about this concept of informed consent. Would you agree with me that when we're talking about that, it's typically, as you mentioned, in the context of informed consent between a caregiver and a patient?

A That's classically the case that I'm experienced with anyways, yes.

Q And it really isn't a concept that applies to let's say, for example, you and the CPSA; they don't come to you and get your consent for a fee or something like that, do they?

A Not in that manner, no, correct.

Q Okay. Towards the tail end of Mr. Kitchen's questions with you, he asked you is asthma a valid exemption to masking, and I think you answered to him that it may or may not be depending on the person and the, I guess, the nature of the asthma or maybe the severity of the asthma --

A Correct.

Q -- would you agree with me -- oh, I'm sorry.

A Sorry, I was just agreeing with you; I said "correct",

yes.

Q Would you agree with me that it's appropriate to get a physician to make a proper assessment and diagnosis of whether asthma is a valid exemption for a particular patient?

A I think, most of the time, that would be a reasonable thing depending on access, of course.

Q You talked about with my friend, I think the question was, as a respirologist, are there medically valid exemptions from wearing a mask, and I think your answer was, yes, absolutely. This will be a little redundant, but, again, is the best course of action to get a physician to properly assess any medical exemption?

A Generally speaking, that would be the usual route, yes.

Q Okay. I'm going to ask you some general questions. Mr. Kitchen went through a great deal of your background in your practice, but I just want to ask you, you haven't had any experience working with the Chief Medical Officer of Health on COVID-19 measures?

A No, I have not.

Q Okay. Would it be fair to say that your views in your expert report are contrary to what AHS or the Chief Medical Officer of Health or the Public Health Agency of Canada say about requirements for masking?

A Yes, they are in opposition.

Q One of the reasons we're at this hearing is the Alberta

College and Association of Chiropractors Pandemic Directive, which I assume you've had a chance to review, and you stop me if I'm wrong, but I think it's fair to say that, under that document when you get into about page 9 or 10, that there's a requirement to wear surgical or procedure masks. You're a member of the CPSA; are you aware that they also have similar masking requirements for you?

A I actually haven't read yours because I never received it, but, yes, if you are -- I'll take your word for it, but, yes, the CPSA also follows the law, I mean that is a Provincial law, so I -- whether or not the College has expressly stated it, I think they're obliged to follow the law, so yes.

Q Yeah, the -- now, there is no great surprise here, but during the break, the question I was asking of Mr. Kitchen was, you know, I've got a CPSA document, and it talks about mandatory masking, and you've just confirmed that I didn't think that was an issue or that I needed to present it to you, so I'm glad we're on the same page.

This is a fairly direct question, I'm assuming you comply with the CPSA's masking requirements?

A Yes, I have, and I've done whatever I legally can to mitigate it, but, yes, I've been in full compliance with the rules.

Q And it's sort of the flip-side of the same coin here, but Alberta Health Services has some mandatory masking requirements as well, and I'm assuming, when you're in the Medicine Hat Regional Hospital, you comply with those as well?
A I do certainly, yes. I obey the law. Doesn't mean I have to agree with them though.
Q Yeah, fair enough, fair enough. As part of you obeying the law -- I'm assuming you would say yes -- I'm wearing a mask when I have to, and I'm observing social distancing when I have to in my practice?
A Correct.
Q This applies to Dr. Wall, but I'll phrase it in the context of you as a physician: There were requirements for you to become a regulated member of the CPSA; is that correct?
A Correct.
Q That would have been your initial registration, your education, et cetera, correct?
A That's correct.
Q And would you also agree that there are ongoing requirements that the CPSA has for you to maintain your licence, like con ed or record retention or paying those fees every year?
A Correct.
Q Would you agree with me that it's the responsibility of

a professional to follow those requirements of their regulatory college?

A For the most part, as long as they do it within their just limits, correct.

Q So is it your view that a member of a profession can opt out of the requirements of their college or regulatory body at their choosing?

A Again, generally, no, but it depends on what the -- as long as they act within their just limits. I mean, the College couldn't say you had to get a golf membership to be -- remain a member, then I think you could justly fight that or even oppose that. I'm just giving a hyperbole example. But within your just limits, yes, there are -- I bring that up because the CPSA had a recent issue, which I think they acted -- where they tried to act beyond their just limits, and they did back down, so I just want to point that out.

Q Sure, well, you know, I'm not trying to be cagey here. The mandatory masking requirement that the CPSA has, even if you disagree with it, that's part of their just limits, isn't it?

A Well, that's I say -- that -- the Province imposed that; they didn't impose that; they just went along with it. But, yes, so far, you know, I should stay in practice, I have to agree to it -- or I'm following the law.

