

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

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DISCIPLINARY HEARING

VOLUME 1

VIA VIDEOCONFERENCE

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Edmonton, Alberta

September 1, 2021

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

4

5 September 1, 2021 Morning Session

6

7 HEARING TRIBUNAL

8 J. Lees Tribunal Chair

9 W. Pavlic Internal Legal Counsel

10 Dr. L. Aldcorn ACAC Registered Member

11 Dr. D. Martens ACAC Registered Member

12 D. Dawson Public Member

13 A. Nelson ACAC Hearings Director

14

15 ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

16 B.E. Maxston, QC ACAC Legal Counsel

17

18 FOR DR. CURTIS WALL

19 J.S.M. Kitchen Legal Counsel

20

21 K. Schumann, CSR(A) Official Court Reporter

22

23 (PROCEEDINGS COMMENCED AT 9:10 AM)

24 THE CHAIR: Good to see everyone here.

25 We're just checking that we've got all the parties.

26 Dr. Wall and counsel are here?



1 MR. KITCHEN: Yes, that's right, we are.

2 THE CHAIR: Okay, and you're together?

3 MR. KITCHEN: We are.

4 THE CHAIR: Okay. Hi, Dr. Wall.

5 DR. WALL: Hello there.

6 THE CHAIR: Good morning. Okay, we have

7 our court reporter, Karoline Schumann. We have for the

8 College, David Lawrence and Mr. Maxston, and we have

9 one observer, Parker Hogan, and our court reporter,

10 Karoline Schumann.

11 Opening Remarks

12 THE CHAIR: Okay, I think we're ready to

13 start, so I'll call this Hearing Tribunal to order, and

14 this is a hearing of the -- this is a hearing of a

15 Hearing Tribunal of the Alberta College and Association

16 of Chiropractors appointed pursuant to the Health

17 Professions Act to consider allegations of

18 unprofessional conduct against Dr. Curtis Wall, an

19 active registered member of the ACAC.

20 My name is James Lees. I am a public member, and

21 I will be acting as Chair of the hearing today and the

22 other days scheduled.

23 I will now introduce the other members of the

24 Hearing Tribunal sitting on this matter. First off,

25 Dr. Leslie Aldcorn. Just stick your hand up and wave,

26 Leslie. Dr. Dianna Martens. And they are both

1 registered members of the College. Mr. Doug Dawson and  
2 myself, and Doug and I are the two public members. In  
3 addition, we have Mr. Walter Pavlic as our independent  
4 legal counsel to the Tribunal.

5 And our court reporter Karoline Schumann, and I  
6 think we've covered everybody else. Thanks, Karoline.

7 I confirm that we will be following the ACAC  
8 hearing steps and procedures for the Hearing Tribunal.  
9 Does anybody have any questions regarding the  
10 procedures?

11 MR. MAXSTON: Mr. Chair, it's Blair Maxston.  
12 I will have some comments during my opening submissions  
13 about a proposed order of proceedings, and I've talked  
14 with Mr. Kitchen about this, and I'll invite his  
15 comments. We may be departing a little bit from your  
16 script or your guidelines, but I think we're going to  
17 be substantially consistent with that.

18 THE CHAIR: Okay, well, we'll cross that  
19 bridge, thank you.

20 Are there any objections to either the composition  
21 of the Hearing Tribunal or the jurisdiction of the  
22 Hearing Tribunal to hear this case?

23 MR. MAXSTON: None from the Complaints  
24 Director.

25 MR. KITCHEN: None from Dr. Wall.

26 THE CHAIR: Thank you. Are there any

1 objections to holding the hearing virtually or by  
2 electronic means?

3 MR. MAXSTON: None from the Complaints  
4 Director.

5 MR. KITCHEN: And none from Dr. Wall.

6 THE CHAIR: Thank you. There are no  
7 objections, so the Chair asks the College legal  
8 representative to file the Notice of Hearing as an  
9 exhibit.

10 MR. MAXSTON: Mr. Chair, I'm going to deal  
11 with the matter of exhibits globally, so I wonder if I  
12 can ask you to just park that for now, and when I get  
13 to my opening submissions, I'll deal with exhibits, and  
14 certainly we'll take you through the Amended Notice of  
15 Hearing at that time.

16 THE CHAIR: Okay. In that case, we will  
17 defer reading the allegations in the Notice of Hearing.

18 The next point to cover is to ask Dr. Wall, do you  
19 admit or deny the allegations in the Notice of Hearing?  
20 And perhaps we should hold on that as well, since we  
21 haven't read them.

22 MR. KITCHEN: That would seem to make the  
23 most sense. I know that my learned friend's going to  
24 be applying to amend the Notice of Hearing, so probably  
25 we should save all that until we've determined exactly  
26 the contents of the Notice of Hearing.

1 THE CHAIR: Yeah, I think that's a fair  
2 thing to do, okay.

3 Then at this point, as this is a contested  
4 hearing, and there is no agreed statement of facts, I  
5 would ask, Mr. Maxston, if you have an opening  
6 statement.

7 Discussion

8 MR. MAXSTON: Mr. Chair, I'm going to invite  
9 Mr. Kitchen's comments on a point. I have an opening  
10 statement that I would like to go through I think sort  
11 of from start to finish, but I wonder if we should be  
12 dealing with the preliminary applications either right  
13 now or I've got about 2 minutes of comments I could  
14 make, and we could turn to the preliminary applications  
15 then.

16 I, frankly, don't want to take you through the  
17 comments I have about the order for the hearing, the  
18 witnesses you're going to hear from, comments about  
19 legal principles and that type of thing when we haven't  
20 taken care of the preliminary applications, so I'd  
21 invite Mr. Kitchen's comments on them.

22 MR. KITCHEN: I agree with that. I think  
23 the very first thing we should deal would be the  
24 preliminary applications before we move into  
25 substantive comments on the rest of it.

26 THE CHAIR: Okay.

1 MR. MAXSTON: So, Mr. Chair, if you're  
2 comfortable, I have about 1 or 2 minutes of just very  
3 preliminary comments, and then we'll turn to the matter  
4 of the preliminary applications.

5 As you've mentioned, today's hearing is to  
6 determine whether Dr. Wall has committed unprofessional  
7 conduct under the HPA concerning certain of his actions  
8 and conduct. Mr. Kitchen is here representing  
9 Dr. Wall, and Dr. Wall is here as well. Despite the  
10 fact that we haven't heard from Dr. Wall about the  
11 actual charges yet, this is a contested hearing, and as  
12 is his right, Dr. Wall is taking the position that he  
13 did not commit unprofessional conduct regarding the  
14 five charges that are in the Amended Notice of Hearing,  
15 which I will probably simply refer to as the Notice of  
16 Hearing today.

17 What we're engaging in right now is what is known  
18 as the liability phase of proceedings. The hearing is  
19 scheduled for four days, as you know, and in the  
20 liability phase of a hearing, both sides present their  
21 evidence, their cases, and the Hearing Tribunal has a  
22 chance to ask questions and test the evidence and,  
23 ultimately, you will decide whether unprofessional  
24 conduct has occurred, and you will issue a written  
25 decision in that regard at some point.

26 Hopefully we can complete the liability phase of

1 the hearing within the four scheduled days, but if we  
2 can't, we'll, of course, need to schedule some  
3 additional days.

4 If and only if findings of unprofessional conduct  
5 are made by the Hearing Tribunal would we convene again  
6 for the penalty phase of the hearing, as distinct from  
7 the liability phase, where you would receive  
8 submissions and potentially evidence from each side  
9 regarding appropriate penalty orders.

10 So that's where we are at the beginning of the  
11 hearing, Mr. Chair, and I'll continue on with the, as I  
12 said, an opening statement in a few minutes, but as you  
13 also know and as you referred to, we have preliminary  
14 applications this morning, and they are coming from  
15 both sides.

16 If you can just give me a minute, I'll get my  
17 documents ready in that regard.

18 THE CHAIR: I'm aware of two.

19 MR. MAXSTON: I'll let Mr. Kitchen speak to  
20 his application in a moment. We talked about this  
21 yesterday actually in the order of when he would bring  
22 it, and I think he is bringing it right after my  
23 applications, but we can speak to that in a few  
24 moments.

25 So just as a starting point for the members of the  
26 Hearing Tribunal, some -- that maybe haven't been in

1     this experience, sometimes there are issues between the  
2     parties that can't be resolved in advance of a hearing.

3             As you know from receiving all of the agreed on  
4     exhibits before today with the consent of both parties,  
5     there are many things that have been agreed to by the  
6     parties, but there are three preliminary applications  
7     that require your decision-making and your direction.  
8     The Complaints Director has two preliminary  
9     applications, and Dr. Wall has a third separate  
10    preliminary application.

11            So again, Mr. Kitchen can speak to the specifics  
12    of his application, but I believe it relates to  
13    tendering a further expert report and having that  
14    expert testify.

15            The Complaints Director has two preliminary  
16    applications. The first one is to make changes to the  
17    Amended Notice of Hearing and specifically the closing  
18    portion of the Notice of Hearing, and the second  
19    preliminary application relates to a request to have  
20    three Alberta Health Services documents be entered as  
21    exhibits.

22            Subject to Mr. Kitchen's comments, what I would  
23    normally see as the process for a preliminary  
24    application would be that the party bringing the  
25    application make submissions, the party opposing it  
26    makes their comments, the Hearing Tribunal would be

1 able to ask questions, and then we would ask you to  
2 take a break and make a decision on the applications.

3 I think it's probably best, Mr. Chair, if you and  
4 Mr. Kitchen are comfortable, for us to go through all  
5 three of the preliminary applications and then have a  
6 break, and you can decide on all of them. I think it  
7 will be a little bit awkward to break after each one.  
8 If you want to do that though, we can do that, but,  
9 again, if Mr. Kitchen has some thoughts on that, I'd  
10 welcome his comments.

11 MR. KITCHEN: I think that's fine. I'm also  
12 fine if the Hearing Tribunal prefers to only hear the  
13 Complaints Director's applications, make a decision,  
14 come back, and hear my application and then make a  
15 decision. Either is acceptable to me really. I'm in  
16 the Tribunal's hands on that.

17 MR. MAXSTON: And so am I, Mr. Chair.  
18 Perhaps what we should do, if you're comfortable, is  
19 I'll make both of the application. If you want to stop  
20 after the first one and break, that's fine; if you want  
21 to stop after the second one and break, that's fine.  
22 We'll just sort of play this by ear. And, of course,  
23 if at any time, you need to caucus on any issue, you  
24 and Mr. Pavlic can go to a breakout room.

25 Submissions by Mr. Maxston (First Preliminary  
26 Application)



1 MR. MAXSTON: So if everyone is comfortable  
2 then, I will just begin with the Complaints Director's  
3 first preliminary application, and that relates to  
4 Exhibit A-1, which is the Amended Notice of Hearing,  
5 dated July 22, 2021.

6 With Mr. Kitchen's consent, the Hearings Director  
7 yesterday sent you what I called a "Preliminary  
8 Application: Complaints Director's Reference  
9 Document", and I believe that's document H-1 in the  
10 batch of documents that have been sent to you. And,  
11 Mr. Chair, before going further, I'll just ask each one  
12 of you to go to that document.

13 Maybe while you're doing that, I will ask  
14 Mr. Kitchen for his thoughts on whether he thinks this  
15 needs to be entered as an exhibit. I'm fine either  
16 way, frankly.

17 THE CHAIR: Mr. Maxston, is this amending  
18 the Notice of Hearing?

19 MR. MAXSTON: Well, this is an application  
20 to amend the Notice of Hearing, and what I'm referring  
21 you to is a supporting document for ease of reference  
22 to show you the changes and also to show you some other  
23 things I'm going to be relying on in the application.  
24 It's essentially the revised version of the Amended  
25 Notice of Hearing and then some excerpts from the HPA  
26 and another excerpt from the Rules of Court that

1 relates to Mr. Kitchen's application.

2 THE CHAIR: In looking at this, I see on  
3 the second page, halfway down, there is some typed  
4 script in red; is that the change?

5 MR. MAXSTON: Yeah, I will get to that,  
6 Mr. Chair. I would like to make a few brief comments  
7 before I take you to that, but I just wanted to be sure  
8 everybody had access to this document.

9 THE CHAIR: I'm just wondering, if it's  
10 going to be the Notice of Hearing that is used that  
11 replaces the previous one, I would have thought it  
12 would have been entered as an exhibit.

13 MR. MAXSTON: Well, maybe we'll -- again, I  
14 invite Mr. Kitchen's comments. My experience in these  
15 types of situations is that you can certainly enter a  
16 revised Notice of Hearing as an exhibit, and I would  
17 intend that Part 1 of this document be that, but we're  
18 not quite there yet. I was wondering if you want to  
19 mark this as an exhibit for identification only or  
20 whether you don't need to mark it at all at this point.  
21 And, again, I'm fine either way.

22 THE CHAIR: Okay, let's not mark it yet,  
23 and let's proceed, and if it starts to get a little  
24 muddy, the waters get a little muddy, we might need to  
25 mark things. There's a lot of documents here, so ...

26 MR. MAXSTON: Mr. Chair, I'll --

1 THE CHAIR: Go ahead.

2 MR. MAXSTON: So I'll just continue on then.

3 As you alluded to, this is an application, this  
4 first application is an application by the Complaints  
5 Director to amend the Notice of Hearing that is before  
6 you, and the red highlighting that is on page 2 of the  
7 reference document are the changes that the Complaints  
8 Director is requesting your direction on and, in fact,  
9 an order that those changes can be made.

10 I want to begin by mentioning that you will see  
11 there are no changes to the five charge wordings  
12 themselves. Those have not changed since the original  
13 Notice of Hearing on this was provided I believe last  
14 year. I believe it was last summer actually.

15 You'll see that there are two changes in red which  
16 are being requested, and I invite again Mr. Kitchen's  
17 comments, but I want to stop and tell you that his  
18 client does not object to the change adding B-1 as a  
19 referred section of the Code of Ethics. So that change  
20 is not before you. Dr. Wall does not agree to the  
21 addition of the phrase "Alberta Health Services  
22 directions and requirements".

23 So, Mr. Chair, just some background facts, and I  
24 alluded to this before, this July 22, 2021 Notice of --  
25 Amended Notice of Hearing was provided to Mr. Kitchen  
26 shortly after that date, and, in fact, it's a

1 reflection of the original Notice of Hearing that was  
2 sent some time ago. In an August 5 email to  
3 Mr. Kitchen, I advised him that the Complaints Director  
4 was seeking to amend the Notice of Hearing, and he  
5 indicated he would be objecting to that.

6 So in support of the Complaints Director's  
7 application, I intend to make submissions in two areas.  
8 The first is the authority given to the Complaints  
9 Director under the Health Professions Act and I think  
10 case law to set the wording for charges, and I'm also  
11 going to take you to some case law in that regard, and  
12 I'm also going to review the legal test for  
13 requirements for charge wordings generally and why this  
14 type of change should not be viewed as prejudicial or  
15 harmful in any way to Dr. Wall.

16 So the first area then is what does the HPA say  
17 about this, and if you look at the -- again, the  
18 reference document that I had the Hearings Director  
19 send to you yesterday, you'll see that Section 66(3) of  
20 the HPA says: (as read)

21 If, on reviewing a report [that's an  
22 investigation report] prepared under this  
23 section, the Complaints Director determines  
24 that the investigation is concluded, the  
25 Complaints Director must refer to the matter  
26 to the Hearings Director for a hearing.

1     So it's the Complaints Director who decides what  
2     charges, what conduct go before the Hearing Tribunal  
3     and has the discretion to prepare the charge wording.  
4     And that's echoed in the next section of the HPA that  
5     I'm referring you to, and that's Section 77(a) in this  
6     same document, which says: (as read)

7             The Hearings Director must, at least 30 days  
8             before the hearing, give the investigated  
9             person a notice to attend and give reasonable  
10            particulars of the subject matter of the  
11            hearing.

12    So again, Mr. Chair, and Tribunal Members, it's clear  
13    that the Complaints Director has the legal authority to  
14    determine the nature and content and number of charges,  
15    and that's known essentially as prosecutorial  
16    discretion in different contexts, and it would not make  
17    sense for the member to have a veto over that, veto  
18    power over that; the member doesn't have that type of  
19    authority. It's the Complaints Director who decides  
20    what charges are brought forward. And, of course, just  
21    as Dr. Wall is doing today, the regulated member can  
22    vigorously contest the charge wordings and argue that  
23    some or all of the charge wordings are incorrect or  
24    inapplicable.

25            So, Mr. Chair, I'm going to veer off a little bit  
26    here, but Mr. Kitchen asked you -- asked the Hearings

1 Director yesterday to send you a case -- actually two  
2 cases in support of his preliminary application, one of  
3 those is a case called Wright, W-R-I-G-H-T, v. The  
4 College and Association of Registered Nurses, and I  
5 appreciate that Mr. Kitchen provided that to you for  
6 his application, but, handily enough, it's also  
7 applicable in one portion to the Complaints Director's  
8 application today.

9 And if all of you are able to access that Wright  
10 decision, I'll just give you a couple of minutes, and  
11 I'm asking you to go to paragraph 47 of the Wright  
12 decision.

13 THE CHAIR: Mr. Maxston, I don't think I  
14 received it. I received the preliminary application  
15 and the MacLeod case.

16 MR. MAXSTON: Yeah, I think Mr. Kitchen,  
17 I'll invite him to comment if he wants to, sent some  
18 cases very late last night or very early this morning,  
19 and he asked the Hearings Director to send them on to  
20 you, and I think that was done.

21 THE CHAIR: Perhaps we can break for 5  
22 minutes and just check to see if we have them. I'll --

23 MR. MAXSTON: Again, I believe there --  
24 sorry, I believe there are two cases, one is the Wright  
25 decision and the other is Mohan, M-A-H-O-N [sic].

26 THE CHAIR: Okay, I think if we're going

1 to discuss these, I'll go to my desktop and see if they  
2 came in this morning. I didn't see them earlier, but  
3 they may have arrived. And did anybody -- other  
4 Hearing Tribunal Members receive these this morning?

5 MS. NELSON: If I can just interject here,  
6 they're actually in File H in the exhibit Dropbox link.

7 THE CHAIR: Okay --

8 MR. MAXSTON: Mr. Chair --

9 THE CHAIR: Yeah, they were also attached,  
10 I downloaded what was attached to the email. I  
11 understood that was the same.

12 MR. MAXSTON: Mr. Chair, these cases are, of  
13 course, important for Mr. Kitchen's cross-application,  
14 so I think it's a good idea if we do just take a couple  
15 of minutes, and you and your colleagues all identify  
16 those cases and find them. I see Mr. Kitchen nodding.  
17 So maybe we'll just informally -- and maybe we all stay  
18 in the room here, in this common room, and let you find  
19 those cases, and I don't intend to take you through  
20 much of this, but I know Mr. Kitchen will want those  
21 cases to be in front of you.

22 THE CHAIR: Okay, let's break. The  
23 Hearing Tribunal is on recess for a short period of  
24 time while we track down these cases. Okay?

25 MR. KITCHEN: Thank you.

26 (ADJOURNMENT)

1 THE CHAIR: Okay, the Hearing Tribunal is  
2 back in session. Mr. Maxston, can you continue please.

3 MR. MAXSTON: Sure, and I'm sorry to have  
4 taken us down this road, but I -- it's a small  
5 digression for this preliminary application, this  
6 specific one, but, of course, as I said, it's important  
7 to get these cases in front of you too.

8 So in the Wright decision, Mr. Chair, I would just  
9 ask you to go to paragraph -- you and your colleagues  
10 go to paragraph 47, and just as I said, conveniently  
11 enough, there's a statement in here that applies. It  
12 says: (as read)

13 Power of a professional organization to  
14 invoke and manage its professional  
15 disciplinary regime is analogous to  
16 prosecutorial discretion, and the grounds of  
17 review of any decisions made are very narrow.

18 And there's a few other comments then in that paragraph  
19 about what prosecutorial discretion is, and I think  
20 it's just important to note that the courts have  
21 recognized that there is this prosecutorial discretion,  
22 and it's the Complaints Director's discretion, no one  
23 else's.

24 So I think it's also important, when you're  
25 looking at amendments to the charges, to consider the  
26 test for charges, the specificity they have to include,



1 and I've given you a case, it came yesterday I believe  
2 to all of you called MacLeod v. Alberta College of  
3 Social Workers, and I'd like you to turn to that and,  
4 in specific, paragraph 20.

5 So maybe I'll wait for a show of hands when  
6 everybody is ready to go on that case. I don't want to  
7 start commenting on it until everyone has it in hand.

8 I was going to proceed, but Mr. Lees, I don't see  
9 you on camera, so I'm --

10 THE CHAIR: I'm --

11 MR. MAXSTON: -- thinking we should wait.

12 THE CHAIR: -- just -- I'm just calling up  
13 on my other computer, and the document I have has 12  
14 pages.

15 MR. MAXSTON: I think I have an 11-page  
16 document, but it should be entitled MacLeod v. College  
17 of Social Workers.

18 THE CHAIR: Okay, and then you said  
19 paragraph 20?

20 MR. MAXSTON: Yeah, paragraph 20.

21 THE CHAIR: Okay, we're good.

22 MR. MAXSTON: So paragraph 20 is -- the  
23 particular facts of this case aren't particularly  
24 relevant, but paragraph 20 is important when it sets  
25 out the test for what charge wordings have to contain,  
26 and it says, this is the Court speaking: (as read)

1 Further, the appellant argues that the rules  
2 of natural justice require sufficient  
3 particulars of a complaint so that the  
4 professional can mount a proper defence.

5 And the Court is saying that common-law rule is carried  
6 forward in Section 77 of the Act, which I just took you  
7 to: (as read)

8 Particulars enable the professional to  
9 identify the particular event that is said to  
10 amount to professional misconduct.

11 Particulars also have the effect of limiting  
12 the scope of the charges so that the  
13 professional does not have to defend his or  
14 her entire career or general character during  
15 the hearing.

16 And if you skip to the next page of that decision,  
17 Mr. Chair, and go to paragraph 24, you'll see there's a  
18 heading of "Scope of Charges", and then the Court  
19 reiterates this principle and says: (as read)

20 As noted, allegations of professional  
21 misconduct must be specific enough that the  
22 professional can know the case he or she has  
23 to meet.

24 So the Complaints Director has the discretion to come  
25 up with these charge wordings, but the charge wordings  
26 have to have a level of specificity to them, and, from

1 the Complaints Director's perspective, that legal  
2 obligation has clearly been -- clearly been discharged  
3 here.

4 The charge wordings are clear and precise  
5 themselves, Charges 1 to 5. They disclose particulars  
6 of the allegations, and they provide more than enough  
7 information for Dr. Wall to know the case to be met.  
8 That's what the Court of Appeal was saying in the  
9 MacLeod decision. Dr. Wall knows what he is being  
10 asked to respond to.

11 And just as importantly, the Amended Notice of  
12 Hearing was originally provided to Mr. Kitchen in March  
13 of -- I believe March of 2021, and Dr. Wall hasn't made  
14 any request for particulars. You haven't heard  
15 anything about the charges being unspecific. I think,  
16 in fact, they're quite detailed, and they set out  
17 exactly what conduct is an issue.

18 And very importantly, the wording of the charges  
19 isn't changing. That's what the courts often key on  
20 is, wait a minute, the professional has to know what  
21 the case is to be met. And from start to finish, from  
22 the first Notice of Hearing to this one, those charges  
23 haven't changed; Dr. Wall knows the case to be met.

24 The addition of the Alberta Health Services  
25 directions and requirements is a commentary at the end  
26 of the charge, and it's the Complaints Director saying

1   there's the potential for Dr. Wall to have contravened  
2   a number of things including Alberta Health Services'  
3   directions and requirements. And it may be that that  
4   part of the charge isn't proven, it may be that it is,  
5   but we'll find that out during the hearing, and there's  
6   certainly no prejudice to Dr. Wall by adding that.

7           And I think I'll go a little bit further, in  
8   addition to Mr. Lawrence, as Complaints Director,  
9   having the discretion to word charges as he sees fit,  
10   Alberta Health Services is relevant. It's the arm of  
11   Alberta Health that administers health care in Alberta  
12   broadly, and the Complaints Director's position is that  
13   Dr. Wall's conduct can be assessed in relation to AHS  
14   requirements and directions. And as you'll know from  
15   the exhibits that have been provided to you, the AHS  
16   actually closed down Dr. Wall's clinic. They're  
17   already involved in this. There's no sense that this  
18   is a third party in the broad sense; AHS is already  
19   involved.

20           So the changes to the Notice of Hearing are minor.  
21   They're not changes to the charges. They're one  
22   element of the, how will I say it, the criteria for  
23   assessing Dr. Wall's conduct in terms of the first five  
24   charges. There's nothing new here. It doesn't  
25   prejudice Dr. Wall in terms of the charges themselves,  
26   and Dr. Wall has had more than enough time to assess

1     these charges and properly prepare for them.

2             So I'm happy to answer any questions you have.

3     Mr. Kitchen, I'm sure, will have some responses, and I  
4     might have a couple quick follow-up comments in terms  
5     of what he says, and we can then either take a break or  
6     move forward to the Complaints Director's second  
7     application, preliminary application.

8     THE CHAIR:                     Perhaps we'll hear from  
9     Mr. Kitchen before we determine whether or not the  
10    Hearing Tribunal has any additional questions.

11    MR. MAXSTON:                  Mr. Kitchen, I think you might  
12    be muted.

13    Submissions by Mr. Kitchen (First Preliminary  
14    Application)

15    MR. KITCHEN:                  My apologies, my mic is muted.  
16    Good, now I know that works. I'll start again.

17             Just a few brief comments. Firstly, I don't  
18    disagree with my learned friend about the particulars  
19    of the charges themselves, that being 1 to 5. The  
20    problem I have is with the -- with this addition and  
21    how vague it is. If you look at the section underneath  
22    the charges where it says "it is further alleged", and  
23    there's a number of things that are specifically listed  
24    there, 1(1)(pp) of the HPA, the Standards of Practice,  
25    and then we have the specific, very specific sections  
26    of the Standards of Practice, very specific sections of

1 the Code of Ethics, and we have the ACAC Pandemic  
2 Directive as specified, the CMOH orders that are  
3 specified, not which ones but they're specified as CMOH  
4 orders, and then we have this very vague Alberta Health  
5 Services directions and requirements. I don't know  
6 what they are, they don't have any sections, they don't  
7 any references, no dates, no nothing. It's very vague.  
8 Hopelessly vague, I would say.

9 The other thing -- and because of that, I would  
10 say that it's also hopeless that there will be any  
11 findings that he's -- that Dr. Wall has contravened any  
12 of these things if we don't even really know what they  
13 are.

14 In response to the comment about prosecutorial  
15 discretion, again, I don't disagree with that generally  
16 speaking. The case referred to that I provided, Wright  
17 v. College and Association of Registered Nurses, one of  
18 the issues in that case was whether or not the  
19 regulatory body in that case really even should have  
20 invoked any kind of process at all or, you know,  
21 whether it should have merely done an informal  
22 resolution as opposed to a formal hearing. The nurse  
23 in that case was challenging that. So I don't disagree  
24 with the analogy of prosecutorial discretion to decide  
25 whether or not to lay charges or, in this case, proceed  
26 to a hearing.

1 But that's a little different than what's going on  
2 here. Here we have a late game amendment to pile on,  
3 and that's a little different than deciding whether or  
4 not at all to proceed to a formal hearing into any  
5 charges. So I don't think that that's necessarily  
6 directly on point.

7 The last thing I'll say when it comes to Alberta  
8 Health Services, yes, they are involved in this case,  
9 but only in regards to the CMOH orders. Yes,  
10 Dr. Wall's office was closed down, but there was no  
11 allegations breaching any AHS directions and  
12 requirements; there was an allegation of breaching a  
13 CMOH order, and when it was discovered that that CMOH  
14 order was no longer breached, AHS opened the office  
15 again. All AHS was in that scenario was an enforcer of  
16 the CMOH order. That was their only role; that's been  
17 their only role.

18 So it's the CMOH orders that matter here, and if  
19 that had have been what the Complaints Director was  
20 trying to add in now, at this stage, Dr. Wall wouldn't  
21 oppose it, but now we have this extra thing of  
22 directions and requirements of AHS, and that's not  
23 what's relevant. What's relevant is the CMOH officer's  
24 orders.

25 Those are my submissions on that. I'll take any  
26 questions if you have any, Chair.

1 Reply Submissions by Mr. Maxston (First Preliminary  
2 Application)

3 MR. MAXSTON: Mr. Chair, I wonder if I can  
4 just make two very brief comments in response.

5 THE CHAIR: Yes.

6 MR. MAXSTON: Very, very briefly, I think  
7 there's a bit of a chicken and egg here, because the  
8 Complaint Director's next application is to enter some  
9 AHS documents, which I think would provide the  
10 specificity that would support that wording.

11 I'll just say that I don't think this is late in  
12 the game. The amendments were provided a few weeks  
13 ago. I don't think it's piling on; it's five words,  
14 six words. And, as Mr. Kitchen says, you'll decide at  
15 the end of the day whether the Complaints Director has  
16 or has not produced evidence to satisfy that particular  
17 phrase, but it's really the Complaints Director's call  
18 to put that phrase in. So those are my comments.

19 THE CHAIR: Okay, well, let's caucus for a  
20 few minutes so that we can determine whether the  
21 Hearing Tribunal has any further questions for counsel.  
22 So we'll take 5 minutes, and if we could be put back in  
23 a waiting room, that would be great, thank you.

24 (ADJOURNMENT)

25 THE CHAIR: We will call the Hearing  
26 Tribunal back in session.



1 Ruling (First Preliminary Application)

2 THE CHAIR: The Hearing Tribunal Members  
3 have discussed and reviewed the comments from counsel.

4 First off, I would say we do not have any  
5 additional or further questions from either counsel  
6 regarding the application.

7 We have found that there was no evidence that  
8 Dr. Wall is being prejudiced by this application, and  
9 we would further add that Dr. Wall and counsel had  
10 ample opportunity, some weeks in which they had -- they  
11 could have raised questions or concerns or tried to  
12 seek further particulars with respect to the  
13 preliminary application by the Complaints Director, and  
14 that didn't happen. So on that basis, we're prepared  
15 to -- I'm not sure of the technical word -- accept the  
16 preliminary application from Mr. Maxston.

17 MR. MAXSTON: Mr. Chair, and I will again --  
18 thank you for your comments, I will again invite  
19 Mr. Kitchen's comments on this. I would intend then to  
20 either have the reference document that I've provided  
21 to you to have in front of that the Amended Notice of  
22 Hearing with the red changes be entered as an exhibit,  
23 or I can, as a housekeeping matter, have the Hearings  
24 Director generate an Amended Amended Notice of Hearing.  
25 I think the changes are on the record, and we could  
26 probably simply use this reference document I have,

1 but, again, I'm in Mr. Kitchen's hands on that.

2 MR. KITCHEN: I think that's fine, enter it  
3 as an exhibit. Yeah, we have a copy. It's part of the  
4 record.

5 THE CHAIR: Okay, just to be clear that,  
6 the Hearing Tribunal Members, your copies show in red  
7 the changes? So we don't need to reword it and reprint  
8 it. Okay, good.

9 EXHIBIT H-1 - Preliminary Application:  
10 Complaints Director's Reference Document  
11 Submissions by Mr. Maxston (Second Preliminary  
12 Application)

13 MR. MAXSTON: Mr. Chair --

14 THE CHAIR: Yeah, Mr. Maxston.

15 MR. MAXSTON: Thank you, I will proceed then  
16 with the Complaints Director's secondary preliminary  
17 application, which is to admit three Alberta Health  
18 Services or AHS documents as additional exhibits, and,  
19 as you know, Dr. Wall is objecting to that.

20 For your reference, I'll tell you I'm going to be  
21 making submissions in three areas, and I think, quite  
22 briefly, the first is to briefly review what the  
23 proposed exhibits are; secondly, I'm going to talk  
24 about what the HPA has to say about evidence and  
25 admissibility; and then I'm going to talk very briefly  
26 about what the courts have to say about evidence and

1     admissibility.

2             So, Mr. Chair, thankfully, the parties agreed that  
3     you could receive copies of these documents in advance,  
4     so I don't have to take you through them line by line.  
5     I would just say to you that the AHS guidelines for  
6     masking are important in terms of -- that's the first  
7     document -- are important in terms of what they say  
8     about the requirements for PPE and how that is  
9     significant for health care providers, and there's a  
10    statement on page 1 about PPE being critical to the  
11    health and safety of health care workers and patients,  
12    so I think that's relevant.

13            The AHS personal protective, PPE, equipment  
14    document similarly on page 1 has comments about  
15    requirements for masking. It talks about the Public  
16    Health Agency of Canada, PHAC, and their views on  
17    masking and similar items. It talks about the fact  
18    that AHS is making a masking order in terms of the goal  
19    of preventing the spread of COVID, and it has some  
20    other comments in there.

21            The third document, Alberta Health Services  
22    directed use of masks during COVID-19, again, has more  
23    comments, particularly on page 1, in the "Principle"  
24    section about: (as read)

25            Continuous masking can be a control and a  
26    protection to people wearing masks and to

1           those around them.

2       And it talks about the importance of that for health  
3       care providers.

4           I could take you through these documents in  
5       detail, but I don't know that's appropriate, given the  
6       nature of the preliminary application, but I just  
7       wanted to give you a sense of the flavour of those  
8       documents and why the comments in them are important.

9           The next thing I want to turn to is to review  
10       Section 79(5) of the HPA, and that is actually in Part  
11       2 of the reference document that had the changes to the  
12       charge wordings and the other HPA sections that you  
13       have. It's on the last page, the third page of that  
14       document, and it's under the heading "Section C", and  
15       then it says "Section 79(5)". I'll just ask all of you  
16       to go to that, and if you can let me know, Mr. Chair,  
17       when you'd like me to proceed.

18       THE CHAIR:                       Okay, just give me a moment,  
19       please. Okay. Everybody okay? Okay, Mr. Maxston.

20       MR. MAXSTON:                    Thank you. And, Mr. Chair,  
21       just for the balance of the hearing, if I start talking  
22       about a section, and there's a straggler who may be or  
23       a document someone hasn't gotten to yet, someone can  
24       raise their hands. I certainly want to make sure that  
25       everybody's on the same page, and I know it's a little  
26       cumbersome with the electronic documents. So, again,

1 if I start off or if Mr. Kitchen starts off, you know,  
2 on something, and you're not there yet, please let us  
3 know.

4 So Section 79(5) is really important in terms of  
5 evidence, and it says: (as read)

6 Evidence may be given before the Hearing  
7 Tribunal in any manner that it considers  
8 appropriate, and it is not bound by the rules  
9 of law respecting evidence applicable to  
10 judicial hearings.

11 This is a common provision in many pieces of  
12 administrative law legislation, and the drafters of the  
13 legislation here are trying to facilitate less formal  
14 proceedings for hearing tribunals and to allow  
15 flexibility to them so they're not bound by the very  
16 strict Rules of Evidence that apply to court  
17 proceedings.

18 Now, I want to be clear that this section doesn't  
19 mean you must ignore the Rules of Evidence, and, in  
20 fact, when evidentiary and other questions come before  
21 you, even though you're not bound by those rules of  
22 evidence, I think they can provide good guidance, and  
23 sometimes they might even be binding: The question is  
24 so important that you will want to rely on the formal  
25 Rules of Evidence. But, as a starting point, you're  
26 not bound by those formal Rules of Evidence.

1           Mr. Kitchen in his application about  
2   Mr. Schaefer's expert report has provided you with a  
3   case called Mohan, which deals with the Rules of  
4   Evidence that are applicable to entering new documents,  
5   and I think, frankly, I agree with the Mohan principle.  
6   I think it's a very well known case. And I'm going to  
7   talk just very, very briefly about what those are and  
8   why these three documents should be entered, bearing in  
9   mind those three principles.

10           So the three elements, the three criteria that I  
11   think are generally accepted are is the evidence  
12   relevant, is it relevant to the facts and issues that  
13   are before the decision-maker, will it provide you with  
14   some assistance in that regard.

15           And the second question is is the evidence  
16   material: Has it got some weight to it, some heft that  
17   is really going to assist you beyond simply being  
18   relevant, and then the third principle, I think  
19   generally, is is there some exclusionary rule that  
20   prohibits this from coming in. Lawyers talk about  
21   hearsay evidence or things like that; where we'd say,  
22   Well, wait a minute maybe those first two branches of  
23   the test are met but the third part isn't. So, again,  
24   number one, is it relevant, does it address some of the  
25   facts and issues before you, and is it material, is it  
26   going to assist you with something.

1           So in terms of the first two elements of the test,  
2   the AHS documents, I think as I mentioned to you,  
3   contain very significant comments about masking and the  
4   efficacy of masking, their effect on patients and  
5   others, and, of course, that's something that is in  
6   play in this hearing; it's something that is before  
7   you.

8           And, of course, Dr. Wall, I anticipate, will be  
9   raising arguments about the lack of scientific evidence  
10   to support masking, and even though the Complaints  
11   Director, for reasons I'll talk about later on, doesn't  
12   believe this hearing turns much, if at all, on masking,  
13   this question is still before you. And I think it's  
14   fair to say that those AHS documents will provide some  
15   guidance, they will provide some help, and they meet  
16   that test for relevance.

17          And I think it's important to remember that even  
18   if you decide to admit this document, in your  
19   deliberations, you'll decide what weight or value to  
20   put on these documents. So the admissibility part is  
21   one step, and then the weight, the -- what lawyers  
22   would call the probative value associated with them is  
23   another step.

24          I think you should be cautious and allow these  
25   documents to be entered, and I think you'll find later  
26   on that that they're of great assistance to you, and

1     that these meet the test of relevance and that there  
2     isn't any exclusionary rule that would prevent these  
3     from going in.

4             I think it's also important to remember that there  
5     are already AHS documents before you that Dr. Wall has  
6     consented to, and that's the AHS order regarding  
7     closure of his clinic and the AHS order opening his  
8     clinic. So, clearly, these documents are relevant, and  
9     they should be before you.

10            I'm happy to answer any questions you have about  
11     these issues, and, if not, my friend, Mr. Kitchen, will  
12     certainly have some comments for you, I'm sure.

13     THE CHAIR:                    So just to double-back and  
14     check and make sure we're all on the same page, we are  
15     talking about the three AHS documents that you noted a  
16     few minutes ago that were not agreed to be part of the  
17     package; is that correct?

18     MR. MAXSTON:                  That's correct. This is a  
19     contested application. These are outside of Files A to  
20     F, and I believe these were provided to you if not the  
21     day before yesterday, maybe yesterday; I think it came  
22     in the afternoon yesterday from the college.

23     THE CHAIR:                    Yeah, they did, and I think  
24     they were in --

25     MR. MAXSTON:                  But --

26     THE CHAIR:                    -- 'H'.



1 MR. MAXSTON: -- yes, with Mr. Kitchen's  
2 consent.

3 THE CHAIR: Okay, Mr. Kitchen?  
4 Submissions by Mr. Kitchen (Second Preliminary  
5 Application)

6 MR. KITCHEN: Yes, thank you. I ask the  
7 Tribunal to consider what the purpose of these  
8 documents is. If the purpose is to add scientific  
9 value, that purpose is not achieved. There's no  
10 scientific studies or reports or reviews contained in  
11 this material.

12 The science on masks is going to be heavily  
13 canvassed in this case, and, indeed, the Complaints  
14 Director has put in an expert on this, on the issues of  
15 masking and scientific evidence, studies, review,  
16 conclusions, et cetera, are discussed in that report.

17 So the purpose of this, I submit, is to simply  
18 appeal to authority. It's basically to say, well, what  
19 we're doing must be good, because AHS is doing it; what  
20 does is good. It's an appeal to authority. That's a  
21 fallacy. Just because has does it, doesn't mean that  
22 it's right, doesn't mean that it's scientific, doesn't  
23 mean that it's lawful.

24 Furthermore, what has and what the ACAC does is  
25 two different things; they're independent of each  
26 other. The CMOH has authority over the ACAC, and, yes,

1     AHS enforces the CMOH order. This material is not CMOH  
2     orders; it's AHS documents. And by the way, it's very  
3     different than the has documents that my learned friend  
4     just discussed, because, again, those documents about  
5     opening and closing Dr. Wall's clinic are merely an  
6     enforcement of the CMOH orders. That's all they are.

7             These documents are different. They're  
8     substantive, and they're independent from the CMOH  
9     orders. They don't add any science, and if they don't,  
10    then they don't have any value. All they do is  
11    prejudice Dr. Wall by adding this element on an appeal  
12    to authority.

13            I'll take you to that case we talked about  
14    earlier, Wright v. The College of Association of  
15    Registered Nurses [sic]. I'm going to be at paragraph  
16    38, so that's about a page earlier than we were before.  
17    And, again, this was a case where a nurse was  
18    challenging a decision of its regulatory body, the  
19    nurse's regulatory body, on one of the issues was human  
20    rights grounds, and there was some evidence heard about  
21    what other regulatory bodies did, and the Court said  
22    that -- this is in paragraph 38: (as read)

23            The Hearing Tribunal was entitled to conclude  
24            that this evidence was irrelevant. If we  
25            speak hypothetically and the College's  
26            policies and practices are compliant with the

1 human rights legislation, the fact that other  
2 professional associations have different  
3 compliant policies and practices is  
4 irrelevant.

5 And, obviously, AHS is not another professional  
6 association, but I would say it's analogous and this  
7 analysis applies.

8 What AHS does about masks to meet its human rights  
9 and Charter obligations is irrelevant. Whether or not  
10 masks are scientific, that's relevant, all right;  
11 that's going to be dealt with in the expert report that  
12 the Complaints Director has submitted.

13 This is different. There's -- since there's no  
14 science in these documents, since the science is  
15 already fully canvassed, there's no value that these  
16 documents can provide, other than at least for the  
17 Complaints Director to say, Well, look, we're not the  
18 only ones doing this, there's other people doing this,  
19 and, you know, AHS is an authority on the matter, so  
20 that justifies what we're doing. And in that sense,  
21 the probative value is outweighed by the prejudice of  
22 these documents.

23 Subject to any questions, Chair, those are my  
24 submissions.

25 MR. MAXSTON: Mr. Chair, if you're  
26 comfortable, I have just a couple of very, very brief

1     comments in response.

2     THE CHAIR:                     Okay, Mr. Maxston.

3     Reply Submissions by Mr. Maxston (Second Preliminary  
4     Application)

5     MR. MAXSTON:                 I think I would take issue  
6     with the comment that this is purely an appeal to  
7     authority. This is all about the framework that the  
8     College was operating in. There may not be references  
9     to science here, but certainly -- or scientific  
10    studies, but certainly this is the arm of Alberta  
11    Health that regulates health care broadly in the  
12    province, and what they're saying on masking and what  
13    they're doing is irrelevant to establish the bona fides  
14    of the College Pandemic Directive, again, even though  
15    the Complaints Director doesn't think masking is really  
16    the issue here.

17         So I think what AHS is saying on this is  
18    important, and we'd ask you to again to admit these  
19    documents and then place the appropriate weight on  
20    them. You've heard from the parties.

21         Those are my submissions, thank you.

22    THE CHAIR:                     Okay, I think we will take a  
23    brief recess here so the Hearing Tribunal can determine  
24    if we have any questions and discuss the matter.

25         So let's -- it's 20 after 10, let's break for 10  
26    minutes, and people can get up and have a stretch and

1 grab a coffee or a bio break or whatever. So 10:30  
2 we'll come back. Thank you.

3 (ADJOURNMENT)

4 Ruling (Second Preliminary Application)

5 THE CHAIR: Okay, I think we're all back.  
6 My apologies, this took a little bit longer than  
7 anticipated, but we're ready to proceed. So the  
8 Hearing Tribunal is back in session. We have no  
9 questions of counsel regarding the most recent  
10 discussions.

11 We have considered the three documents and looked  
12 at the information that counsel provided. With respect  
13 to the test, we do feel that these documents are  
14 relevant; they deal with masking, which is certainly  
15 one of the issues in this matter. We do feel they are  
16 material, and we don't find that there is an  
17 exclusionary rule which would eliminate them.

18 So the Hearing Tribunal's decision is to admit  
19 them, and with the knowledge and the understanding  
20 that, although we don't have information on the merits  
21 of the case at this time, we can assign whatever weight  
22 we feel is appropriate when we get to that point in  
23 these proceedings. So the documents submitted by  
24 Mr. Maxston are admitted.

25 EXHIBIT H-2 - Karen MacLeod v. The Alberta  
26 College of Social Workers, dated January 12,

1           2018

2           EXHIBIT H-3 - R. v. Chikmaglur Mohan 1994 SCC

3           80

4           EXHIBIT H-4 - Genevieve Wright v. The College  
5           and Association of Registered Nurses of  
6           Alberta, 2012 ABCA 267

7   THE CHAIR:                   And I would just like to  
8   comment on, very quickly, on two other documents, which  
9   I believe Mr. Kitchen were your submissions, and that's  
10   the résumé of Mr. Schaefer and his report. Is it your  
11   intent to ask that these be admitted later on when you  
12   are making your submissions on the allegations?

13   MR. KITCHEN:                No, I don't think that's quite  
14   right, Mr. Chair. The idea is, at this point,  
15   Mr. Maxston and I agreed that I would make an  
16   application to have this report and cv admitted now,  
17   and then, if admitted, we would proceed to an  
18   examination/cross-examination of Mr. Schaefer later  
19   down the road when Dr. Wall puts in his -- the expert  
20   evidence side of his case.

21   THE CHAIR:                   Okay. So I'd you'd like us to  
22   consider these now?

23   MR. KITCHEN:                Yes.

24   THE CHAIR:                   Okay, would you like to speak  
25   to them?

26   MR. KITCHEN:                Yes, unless Mr. Maxston has

1 any objections to doing that now.

2 MR. MAXSTON: No, I think that's actually  
3 the best way to go, and, of course, Mr. Chair, after  
4 Mr. Kitchen has made his comments, I'll, of course,  
5 have some response comments.

6 THE CHAIR: Yes, yeah.  
7 Submissions by Mr. Kitchen (Third Preliminary  
8 Application)

9 MR. KITCHEN: All right, so you have in  
10 front of you this expert report from Chris Schaefer and  
11 his cv.

12 As you know, the Complaints Director does not  
13 consent to this being entered, notwithstanding the  
14 admittance of the four other expert reports, one from  
15 the Complaints Director and three others from Dr. Wall.

16 I submit that this expert report should be  
17 admitted. It meets the test for admission, and it is  
18 very helpful. I'll walk you through that test. It's  
19 well known. There's four criteria for admitting an  
20 expert opinion. It's found in the case we've already  
21 discussed of Mohan, the citation is 1994 SCC 80.

22 The criteria are relevance, necessity in assisting  
23 the trier of fact, absence of an exclusionary role, and  
24 a properly qualified expert.

25 THE CHAIR: Mr. Kitchen, I'm sorry to  
26 interrupt you, I was trying to catch up on my writing.

1     Could you just go over the tests again.

2     MR. KITCHEN:                     Sure. The four criteria, and  
3     you'll find this at paragraphs 17 to 21 of the Mohan  
4     decision, which you should have a digital copy of that.  
5     The four criteria are relevance, necessity in assisting  
6     the trier of fact, the absence of an exclusionary role,  
7     and, of course, a properly qualified expert.