Q And you followed your college?
A Yes.
Q Dr. Wall's testimony was, in part, that he had a medical exemption that allowed him to not comply with CMOH orders, and his medical exemption, and Mr. Kitchen can correct me, but I believe it was two-fold, it was anxiety and claustrophobia. Consistent with the discussion I had with you a few minutes ago, I'm assuming that you would expect someone would approach a physician to have a clinical diagnosis of anxiety or claustrophobia when they're seeking a medical exemption for masking?
A That would be the usual case. I mean, there is certainly individual circumstances, but that is generally the case.
Q Would you want someone to self-diagnose, a nonphysician to self-diagnose their own exemption for masking, their medical exemption for masking?
A Am I okay to explain this a little bit more or --
Q I asked the question, so yeah.
A So in general, yes, I would agree with you. However, as I mentioned before, it depends on access and the situation. If I fill -- I fill out -- as you know or you may not know, the Province has its specific mask exemption form there to fill, and in it, I'm not -- because I've signed some of them -- it lists all the

different conditions, amongst them psychiatric, of course, or anxiety and that sort of thing.

And, generally speaking, a patient comes, and I assess them within my competence, which would be lung disease, and if I agree with them, then I would fill out the form, and it's basically just signing the form.

The form, because of patient confidentiality, does not require you to tell anyone -- the patient's telling anyone else what specific condition they have; they just have to indicate they have a valid medical condition from amongst a list of that, and one of them, of course, is psychological or psychiatric.

I will say, however, the -- if a patient comes in and tells me they are extremely short of breath, and the mask makes it worse, I mean I can do a whole bunch of testing, but at the end of the day, you have to rely, to some degree, on the patient being truthful and honest, right? Everyone -- we're not here -- we're not a court of law, we're here to try to help our patient, we assume they tell us what is true or not. So if a patient comes in and says, This causes me severe anxiety or whatever, and I cannot wear the mask and function; well, what are you going to do, you're going to agree to that, I think, because --

Q I think we're on the same page. Yeah, I think we're on the same page. My comment to you is shouldn't the

person come to you as the physician or respirologist and review that with you?

A Generally speaking, yes. I mean, I don't know the circumstances of Dr. Wall honestly but -- in terms of his medical exemption, but, yes, generally, that would be the case.

MR. [redacted] I'm going to ask Mr. [redacted] if he thinks we need to caucus, but other than that, I don't think I have any further questions for you. He's saying no; he's shaking his head. So those are all my questions, Dr. [redacted] Thank you for your time today.

A Sure. Thank you.

THE CHAIR: Thank you, Mr. [redacted] The Hearing Tribunal is going to caucus for just a couple of minutes to see if we have any questions.

Yes, Mr. Kitchen, did you have anything in redirect?

MR. KITCHEN: I've just got one question on redirect.

THE CHAIR: Okay.

Mr. Kitchen Re-examines the Witness

Q MR. KITCHEN: Dr. [redacted] you said -- you were talking to Mr. [redacted] you said that you do wear a mask when you legally have to. When you wear a mask because you have to because of the CPSA or the CMOH orders, are you doing it against your will?

A Well, I'm being coerced I believe, yes. If it were not for that rule, I would not be wearing it.

Q So you're not wearing it willingly?

A Correct.

MR. KITCHEN: Thank you. That's it.

THE CHAIR: Okay, Dr. [redacted] if you could just bear with us for 2 or 3 minutes while we caucus to see if the Hearing Tribunal has any further questions of you, and we'll be right back.

A Okay.

THE CHAIR: Thank you.

(ADJOURNMENT)

THE CHAIR: We're back in session.

Dr. [redacted] the Hearing Tribunal does not have any further questions for you. We'd like to thank you for taking the time to attend and to provide your testimony. You are free to leave and with our good wishes.

A All right, thank you, you as well, good night.

(WITNESS STANDS DOWN)

THE CHAIR: On that note, we will adjourn the hearing for today. We've got dates set for I think the end of January, if I remember. So unless either party has something they wish to raise at this time.

MR. [redacted] I think, Mr. Chair, Mr. Kitchen and I are to stay on to help out the court

reporter with a couple of questions, so I'd just ask [redacted] to leave us in the room, and, otherwise, thank you to everyone for their time today.

THE CHAIR: Okay, although it's still November. Merry Christmas. We won't see you all; enjoy the holidays, and we'll see you in January.

MR. KITCHEN: Thanks, you too.

THE CHAIR: Thanks, bye-bye.

PROCEEDINGS ADJOURNED

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 1st day of December, 2021.

[redacted]

[redacted] CSR(A)
Official Court Reporter