8             And I'll start -- I'll go chronologically through  
9     this. For relevance, the Schaefer report focuses on  
10    what medical masks actually are and two specific harms  
11    from these types of masks.

12            And by "medical", by the way, I mean the VU masks,  
13    the surgical masks, the masks that are in the ACAC  
14    Pandemic Directive. Those are the types of masks  
15    everybody's going to be talking about. We're probably  
16    going to use the term "masks" a lot, but that's what  
17    we're talking about, as far as I know. We're not  
18    talking about cloth masks, N95; we're talking about  
19    these types of masks.

20            So the report focuses very briefly and narrowly on  
21    these masks, what they actually are, and then two  
22    specific harms that fall from those harms, being oxygen  
23    deprivation and toxic overexposure to carbon dioxide.

24            Now, this content is obviously relevant to one of  
25    the central issues in this case, which is whether or  
26    not masks cause harm and whether or not, because



1     they -- because they cause harm, if they cause harm,  
2     whether or not they violate anybody's rights.

3             It's also legally relevant to whether the ACAC  
4     mask mandate Dr. Wall is challenging engages his  
5     security of a person under Section 7 of the Charter and  
6     his eventual argument that he was acting in the best  
7     interests of his patients by protecting them from the  
8     harms of surgical masks when he permitted them to not  
9     wear masks.

10            Moving on to necessity. The Schaefer report  
11     provides information that is outside the knowledge of  
12     the Members of the Tribunal. Common sense would  
13     support the notion that surgical masks decrease masks  
14     to oxygen, increase exposure to carbon dioxide, but  
15     only an expert can determine to what degree that that  
16     carbon dioxide overexposure is happening and that  
17     decrease in oxygen, and if that degree is actually  
18     harmful or merely a discomfort, actually determining,  
19     technically, exactly what the oxygen deprivation and  
20     the overexposure to carbon dioxide is. That knowledge  
21     is not attainable without an expert. That -- a  
22     determination on that cannot be made by people with  
23     ordinary knowledge.

24            This report, therefore, is required for the trier  
25     of fact, the Tribunal, to determine what is a central  
26     issue in this case, that is whether masks are, in fact,

1     harmful.

2             There is no applicable exclusionary rule engaged  
3     in this case. And I suppose my friends are going to  
4     argue that there's prejudice because the report was  
5     filed three weeks before the hearing, and so if there's  
6     any prejudice, that would be it, and I'll deal with  
7     that momentarily.

8             But just to deal with proper qualifications,  
9     because obviously we're dealing with an expert opinion  
10    here, so we can't have a qualified expert when we don't  
11    have something that's admissible. Mr. Schaefer  
12    presents us precisely the experience and certifications  
13    to be expertly discussing masks, surgical masks, and to  
14    competently conduct the type of testing needed to make  
15    the conclusions he does in his report about oxygen and  
16    carbon dioxide levels.

17            You can see from his cv there's a lot to do here  
18    with respirators, masks, testing them, instructing on  
19    them, he's got certifications in them. In fact, a lot  
20    of what he does and what he says has been doing for  
21    decades has to do with different types of masks,  
22    broadly speaking, or whatever you want to call it,  
23    breathing barriers or respirators or whatever. All  
24    these various types of devices that go on people's  
25    faces to protect them from certain things, he has an  
26    enormous amount of experience in it.

1           Now, I'll just deal briefly with comparing the  
2 probative value to the prejudicial effect. The  
3 Schaefer report is a rival, it's brief, it's not  
4 confusing or overly overcomplicated, which may be a  
5 reason to exclude it if it was; it's not going to take  
6 an enormous amount of time; it's a three-page report.  
7 It's not going to take an enormous amount of time for  
8 myself to take Schaefer through his report. I don't  
9 imagine it would take an enormous amount of time for  
10 the Complaints Director to cross-examine and test the  
11 value of it. It's needed to establish important and  
12 relevant facts, and that's very important for  
13 understanding probative value.

14           As I mentioned, there's no relevance to  
15 prejudicial effect to the Complaints Director except  
16 possibly that this report was provided to the  
17 Complaints Director three weeks prior to the hearing,  
18 and it seems he's of the position three weeks is not  
19 long enough to respond to the report. I submit that  
20 contention lacks any merit. The report's three pages  
21 long, as I mentioned, contains only five citations.  
22 Either the Complaints Director could have found a new  
23 expert to respond, or his current expert could have  
24 responded, had three weeks to respond. Three weeks is  
25 sufficient time to prepare to respond to a three-page  
26 report, whether it's in the form of a rebuttal report

1     that is written and provided to Dr. Wall and the  
2     Tribunal or in the form merely of dealing with it in  
3     direction examination. I submit that the probative  
4     value far outweighs any prejudicial effect on the  
5     Complaints Director.

6             However, if the Tribunal was to agree with the  
7     Complaints Director that there is prejudice to the  
8     degree that it challenges or competes with the  
9     probative value of this expert report, the only proper  
10    remedy is to order an adjournment, to provide the  
11    Complaints Director more time to respond. It's not to  
12    disallow the evidence. Dr. Wall has a right to a full  
13    answer in defence and should not be prevented from  
14    putting in all the relevant evidence, including expert  
15    evidence.

16            Now, Dr. Wall opposes a further adjournment.  
17    However, if one is to be issued, Dr. Wall requests and  
18    proposes that the adjournment only be in regards to the  
19    expert opinion evidence, and that the first two days of  
20    the hearing, today and tomorrow, proceed, at least with  
21    the attempt to get in all of the lay evidence and not  
22    waste the time of so many witness. And, in fact, if  
23    there is an adjournment of experts, then perhaps we can  
24    go into Day 3 next week to finish off all the lay  
25    witnesses.

26            That's very important to Dr. Wall, that there's no

1 further adjournment -- no further complete adjourned.  
2 If we feel there has to be an adjournment, it should be  
3 for the expert evidence only.

4 Lastly, I'll note, you know, my learned friend has  
5 given you Rule 8.16 of the Alberta Rules of Court that  
6 no more than once expert is permitted to give opinion  
7 evidence on any one subject on behalf of a party.  
8 Well, as we've already discussed, the Tribunal is not  
9 bound by strict rules of evidence, it's not bound by  
10 the Alberta Rules of Court. So in that sense, there's  
11 nothing binding here in any event.

12 But I'll say this, it should be quite obvious that  
13 this report deals with a different subject than  
14 Dr. Wall's other three experts. The other three  
15 experts are various scientists and medical doctors,  
16 immunologists, virologists, respirologists, and they  
17 are all dealing with the effectiveness or lack thereof  
18 of masks. They're deal with COVID-19; they're dealing  
19 with the SARS-CoV-2 virus. They're not dealing with  
20 whether or not masks are harmful. Certainly not in a  
21 specific sense that Chris Schaefer is doing with, and  
22 that being oxygen levels and carbon dioxide levels.

23 So this is a different subject, right? The  
24 effectiveness of masks is a different subject from the  
25 harms of masks. There's no way we can conflate those  
26 two. Those are different subjects; those are different

1 issues. Right? Does it fall under the broad issue of  
2 masks? Sure, it does. But that's a very important and  
3 different side of the coin as to whether or not it  
4 causes harm, right? Because when it comes to masks,  
5 there's a lot of different issues we've got to deal  
6 with. Do we need them, first of all? Second of all,  
7 do they help, even if we did need them? And then, of  
8 course, are they harmful?

9       So we have one report on a totally different issue  
10 here. That's the harms. The Complaints Director is  
11 saying that it's a fourth report on the same subject.  
12 That's just not the case. It's one report on a  
13 different subject. And so on that basis, even if the  
14 Rules of Court apply, it cannot be excluded on that  
15 basis.

16 THE CHAIR:                               Thank you, Mr. Kitchen.

17 MR. KITCHEN:                             Thank you.

18 THE CHAIR:                             Mr. Maxston?

19 Submissions by Mr. Maxston (Third Preliminary  
20 Application)

21 MR. MAXSTON:                           Thank you, Mr. Chair. I've  
22 got a few comments.

23       I'm going to start with an overall comment, and  
24 that is that -- and I'll echo this in my opening  
25 statement, and you'll certainly hear about it in  
26 closing statements -- Dr. Wall would like this hearing

1 to be about masking and the efficacy of masking or the  
2 science that does or doesn't support it, but the  
3 Complaints Director is strongly of the view that that's  
4 not the issue before you. The issue before you is one  
5 of governance and the responsibility of professionals  
6 to adhere to the requirements of their regulatory body,  
7 which is a cornerstone of professional regulation.

8 I think there are a number of very significant  
9 concerns that the Complaints Director has with the  
10 introduction of this report. The first thing I will  
11 say is that Rule 8.16(1) that I've quoted from the  
12 Rules of Court, as my friend said, says that: (as  
13 read)

14 Unless the Court otherwise permits, no more  
15 than one expert is permitted to give opinion  
16 evidence on any one subject on behalf of a  
17 party.

18 Now, my friend is quite right, and I've said this,  
19 you're not bound by the formal rules of evidence, but,  
20 as I've said to you before, the formal Rules of  
21 Evidence can provide you with important guidance, and  
22 this is a very serious and significant issue: It's an  
23 expert being called in to testify.

24 And I think the rationale behind that Rule 8.16  
25 applies here. The courts don't intend for you, as a  
26 decision-maker, to be inundated with report after

1 report after report, and that's why this rule is there.

2 And I think, although you're not, again, bound by  
3 the rules, strict Rules of Evidence, and you can bend  
4 those rules, what Dr. Wall is asking you to do here  
5 breaks those Rules of Evidence. This is a situation  
6 where Dr. Wall already has three experts testifying,  
7 three expert reports, three cv's, a serious and  
8 significant amount of expert evidence. And to allow  
9 further evidence on this question, I think, invites a  
10 circle of expert after expert after expert and takes  
11 away from what your role is. And, frankly, again from  
12 the Complaints Director's perspective, this is not  
13 about masking.

14 I think, as my friend mentioned, getting this  
15 report three weeks before the hearing is prejudicial.  
16 It's three pages long, but there's a fair bit of  
17 information in it. It's information that the College  
18 would conceivably want to respond to.

19 Our expert, Dr. Hu is a very, very busy  
20 individual, as we all are, and I can tell you that it  
21 is challenging, if not impossible, to find time, on a  
22 three-week notice, to consult with your expert,  
23 consider preparation of a rebuttal report, prepare the  
24 expert for the hearing, and do all the things that you  
25 would normally do with an expert in preparation for a  
26 hearing. So, again, I don't think this bends the



1 rules; it breaks the rules.

2 And there are three experts that the Complaints  
3 Director has, with a measure of reluctance will not be  
4 raising objections to them testifying. They can  
5 certainly weigh in on any kind of harm issues relating  
6 to masking. There's no independent need for this. And  
7 the prejudicial value to the Complaints Director is  
8 significant. This is a serious set of circumstances  
9 that the Complaints Director would need to respond to,  
10 and there simply isn't the time or ability to do that  
11 properly.

12 Now, I want to say one thing in that regard, my  
13 client opposes an adjournment. Mr. Schaefer's report  
14 could have been provided back in April or May, when  
15 Mr. Kitchen quite properly, and I commend him, sent the  
16 original three expert reports. We got those well in  
17 advance, and Mr. Kitchen I think made significant  
18 efforts in that regard.

19 We're not getting that here, and it's -- I'm not  
20 blaming anyone. I'm sure Mr. Schaefer is busy, but  
21 three weeks is awfully short, and it puts the  
22 Complaints Director at a serious disadvantage. And an  
23 adjournment, frankly, scratching expert evidence now,  
24 trying to find another time for Dr. Hu to testify I  
25 think is going to, frankly, be a loss, a real loss to  
26 this Tribunal, and we ought to proceed with the hearing

1 as scheduled.

2 So, Mr. Chair, those are my comments. I'm happy  
3 to answer any questions, and Mr. Kitchen may have some  
4 response comments as well in fairness to him.  
5 Reply Submissions by Mr. Kitchen (Third Preliminary  
6 Application)

7 MR. KITCHEN: I do have some response  
8 comments just briefly.

9 First, the -- I hear again the comment that this  
10 isn't about masking as far as the Complaints Director  
11 is concerned; yet, he has put in an expert report  
12 himself on masking. We just went through an  
13 application where the Complaints Director sought to put  
14 in more documents about masking from AHS. Clearly the  
15 case is about masking. The Complaints Director is  
16 speaking out of both sides of his mouth when it's  
17 convenient to do so to oppose Dr. Wall's evidence or  
18 support his evidence when he wants it in.

19 The knife cuts both ways. If we are going to  
20 allow all this extra evidence about masking, if we're  
21 going to put in all the expert evidence about masking,  
22 then let's put it all in, let's actually get to the  
23 truth of the matter, and let's actually canvass all the  
24 issues, which is really what we're here to do.

25 Furthermore, Dr. Wall gets to decide what his  
26 defence is going to be. And I understand that the

1 Complaints Director's position is that, well, he  
2 disobeyed the rules, and that's it. But he's  
3 challenging the rules. He is impugning the ACAC mask  
4 directive as unlawful. That's his defence. So a key  
5 issue to that is not just the ineffectiveness of masks  
6 but whether or not they're harmful. If he's going to  
7 claim Charter rights and human rights violations, as he  
8 is, if he's going to challenge the lawfulness of the  
9 ACAC mask mandate, which he is, then this evidence is  
10 highly relevant to those legal legitimate legal claims.

11 That's my response.

12 THE CHAIR: Thank you.

13 MR. MAXSTON: Mr. Chair, this is a little  
14 unusual, but there's one thing that Mr. Kitchen brought  
15 up that I do want to speak to very briefly, if you'll  
16 just allow me 1 minute.

17 THE CHAIR: Okay.

18 Reply Submissions by Mr. Maxston (Third Preliminary  
19 Application)

20 MR. MAXSTON: The comment was to the effect  
21 of the Complaints Director can't have it both ways,  
22 he's talking out of both sides of his mouth, he's  
23 putting in these documents about masking; I'll speak to  
24 this in my opening submissions, but the Complaints  
25 Director's view is this is a very focused hearing, and  
26 it's focused on a question of governability and what it

1 means to be a professional.

2 Dr. Wall has chosen to bring masking in and the  
3 efficacy of masking. The Complaints Director had no  
4 choice but to respond in some manner to that and called  
5 one expert in opposition to the three that were called.  
6 The Complaints Director didn't have any options there,  
7 because, of course, if we hadn't called an expert, what  
8 we would hear from Dr. Wall and Mr. Kitchen is that  
9 their expert evidence was unopposed, but we do not  
10 think this is about masking, and we're not having it  
11 both ways. We simply had to have an expert come in and  
12 have to talk about masking, because that's the case  
13 that Dr. Wall is mounting.

14 Thank you for allowing me that further comment.

15 THE CHAIR: I'm sure will get into that  
16 more when we get into the opening submissions.

17 Okay, let's take a brief caucus here so the  
18 Hearing Tribunal can determine if we have any further  
19 questions and deliberate on the admissibility of the cv  
20 and expert report from Mr. Schaefer, so hopefully it  
21 won't take us long. Let's plan for 10 after 11, and  
22 we'll try and be back by then, but if we're not, please  
23 bear with us. Thank you.

24 (ADJOURNMENT)

25 THE CHAIR: Okay, this Hearing Tribunal is  
26 back in session.

1 Ruling (Third Preliminary Application)

2 THE CHAIR: Members of the Tribunal with  
3 the assistance of our legal counsel have discussed the  
4 two items in question, that being the cv from  
5 Mr. Schaefer and his expert report. Our finding is  
6 that it does meet -- these two documents do meet the  
7 requirements for admissibility, and as such, we will  
8 admit them as evidence.

9 EXHIBIT G-4 - 2-page curriculum vitae of  
10 Chris Schaefer

11 EXHIBIT G-5 - 89-page document titled "Chris  
12 Schaefer Expert Witness Report"

13 THE CHAIR: We do recognize that there is  
14 potentially a problem for the Complaints Director and  
15 counsel in terms of getting an expert of their own to  
16 rebut this information or this evidence.

17 If that is an issue, then we would ask that we do  
18 our best to work around it, given the dates that we  
19 have booked. We very much would agree with counsel  
20 that we would like to avoid any further adjournments,  
21 but, at the same time, we do not want to interfere with  
22 counsel's ability to prepare the case they want to  
23 present, so we will certainly listen to any requests  
24 from counsel if timing is a concern and further time is  
25 required.

26 MR. MAXSTON: Mr. Chair, thank you for your

1     comments. I believe just before we began the  
2     preliminary applications, you had finished the  
3     questions you needed to ask of everyone and had gone  
4     through your checklist, for lack of a better phrase,  
5     and I was to begin my opening statement, so if, subject  
6     to anything Mr. Kitchen needs to add, I'm going to  
7     proceed with the balance of my opening statement.

8     THE CHAIR:                     Yeah, that would be --  
9     Mr. Kitchen, anything -- does that process work for  
10    you?

11    MR. KITCHEN:                  Yes, it does. It sounds like  
12    the Complaints Director is not going to seek any kind  
13    of adjournment, and that's certainly fine with  
14    Dr. Wall, so I think we're fine to proceed.

15    MR. MAXSTON:                 Yeah, I think what I would do,  
16    and I think this is consistent with your comments,  
17    Mr. Chair, is that if there becomes an issue from the  
18    Complaints Director's perspective with respect to  
19    Mr. Schaefer's evidence, we'd reserve our right to  
20    perhaps call -- and this would be a little out of  
21    order -- a rebuttal expert or something like that, but  
22    I think that leeway has to be given to us, and I think  
23    your comments were consistent with that. I don't know  
24    if we'll need to do that, frankly, but I appreciate  
25    the -- I appreciate that, and, again, we'll reserve our  
26    rights in that regard.

1 Opening by Mr. Maxston

2 MR. MAXSTON: So I will then just continue  
3 with where we were at about maybe two hours or so ago.  
4 I'd begun my submissions by telling you that we were in  
5 what is called the liability phase of the hearing, the  
6 contested phase, where both sides present their  
7 evidence, and I'll just carry on then in terms of my  
8 opening submissions.

9 To give you a road map, I have a couple of very  
10 quick -- I have I think five or six areas -- seven  
11 areas I'm going to chat about. The first thing is I've  
12 got a couple of very quick questions for Mr. Kitchen  
13 that I want to just do some housekeeping with.

14 The second thing I want to do is speak to the  
15 exhibits and the exhibit list that is before you, those  
16 are the agreed on exhibits.

17 The third thing I want to do is take you through  
18 what I anticipate will be an order of proceedings for  
19 the next four days. I've chatted a little bit with  
20 Mr. Kitchen about this, and I'll welcome his comments.

21 The fourth thing I want to do is talk about some  
22 of the legal and evidentiary principles that apply to  
23 this hearing.

24 The fifth thing I want to do is to comment about  
25 the difference between expert witnesses and lay  
26 witnesses.

1           The sixth thing I want to do is very, very briefly  
2     give you a sense of what each of the Complaints  
3     Director's witnesses will testify to.

4           And the final thing, the seventh thing I want to  
5     do is to comment on what the Complaints Director  
6     believes are the critical issues before you and what  
7     your role is in these proceedings.

8           So, again, the first thing I'll deal with is a  
9     couple of housekeeping matters for Mr. Kitchen.  
10    Mr. Chair, you helpfully dealt with the jurisdiction  
11    and composition of the Hearing Tribunal and consent to  
12    a virtual hearing. I'll just get Mr. Kitchen to  
13    confirm that all of the agreed-upon exhibits have been  
14    provided to him and his client.

15   MR. KITCHEN:                   Yes, they have.

16   MR. MAXSTON:                  So I'll turn now to the second  
17    area I wanted to speak to, and that is the agreed on  
18    exhibits, and I think, frankly, now the additional  
19    exhibits, which are before you, with the consent of  
20    Dr. Wall, the agreed on exhibits were provided to you  
21    in advance of the hearing to allow you to review them  
22    for information and, of course, to not deliberate  
23    amongst yourselves.

24           As you know, the exhibits are listed in blocks of  
25    documents, Files A, B, C, D, E, and F, and we now have  
26    an additional File H, which has a few straggler



1 documents.

2 I'm going to ask that the court reporter, either  
3 during a break in the hearing or perhaps after the  
4 hearing, formally mark those exhibits; they will need  
5 to be formally marked.

6 And I'll just, again, get Mr. Kitchen to confirm  
7 that those exhibits are entered with his client's  
8 consent, and he has no problem with the court reporter  
9 marking them during a break or after, in fact.

10 THE CHAIR: And, Mr. Maxston, how do you  
11 propose we mark these: A-1, A-2, A-3, et cetera?

12 MR. MAXSTON: I think we use the exhibit  
13 list that was provided to you as a PDF with each of  
14 them, and we use the numbering. I think that's how  
15 I've been preparing for the hearing. If we change  
16 that, I'm going to have some problems in referring you  
17 to documents, so I'm assuming that's all right, and  
18 Mr. Kitchen, again, will agree to having those exhibits  
19 marked.

20 THE CHAIR: Any issues with that,  
21 Mr. Kitchen?

22 MR. KITCHEN: No.

23 THE CHAIR: No, okay. It would just be  
24 good to make sure we're all on the same numbering  
25 system here because there are a lot of them.

26 MR. MAXSTON: So, Mr. Chair, then we'll use

1 the numbering system that is there and the list of  
2 exhibits that has been provided to you as a PDF.

3 EXHIBIT A-1 - Amended Notice of Hearing,  
4 Notice to Attend as Witness, and Notice to  
5 Produce, July 22, 2021

6 EXHIBIT A-2 - Email from AHS to Member re  
7 Complaint, dated December 1, 2020

8 EXHIBIT A-3 - Letter of Complaint Referral  
9 from Registrar, dated December 2, 2020

10 EXHIBIT A-4 - ACAC Statement on Alberta  
11 Health Notice of Closure for a Calgary  
12 Chiropractic Clinic, December 15, 2020

13 EXHIBIT A-5 - Letter to Member re s.56  
14 Complaint, dated December 21, 2020

15 EXHIBIT A-6 - Letter from Member in Response  
16 to Complaint, January 11, 2021

17 EXHIBIT A-7 - ACAC Complaint Investigation  
18 Report

19 EXHIBIT A-8 - Letter from Dr. Salem, dated  
20 December 12, 2020

21 EXHIBIT A-9 - Letter from Dr. Salem, dated  
22 January 11, 2021

23 EXHIBIT A-10 - ACAC Code of Ethics

24 EXHIBIT A-11 - ACAC Standards of Practice

25 EXHIBIT B-1 - Letter Requesting s.65 Review,  
26 dated December 3, 2020

1 EXHIBIT B-2 - Letter Requesting Extension,  
2 dated December 9, 2020  
3 EXHIBIT B-3 - Response of Dr. Wall s.65  
4 Request, dated December 10, 2020  
5 EXHIBIT B-4 - Response of Dr. Wall s.65  
6 Request and Enclosures, dated December 16,  
7 2020  
8 EXHIBIT B-5 - Letter of Decision re s.65  
9 Review, dated December 18, 2020  
10 EXHIBIT C-1 - ACAC Notice to Members re  
11 Telehealth Billing, dated March 26, 2020  
12 EXHIBIT C-2 - ACAC Notice to Members re  
13 Consultation, dated April 21, 2020  
14 EXHIBIT C-3 - ACAC Notice to Members re  
15 Consultation, April 22, 2020  
16 EXHIBIT C-4 - ACAC Website Update on COVID  
17 Practices, April 29, 2020  
18 EXHIBIT C-5 - ACAC Notice to Members re  
19 Return to Practice, dated April 30, 2020  
20 EXHIBIT C-6 - ACAC Notice to Members re  
21 Return to Practice, dated May 1, 2020  
22 EXHIBIT C-7 - ACAC Notice to Members re  
23 Approval of Plan, dated May 3, 2020  
24 EXHIBIT C-8 - ACAC Notice to Members about  
25 Masking, May 25, 2020  
26 EXHIBIT C-9 - ACAC Notice to Members about

- 1 Masking, dated July 24, 2020
- 2 EXHIBIT C-10 - ACAC Council Updates re
- 3 Telehealth, July 31, 2020
- 4 EXHIBIT C-11 - ACAC Registrar's Report,
- 5 August 4, 2020
- 6 EXHIBIT C-12 - ACAC Notice to Members re
- 7 COVID Practices, dated August 11, 2020
- 8 EXHIBIT C-13 - ACAC Website re Telehealth,
- 9 October 20, 2020
- 10 EXHIBIT C-14 - ACAC Notice to Members re
- 11 Directive, dated November 23, 2020
- 12 EXHIBIT C-15 - ACAC Notice to Members re
- 13 Restrictions, dated November 25, 2020
- 14 EXHIBIT C-16 - ACAC Website COVID FAQs, dated
- 15 November 25, 2020
- 16 EXHIBIT C-17 - ACAC Website Update on COVID
- 17 Practices, December 1, 2020
- 18 EXHIBIT C-18 - Notice to Members about
- 19 Masking, dated December 9, 2020
- 20 EXHIBIT C-19 - ACAC Notice to Members re PPE,
- 21 date December 10, 2020
- 22 EXHIBIT C-20 - ACAC COVID-19 Pandemic
- 23 Practice Directive, May 5, 2020
- 24 EXHIBIT C-21 - ACAC COVID-19 Pandemic
- 25 Practice Directive, May 25, 2020
- 26 EXHIBIT C-22 - ACAC COVID-19 Pandemic

1 Practice Directive, January 6, 2021  
2 EXHIBIT D-1 - COVID-19 Business Closure Order  
3 CMOH 25-2020, dated December 8, 2020  
4 EXHIBIT D-2 - AHS Order to Rescind Closure  
5 Notice, January 5, 2021  
6 EXHIBIT D-3 - CMOH Order 19-2021, dated May  
7 6, 2021  
8 EXHIBIT D-4 - CMOH Order 20-2021, dated May  
9 6, 2021  
10 EXHIBIT D-5 - CMOH Order 22-2021, dated May  
11 13, 2021  
12 EXHIBIT D-6 - CMOH Order 26-2020, dated June  
13 6, 2020  
14 EXHIBIT D-7 - CMOH Order 34-2021, dated June  
15 30, 2021  
16 EXHIBIT D-8 - CMOH Order 38-2020, dated  
17 November 24, 2020  
18 EXHIBIT D-9 - CMOH Order 42-2020, dated  
19 December 11, 2020  
20 EXHIBIT D-10 - City of Calgary - Temporary  
21 COVID-19 Face Covering Bylaw, March 11, 2020  
22 EXHIBIT D-11 - City of Calgary - Bylaw that  
23 repeals Mask Bylaw, dated July 5, 2021  
24 EXHIBIT E-1 - 9-page curriculum vitae for  
25 Dr. Jia Hu  
26 EXHIBIT E-2 - Dr. Jia Hu - Expert Report

1           Masking  
2           EXHIBIT E-3 - 9-page curriculum vitae for  
3           Dr. Bao Dang  
4           EXHIBIT E-4 - Dr. Bao Dang - Expert Report  
5           Masking  
6           EXHIBIT E-5 - 95-page curriculum vitae for  
7           Dr. Byram Bridle  
8           EXHIBIT E-6 - Dr. Byram Bridle - Expert  
9           Report Masking  
10          EXHIBIT E-7 - 5-page curriculum vitae for  
11          Dr. Thomas A. Warren  
12          EXHIBIT E-8 - Dr. Thomas A. Warren - Expert  
13          Report Masking  
14          EXHIBIT F-1 - GOA Albert's safely staged  
15          COVID-19 relaunch, dated April 30, 2020  
16          EXHIBIT F-2 - CMOH Order 16-2020, dated May  
17          3, 2020  
18          EXHIBIT F-3 - ACAC Registrar's Report, dated  
19          July 5, 2021  
20          EXHIBIT F-4 - ACAC Frequently Asked  
21          Questions, dated July 7, 2021  
22   MR. MAXSTON:                   I do want to comment a little  
23   bit about some other aspects of the exhibits.  
24           Typically, only evidentiary documents are entered  
25   as exhibits, those would be patient charts, CMOH  
26   orders, those types of things. Things like the Health

1 Professions Act or the Chiropractors' Profession  
2 Regulation don't have to be entered as exhibits.  
3 Mr. Pavlic can tell you, as a courtesy, we've added the  
4 Standards of Practice and the Code of Ethics as  
5 exhibits, but they really don't have to be marked as  
6 exhibits, but we've done that for ease of reference.

7 From time to time, I think during the hearing  
8 we're going to be taking you, at least I'm going to be  
9 taking you to a couple of sections in the HPA, and to  
10 the extent that you're able to do this, I'd encourage  
11 you to have a copy of the HPA handy or maybe be able to  
12 access it on the Queen's Printer. I'm not going to  
13 take you through a lot of things, but having some of  
14 those sections in front of you might be helpful.

15 The third thing I want to do is talk about the  
16 order of proceedings over the next four days, and again  
17 I've talked with Mr. Kitchen about this, we're each  
18 going to be providing opening statements. I will then  
19 present my case on behalf of the Complaints Director,  
20 which involves calling three witnesses, Dr. Todd  
21 Halowski, the College's Registrar, Dr. Hu, who is an  
22 expert, and then Mr. David Lawrence, who is the  
23 College's Complaints Director. I'll talk about the  
24 order of witnesses when we get a little bit closer to  
25 our lunch break, the actual order.

26 Each of the Complaints Director's witnesses would

1 be questioned by me, Mr. Kitchen would carry out a  
2 cross-examination, I might have a couple of follow-up  
3 questions, and then the Hearing Tribunal would be able  
4 to ask questions of those witnesses, and then they  
5 would be excused. The process for Dr. Wall's witnesses  
6 would repeat, and I would, of course, be in the  
7 position of cross-examining, and we would go from  
8 there.

9 After all of the witnesses for both sides have  
10 completed their testimony, I would make a closing  
11 statement, and Mr. Kitchen would make a closing  
12 statement on behalf of his client.

13 Mr. Kitchen, are you comfortable with that order  
14 for the proceedings?

15 MR. KITCHEN: Yes. Just to clarify, when it  
16 comes to closing statements, are we, at that point,  
17 just simply reviewing the evidence, or are we also  
18 going to be making legal submissions and supplying  
19 cases, et cetera?

20 MR. MAXSTON: I thought we would be  
21 reviewing the evidence, and we'd be providing cases in  
22 making our legal argument. If you and I need to  
23 fine-tune that, I'm happy to discuss that with you.

24 It's occurred to me that, for example, if we were  
25 to finish on day 4 at 3:00, probably neither of us is  
26 in a position to get all our thoughts together after



1 three days of evidence in the very brief period of  
2 time, so I think we can probably accommodate some other  
3 arrangement as necessary for that, but, yes, that was  
4 my thought.

5 MR. KITCHEN: In that sense, closing  
6 statements would probably be significantly larger than  
7 opening statements, so --

8 MR. MAXSTON: I think they would --

9 MR. KITCHEN: -- I want the Tribunal to know  
10 that.

11 THE CHAIR: And I just didn't hear in  
12 Mr. Maxston's description an opening statement from  
13 you, should you choose to make one, Mr. Kitchen. I'm  
14 assuming that would be the case before your witnesses  
15 are called.

16 MR. MAXSTON: And I intended that,  
17 Mr. Chair. I'm sorry, if I omitted that.

18 MR. KITCHEN: No, I recalled you saying  
19 that, but, yes, I will be giving an opening statement,  
20 very brief.

21 THE CHAIR: Okay.

22 MR. MAXSTON: So, Mr. Chair, then once the  
23 liability phase of the hearing is completed, you would  
24 go away as a tribunal, and you would deliberate, and  
25 then you'll issue your written decision, and if you  
26 make any findings of unprofessional conduct, we would

1 reconvene to deal with the matter of penalty orders.

2       The fourth area I want to speak to you about is to  
3 very briefly review some of the legal principles that  
4 are in play in a discipline hearing like this and more  
5 specifically to responsibilities that the Complaints  
6 Director has, and Mr. Pavlic certainly can canvass this  
7 with you.

8       The first is that a Complaints Director has to  
9 prove the facts that underlie or give rise to the  
10 alleged unprofessional conduct, and I think, frankly,  
11 the facts in this matter are not in dispute or are  
12 almost in -- largely not in dispute, but it's important  
13 to remember that these are civil proceedings not  
14 criminal proceedings, and the burden of proof on the  
15 Complaints Director is what's called the balance of  
16 probabilities, not the beyond a reasonable doubt  
17 standard that applies in criminal proceedings, which is  
18 much, much higher. The burden of proof on the  
19 Complaints Director here is again on the balance of  
20 probabilities, and that's really 50.1 percent it's more  
21 probably than not. So that's the first onus on the  
22 Complaints Director: Proving the facts on a balance of  
23 probabilities.

24       The next onus or responsibility on the Complaints  
25 Director is to prove that those facts rise to the level  
26 of unprofessional conduct. And you have, Mr. Chair and

1 Tribunal Members, several tools available to you to  
2 assess the conduct and determine whether unprofessional  
3 conduct has occurred.

4 So what are those tools; what can you look to?  
5 The first tool is the Health Professions Act and the  
6 definition of unprofessional conduct that appears in  
7 Section 1(1)(pp) of the HPA. You don't have to have  
8 this handy in front of you; I'm just going to read it  
9 to you. Section 1(1)(pp) says: (as read)

10 Unprofessional conduct means one or more of  
11 the following, whether or not it is  
12 disgraceful or dishonourable.

13 And then it has a bunch of subheadings, and from the  
14 Complaints Director's perspective, there are four of  
15 those subheadings that are triggered and that apply in  
16 this hearing.

17 The first one is item (i): (as read)  
18 Displaying a lack of knowledge of or lack of  
19 skill or judgment in the provision of  
20 professional services.

21 So that's subsection (i). Then subsection (ii): (as  
22 read)

23 Contravention of this Act, a Code of Ethics  
24 or Standards of Practice.

25 And then subsection (iii): (as read)

26 Contravention of another enactment that

1 applies to this profession.

2 And then the final sub definition in section 1(1)(pp)  
3 that applies is item 12, (xii): (as read)

4 Conduct that harms the integrity of the  
5 regulated professional.

6 So those are in the Complaints Director's submissions  
7 the four parts of the definition of unprofessional  
8 conduct that apply today.

9 I did want to mention that in prior discipline  
10 legislation, there were often terms like "unskilled  
11 practice" and "professional conduct". "Unskilled  
12 practice" meaning some sort of a technical lapse in  
13 what you're doing, a competence lapse; and then  
14 "professional conduct" meaning some type of ethical or  
15 moral turpitude that is occurring. Well, under the  
16 HPA, we have one term "unprofessional conduct" that  
17 covers both of those. And as I mentioned at the  
18 beginning of the definition of section 1(1)(pp), it  
19 says: (as read)

20 Regardless of whether the conduct is  
21 disgraceful or dishonourable.

22 We're not talking about that; we're talking -- in the  
23 HPA world, we're talking about whether these actions  
24 constitute unprofessional conduct.

25 Very briefly, I'll also mention to you that  
26 Section 1(1)(j) of the HPA says that: (as read)

1           Conduct is defined as meaning an act or an  
2           omission.

3       So when we're talking about unprofessional conduct,  
4       it's doing something and/or failing to do so.

5           So that's the first tool that's available to you:  
6       What's in the HPA, what it says about what constitutes  
7       unprofessional conduct.

8           The second tool available to you are the sections  
9       of the College's Standards of Practice and Code of  
10      Ethics, and of course as you know from the preliminary  
11      application, we've referenced a number of those  
12      sections in the Notice of Hearing and the closing  
13      paragraph. Those are things that I'll take you through  
14      in my closing submissions, and those, again, are ways  
15      you measure and assess Dr. Wall's conduct.

16          The third tool available to you in these  
17      proceedings is the Pandemic Directive the College  
18      issued, and we haven't talked about that yet, we're not  
19      there yet, but you have seen it as the result of your  
20      review of the exhibits. There are three versions of  
21      the Pandemic Directive. They don't change very much.  
22      We're going to really rely on the final one, the most  
23      recent one, from January of this year; I'll be using  
24      that document. But that Pandemic Directive is another  
25      way that you can assess Dr. Wall's conduct.

26          The fourth tool that's available to you, and this

1 is for the chiropractors on the Tribunal or if any of  
2 the public members have health care experience is to  
3 use your knowledge and training and experience as a  
4 health care provider to assess Dr. Wall's conduct and  
5 whether it is a departure from the profession that  
6 falls within the category of unprofessional conduct.

7 The final tool that's available to you, and it's  
8 available to all of you, is to use your common sense  
9 and to carefully consider whether what Dr. Wall did is  
10 something that chiropractors shouldn't do and whether  
11 it, again, rises to the level of unprofessional  
12 conduct.

13 I want to turn now to the fifth area that I want  
14 to speak to, and that's the difference between  
15 testimony from lay witnesses, regular people for lack  
16 of a better phrase, and expert witnesses.

17 So we talked about Section 79(5) of the HPA, and  
18 it's saying to you that you're not bound by the formal  
19 Rules of Evidence, and that's to allow more flexibility  
20 and to have an easier process than what would occur in  
21 the courts, but I also mention to you that Section  
22 79(5) doesn't say you must ignore the Rules of  
23 Evidence, and, in fact, there are certainly situations  
24 where the Rules of Evidence are going to apply, and  
25 they're going to not only give you guidance, they're  
26 going to require you, in my submission, to take certain

1 steps when it comes to evidence.

2 So I want to reinforce here the very important  
3 distinction at law between expert witnesses and lay  
4 witnesses and, more specifically, what the courts have  
5 established those kinds of witnesses can and cannot say  
6 when they're testifying. And in my (INDISCERNIBLE) to  
7 you, those principles apply to this hearing, and they  
8 should be adhered to.

9 You'll know we've got a number of expert  
10 witnesses: Dr. Hu, Dr. Dang, Dr. Bridle, Dr. Warner.  
11 And then we have a series of lay witnesses, everyone  
12 from the Registrar of the College to Dr. Wall himself,  
13 Dr. Gauthier, a chiropractor who Dr. Wall is calling,  
14 and I think four of his patients are being called as  
15 well.

16 So as your independent legal counsel can review  
17 with you, and I'm sure Mr. Kitchen would agree, the  
18 general rule is that lay witnesses can only provide a  
19 decision-maker with their observation of facts, things  
20 that are within their direct knowledge that are factual  
21 in nature. And the Rules of Evidence I would suggest  
22 to you, submit to you, is that lay witnesses are  
23 prohibited from providing opinion evidence to you, and  
24 that's why we have a separate category of witnesses  
25 known as expert witnesses, and those witnesses, after  
26 being qualified, that is, after hearing about their

1 background, their knowledge and training, are able to  
2 provide you with opinion evidence, and you're going to  
3 hear some opinion evidence, of course, in this hearing.

4 Based on the information Mr. Kitchen has given to  
5 me, among the lay witnesses that Dr. Wall is calling,  
6 he's calling another chiropractor, he's calling  
7 patients of his, I understand that they're going to be  
8 providing you with opinions about masking and maybe  
9 COVID, their opinion of Dr. Wall as a chiropractor,  
10 their opinion of the College.

11 Based on the strict Rules of Evidence, the College  
12 could object to that and say, no, we don't think these  
13 people should be heard, they can't be heard, they are  
14 lay witnesses that they could talk about if they were a  
15 patient making a complaint, what happened when an  
16 adjustment was done. But they can't just be called to  
17 give opinion evidence: Here's what I think, as a lay  
18 witness, a man on the street or a woman on the street,  
19 about the College or COVID or something like that.

20 So the College -- the Complaints Director, as I  
21 said, could have objected to those people testifying,  
22 but, with a measure of reluctance, I will say to you  
23 we're not going to do that, but we're going to submit  
24 to you later on that the lay witness evidence should be  
25 given very, very little effect, very, very little  
26 weight, because it is just that, it's lay witness



1 evidence. And this hearing isn't about what patients  
2 think about Dr. Wall, what Dr. Gauthier, his  
3 chiropractor witness, thinks about him; this is about  
4 the issue of unprofessional conduct as described in the  
5 charges.

6 So that's a very, very important I think qualifier  
7 to the lay witness testimony you're going to hear, and  
8 I'll speak more about that in my closing submissions.

9 The sixth thing I want to talk about is the three  
10 witnesses that the College is going to call and what I  
11 anticipate they will be saying, and I'm going to be  
12 very brief on this, because you'll hear from the  
13 witnesses, but just to let you know where we're coming  
14 from.

15 I intended to call Dr. Todd Halowski first today,  
16 but that won't happen I don't think. Dr. Halowski will  
17 testify sometime tomorrow I believe. Dr. Halowski is  
18 the College's Registrar, as the chiropractors on  
19 (INDISCERNIBLE), and he'll give some evidence about the  
20 function of the College and the development of the  
21 Pandemic Directive, and he'll talk about his  
22 involvement in the complaint that gives rise to these  
23 proceedings.

24 Dr. Hu is a College's -- Complaints Director  
25 expert witness, and you'll see that he has extensive  
26 background in public health. He was involved or

1 testified that he was involved in the CMOH orders  
2 themselves, and he'll speak to the validity of the  
3 science supporting masking and supporting other  
4 COVID-19 measures that are in the Pandemic Directive.

5 The final witness that the College will be calling  
6 is Mr. David Lawrence, who is the College's Complaints  
7 Director. He's going to comment, to some degree, about  
8 the CMOH orders and Pandemic Directive as they relate  
9 to discipline matters, and he's also going to speak to  
10 the complaint, investigation, and referral to hearing.

11 So that's just to give you a favour of the  
12 College's witnesses, and I anticipate Mr. Kitchen will  
13 be speaking to you about what he anticipates his  
14 client's witnesses will be testifying on.

15 So I want to turn to the seventh and final area  
16 that I want to speak to you about, and that is some  
17 comments about what the Complaints Director believes  
18 this hearing is about and, just as importantly, what  
19 it's not about, and what your role is in the hearing.

20 So, Mr. Chair and Hearing Tribunal Members, it's  
21 very obvious to say that this hearing is not, of  
22 course, occurring in a vacuum. Among other things, the  
23 charges relate to Dr. Wall not masking, not observing  
24 social distancing, not having plexiglass barriers in  
25 place, and there is a debate, at times a vigorous one  
26 in our society, about masking restrictions and other

1 COVID-19 restrictions. Some people support them,  
2 others do not, and some people challenge the scientific  
3 efficacy of those provisions or those measures, and  
4 other's take a very different view.

5       So Dr. Wall and his expert witnesses, we suspect,  
6 will want to make this hearing about that very issue,  
7 that very question, the science or lack thereof  
8 supporting masking, supporting social distancing, those  
9 types of things. That's where they're going to want to  
10 take you in this hearing. I anticipate they're going  
11 to argue that the science supports Dr. Wall's  
12 independent choice to not comply with the College's  
13 Pandemic Directive, and that he had some type of a  
14 reasonable basis for doing that, and that the science  
15 does not support masking and, therefore, excuses and  
16 other COVID measures, and that that somehow excuses his  
17 conduct, and that it means that he's not guilty of  
18 unprofessional conduct.

19       On behalf of the Complaints Director, I'm going to  
20 urge you to not be distracted by that, even though  
21 you're going to hear a great deal of information about  
22 that. That's because that's not what this hearing is  
23 about, and you do not, let me be clear, you do not have  
24 to make the finding or decision about whether masking  
25 is or isn't warranted, whether social distancing is or  
26 isn't warranted, whether the CMOH orders are the right

1     thing or the wrong thing. You don't have to make any  
2     decisions about science. That's not your role here.  
3     This hearing is not about masking, it's not about  
4     social distancing, it's not about Dr. Wall's personal  
5     beliefs or conclusions.

6             This hearing is about the public. It's about  
7     patients and their well-being, and it's really about  
8     being a member of a regulated profession, a regulated  
9     profession. It's all about government through the HPA  
10    creating the profession of chiropractic in Alberta,  
11    and, at the same time, doing that for about 30 other  
12    health care professions in Alberta. It's about  
13    Section 3 of the Health Professions Act that says: (as  
14    read)

15            A College must discharge its duties in the  
16            public interest and must maintain and enforce  
17            standards for the profession.

18            Must maintain, must enforce standards for the  
19            profession.

20            This hearing is about mandatory obligations and  
21            responsibilities that all professionals have:  
22            Chiropractors, dentists, doctors, lawyers, nurses.  
23            Practicing in a profession is a privilege, it is not a  
24            right; it is a privilege, not a right.

25            And with that privilege come a host of  
26            responsibilities that a professional is required to

1 discharge. Those are things like getting the right  
2 education to get into a profession. Things like paying  
3 for a practice permit each year and satisfying CPR and  
4 emergency training requirements each year. Things like  
5 abiding by Standards of Practice and Codes of Ethics.  
6 Things like required life-long learning as a  
7 professional through continuing competence, and this  
8 College has a continuing competence program. It's  
9 through things, a myriad of things, standards and  
10 directives relating to charting and patient consent and  
11 sexual relationships with patients, all those things  
12 that govern how professionals must conduct themselves.  
13 That's what this hearing is about, because practicing,  
14 again, is a privilege not a right.

15 I told you earlier that the -- this hearing, I  
16 don't believe, is really about factual issues, because  
17 the facts aren't really in dispute. I'm almost certain  
18 you're going to hear direct evidence from Dr. Wall that  
19 he made a decision in June of 2020 to deliberately not  
20 follow the College's Pandemic Directive and the masking  
21 and social distancing and that plexiglass barrier  
22 requirements that it had.

23 And I want to make it very clear from the  
24 Complaints Director's perspective that the Pandemic  
25 Directive is mandatory. It's a mandatory requirement  
26 for members of the profession. And as you'll hear from

1 the Complaints Director's witnesses, that mandatory  
2 Pandemic Directive was a requirement from Government  
3 for chiropractors to re-enter practice after COVID-19  
4 first hit this province. It wasn't a choice for the  
5 College. It wasn't something they decided to do or had  
6 any discretion about. This was the law for  
7 chiropractors to re-enter practice. And you'll see  
8 that through a series of exhibits coming from the  
9 Alberta Government and the CMOH orders. It was a  
10 requirement the Pandemic Directive be created in order  
11 for chiropractors to practice, and it was a requirement  
12 for chiropractors to follow it.

13 So again this hearing is about Dr. Wall, on his  
14 own and, as you'll see from the evidence, without ever  
15 contacting the College, deciding that he knew best and  
16 deciding that he would opt out of the Pandemic  
17 Directive, that he could decide whether it was  
18 applicable to him or not. And I can't emphasize enough  
19 that there is going to be evidence and, I think this  
20 will be admitted by Dr. Wall, that there was no contact  
21 with the College by him from June to December of 2020  
22 on the charges -- or the related charges.

23 I'm going to say something that to the Complaints  
24 Director is very obvious and yet it's very important,  
25 and that is that members of the chiropractic profession  
26 and, indeed, any profession can't on their own on any

1 given day decide what professional obligations they  
2 will or won't follow.

3       What if Dr. Wall said, for example, Today's a day  
4 where I don't think the College's charting requirements  
5 are important, I'm going to chart my own way; or what  
6 the College says about patient consent, You know, I  
7 don't think they've got it right, I'm going to get  
8 patient consent my own way or I'm not going to get it  
9 at all, I'm going to decide what happens. What about a  
10 physician who says, You know what, there are  
11 requirements from my college to not date a patient or  
12 have a sexual relationships; well, I'm a physician, I'm  
13 a bright guy or lady, I'm going to decide whether that  
14 applies to me or not, and a lawyer deciding,  
15 Mr. Kitchen and I, how we want to treat our trust  
16 monies that are in our accounts on behalf of clients  
17 and opt out of Law Society requirements. Well, of  
18 course, members of a profession can't do that; they  
19 can't on their own on a daily, weekly, monthly basis  
20 decide what does or doesn't apply to them in terms of  
21 their regular Code of Ethics.

22       And there's some very good reasons for that.  
23 There's obvious ones, that it's illegal to do that.  
24 There's a regime in place for public protection and for  
25 the regulation of professionals. This is really about  
26 public trust in professionals and the integrity of the

1 profession in the eyes of the public, and that  
2 absolutely depends on members of the public knowing  
3 that professionals will meet their obligations, knowing  
4 that, when they walk into a chiropractor's office, he  
5 or she has the right training, that he or she has a  
6 valid practice permit, that he or she is following up  
7 with their continuing competence requirements, that he  
8 or she is complying with the College's Pandemic  
9 Directive.

10 So let me be clear also, on behalf of the  
11 Complaints Director, that there can be a vigorous  
12 wholesome discussion in the chiropractic profession  
13 about any particular issue in front of it, whether it's  
14 masking and social distancing or anything else.

15 And, in fact, you'll see from the documents and  
16 witnesses in front of you that the College invited  
17 discussion about the Pandemic Directive and was  
18 available to discuss the Pandemic Directive with its  
19 members. Of course, Dr. Wall chose to not do that. He  
20 declined; he chose to not contact the College.

21 If Dr. Wall had concerns about the Pandemic  
22 Directive, really significant concerns, his recourse  
23 should be to the courts or the legislature. It should  
24 not be to decide, while he's practicing, to opt out of  
25 these requirements.

26 If this hearing isn't about masking, and I've made



1     that comment to you a number of times, and it's not  
2     about social distancing or plexiglass barriers, and  
3     it's not about science that supports those or doesn't  
4     support them, well, why is the Complaints Director  
5     calling an expert witness in that field. I touched on  
6     this a little bit on this with you before, but Dr. Wall  
7     is going to be making arguments about those issues, and  
8     that, frankly, couldn't occur in this hearing without  
9     some type of response from the Complaints Director,  
10    even though the Complaints Director strongly believes  
11    this isn't about masking and that expert witnesses  
12    aren't necessary. Dr. Wall has, as is his right, put  
13    that before you as an issue, and it was necessary for  
14    the Complaints Director to respond by providing an  
15    expert report.

16           The Complaints Director is very confident that  
17    after hearing from Dr. Hu, the College's expert on this  
18    issue, after reading his report and looking at the CMOH  
19    orders, looking at those AHS documents, looking at the  
20    Canada Health [sic] documents and references that are  
21    in some of the exhibits before you, the Complaints  
22    Director is very confident that you will ultimately  
23    determine that there is overwhelming clinical evidence  
24    in support of the Pandemic Directive. And, again,  
25    that's not -- in -- from a Complaints Director's  
26    perspective, that's not really what's in front of you,

1     that's not really what's before you, but there is  
2     overwhelming evidence to support the Pandemic  
3     Directive, and, again, it was a legal obligation of the  
4     College to create that Pandemic Directive.

5             So in closing, again, I would urge you to not be  
6     distracted from your role. The pandemic directive is  
7     one of many professional obligations that chiropractors  
8     have, and this applies to all professions and, as I  
9     said to you, practicing in a profession is a privilege  
10    not a right. You're not here to pass adjustment on the  
11    Pandemic Directive; you're here to assess Dr. Wall's  
12    actions, his conduct, his choices to independently opt  
13    out of the Pandemic Directive.

14            So in closing, while the Complaints Director urges  
15    you to accept the scientific foundation for the CMOH  
16    orders and masking and other COVID-19 measures and to  
17    find that there is overwhelming support for the  
18    Pandemic Directive, this case is about whether a  
19    regulated professional can independently and  
20    selectively decide what does and doesn't apply to him  
21    in his profession. That's what this hearing is about.

22            I'm happy to answer any questions you have about  
23    my opening comments, Mr. Chair. Otherwise, my friend,  
24    Mr. Kitchen, I'm sure has an opening statement.

25    Discussion

26    THE CHAIR:                             Thank you, Mr. Maxston. Do

1 any of the Tribunal Members have a question for  
2 Mr. Maxston at this point? Okay, Mr. Kitchen, just for  
3 housekeeping, how long do you expect your statement  
4 will be? Can you give us an idea?

5 MR. KITCHEN: I'll say 10 minutes.

6 THE CHAIR: 10 minutes.

7 MR. KITCHEN: Now, while we're on that  
8 point, Mr. Maxston, you can clarify if this has  
9 changed, but my understanding is that you really wanted  
10 to have Dr. Hu go around 1 PM, and that that was quite  
11 important we stick to that. We're already --

12 MR. MAXSTON: Yeah.

13 MR. KITCHEN: -- a few minutes to 12 here.

14 MR. MAXSTON: Very quickly -- thank you,  
15 Mr. Kitchen, for reminding me of that -- I had  
16 intended, as I said, to call Dr. Halowski first, but we  
17 had preliminary applications, which were no one's  
18 fault, we've had taken up the morning.

19 So my -- I've arranged with Dr. Hu to be here at  
20 1:00, and that really is a target that can't be  
21 changed. Of course, just like everyone, he's very  
22 busy, and I would anticipate having him start  
23 testifying at 1:00. He's available to continue  
24 tomorrow morning if we don't finish with him today. If  
25 my friend is going to be about 10 minutes or so, I  
26 don't think I'll have anything in response. I'm going

1 to suggest that maybe by whatever it is, five after,  
2 ten after, quarter after 12, we just break for lunch  
3 and come back at 1:00.

4 Thank you again Mr. Kitchen, for reminding me of  
5 that.

6 MR. KITCHEN: And that's fine with me.

7 Chair, is that how you want to proceed?

8 THE CHAIR: Yes, that's what I wanted to  
9 clear up, where we fit in a lunch break and what our  
10 commitments were with respect to witnesses, because I  
11 know they're taking time out of their valuable days.

12 So, thanks, Mr. Kitchen, the floor is yours.

13 Opening by Mr. Kitchen

14 MR. KITCHEN: All right, thank you.

15 Well, Tribunal Members, you've heard a lot about  
16 what this case is and isn't about; I guess there's  
17 going to be some serious disagreement on that.

18 I'll tell you what I do think this case is about.  
19 This case is about the very principles that underlie  
20 the chiropractic profession or at least used to. This  
21 case is about science, truth, and ethics.

22 The key issues that must be determined in this  
23 case is whether the Alberta chiropractic regulatory  
24 body, in its zeal to please the Chief Medical Officer  
25 of Health, violated the statutory human rights and  
26 constitutional Charter rights of one of its members.

1 That's the issue.

2 This is not a simple case, as the Complaints  
3 Director would have you believe, of determining  
4 whether, in fact, the impugned member contravened the  
5 directive of the College. No. This case is about  
6 whether that directive itself is lawful, whether it is  
7 reasonable, whether it is scientific, whether it is  
8 harmful to members and chiropractic patients.

9 If mandated mask wearing confers no benefits and  
10 yet imposes harm, as Dr. Wall submits the evidence he  
11 will provide shows, then not adhering to such a mandate  
12 is not unprofessional conduct. It cannot possibly be  
13 unprofessional to not comply with directives that are  
14 unbeneficial and harmful.

15 Dr. Wall will herein challenge the lawfulness of  
16 the College's no exception mask mandate. He asks this  
17 Tribunal to exercise its discretion to declare the  
18 College's mask mandate of no force and effect, because  
19 it unjustifiably limits Dr. Wall's Charter rights and  
20 breaches the Alberta Human Rights Act.

21 Dr. Wall denies that anything he has done since  
22 the spring of 2020 has placed any increased risk of  
23 negative health outcomes on his patients or constitutes  
24 unprofessional conduct. In fact, he submits that he  
25 sought to protect his patients from the increased risk  
26 of harm that comes through masking and has thereby

1 maintained his integrity in the face of persecution  
2 from his regulatory body.

3         The College wants to make this all about Dr. Wall,  
4 and that's fine, Dr. Wall has no problem with that.  
5 But that's -- part of that is to distract from making  
6 this about them, from making this about the  
7 unlawfulness of portions of the Pandemic Directive. Of  
8 course, Dr. Wall is not challenging the whole  
9 directive; he's only challenging the narrow bit that  
10 mandates masking and penalizes members who are unable  
11 to wear a mask but still treat their patients, and that  
12 penalization being, well, now you've broken the  
13 distancing rule because you treated somebody without a  
14 mask.

15         Again, I know that the Complaints Director is  
16 speaking out of both sides of his mouth. He says it's  
17 all about the public interest, it's all about  
18 protecting the public, it's all about public perception  
19 of the profession. And yet even before hearing from  
20 four members of the public, which you will hear from,  
21 the Complaints Director is trying to downplay what they  
22 have to say, he's trying to say it's not important,  
23 it's not valuable, you shouldn't really listen to them.

24         Well, in fact, you still should listen very  
25 carefully to what they have to say. And not their  
26 opinions on expert things, not their opinions on COVID,

1 not their opinions on whether Dr. Wall is a good  
2 chiropractor, but if they have something to say about  
3 their own interests in the face of the ACAC actions  
4 over the last year-and-a-half, and that's not opinion,  
5 that's information and belief, and it's very valuable,  
6 and it's exactly what this Tribunal needs to hear,  
7 because if it is about the public interest and if it is  
8 about the perception of the profession, which it must  
9 be to some degree, then that is very valuable evidence.

10 Dr. Wall finds it offensive that there would be  
11 this comparison to sexual misconduct. It's just  
12 egregious and uncalled for. That is the kind of  
13 conduct that professionals have their licences or  
14 permits to practice suspended on an interim basis. And  
15 as you will hear about, there was an application by the  
16 Complaints Director to suspend Dr. Wall's licence on an  
17 interim emergency basis. That application was denied.  
18 One of the reasons for that is because those  
19 applications are only granted in serious situations,  
20 when actual, demonstrable harm is being done or is very  
21 likely to be done to the public, such as sexual  
22 misconduct or such as stealing from clients, which was  
23 also alluded to. That's not what's going on here.  
24 We're not dealing with that type of stuff, and  
25 comparisons to that are uncalled for and unhelpful.

26 I note the word "overwhelming" was used to

1 describe the evidence in support of the science, even  
2 though this supposedly isn't about masking. On the  
3 other side, the Complaints Director is saying the  
4 evidence is overwhelming. In fact, his expert used  
5 that word six times in his report.

6 Well, I think that's overstating it. I think if  
7 it was so overwhelming we wouldn't be here, and  
8 Dr. Wall wouldn't have four experts talking about how  
9 underwhelming the evidence is, scientific evidence is  
10 in support of this directive.

11 Lastly, I would agree that you are here to judge  
12 the actions of Dr. Wall and whether or not he acted  
13 professionally, ethically, with integrity. You are  
14 here to judge that. Part of the way you need to do  
15 that is to look at whether or not the requirement that  
16 he didn't follow was unlawful, because if it is  
17 unlawful, then he didn't do anything unprofessional in  
18 not following it. It's not unprofessional to refuse to  
19 follow unlawful orders or unlawful directives. It's  
20 not unprofessional to say, No, I'm not going to suffer  
21 the violation of my own rights or suffer the violation  
22 of the rights of my patients.

23 If human rights, the constitutional rights are  
24 engaged, they're being violated, and there's no  
25 justification for them, then it's my ethical and  
26 professional obligation to not be explicit in that.



1 That's the approach Dr. Wall has had. And you will  
2 ultimately have to determine the lawfulness of the  
3 policies that he's challenging.

4 If you determine they're lawful, then perhaps  
5 there's a basis for finding unprofessional conduct, but  
6 if you, as Dr. Wall submits, should find, if you find  
7 that these mandates, these no-exception mandates are  
8 unlawful because they violate rights, then there's no  
9 unprofessional conduct.

10 That's my opening comments.

11 THE CHAIR: Thank you, Mr. Kitchen.

12 Any -- Mr. Maxston, you looked like you were about  
13 to speak?

14 Discussion

15 MR. MAXSTON: I may be looking like that  
16 throughout this hearing, and Mr. Kitchen may have that  
17 look on his face from time to time, but I actually, I  
18 don't want to add anything. I think both parties, at  
19 the opening stage, I -- we'll both have comments in  
20 closing about a number of issues, so I don't have  
21 anything further.

22 The College's first witness, its next witness will  
23 be Dr. Hu at 1:00.

24 I don't have anything else that we can do over the  
25 lunch break. I think we've done the preliminary  
26 application. Unless Mr. Kitchen needs to stay on here,

1 I think we can simply break till 1:00.

2 MR. KITCHEN: Yes, that's fine with me.

3 THE CHAIR: Yeah, that's fine with me.

4 It's just a couple of minutes after 12, so we'll  
5 reconvene at 1:00 with the College's first witness.  
6 The hearing will go into recess until then.

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8 PROCEEDINGS ADJOURNED UNTIL 1:00 PM

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

4

5 September 1, 2021 Afternoon Session

6

7 HEARING TRIBUNAL

8 J. Lees Tribunal Chair

9 W. Pavlic Internal Legal Counsel

10 Dr. L. Aldcorn ACAC Registered Member

11 Dr. D. Martens ACAC Registered Member

12 D. Dawson Public Member

13 A. Nelson ACAC Hearings Director

14

15 ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

16 D. Lawrence ACAC Complaints Director

17 B.E. Maxston, QC ACAC Legal Counsel

18

19 FOR DR. CURTIS WALL

20 J.S.M. Kitchen Legal Counsel

21

22 K. Schumann, CSR(A) Official Court Reporter

23

24 (PROCEEDINGS RECOMMENCED AT 1:03 PM)

25 THE CHAIR: The Hearing Tribunal regarding

26 Dr. Wall is back in session, and we will ask

1 Mr. Maxston to introduce his first witness, but before  
2 doing so, Dr. Hu, we would ask that our court reporter,  
3 Karoline Schumann, either swear or affirm you prior to  
4 your giving testimony.

5 THE WITNESS: Sure.

6 DR. JIA HU, Sworn, Examined by Mr. Maxston  
7 (Qualification)

8 MR. MAXSTON: Mr. Chair and Tribunal  
9 Members, just so you're familiar with what I'm going to  
10 do next, and some of you may well have been in hearings  
11 that have involved expert witnesses, and Mr. Kitchen  
12 will know this and Mr. Pavlic will know this, before I  
13 begin asking Dr. Hu questions about the substance of  
14 his report, I need to take a step which is called  
15 qualifying him as a witness. That will involved me  
16 asking some background questions of him in terms of his  
17 knowledge, training, experience. Mr. Kitchen may have  
18 some comments about that as well, and I will then  
19 tender him to be accepted as an expert witness, and,  
20 only then, would I start taking him through his expert  
21 report.

22 Q MR. MAXSTON: So, Dr. Hu, I'll just ask you  
23 to state your full name for the record, please.

24 A Yeah, Jia Hu.

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

1 A Yes.

2 Q Also Exhibits E-1 and E-2 are your cv and expert  
3 report. Can you confirm that's correct?

4 A Yes.

5 Q And your expert report is dated July 28, 2021. I have  
6 just a housekeeping question before I start to qualify  
7 you. I note that on --

8 MR. MAXSTON: Oh, and Mr. Chair, I'm  
9 assuming everyone is at Exhibits E-1 and E-2.

10 THE CHAIR: Raise your hand if not. Okay.

11 MR. MAXSTON: Sorry, I was diving right in  
12 there.

13 Q MR. MAXSTON: Just as a housekeeping matter,  
14 I note that on page 1 of your expert report, again  
15 that's Exhibit E-2, it says: (as read)

16 Prepared by Jia Hu and Margaret Pateman.

17 Can you please tell me who Ms. Pateman is and what her  
18 role was in preparing the report?

19 A Yeah, so Margaret Pateman is a -- was a Masters in  
20 Public Health student who worked with me on various  
21 things in my Public Health position role, and she did  
22 some of the preliminary sort of literature review,  
23 which is looking for papers around masking, the  
24 evidence for or lack thereof, and draft -- doing an  
25 initial draft of the report as well.

26 Q And I'm assuming that, nonetheless, you stand by this

1 expert report as your expert report?

2 A I did make, yes, substantial revisions to her -- her  
3 review is good, but I made a lot of revisions, so, yes.

4 Q Okay, thank you very much.

5 MR. MAXSTON: So I'm going to ask everyone  
6 to go to your cv, which again is E-1. I'll wait a  
7 minute till everyone is there, wait a few seconds.

8 Q MR. MAXSTON: Dr. Hu, can you tell me what  
9 your current occupation, profession is?

10 A Yeah, so I'm a Public Health physician and a family  
11 physician. I have a few different roles right now.  
12 One of them I guess is to lead the provincial vaccine  
13 rollout from the -- primary care. I chair a group  
14 called 19 To Zero, which is a multi-sector coalition,  
15 you know, aimed at providing education around COVID-19  
16 and vaccinations. I have various -- I was quite  
17 recently a Medical Officer of Health with Alberta  
18 Health Services in the Calgary zone, and many other  
19 miscellaneous things, but, generally, often lots of  
20 COVID-related things.

21 Q Okay, well, we'll probably touch on those in a little  
22 more detail in a moment, but I'd like to go to page 1  
23 of your cv and ask you to just briefly summarize  
24 Section 1, which is your education.

25 A Yeah, so in terms of education, so I mean I have a  
26 Bachelor's degree in Economics from Harvard University;

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

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

15 A I am.

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

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

23 Q And those would be COVID-related?

24 A Yeah.

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

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

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

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

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

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

26 Also quite a lot of articles on sort of like lab



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 A Yeah.

9 Q -- was involved there?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12      A    Yeah.

13      Q    -- two entries there?

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

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

1 to like carve out strategic direction and overall  
2 objectives.

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

10 Q Okay. Thank you very much.

11 MR. MAXSTON: Subject to any questions from  
12 Mr. Kitchen, Dr. Wall's lawyer, Mr. Chair and Hearing  
13 Tribunal Members, at this time, I would tender Dr. Hu  
14 as an expert in the area of public and, in particular,  
15 COVID-19 and the efficacy of masking and other COVID-19  
16 measures.

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

19 MR. KITCHEN: Can you hear me?

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

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

23 THE CHAIR: Yeah.

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



1 to have some issues with how long that is?

2 Oh, Mr. Maxston, you're now muted. I've given you  
3 the idea.

4 MR. MAXSTON: Yeah, well, maybe when I'm  
5 muted, you've heard me at my best then, I don't know,  
6 but I'll try to do better.

7 I was tendering Dr. Hu as an expert in the area of  
8 public health but, in particular, COVID-19 and the  
9 efficacy of masking and related COVID-19 measures,  
10 prevention measures I guess you would say.

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

13 MR. MAXSTON: I think I said preventive  
14 measures.

15 MR. KITCHEN: And other preventative  
16 measures.

17 MR. MAXSTON: Measures, yeah.

18 Mr. Kitchen Cross-examines the Witness (Qualification)

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

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

- 1 A No, if you define AHS as a government entity, then I  
2 would not disagree with that.
- 3 Q Okay. No, and I would. I meant --
- 4 A Okay.
- 5 Q -- that very broadly, and nothing sneaky about --
- 6 A Yeah, yeah, yeah --
- 7 Q -- (INDISCERNIBLE) --
- 8 A -- yeah. Got it, yeah.
- 9 Q In fact, Dr. Hu, you worked for AHS as a Medical  
10 Officer of Health up until a few months ago; isn't that  
11 right?
- 12 A That's correct.
- 13 Q You've also done and are doing currently some research  
14 work for pharmaceutical companies; wouldn't you agree?
- 15 A For -- yeah, I mean, I research the different -- I do  
16 research on how to increase uptake of all the vaccines,  
17 including like the Pfizer, Moderna, and, well,  
18 previously AstraZeneca vaccine, so yes.
- 19 Q Thank you. You would also agree, wouldn't you, that a  
20 lot of your research in efficacy work has centred on  
21 vaccines; isn't that right?
- 22 A That's correct.
- 23 Q And that includes COVID vaccines, doesn't it?
- 24 A Yes, primarily COVID vaccines actually, but yes.
- 25 Q I see that you have, like you said, published several  
26 recent studies regarding COVID. That's accurate,

1 correct?

2 A M-hm.

3 Q I think probably for the court reporter, and I know  
4 this is a common tendency, even I myself fall under  
5 this --

6 A Yes.

7 Q -- when saying "yes", you need to -- yeah, it's best to  
8 say --

9 A Yeah, I'll --

10 Q -- "yes" --

11 A -- say "yes" --

12 Q -- (INDISCERNIBLE) --

13 A -- yeah, yes. Sorry, sir --

14 Q We all do it.

15 Now, none of these studies that you've -- or these  
16 articles that you've published focus on masking, do  
17 they?

18 A That is correct.

19 Q Thank you. Now, I'm looking at your clinical work  
20 experience. I see the title "Physician" in every  
21 position. You would agree it is accurate to call you a  
22 physician, would you not?

23 A Yes.

24 Q You're not a virologist, correct?

25 A I am not a virologist.

26 Q You're not an immunologist, correct?

1 A No.

2 Q You're not a respirologist, correct?

3 A Correct.

4 Q You're not a medical microbiologist, correct?

5 A Correct.

6 Q Now, I'm looking at your research funding in 2020, it  
7 looks to me like you received almost 20 new sources of  
8 research funding in the year 2020; is that correct?

9 A As the -- like as a lead or generally a co-lead  
10 investigator, so a lot of that money isn't coming to  
11 me. Most of it isn't actually, but you tend to report  
12 grants that you win even if they're like -- they tend  
13 to be led by a team of people, but, yes, I guess my  
14 name is on that value of grants for the 2020.

15 Q Yeah, I'm looking on page 4, and I take your point, and  
16 I see "Principal" --

17 A Yeah.

18 Q -- "investigator", there's quite a few where you're the  
19 principal investigator, there's no others.

20 A M-hm.

21 Q There's one where you're the principal partner to one  
22 other. Now, when it says "principal partner", I  
23 suppose that means there's an investigator, and you're  
24 the partner?

25 A So normally the way these research grants work are  
26 there is a -- one personal who is primarily responsible

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

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

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

19   A    Oh, okay.

20   Q    Do you dispute that?

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

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

25   A    Yes. Absolutely.

26   Q    And you agree that some of this funding comes from

1 manufacturers of COVID vaccines, do you not?

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

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

8 A Yeah, that's true.

9 Submissions by Mr. Kitchen (Qualification)

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

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

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

25 We've heard from Dr. Hu lots about COVID-19  
26 vaccines, but we haven't seen anything about experience

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

5 Subject to any questions from the Tribunal on my  
6 comments, that's what I would say about the  
7 qualifications and the scope of the qualifications of  
8 Dr. Hu.

9 Mr. Maxston Re-examines the Witness (Qualification)

10 MR. MAXSTON: Mr. Chair, it's Blair Maxston,  
11 I'll have a couple of comments in response, but I think  
12 Dr. Hu was kind of motioning that he might have  
13 something to say about the comments that Mr. Kitchen  
14 made, so I'm, frankly, going to ask him to make his  
15 comments.

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

18 A Yes, for sure.

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

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

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

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

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

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

16 A M-hm.

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

20 A Okay.

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

23 A Okay, that's fine.

24 MR. MAXSTON: Mr. Chair, I think,

25 Mr. Kitchen, you're finished, I can --

26 MR. KITCHEN: Yes, I am.



1 Discussion

2 MR. MAXSTON: Yeah, thank you, yeah.

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

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

16 MR. MAXSTON: Well, that's not the basis on  
17 which I'm tendering this expert. I'm not tendering him  
18 as an expert on vaccinations, although he may have  
19 something to say about that, but I've made my comments,  
20 and I leave it to the Chair.

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

26 THE CHAIR: Okay, thank you, gentlemen. I

1 think we will recess so that we can consider the  
2 submissions from both parties of Dr. Hu.

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

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

14 A Thank you.

15 THE CHAIR: Okay, and, Dr. Hu, we will,  
16 the Hearing Tribunal and our independent legal counsel,  
17 will leave this meeting and go to a breakout room --

18 A Okay.

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

22 A Great, thank you.

23 (ADJOURNMENT)

24 Ruling (Qualification)

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

1 College to qualify Dr. Hu as an expert witness, and our  
2 decision is that we will qualify Dr. Hu as an expert  
3 witness as submitted by Mr. Maxston.

4 So, Mr. Maxston, if you'd like to just repeat your  
5 submission for the record, so we're all clear.

6 MR. MAXSTON: I'm going to try to get this  
7 as accurate as I can, but I'll invite the court  
8 reporter to maybe correct me, and if we -- we can  
9 almost go back and revisit this if we need to I suppose  
10 later, but my original comment was, I believe, I'm  
11 tendering Dr. Hu as an expert in the area of Public  
12 Health and, in particular, COVID-19 and the efficacy of  
13 masking and related measures --

14 THE CHAIR: That's --

15 MR. MAXSTON: -- or words to that effect.  
16 I'm pretty close, I think.

17 THE CHAIR: Yeah, that's what we  
18 understood, and we also understood, Mr. Kitchen, the  
19 different wording that you had, and we've decided to  
20 qualify Dr. Hu based on Mr. Maxston's submission, so  
21 we'll move on from there.

22 If you have -- if you'd like to start your  
23 questions with Dr. Hu.

24 MR. MAXSTON: Thank you, Mr. Chair.

25 Dr. Jia Hu, Previously sworn, Examined by Mr. Maxston

26 Q MR. MAXSTON: I want to ask a question right

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

7 A Yes, completely. And I will say this, yes, I receive  
8 research grants, but I don't get any of that money  
9 myself. And in reality during COVID, I probably put in  
10 \$500,000 of my own money doing research and other  
11 related activities because -- well, COVID is a  
12 disaster, and so I get why, you know, like you can  
13 think that it's biased, but also I mean, you know, as  
14 Dr. -- as Mr. Kitchens [sic] was saying, a lot of my  
15 research is around vaccines, which is accurate, and,  
16 you know, it's not like there's -- I don't publish  
17 stuff on masking. But, yes, regardless, the masking  
18 report is impartial, and I don't get money from  
19 research, just try to do the right thing.

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

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

1           than --

2       Q     Outbreaks?

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

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

12      A     Yes.

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

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

15      Q     And again --

16           MR. MAXSTON:                   -- and I'll be careful,  
17           Mr. Kitchen, I'm going to ask a bit of a leading  
18           question, but it's just for cleanup here --

19      Q     MR. MAXSTON:                -- that would have involved  
20           outbreak management, contact tracing, transmission,  
21           masking, the things you've already mentioned?

22      A     Yes.

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

25      A     Yes.

26      Q     Can you describe that?

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

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

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

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

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

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

13 A Yes.

14 Q Can you describe that to me?

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

25 I'll just pause a moment and make sure everybody,  
26 including you, Dr. Hu, has been able to find, again,

1 CMOH 38-2020.

2 A Yeah. This is CMOH 42?

3 Q No, this is CMOH 38-20 [sic]. I'm going to take you to  
4 42 in a minute --

5 A Okay.

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

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

9 MR. MAXSTON: Mr. Chair, are you and your  
10 colleagues all -- do you all have that document? I can  
11 proceed?

12 THE CHAIR: I think so. Anybody having  
13 problems? No, I think we're good. Thanks,  
14 Mr. Maxston.

15 Q MR. MAXSTON: Okay, I'll go ahead then.

16 I'm going to ask you to turn to page 4, Dr. Hu,  
17 and it's -- there's a heading, "Part 4 - Masks".

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

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

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

1 includes the city of Calgary.

2 So, Dr. Hu, this CMOH would apply to the city of  
3 Calgary?

4 A Correct.

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

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

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

14 A Yes, yes, must, correct.

15 Q There's an exception in Section 27, specifically  
16 26(c) [sic] that says you're exempted from masking if a  
17 person: (as read)

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

20 Are you familiar with that exemption?

21 A I am.

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

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

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

2 THE CHAIR: Mr. Maxston, you said the date  
3 on D-9 was --

4 MR. MAXSTON: I think, Mr. Chair, I'm  
5 looking at page 9, it says December 11th, 2020.

6 THE CHAIR: Okay.

7 Q MR. MAXSTON: Okay, so, Dr. Hu, I'm looking  
8 at Exhibit D-9 then, CMOH Order 42-20, and there's a  
9 final "whereas" paragraph --

10 MR. MAXSTON: -- and, Mr. Kitchen, there's a  
11 question coming --

12 Q MR. MAXSTON: -- whereas having determined  
13 that measures in CMOH Order 38-2020 are insufficient to  
14 protect Albertans. Is -- to your understanding, was  
15 CMOH Order 42-2020 to strengthen masking and other  
16 measures?

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

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

1           Edmonton in particular.

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

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

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

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

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

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

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

20 Q Okay, thank you. When I look CMOH Order -- the same  
21 CMOH order, if we go to paragraph -- or Order Section  
22 28(a), it talks about: (as read)

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



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

3     A    Could you repeat that question?

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

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

9     Q    Provided that the CMOH orders were complied with?

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

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

4 A Okay, let me pull it up.

5 MR. KITCHEN: I'm sorry, Mr. Maxston, which  
6 CMOH order are we talking about?

7 MR. MAXSTON: It's Exhibit F-2.

8 MR. KITCHEN: F-2.

9 MR. MAXSTON: 'F' as in Fred, and that's  
10 16-2020, and May 3, 2020.

11 MR. KITCHEN: Thank you.

12 MR. MAXSTON: I just need to consult with my  
13 client for a moment. I'm just going to put myself on  
14 mute, if you can just give me a minute.

15 (DISCUSSION OFF THE RECORD)

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

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

1     A     Yeah.

2     Q     -- read those sections, so ...

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

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

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

26                 So that basically summarized this.  So part of --

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

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

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

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

17 A M-hm.

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

20 A Yes, I can. Oh, sorry --

21 Q It starts off with "All staff providing".

22 A Yeah: (as read)

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

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

4 Q So this is --

5 A (INDISCERNIBLE)

6 Q Oh, sorry.

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

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

12 Q So this is, if we go back to paragraph 2, it says you  
13 must comply with this guideline, and then we have order  
14 3 saying subject to Section 5, each college can create  
15 their own masking guidelines; is that correct?

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

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

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

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

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

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

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

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

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

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

9 Q If I look at order number 5, it says: (as read)  
10 The CMOH may amend any COVID guidelines  
11 created by a college under Section 3 if the  
12 CMOH determines that the guidelines are  
13 insufficient to reduce the risk of  
14 transmission of COVID-19 in the practice of  
15 the regulated profession.

16 Is this a check and a balance?

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

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

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

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

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

18 A M-hm.

19 Q -- under this order?

20 A Yes.

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

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



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

3     A    Yes, I believe so.

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

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

11       That's mandatory language?

12    A    Yes, I think so.

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

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

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

26       MR. MAXSTON:                   And, Mr. Chair, I'm just going

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

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

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

19 Q MR. MAXSTON: So, Dr. Hu, I'll just ask you  
20 to call up this document then, and, again, it's January  
21 26th, 2021 Pandemic Directive, and this is the ACAC's  
22 Pandemic Directive that was created pursuant to CMOH  
23 Order 16-2020.

24 MR. KITCHEN: Mr. Maxston, so you're going  
25 to ask questions about --

26 MR. MAXSTON: I am, yeah, and I'm sorry,

1 Mr. Kitchen, I gave some background there on these  
2 three versions of the documents, but I do want to use  
3 the January 16 [sic] one. Dr. Halowski's going to  
4 testify to what I said a couple of minutes ago.

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

6 MR. MAXSTON: January 6th, pardon me. I may  
7 have written that down wrong.

8 THE CHAIR: And, Mr. Maxston, we're in 'C'  
9 now, the --

10 MR. MAXSTON: Yeah --

11 THE CHAIR: -- 'C' folder?

12 MR. MAXSTON: -- C-22.

13 THE CHAIR: C-22, thank you.

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

17 MR. MAXSTON: Yeah.

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

19 MR. MAXSTON: Yeah, we are, and I think what  
20 I want to do though is the section -- Mr. Kitchen, in  
21 fairness to you, the sections I'm going to take Dr. Hu  
22 to haven't changed from -- that's what Dr. Halowski's  
23 evidence is going to be, and I think it's better to use  
24 one document, not three, and just use the most current  
25 version of it.

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

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

10      MR. MAXSTON:                   Well, I'll ask my question,  
11      and I guess you'll object if you need to. I just  
12      wanted to set the stage frankly on a document-basis as  
13      to why I was going to the third version, not the first  
14      two.

15      MR. KITCHEN:                   I have no issue with that.

16      MR. MAXSTON:                   Yeah, okay.

17   Q   MR. MAXSTON:                   So, Dr. Hu, I'll get you to  
18       turn to page 8 of the --

19   A   Yeah.

20   Q   -- Pandemic Directive.

21   A   Yeah, I'm there.

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

23   A   M-hm.

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

1 requirements, are those acceptable, are those  
2 warranted?

3 A Yes.

4 Q Can you tell me why?

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

8 Q MR. MAXSTON: I'll rephrase my question.  
9 Are these scientifically supported?

10 A Yes.

11 Q Can you tell me why?

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

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

26 You see more to another (INDISCERNIBLE)

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

14 Q Okay, thank you. I'm going to turn to another area,  
15 which is what I'm going to call the AHS documents.

16 MR. MAXSTON: And those were three  
17 documents, Mr. Chair and Tribunal Members, that were  
18 admitted as exhibits this morning.

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

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

1 Q MR. MAXSTON: -- Dr. Hu, I'll just ask you  
2 to call up my email to you which had those three  
3 documents attached.

4 A Yeah.

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

7 Q MR. MAXSTON: Okay, I'm just going to go to  
8 the first document, which is -- sorry, open my  
9 documents, my apologies.

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

14 A I do.

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

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

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

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

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

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

7 Do you agree with the statements in this document?

8 A Definitely, yes.

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

12 A Yeah. I have that.

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

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

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

21 Do you agree with that statement?

22 A Yes.

23 Q Can you tell me why?

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



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

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

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

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

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

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

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

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

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

8           MR. MAXSTON:                   I'll just everybody get to  
9           that document.

10   Q   MR. MAXSTON:                   And I only have I think one  
11           question for you -- one or two on that document.

12           On page 1 of that document --

13           MR. MAXSTON:                   I'll just wait. Is everybody  
14           there? Okay.

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

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

23           Can you describe this dual purpose of masking?

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

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

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

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

16    A    Yes.

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

19          MR. MAXSTON:                   Just let everybody get to that  
20          expert report. Mr. Chair, I'll assume that everybody  
21          has that document in front of them.

22    Q    MR. MAXSTON:                   I just have a general question  
23          for you, Dr. Hu, about your expert report --

24    A    M-hm.

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

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

3     A     Yes.

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

6     A     Yes.

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

9     A     Yes.

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

13    A     No.

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

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

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

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

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

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

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

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

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

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

17    A    Extremely high.

18    Q    Did you review -- and I should go back, you're aware  
19       that some cv's and expert reports from Drs. Dang,  
20       Bridle, and Warren have been put before the Tribunal as  
21       well. Did you review those expert reports when you  
22       prepared your expert report?

23    A    I did, yes.

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

26    A    No.

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

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

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

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

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

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

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

25 A Oh --

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



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

2 Q No --

3 A -- (INDISCERNIBLE) --

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

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

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

11 A Yes.

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

19 A Yes. And I apologize, again, to Karoline, I keep on  
20 talking over Blair, and I said I wouldn't, and I've  
21 really sorry about that.

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

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

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

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

15    Q    Yeah, I think you -- in the paragraph above, you talk  
16          about the historical use of masks dating back to the  
17          1600s, and then you've got some comments here about  
18          some of the more recent experience, and I'm just asking  
19          you to summarize that.

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

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

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

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

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

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

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

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

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

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

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

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

10 Q Okay. I want to turn to the next page on your report,  
11 and you talk there about "Methods", and on line number  
12 2 -- oh, I should go back -- you talk E-2 about  
13 databases such as PubMed, JSTOR, Cochrane Library,  
14 high-quality peer reviewed. I think you've commented  
15 on what peer reviewed means, but there's something  
16 interesting in the -- at the end of your --

17 that sentence -- or that paragraph, it says: (as read)

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

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

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

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

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

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

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

18 And then: (as read)

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

22 What are you trying to communicate in that paragraph,  
23 Dr. Hu?

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

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

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

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

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

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

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

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

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

18 Q I'm looking at the next --

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



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

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

7 MR. MAXSTON: I'm thinking, and as I  
8 mentioned to you, Mr. Kitchen, Dr. Hu is available to  
9 come tomorrow morning at 9 AM to finish any examination  
10 and cross-examination, so yes.

11 A Yeah.

12 MR. KITCHEN: Okay, that's fine.

13 Q MR. MAXSTON: The next paragraph in your  
14 report, Dr. Hu, says: (as read)

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

20 Can you comment on why physical distancing is  
21 important?

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

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

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

13            And, you know, the line between -- here's how our  
14    understanding evolved, right? Before, we were like  
15    contacting droplet means if you're outside of the  
16    2-metre range, you're probably not going to get the  
17    virus, and if you're within the 2-metre range, you're  
18    (INDISCERNIBLE). But conceptually, and this is where  
19    like our understanding has really evolved over COVID,  
20    if you coughed into a fan, and like clearly like your  
21    little wet spray droplets can go more than 2 metres  
22    presumably, right. And so when I say aerosol  
23    transmission, you know, we can go further than 2  
24    metres, and, you know, these droplets sometimes linger  
25    in the air. And so it's less of like a -- you know,  
26    it's airborne versus contacting droplet, like, you

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

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

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

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

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

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

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

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

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

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

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

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

20 Q Just one quick question before we break, it's almost  
21 3:00, you have a -- in the last paragraph on that  
22 section, just about masking for health care workers:  
23 (as read)

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

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

5 I take it that's still your conclusion?

6 A Yes.

7 Q And what's an AMSTAR rating?

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

22 Q Thank you.

23 MR. MAXSTON: Mr. Chair, I would propose to  
24 take a 15-minute break now and then give everyone a  
25 chance to take a bio break and then proceed from about  
26 3:15 till about 4:15 if that works for everybody, and I

1 think I'll be able to be finished with Dr. Hu today on  
2 that timeline.

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

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

9 (ADJOURNMENT)

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

19 So I'll turn it back to you, Mr. Maxston.

20 MR. MAXSTON: Thank you, Mr. Chair.

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

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

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

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

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

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

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



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

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

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

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

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

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

26 But, you know, essentially this study looks at,

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

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

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

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

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

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

25       A   Yes.

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

1       your testimony, are using masks perfect?

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

7       Q   I'm going to take you to the next part of your report,  
8       which is your response to the statements by the other  
9       experts, Drs. Warren, Dang, and Bridle, and I'm going  
10      to ask you about Mr. Schaefer's expert report, but  
11      that, of course, came in after you prepared this  
12      document.

13               When I took you through your report, we talked  
14      about a series of phrases, randomized control trials,  
15      the AMSTAR rating, the quality peer-reviewed evidence,  
16      systematic reviews, I think we talked about  
17      meta-analysis. Bearing that in mind as a reference and  
18      remembering the Journal of the American Medical  
19      Association and Lancet, how would you characterize the  
20      documents and studies cited by Drs. Warren, Dang, and  
21      Bridle?

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

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

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

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

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

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

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

1 institutions in the citations from the three other  
2 expert reports?

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

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

14 A Yeah. I mean, I think that this is an example of the  
15 statement is not directly salient to our discussion,  
16 right, which is that, you know, he's saying that not a  
17 lot of young people die from COVID. And it's true that  
18 if you're over, let's say, 80, your risk of dying from  
19 COVID is very, very, very high, but, you know, plenty  
20 of people under 60 have died in Canada, 1475 since June  
21 2021. I think about 3,000 people under 18 in the  
22 United States have died of COVID. And so I acknowledge  
23 that COVID is less likely to kill you if you're young,  
24 I also acknowledge that COVID can kill you if you're  
25 young, but, lastly, like this doesn't -- it's not  
26 relevant.

1 Q Okay, I'm going to take you to your next comment where  
2 you've quoted Dr. Warren's report by saying: (as read)  
3 Asymptomatic transmission does occur, but the  
4 rates of transmission from asymptomatic  
5 persons is substantially less than from  
6 symptomatic persons and does not warrant  
7 being considered a significant contributor to  
8 the overall transmission burden.

9 Can you comment on your thoughts to that statement?

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

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

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

3     Q    Okay.

4     A    -- 1 percent.

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

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

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



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

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

8 Do their reports not relate to health care settings?

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

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

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

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

26 Dr. Bridle argues that masking is not helpful

1           given the aerosol route of transmission.

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

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

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

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

26                Dr. Bridle's critique of how well masks fit

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

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

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

12         Why do you say that?

13       A   Well, I mean, I -- like there's a -- I think I do say  
14           this somewhere in my report, but there's a big  
15           meta-analysis in the Lancet, a highly reputable  
16           journal, looked at -- I mean, I think they looked at  
17           200-plus studies, and that study basically showed  
18           there's about an 85 percent reduced odds of  
19           transmission when people have masks on. And like  
20           there's just so many studies like that over and over  
21           again, right. And when I say "real-world ecological",  
22           yes, masks are imperfect, yes, the pores might not be  
23           perfect, yes, there's like air released. Like putting  
24           on masks leads to reduced transmission, and we see that  
25           in the real world over and over again, they probably  
26           reduce transmission.

1 Q You've got a comment after a quote from Dr. Dang's  
2 report about his statement being false and not backed  
3 up by any evidence. Can you comment what you're  
4 saying -- about what you're saying in that paragraph?

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

12 When we implemented the lockdown, like CMOH Order  
13 38, which was pretty aggressive, followed by CMOH Order  
14 42, cases still went up for a while, and then they went  
15 down, right. That doesn't mean the lockdown didn't  
16 work. There's so many factors that lead to  
17 transmission of COVID. Masks are one thing that  
18 like -- that is protective, but, you know if people all  
19 wear masks, but they then go around to basement parties  
20 and kiss each other, you're still getting a lot of  
21 transmission.

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

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

3 Lastly, both Dr. Dang and Dr. Bridle make  
4 unsubstantiated claims that there are  
5 "numerous harms associated with masking".

6 And then you say: (as read)

7 There are no known harms associated with  
8 masking.

9 Can you explain that?

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

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

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

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

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

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

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

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

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

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

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

22 Q I'm going to ask you a couple of very brief questions  
23 about Mr. Schaefer's report, and I know you only  
24 received that a little while ago.

25 MR. MAXSTON: And I just want to, Mr. Chair,  
26 be clear to the Tribunal that in asking these questions

1 of Dr. Hu, I am again reserving my client's right to  
2 call further rebuttal evidence on that point, but I  
3 want to ask him about them.

4 Q MR. MAXSTON: You had a chance to read  
5 Mr. Schaefer's report?

6 A M-hm, yeah.

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

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

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

17 But, again, I -- again, I refer to the Canadian  
18 Thoracic Society, these other sort of experts, you  
19 know, basically said that like mask wearing is safe and  
20 fine. There's so much evidence, and like we've been  
21 wearing masks in hospitals every day for a  
22 year-and-a-half, and if it was that bloody dangerous,  
23 we'd have somebody passed out from low oxygen or too  
24 high CO<sub>2</sub>, and that has not happened to any health care  
25 worker in Alberta in AHS that I'm aware of, right? And  
26 so like that's -- that's about all I'll say about that.



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

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

13 A No. For COVID transmission, no.

14 Q Yeah, for COVID and --

15 A No, no.

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

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

1     lots of areas to debate, you know.

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

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

21    Discussion

22    MR. MAXSTON:                     Okay, well, thank you, Dr. Hu.

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

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

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

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

21           My intention would be, after the completion of  
22      Dr. Hu, to have Dr. Halowski testify.

23      MR. KITCHEN:                   That's fine with me.

24      THE CHAIR:                    Okay, Dr. Hu, you are okay for  
25      9:00 tomorrow morning to --

26    A    Yes.

1 THE CHAIR: -- continue?

2 A Yes.

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

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

16 \_\_\_\_\_  
17 PROCEEDINGS ADJOURNED UNTIL 9:00 AM, SEPTEMBER 2, 2021

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1 CERTIFICATE OF TRANSCRIPT:

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3 I, Karoline Schumann, certify that the foregoing  
4 pages are a complete and accurate transcript of the  
5 proceedings, taken down by me in shorthand and  
6 transcribed from my shorthand notes to the best of my  
7 skill and ability.

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

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A handwritten signature in cursive script that reads "Karoline Schumann". The signature is written in dark ink and is positioned above a horizontal line.

14

Karoline Schumann, CSR(A)

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Official Court Reporter

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Exhibits	Exhibit A-8 - Letter from Dr. Salem - December 12, 2020 5:10 68:19	Exhibit B-5 - Letter of Decision re s. 65 Review - December 18, 2020 5:24 69:8	Exhibit C-7 - ACAC Notice to Members re Approval of Plan - May 03, 2020 6:13 69:22	Exhibit C-14 - ACAC Notice to Members re Directive - November 23, 2020 7:1 70:10
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<p><b>Exhibit C-21 - ACAC COVID-19 Pandemic Practice Directive - May 25, 2020</b> 7:15 70:24</p> <p><b>Exhibit C-22 - ACAC COVID-19 Pandemic Practice Directive - January 06, 2021</b> 7:17 70:26 148:2,14,15</p> <p><b>Exhibit D-1 - AHS Closure Notice of Clinic - December 08, 2020</b> 7:19 71:2</p> <p><b>Exhibit D-2 - AHS Order to Rescind Closure Notice - January 05, 2021</b> 7:21 71:4</p> <p><b>Exhibit D-3 - CMOH Order - 19-2021 - May 06, 2021</b> 7:23 71:6</p> <p><b>Exhibit D-4 - CMOH Order - 20-2021 - May 06, 2021</b> 7:25 71:8</p> <p><b>Exhibit D-5 - CMOH Order - 22-2021 - May 13, 2021</b> 8:1 71:10</p> <p><b>Exhibit D-6 - CMOH Order - 26-2020 - June 06, 2020</b> 8:3 71:12</p>	<p><b>Exhibit D-7 - CMOH Order - 34-2021 - June 30, 2021</b> 8:5 71:14</p> <p><b>Exhibit D-8 - CMOH Order - 38-2020 - November 24, 2020</b> 8:7 71:16 133:23</p> <p><b>Exhibit D-9 - CMOH Order - 42-2020 - December 11, 2020</b> 8:9 71:18 135:26 136:1,8</p> <p><b>Exhibit D-10 - City of Calgary - Temporary COVID-19 Face Coverings Bylaw - March 11, 2020</b> 8:11 71:20</p> <p><b>Exhibit D-11 - City of Calgary - Bylaw that repeals Mask Bylaw - July 05, 2021</b> 8:13 71:22</p> <p><b>Exhibit E-1 - Dr. Jia Hu - CV</b> 8:15 71:24</p> <p><b>Exhibit E-2 - Dr. Jia Hu - Expert Report Masking</b> 8:17 71:26 72:1 103:15 158:18</p>	<p><b>Exhibit E-3 - Dr. Bao Dang - CV</b> 8:18 72:2</p> <p><b>Exhibit E-4 - Dr. Bao Dang - Expert Report Masking</b> 8:20 72:4,5</p> <p><b>Exhibit E-5 - Dr. Byram Bridle - CV</b> 8:22 72:6</p> <p><b>Exhibit E-6 - Dr. Byram Bridle - Expert Report Masking</b> 8:24 72:8,9</p> <p><b>Exhibit E-7 - Dr. Thomas Warren - CV</b> 9:1 72:10</p> <p><b>Exhibit E-8 - Dr. Thomas Warren - Expert Report Masking</b> 9:3 72:12</p> <p><b>Exhibit F-1 - GOA Alberta's safely staged COVID-19 relaunch - April 30, 2020</b> 9:5 72:14</p> <p><b>Exhibit F-2 - CMOH Order - 16-2020 - May 3, 2020</b> 9:7 72:16 140:3,7</p> <p><b>Exhibit F-3 - ACAC Registrars Report - July 05, 2021</b> 9:9 72:18</p>	<p><b>Exhibit F-4 - ACAC Frequently Asked Questions - July 07, 2021</b> 9:11 72:20</p> <p><b>Exhibit G-4 - Chris Schaefer CV</b> 4:14 63:9</p> <p><b>Exhibit G-5 - Chris Schaefer Expert Opinion Report</b> 4:16 63:11</p> <p><b>Exhibit H-1 - Preliminary Applications - Complaints Director Reference Document</b> 4:5 36:9</p> <p><b>Exhibit H-2 - MacLeod v. ACSW</b> 4:7 47:25</p> <p><b>Exhibit H-3 - R v Mohan 1994 SCC 80</b> 4:10 48:2</p> <p><b>Exhibit H-4 - Wright v College and Assn of Registered Nurses of Alberta 2012 ABCA 267</b> 4:11 48:4</p> <hr/> <p><b>\$</b></p> <hr/> <p><b>\$500,000</b> 126:10</p> <hr/> <p><b>(</b></p> <hr/> <p><b>(i)</b> 77:17,21</p>	<hr/> <p><b>1</b></p> <hr/> <p><b>1</b> 2:5 3:11 4:22 6:12 7:8 10:5 15:2 20:17 29:5 31:19 37:10,14, 23 61:16 68:7 69:21 70:17 93:10 101:5 103:14 104:22,24 108:14 138:24 154:15 157:12,15 162:3 172:2 186:4</p> <p><b>1(1)(j)</b> 78:26</p> <p><b>1(1)(pp)</b> 31:24 77:7,9 78:2,18</p> <p><b>10</b> 2:5 5:21 7:12 46:25 62:21 69:4 70:21 93:5,6,25 124:4</p> <p><b>101</b> 3:11</p> <p><b>102</b> 3:12</p> <p><b>10:30</b> 47:1</p> <p><b>11</b> 2:6 5:7,13 6:24 8:10,12 62:21 68:16,22 70:7 71:19,21 113:23 136:1</p> <p><b>11-page</b> 27:15</p> <p><b>115</b> 3:14</p> <p><b>11th</b> 136:5</p> <p><b>12</b> 4:8 5:11 27:13 47:26 68:20 78:3 93:13 94:2 100:4 119:17</p> <p><b>120</b> 3:16</p> <p><b>121</b> 3:17</p> <p><b>122</b> 3:19</p> <p><b>123</b> 3:21</p> <p><b>124</b> 3:22</p> <p><b>125</b> 3:23</p>
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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

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DISCIPLINARY HEARING

VOLUME 2

VIA VIDEOCONFERENCE

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Edmonton, Alberta

September 2, 2021

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

4

5 September 2, 2021 Morning Session

6

7 HEARING TRIBUNAL

8 J. Lees Tribunal Chair

9 W. Pavlic Internal Legal Counsel

10 Dr. L. Aldcorn ACAC Registered Member

11 Dr. D. Martens ACAC Registered Member

12 D. Dawson Public Member

13 A. Nelson ACAC Hearings Director

14

15 ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

16 B.E. Maxston, QC ACAC Legal Counsel

17

18 FOR DR. CURTIS WALL

19 J.S.M. Kitchen Legal Counsel

20

21 K. Schumann, CSR(A) Official Court Reporter

22

23 (PROCEEDINGS COMMENCED AT 9:03 AM)

24 THE CHAIR: I think the point we were at

25 yesterday was that Mr. Maxston had presented or had

26 direct examination of his expert witness, and we

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

4 Discussion

5 MR. MAXSTON: Mr. Chair, it's Mr. Maxston.  
6 I think that's accurate. I do have one quick  
7 housekeeping comment I need to make based on a  
8 discussion I had with the court reporter about  
9 exhibits. I also believe Mr. Kitchen has I'll call it  
10 something in the nature of a preliminary application to  
11 make concerning some documents he wants to place before  
12 Dr. Hu, which my client is objecting, and we'll have to  
13 ask Dr. Hu to be excused and put in a breakout room  
14 while we deal with that.

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

18 THE CHAIR: Okay.

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

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

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

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

16 THE COURT REPORTER: (NO VERBAL RESPONSE)

17 THE CHAIR: Good. So then --

18 MR. MAXSTON: Mr. Chair, my apologies, I  
19 think it's time to turn this over to Mr. Kitchen, but  
20 we are going to have to ask Ms. Nelson to move Dr. Hu  
21 into a breakout room I think for a relatively brief  
22 period of time, but I think we need to do that first.

23 THE CHAIR: Okay. And just before Mr. Hu  
24 departs, I will just remind him that he is -- well,  
25 he's gone. Okay. We have to remind him that he's  
26 still under oath from yesterday.

1           Okay, Mr. Kitchen.

2       Submissions by Mr. Kitchen (Application)

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

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

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



1 to see them and comment on them.

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

8 THE CHAIR: Mr. Maxston?

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

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

20 Submissions by Mr. Maxston (Application)

21 MR. MAXSTON: Okay, well, then I will make  
22 my submissions.

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

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

4 Just by way of background, I received -- or I  
5 opened my emails this morning and saw an email from  
6 12:11 AM from Mr. Kitchen attaching these two studies.  
7 Again, my client strongly objects to these going in;  
8 it's highly prejudicial. I haven't been able to print,  
9 much less read, these studies. Mr. Lawrence hasn't  
10 been able to read them, and certainly Dr. Hu hasn't  
11 been able to read them.

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

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

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

4           So, again, no time for Mr. Lawrence or I to read  
5   and review these, certainly no time to consult with  
6   Dr. Hu to allow him to provide a fulsome and informed  
7   response.

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

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

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

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

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

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

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

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

7 Reply Submissions by Mr. Kitchen (Application)

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

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

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

1     That's it.

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

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

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

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

1 MR. KITCHEN: Yes.

2 THE CHAIR: Has it been published?

3 MR. KITCHEN: Not that I know of.

4 THE CHAIR: And the other study is  
5 ongoing.

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

8 THE CHAIR: Okay --

9 Reply Submissions by Mr. Maxston (Application)

10 MR. MAXSTON: Mr. Chair, I wonder if I might  
11 just have an opportunity to make one or two very brief  
12 comments in response to what Mr. Kitchen said.

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

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

1 experts testify to these matters. I don't see that  
2 putting Dr. Hu in this position is at all fair to my  
3 client.

4 Reply Submissions by Mr. Kitchen (Application)

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

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

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

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



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

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

9 MR. KITCHEN: No, he is not.

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

11 MR. KITCHEN: And what I'm doing is I'm  
12 just -- I haven't provided these documents yet, so I'm  
13 just providing them to Ms. Nelson so that she can  
14 provide them to you.

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

18 MR. KITCHEN: Thank you.

19 (ADJOURNMENT)

20 Ruling (Application)

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

26 We have decided to allow these within certain

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

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

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

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

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

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

26 I understand the narrow parameters you've placed

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

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

14 MR. MAXSTON: Can I --

15 THE CHAIR: Yeah?

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

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

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

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

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

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

1 are tight.

2 THE CHAIR: Yeah, we --

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

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

8 MS. NELSON: I can send those to him via  
9 email right now.

10 THE CHAIR: Could you send them, please.  
11 Dr. Hu, we're back. Dr. Hu, can you hear me? Can  
12 you hear me?

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

14 THE CHAIR: Yeah, okay, thanks, Dr. Hu,  
15 sorry to keep you waiting.

16 A That's okay.

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

20 A (INDISCERNIBLE) all good.

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

1 A Yeah.

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

6 A Okay.

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

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

15 A Sure.

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

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

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

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

1 THE CHAIR: Okay, we will recess now, and  
2 we will reconvene at 10:00 with Dr. Hu and Mr. Kitchen.

3 A Thank you.

4 THE CHAIR: Thank you.

5 (ADJOURNMENT)

6 THE CHAIR: Okay, the session is --  
7 obviously, we've reconvened, just to remind everybody,  
8 and the floor is Mr. Kitchen's to cross-examine Dr. Hu.

9 MR. KITCHEN: Thank you, Chair.

10 DR. JIA HU, Previously sworn, Cross-examined by  
11 Mr. Kitchen

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

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

20 A Yeah. Yes.

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

23 A Yes.

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

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

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

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

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

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



1 mask?

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

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

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

16 A No --

17 Q -- let's call them surgical masks?

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

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

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

11     Q    Now, just to confirm --

12     A    M-hm.

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

15     A    That is correct.

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

19     A    M-hm.

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

24     A    Yes.

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

1 A Yeah.

2 Q -- a classification of masks between N95 and cloth.

3 Would you agree that's what we're talking about, when

4 we're talking about what's acceptable for the ACAC

5 Pandemic Directive, we're talking about masks that are

6 not cloth and not N95 but in that surgical category in

7 between? Would you agree with me on --

8 A Yes.

9 Q -- that? Okay.

10 A Yes. Although, I'm not entirely -- like I think that

11 like if somebody wanted to wear an N95 mask like in

12 the, you know, clinical setting, like ACAC in a

13 chiropractor's office, I mean you could mask, I would

14 say an N95 is better than a cloth mask -- like, sorry,

15 than a medical-grade mask, which serves different

16 purposes, but it's not inferior, I'll say, to a medical

17 blue mask.

18 Yeah, so -- and I don't think there's trickery,

19 I'm trying to explain, because I wasn't specific in my

20 report around what I mean by "masks", so yeah.

21 Q Well, and that's just it, I don't want us to talk at

22 cross-purposes.

23 Now, would you agree that these medical or

24 surgical or blue masks are of low cost?

25 A What do you mean by "low cost"?

26 Q I mean that they are not expensive; would you agree?

1     A     I don't know. I mean -- so the price of a  
2           medical-grade mask before the pandemic started was  
3           around, I think in bulk procurement prices, 6 cents a  
4           mask. In the midst of the first wave, that price went  
5           up to 60 cents to \$1 a mask, given our shortage of  
6           masks, right? And so I mean -- and then I think it's  
7           gone down again, but I would say that 6 cents a mask is  
8           pretty cheap. I would say that during the pandemic, a  
9           10X increase in price is not insignificant, but, yeah,  
10          those are the prices. So now you know what the prices  
11          are.

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

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

18     Q     Thank you. And, Dr. Hu, you're proud of the work  
19           you've done for AHS during COVID, aren't you?

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

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

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

1           that I don't. I would defend the masking one for sure.

2    Q   And you would defend the distancing one?

3    A   Yes.

4    Q   When it comes to COVID, you think information is more  
5           likely to be scientifically accurate if it comes from a  
6           government public health source than if it comes from  
7           some other source, don't you?

8    A   What is the "other source" referring to?

9    Q   Exactly that, an other source, other than government  
10           public health source.

11   A   Yeah, I mean, I would say that I -- yes, with the  
12           caveat that I think government and public health  
13           sources tend to aggregate the, you know, hopefully the  
14           studies and what we know about COVID sort of at the  
15           time, and so I would say stuff like that, or, you know,  
16           things published in high quality peer-reviewed journals  
17           are good, but, yes, I would agree broadly with the  
18           statement that I trust those sources a fair amount, but  
19           we've also been wrong, right? So ...

20   Q   What I'm asking you is do you trust government public  
21           health sources more than any other source?

22   A   I mean not -- like it depends, right? And so like  
23           here, I'll give you an idea of things that I trust,  
24           right? So I generally trust things that AHS comes out  
25           with, right? I generally trust things like the  
26           meta-analysis and the Lancet, you know, that I refer to

1 in my expert report.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

6 Nobody would argue against masking in a  
7 health care setting.

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

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

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

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

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

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

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

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

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

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

19 A M-hm.

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

25 A M-hm.

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

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

1 Q Okay, excellent. I'm at the end here -- or I should  
2 say the end of the main section, so this is page 5.

3 A Okay.

4 Q And you say: (as read)

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

8 You provide no independent source to verify your claim  
9 about these so-called anti-masking movements, do you?

10 A No, but I can just pull up an article from, you know,  
11 like the news. There was a group called Masks not --  
12 Hugs Not Masks [sic] as I recall. I thought they had  
13 quite a catchy name, and -- but I mean -- and I think  
14 the point of that line was to say that when I look at  
15 the masking debate, so to speak, let's say the debate  
16 around mandatory masking, right, I think there's a lot  
17 more contention around mandatory masking in, say,  
18 public spaces, indoor public spaces, versus the debate  
19 around masking in health care settings, generally  
20 speaking, right? So, yeah, I can give you sources if  
21 you like.

22 Q You said yesterday that the final decision on the  
23 content of the CMOH orders lies with the Cabinet of the  
24 Alberta Government; isn't that right?

25 A Yes, I would say so.

26 Q You agree that cabinet is a political body, do you not?

1 A I do, yes.

2 Q Yesterday, you said that COVID public health  
3 restrictions, including mandatory masking, have become  
4 politicised; isn't that right?

5 A Correct.

6 Q Now, Dr. Hu, chiropractic offices are not true health  
7 care settings; isn't that right?

8 A I mean, I think they're health care settings. You're  
9 providing treatment to a person. You spend like a --  
10 you know, I'm a -- sometimes a family doctor, right,  
11 you know, what I do is, you know, talk to patients, do  
12 a physical exam once in a while, prescribe medications.  
13 Yeah, I think chiropractors, you know, do much of the  
14 same, but I think they spend probably more time with a  
15 patient than I normally would, like, you know, so I  
16 think that they're a health care setting.

17 Q Chiropractic offices really are community settings;  
18 isn't that right?

19 A I mean, I believe I call it a community health care  
20 setting in the same way that a family doctor's office  
21 is a community setting, as opposed to a hospital  
22 setting, right, but health care is provided in a  
23 community setting. A dialysis clinic is a community  
24 setting if it's outside of the hospital, right, like --  
25 but, yeah, health care is provided, and sometimes it's  
26 provided in the community, as in not in the hospital,

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

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

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

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

12      A   Yes.

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

16      A   Correct.

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

21      A   Yes.

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

26      A   Yes.

1 Q On a daily basis --

2 A (INDISCERNIBLE) --

3 Q -- isn't that right?

4 A Oh, no, it's true, yeah. I mean, I -- although I mean  
5 I kind of see your questioning, but I'll just say that,  
6 you know, family doctors often -- like I would say when  
7 it comes to, you know, let's -- I'll talk about a  
8 community family doctor practice, right. You know, you  
9 see patients that are actively ill; you take those  
10 precautions that you can. You also see people who  
11 don't have symptoms, right, or don't have respiratory  
12 symptoms, and you see them for other things, as a  
13 chiropractor would, right? Like it's a family doctor  
14 who sees somebody for lower back pain, a chiropractor  
15 sees somebody for lower back pain, no symptoms, no  
16 respiratory symptoms.

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

26 I will agree that there are higher risk settings

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

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

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



1 A Yes.

2 Q In fact, people, who think they might be ill with an  
3 infectious illness, intentionally set out health care  
4 settings like hospital ER rooms and walk-in clinics to  
5 get the medical health care they need; isn't that  
6 right?

7 A Yes. And you're talking about "symptomatic" as in  
8 respiratory symptoms, right, like COVID symptoms  
9 that -- correct? As opposed to, say, what I might see  
10 a chiropractor for or a family doctor for, right, so --  
11 but you're -- I assume you're talking about respiratory  
12 symptoms here?

13 Q Yes --

14 A Okay.

15 Q -- and just so it's fair to you, I wasn't trying to  
16 name symptomatics, as in any symptoms, what I meant was  
17 visibly symptomatic with a cold, flu, respiratory type,  
18 runny nose, coughing, et cetera.

19 A Okay.

20 Q In health care setting such as hospitals or medical  
21 doctors' offices, a wide range of interventions,  
22 treatments, and tests are likely to occur on a regular  
23 basis; isn't that right?

24 A Yes.

25 Q Now, community office settings, such as the types of  
26 offices where chiropractors typically work, it's quite

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

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

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

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

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

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

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

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

18             Anyways, keep going.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23       Q    Let me ask you --

24            MR. MAXSTON:                   Mr. Chair, Mr. Chair, it's  
25            Mr. Maxston, and I apologize for interrupting my  
26            friend's questions here, but I'm going to have to

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

9 THE CHAIR: I think I have to agree,  
10 Mr. Maxston. Dr. Hu is qualified as a public health  
11 expert and not a chiropractor, so if we could focus the  
12 questioning.

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

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

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

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

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



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

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

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

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

26    A       Yes.

1 Q Going to go back to your report, I note in your report  
2 that you did not respond -- actually, and I'm going to  
3 refer to Dr. Dang's report. Do you want me to give you  
4 a moment to get that up?

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

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

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

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

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

26 A I -- yes.

1 Q And yet, you specifically put in your report a  
2 reference to masks during the Manchurian plague?

3 A Yeah, that was like a -- think of that as like fun  
4 introduction, I mean, you know, a historical preamble.

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

12 Q You don't think it's fun that bacteria are hundreds of  
13 times bigger than viruses, do you?

14 A Say that again?

15 Q You don't think it's fun; you used the word "fun", did  
16 you not?

17 A Yeah, I'm sorry. Yeah, I shouldn't have used that, my  
18 bad. Very casual.

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

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

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

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

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

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

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

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

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

1 Q I'm going to ask you the question again, because this  
2 is my memory of what was said yesterday.

3 A M-hm.

4 Q And if you disagree with me you tell me. You said  
5 yesterday that nobody should be exempt from wearing a  
6 mask except maybe those few people with anxiety.

7 A Yeah, and I'll add in like in a health care setting  
8 especially.

9 Q Okay, especially.

10 A M-hm.

11 Q But help me out here --

12 A Yeah, that's fine.

13 Q -- I'm not trying to trick you, I just -- I want to  
14 know --

15 A Yeah.

16 Q -- did you say yesterday, because that's what I have  
17 written down, you said yesterday that nobody should be  
18 exempt from wearing a mask except maybe those few  
19 people with anxiety?

20 A I did say that, and I -- like what I was referring to  
21 in a health care setting. And like, let me explain  
22 that, right, like -- the riskier the setting, the more  
23 important it is to wear a mask, right? And so do I  
24 care if you're wearing a mask outside in public, you  
25 know, in a park? No, I don't really care if you wear a  
26 mask there or not, because the risk of transmission is

1           very low.

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

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

9    A    Yes.

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

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

16   Q    Well, let me ask you again.

17   A    Okay.

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

20   A    M-hm.

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

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

1 all.

2 Q Okay.

3 A Now, I'm defining community indoor like as separate  
4 from community health care. Community indoor would be  
5 a mall, a restaurant, you know just not a place where  
6 you receive health services.

7 Q So is it your position then that in a place where  
8 health services are received, regardless of what the  
9 health service is, nobody should be exempt from wearing  
10 a mask?

11 A Yes, while they're providing care to a clinic -- you  
12 know, while they're providing, you know, like patient  
13 care, I mean, that's also in all the orders, right?  
14 Yes.

15 Q And that includes --

16 A (INDISCERNIBLE)

17 Q And that includes --

18 A Pardon?

19 Q -- and that includes the patients, correct?

20 A Well, I'm focused more on the health care worker side  
21 right now, but, again, I would say patients sort of  
22 should wear like a mask in those settings, and, yeah,  
23 but like, sure, yes.

24 Q Just to clarify, because I asked you, in fairness --

25 A Yes.

26 Q -- to you, I asked you in a setting where health care

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

5 A Yeah, I mean --

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

8 A Okay.

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

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

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

14 A Yes.

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

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

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



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

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

12      A   M-hm.

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

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

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

1       for those, you know, patients.

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

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

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

25       MR. MAXSTON:                   Mr. Chair, I have to object to  
26       that question. This is far beyond the purview of what

1 Dr. Hu has been called to testify on. That's -- if  
2 anything, that's a legal issue. It's certainly not for  
3 an expert, like Dr. Hu, to comment on.

4 MR. KITCHEN: Chair, Dr. Hu, yesterday, gave  
5 a lot of opinions on the CMOH orders. He gave a lot of  
6 opinions on mandatory masking; okay, mandatory masking  
7 he gave opinions on.

8 A M-hm.

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

14 MR. MAXSTON: You're not exploring,  
15 Mr. Kitchen, clinical positions, you're exploring  
16 religious beliefs. I'm going to strongly object to  
17 that.

18 THE CHAIR: I have to agree with  
19 Mr. Maxston, that's a protected ground. I don't think  
20 we need to get into that.

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

24 A What do you mean by "better"?

25 Q Well, that's the word I heard you use yesterday.

26 Yesterday, did you not say that it would have been

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

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

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

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

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

26 A Yes. M-hm, yes.

1 Q From a Public Health policy perspective, you support  
2 the Alberta Chiropractic College's mask mandate,  
3 correct?

4 A Yes.

5 Q You think the Alberta Chiropractic College got it right  
6 by not permitting exemptions; isn't that right?

7 A This is for health care workers, right?

8 Q Yes. From a policy perspective, you support mandatory  
9 vaccination, don't you?

10 A Define "mandatory vaccination". I mean, this is a  
11 very, yeah, complex topic, right?

12 Q I define it exactly the same as I define mandatory  
13 masking.

14 A Sorry, you're talking about do I support mandatory  
15 vaccination of health care workers who work in health  
16 care settings? Is that what you mean by mandatory  
17 vaccination?

18 Q Well, I'll ask you again. From a Public Health policy  
19 perspective, do you support mandatory vaccination of  
20 all health care workers?

21 A I do, yes. But as somebody who also like works a lot  
22 in like trying to create having this policy, you know,  
23 you can't -- I think it would be wonderful if all  
24 health care workers were immunized. I think that what  
25 you want to do is not use a mandate if you can convince  
26 people to be immunized without a mandate, right? You

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

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

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

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

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

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

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

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

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

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

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

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

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

1 A No, I was not.

2 Q I'm looking now at the second-to-last paragraph on page  
3 4 of your report where you discuss health care workers  
4 in Alberta.

5 A M-hm.

6 Q That paragraph starts with "If we look closer to home".  
7 You cite no scientific reports or peer-reviewed studies  
8 in that entire paragraph, do you?

9 A Yeah, because nothing has been like peer-reviewed yet  
10 on this, yeah, but you're right.

11 Q You provide no independent sources to verify your  
12 claims regarding the number of infections between  
13 COVID-19 infectious patients and health care workers in  
14 Alberta, did you?

15 A No, but I can provide them.

16 Q You provided no independent sources to verify your  
17 claims regarding the number of transmission events, did  
18 you?

19 A No, I did not.

20 Q Everything discussed in this paragraph is simply your  
21 assessment of what happened, is it not?

22 A My assessment in discussion with a bunch of other  
23 people, like Workplace health and safety, Alberta  
24 Health Services, you know, hospital management,  
25 leadership, and all that, but, yes, you're right, I do  
26 not cite anything, that is true.



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

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

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

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

14 MR. KITCHEN: Mr. Maxston, I can tell you  
15 I'm at least half way through.

16 MR. MAXSTON: I think we should let Dr. Hu  
17 go, and maybe we can chat about, after he's gone, just  
18 take 5 minutes of that 15-minute break to chat about  
19 the balance of the day.

20 MR. KITCHEN: Sure.

21 THE CHAIR: Before we do that, Dr. Hu, you  
22 mentioned that you might be a little more flexible on  
23 the noontime if you're able --

24 A Yeah --

25 THE CHAIR: -- to deal with it.

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

1           little bit, so ...

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

4    A    Yes.

5           THE CHAIR:                    -- time to be done? Does that  
6           work for you, Mr. Maxston, Mr. Kitchen, if needed?

7           MR. MAXSTON:                 Yeah, I have a -- I think that  
8           would be as far as I would want to go without having  
9           people take a lunch break, frankly.

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

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

24           (ADJOURNMENT)

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

1 Dr. Hu.

2 MR. KITCHEN: Thank you.

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

8 A Yes.

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

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

14 Q (INDISCERNIBLE)

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

17 Q The overall survivability rate of COVID is 99 percent;  
18 isn't that right?

19 A Yes.

20 Q RCTs --

21 A (INDISCERNIBLE) -- oh, sorry.

22 Q -- RCTs regarding the efficacy of masks have been  
23 conducted and are currently being conducted, are they  
24 not?

25 A In the community setting, yes, not in the health care  
26 setting really.

1           And maybe I'll just explain, so, I mean, I used  
2           the parachute example just like -- just to describe  
3           certain situations where you can't do an RCT, but I  
4           believe I -- I used a term yesterday called "clinical  
5           equipoise", and that basically means that when you do  
6           an RCT for anything, medication, intervention, right,  
7           like, you can't do it if you think that like one --  
8           like the placebo, if the treatment is like -- you think  
9           is like definitely better than the non-treatment  
10          placebo group, right?

11           And I think right now it would be probably not  
12          ethical to do an RCT of mask wearing in a health care  
13          setting, because there's so much evidence supporting  
14          masking in health care setting. Now, in a community  
15          indoor setting, it's a bit different, right? There's a  
16          lot more sort of debate around that one.

17   Q       So RCTs regarding the efficacy of mask and mask wearing  
18           in community settings --

19   A       Yes.

20   Q       -- are being conducted and has been conducted?

21   A       Yes.

22   Q       Thank you. Now, on the top of page 3 of your report --  
23           forgive me, I put it down -- the top of page 3 of your  
24           report --

25   A       Yeah.

26   Q       -- you cite to a study sponsored by the World Health

1           Organization that is authored by Chu et al., so I'm  
2           going to call that the Chu study.

3     A     Sure.

4     Q     You know what I mean by that?

5     A     Yeah.

6     Q     And you discuss this same study in the second paragraph  
7           of page 4. This study was published in June 2020,  
8           correct?

9     A     Yeah.

10    Q     Now, this study is also discussed by Dr. Thomas Warren  
11          on page 6 of his report in the second-to-last paragraph  
12          of his report. Dr. Warren --

13    A     Okay (INDISCERNIBLE) --

14    Q     (INDISCERNIBLE)

15          (INDISCERNIBLE - OVERLAPPING SPEAKERS)

16    Q     MR. KITCHEN:                Let me know when you've got  
17          it.

18    A     Yeah. This is page 6 of his report.

19    Q     Right, that's these -- the paragraph there at the  
20          bottom that starts with: (as read)

21                Finally, a comment should be made.

22          Dr. Warren refers to a Cochrane review that was  
23          evidently published after the Chu study. This Cochrane  
24          review is found at footnote -- or I should say, sorry,  
25          end note 62 of Dr. Warren's report. The first author  
26          listed for this report is Jefferson.

1 A Okay.

2 Q Jefferson/Cochrane review.

3 A M-hm.

4 Q Dr. Warren quotes directly from this Jefferson/Cochrane  
5 review, in which it is stated that the Chu study,  
6 quote: (as read)

7 Has been criticized for several weeks. Use  
8 of an outdated risk of bias tool, inaccuracy  
9 of distance measures, and not adequately  
10 addressing multiple sources of bias,  
11 including recall and classification bias and,  
12 in particular, confounding.

13 My question is you don't deny the existence of this  
14 Jefferson/Cochrane review cited by Dr. Warren, do you?

15 A No.

16 Q You don't contest that the portion of the  
17 Jefferson/Cochrane review quoted by Dr. Warren was  
18 quoted accurately, do you?

19 A No.

20 Q And you don't disagree with Dr. Warren that Cochrane  
21 systemic reviews are widely recognized in the medical  
22 community as authoritative, do you?

23 A Yeah, they are. I agree.

24 Q I note --

25 A I'm trying to download this Cochrane review; is that  
26 okay? Can I like crack it open?

1 Q Well, yes, because it's part of the record, it's --

2 A Yeah, just trying to --

3 Q It's in Dr. Warren's report.

4 A Is it one of the -- it's not one of the exhibits,  
5 right? I'm just trying to download the PDF of it right  
6 now.

7 THE CHAIR: It's in E-7.

8 A Oh, it's in E-7, okay, thank you. (INDISCERNIBLE)

9 (INDISCERNIBLE - OVERLAPPING SPEAKERS)

10 Q MR. KITCHEN: (INDISCERNIBLE)

11 A The paper itself, the Cochrane review itself.

12 Q So just so you know, Dr. Hu, I'm not going to question  
13 you any further on the report, so ...

14 A I'm just reading that study right now, the Cochrane one  
15 where -- I mean, so they talk about medical surgical  
16 masks compared to no masks, but I think that what  
17 they're looking -- and they basically in that study say  
18 that wearing a mask may make little or no difference to  
19 the outcome of influenza-like illness if not wearing a  
20 mask. And so what we're trying to look at is if like  
21 what they're looking at is general influenza-like  
22 illness for COVID specifically.

23 So, now, this Cochrane review was published  
24 initially in 2007, and then -- as Cochrane reviews  
25 often are, right; you have an initial one on masking,  
26 and then updated in 2009, '11, '17. And so I mean I --

1       again, I kind of wanted to look at it just to see if  
2       the studies this Cochrane review talks about, which --  
3       Cochrane reviews are very good -- refer directly to the  
4       transmission of COVID and masking to prevent that.

5               The comments around criticizing, you know -- you  
6       know, with the Lancet paper, I mean, yes, you can  
7       always critique these meta-analyses, but it really is  
8       seen as like a, you know, a fairly good study. No  
9       study is perfect, but -- oh, thanks for flagging the --  
10      the -- yeah, yeah, I'm just reading this document right  
11      now. I'm going to -- keep going though.

12   Q    I note that in your report, you state no less than six  
13       times that the evidence in support of masking is,  
14       quote, overwhelming. Do you --

15   A    Yes.

16   Q    Do you today remain of that opinion?

17   A    Yes, for health care -- for prevention of COVID in a  
18       health care setting, yes. I do.

19   Q    You state on page 8 of your report that the efficacy of  
20       mask wearing is beyond doubt; do you stand --

21   A    (INDISCERNIBLE)

22   Q    -- by that statement?

23   A    Yes, in a health care worker setting, yes.

24   Q    So it's not beyond doubt in a community setting; do I  
25       have your position right?

26   A    Yes. I mean, I will say the other thing that like



1 affects this is like the number of cases you have,  
2 right, of COVID.

3 And so, for example, like -- and this is quite --  
4 I think I may have talked about this yesterday, but if  
5 we had zero COVID, we wouldn't need to wear masks,  
6 right; like I fully support that, right. And so, like,  
7 a lot of what I'm trying to say is that, you know, when  
8 you wear -- like -- and zero COVID is a type of, you  
9 know, like if there's no COVID cases, your risk is very  
10 low of getting COVID. I think that, you know, your  
11 risk is sort of determined by a number of factors,  
12 including, you know, the prevalence of COVID but also  
13 what you're doing exactly.

14 But I will stand by my fact that right now, like,  
15 yeah, like, beyond doubt people should wear masks to  
16 prevent COVID-19 in health care settings. If there was  
17 no COVID for ten years, I would take that back, right?  
18 But, you know, that's -- these are all important things  
19 that I, you know, actually even think about. The  
20 community setting is very, very different.

21 For example, do I think people should engage in  
22 indoor masking in -- let me pick an area with very few  
23 COVID cases -- in, I don't know, there's a big outbreak  
24 in the Northwest Territories -- like in Nunavut, right,  
25 where I don't really think they have many cases right  
26 now. Like, no, not in, you know, a community setting.

1           It's really important to make a difference between  
2           a health care setting and a community setting. They're  
3           completely different.

4    Q    When -- well, I want to make sure I have your position  
5           correct --

6    A    M-hm.

7    Q    -- so you --

8    A    (INDISCERNIBLE) again?

9    Q    Sorry?

10   A    Do you want me to say my position again --

11   Q    No, no, sorry, I'm going to ask you a question, I  
12           apologize.

13   A    Okay, yeah, no problem.

14   Q    So you would say that the evidence of the effectiveness  
15           of masking in what you call a health care setting is  
16           overwhelming, correct?

17   A    Yes.

18   Q    It's not overwhelming in what you would call a  
19           non-health care setting?

20   A    Correct. I think there's lots of evidence for it; it's  
21           just not as overwhelming, right, like -- but yes.

22   Q    And, again, embellish me, you would say that the  
23           evidence for the efficacy of mask wearing in what you  
24           would call a health care setting --

25   A    M-hm.

26   Q    -- beyond doubt --

1 A Yes.

2 Q -- (INDISCERNIBLE)

3 A And I will --

4 Q -- and you would say it's not beyond doubt in what you  
5 would call a non-health care setting?

6 A I would say that -- and, you know, these terms are not  
7 very specific, right, beyond doubt, overwhelming. So  
8 let me try to describe these terms.

9 When I say "overwhelming", what I mean is that in  
10 a health care setting, basically every study on --  
11 pretty much every study or the vast majority, let's say  
12 95 percent plus studies have been done on masking in a  
13 health care setting during COVID which show that it  
14 provides benefit, right, and so that's pretty  
15 overwhelming, I think.

16 And now when I talk about studies around masking  
17 in a community setting, again, there's a lot of studies  
18 that show, you know, masking previously, like in a  
19 classroom, for example. That's probably one of most  
20 interesting ones right now. Like it's also strong, but  
21 like the effect size is not as strong. By "effect  
22 size", I mean the extent to which like the proportion  
23 of like -- the risk reduction of transmission is not as  
24 high in the community settings as in a health care  
25 worker setting. And so while there's lots of studies  
26 supporting it, like the magnitude of the risk reduction

1 does matter as well, so, yeah.

2 Q Going to take you to page 8 --

3 A M-hm.

4 Q -- of this report, now we're in the response  
5 sections --

6 A Yeah.

7 Q -- I guess this is the last page. You make a comment  
8 on this page, page 8 --

9 A Yeah.

10 Q -- in response to Dr. Bao Dang's statement regarding  
11 mask mandates in other countries. You say that  
12 Dr. Dang's remark about Sweden is, quote, false and not  
13 backed by any evidence. However, you do not refer to  
14 any study or other evidence that supports your claim  
15 that Dr. Dang's Sweden remark is, in fact, false, do  
16 you?

17 A You're right. And let me explain that, maybe I didn't  
18 use my words, like language correctly, but Dr. Dang's  
19 real-world data from various countries shows that cases  
20 increased after masked mandates were enacted, and  
21 countries that had no mask mandates did just as well or  
22 better than other countries with masked mandates.

23 You know what, my -- like I will -- I like -- my  
24 main critique with that is, you know, I'll give you an  
25 example, right, like China after the first wave as of,  
26 let's say, June of 2020, no longer had any

1 restrictions, right, because they had no COVID anymore,  
2 because they managed to suppress it completely. You  
3 know does that mean masking doesn't work? No, because  
4 there's no COVID, so you don't like necessarily need to  
5 mask.

6 I think that when we're looking -- and this is  
7 what I was talking about like a -- like spurious, you  
8 know, causation, a lot of factors drive up cases.  
9 Masking can reduce transmission, but like a lot of  
10 things can reduce transmission and a lot of things can  
11 increase transmission as well, right? And I would say  
12 the biggest predictor overall case counts in a  
13 particular country, you know, is just the total number  
14 of -- you know, actively interaction between people.

15 And so, you know, you can't just like make like --  
16 it's kind of like -- yeah, you know what I'm talking  
17 about when you have like a -- like a spurious like, you  
18 know, causation like -- correlation versus causation  
19 are very different.

20 I think the example I used yesterday was -- and,  
21 you know, November -- like late November, we  
22 implemented some strict measures, and then in December,  
23 in Alberta, we implemented stricter measures, but cases  
24 kept on going up. They eventually started falling, but  
25 I can say that, you know, the implementation of  
26 measures in November, December, like initially led to a

1       rise in cases, right, and like -- and so you'd be like,  
2       oh, so maybe your like lockdowns don't work.

3               But, you know, it's factually true, the cases went  
4       up after we implemented lockdowns, right, for a bit.  
5       That doesn't mean lockdowns don't work. I'm just  
6       saying lots of other factors determined, you know, what  
7       our case counts are.

8       Q     So you would say that when cases went up after what you  
9       called the lockdown --

10      A     M-hm.

11      Q     -- you would say it's just correlation; it's not  
12      causation?

13      A     Yeah, I mean, like, sorry, like if you're like  
14      correlation like, you know, like mathematically,  
15      statistically is like there's a -- like something  
16      happens, and something goes up or down, right? It's  
17      just like a direct -- this immediately -- how do I  
18      define correlation? Like correlation just describes  
19      the relationship between sort of like two variables,  
20      right?

21             And so whereas causation is more like, okay, so  
22      what our action -- what is driving, you know did  
23      lockdowns lead to lower cases in the end? Yeah, they  
24      did, but it took some time for that to happen, right;  
25      but if I took a slice of time, like a week after, cases  
26      were still high. Anyways --

1 Q So you --

2 A -- (INDISCERNIBLE) say.

3 Q You would say the relationship between cases going down  
4 after what you call the lockdown is causation not  
5 correlation?

6 A Yes.

7 Q So you would agree that the lockdown caused those cases  
8 to go down?

9 A Yes. And then let me like -- and we have to like get  
10 into more specifics like because many, many things like  
11 lead to a decrease in cases, right?

12 What did the lockdown actual -- okay, for just a  
13 fun public health discussion, right? So, again, you  
14 know, just illustratively, what was causing our cases  
15 to be very high in the late fall was indoor private  
16 social gatherings, right? The lockdown really said you  
17 couldn't do those things, and, you know, that led to a  
18 decrease in the number of indoor private social  
19 gatherings that occurred, as in people going to  
20 people's houses, or we think it did.

21 And that is sort of like the causal link, because,  
22 you know, when you say "causation" -- like establishing  
23 causation, as you know, can be very difficult, but, you  
24 know, the reason why I think lockdowns generally -- and  
25 there's a whole set of criteria and epidemiology to,  
26 like, try to determine causation.

1           But I would say that I guess point one is you  
2           can't just look at correlation; point two when you're  
3           trying to assert causation, you know, you have to  
4           consider a number of factors, you have to have an  
5           understanding of like, you know, the sort of like the  
6           drivers of transmission, the things that make it worse,  
7           the things that make it better.

8    Q    Now, I'm going take you back to -- I know you just  
9           talked about a lot of stuff, but I'm going to take you  
10          back to exactly what we were talking about before,  
11          okay --

12   A    Yeah.

13   Q    -- we're talking about this Sweden reference here.

14   A    Yeah.

15   Q    Okay, so you've got your sentence here where you say,  
16          And this statement is false and has not been backed up  
17          by any evidence.

18               Now, in the very next sentence, you state in your  
19          report: (as read)

20               The use of masks has decreased the  
21               transmission of COVID-19 across every country  
22               that has imposed them.

23   Q    That's what you state in your report. You do not cite  
24          or refer to any study or other evidence at the end of  
25          that sentence to back up that claim, do you?

26   A    No. But I can give you some citation.



1 Q On page 6 of your report, you accuse Dr. Warren of  
2 committing a factual error in stating that 1,010  
3 COVID-related deaths says, as of April 16th, 2021, our  
4 last deaths than the 1,191 motor vehicle accident  
5 deaths in the year 2018. Do you today stand by that  
6 accusation?

7 A I do. Sorry, like -- like I think what Dr. Warren put  
8 in is accurate, right? Like I'm not arguing that.  
9 Like I think what I'm trying to articulate is that,  
10 one, it doesn't really matter for the purposes of our  
11 discussion to talk about again, which is, you know,  
12 whether or not which of these masks can be in a health  
13 care setting, right, and whether or not that reduces,  
14 you know, transmission.

15 You know, the spirit of I think what, you know,  
16 Dr. Warren is talking about is basically like COVID  
17 isn't that serious, and, you know, whether or not you  
18 think COVID is serious or not, right, like -- like,  
19 again, like the focus of this is, you know, health  
20 care -- like use of masking in a health care setting to  
21 reduce transmission, right?

22 And I think one of the issues that I have with a  
23 lot of the expert reports -- and, you know, like I can  
24 actually chat at length actually about how serious or  
25 not serious I think COVID is. You know, there's a lot  
26 of room for discussion, I think, frankly, right? Like,

1 lockdown I think is actually -- you know, more people  
2 have died from non-COVID causes than COVID, you know,  
3 during like our -- the last 18 months in terms of  
4 excess mortality.

5 But, you know, at the end of the day, it's just  
6 not relevant, and, you know, I think with a lot of the  
7 expert reports, like a lot of their reports are spent  
8 like just talking around the issue -- or like around  
9 COVID, but not around masking. There's very little in  
10 the reports about masking as a portion of the total  
11 report.

12 And I made that error too, I talked about the  
13 Manchurian plague thing, which is also not relevant, so  
14 point taken.

15 Q Now, that was a long answer, and I want to make sure I  
16 have your answer, okay?

17 A Okay.

18 Q You stand by the accusation that Dr. Warren made a  
19 factual error in stating that 1,010 COVID deaths as of  
20 April are less than the 1,191 motor vehicle accident  
21 deaths in the year 2018?

22 A Yeah -- no, I don't. Like his statement is accurate --

23 Q No, you don't -- hold on, like I don't want to  
24 interrupt you, but, no, you --

25 A Okay.

26 Q -- don't stand by your accusation?

1     A     Sorry, what I'm saying -- okay, like what he says is  
2           that, in Canada, there have been a thousand COVID  
3           deaths in people under 60 as of April 2021. In Canada,  
4           in 2018, there were 1191 motor vehicle fatalities. And  
5           what I say is that as of June, so like two months  
6           later --

7     Q     But I didn't ask you what you said --

8     A     Okay.

9           MR. MAXSTON:                   Mr. Chair, Mr. Chair,  
10          Mr. Kitchen may not like the answer Dr. Hu is giving,  
11          but he's got to let him finish, and he should be  
12          allowed to finish his answer.

13    Q     MR. KITCHEN:                   Okay, you go ahead, Dr. Hu.

14    A     So I mean, I think that Dr. -- that is what Dr. Warren  
15          said, right, and he's basically saying there were fewer  
16          COVID deaths than motor vehicle deaths, you know, as of  
17          April 2021. What I say is, as of June 29, there were  
18          more COVID deaths than motor vehicle deaths, right, and  
19          so that's it, and both are factually correct  
20          statements, right?

21                 And, yeah, so you're right, the point where I say,  
22          notwithstanding the factual error, I mean, like it's  
23          not his fault, because like at the point he cited it,  
24          there were more motor vehicle deaths than like there --  
25          than COVID deaths, and two months later, there are more  
26          COVID deaths than motor vehicle deaths, but like --

1 but -- and when you like pick a point in time for  
2 looking at COVID deaths, right?

3 Q Now, I feel like I've gotten two answers from you, and  
4 I want to make sure everybody's got this right, because  
5 you just said -- you just said that there is a factual  
6 error --

7 A Yes, the factual error is that --

8 Q -- you stand by the claim that Dr. Warren made a  
9 factual error?

10 A Okay, let me be precise here. So at the time of him  
11 citing, you know -- picking April -- like so he says  
12 two things really, right? He says as of April 16th,  
13 there were more motor vehicle deaths than COVID deaths,  
14 right? And that's true. And then he goes on to say so  
15 the risk of death due to COVID in persons under 60 is  
16 less than the risk of death due to a motor vehicle  
17 fatality. So, I mean, I think that part is not true  
18 based on, you know, by June 2021, you know. There have  
19 been 1400 COVID-related deaths under 60, right?

20 And so what I'm saying is like the first part of  
21 his statement is accurate, right, like numbers of  
22 deaths at this point versus number of motor vehicle  
23 fatalities, but the second part, the risk due to COVID  
24 in a person under 60 is less than death to a motor  
25 vehicle fatality, because like if you go like two  
26 months later, you see that the number of COVID deaths

1 is quite a bit higher than the number of motor vehicle  
2 deaths, right?

3 Q So what he said was accurate on April 16th?

4 A Yes. But --

5 Q (INDISCERNIBLE)

6 A -- as of June, it is no longer accurate, right, and so  
7 there's a factual error there, right?

8 Q But Dr. Warren didn't say June, he said April; isn't  
9 that correct?

10 A That's true. Yeah, but like he did, so you're right,  
11 at that time, he was correct, but like two months  
12 later, he was no longer correct, right?

13 Q There are --

14 THE CHAIR: Please --

15 Q MR. KITCHEN: -- (INDISCERNIBLE)

16 THE CHAIR: -- Mr. Kitchen, I'm wondering  
17 if Dr. Hu is referring to the second -- he said there  
18 were two parts to the answer, one, what happened in  
19 April, and then a broader generalization. I think,  
20 Dr. Hu, were you not saying that it's the broader  
21 generalization that's not true?

22 A Yeah, so the generalization he makes is -- I mean, and  
23 like we can move off this, like I -- is like so the  
24 risk of death due to COVID in persons under 60 is less  
25 than the risk of death due to a motor vehicle fatality.  
26 And while that was true in April, it is not true now,

1           because we had a lot more COVID deaths, right? And so  
2           that is like the sort of factual error. I mean,  
3           regardless, I will -- yeah.

4    Q   MR. KITCHEN:                   Let me ask you this, Dr. Hu:  
5           There are 12 months between April 16th, 2020, and April  
6           16th, 2021, are there not?

7    A   Yeah.

8    Q   And there were 12 months in the year 2018, were there  
9           not?

10   A   M-hm. Would you like me to calculate like a death by  
11          month rate because -- okay, so, here, let's do this --

12   Q   Now, Dr. Hu, look, I didn't ask, and Mr. Maxston can  
13          chime in here, I didn't ask you a question.

14   A   Sorry, my bad.

15   Q   You're asking me, Can I do this, and then you're  
16          talking, and, you know, I've let you do that a lot, I  
17          don't generally have an issue with that, but --

18   A   Sorry, but --

19   Q   -- the idea is that you --

20   A   -- (INDISCERNIBLE) --

21   Q   -- I ask a question and you answer it. And that's  
22          exactly why Mr. Maxston rightfully stepped in and said,  
23          Well, you know, look, my witness --

24   A   Yeah.

25   Q   -- is answering a question that you asked.

26   A   Right, that's fair.

1 Q Now, in the next sentence, you accuse Dr. Warren of  
2 lacking, quote, a basic understanding of disease  
3 patterns. Do you today stand by that accusation?

4 A Well, it's a little bit general accusation. I don't  
5 know, like I -- maybe I won't say that anymore, right?  
6 Like I don't know Dr. Warren well enough.

7 Q So you don't stand by that accusation; do I have that  
8 right?

9 A Yes. I don't anymore. It's too general. It's too  
10 like general in my writing.

11 Q It must surprise you that someone who you up until just  
12 now said has no basic understanding of disease patterns  
13 has written a seven-page report about COVID that  
14 contains 98 citations to academic literature, doesn't  
15 it?

16 A No, I mean, like -- like I said, like I -- I will  
17 retract my statement as I think he has no understanding  
18 of disease patterns, and, fair. I mean I think he has  
19 a lot of citations, but I think, yeah, when it comes to  
20 the whole masking thing, which is the thing we should  
21 be focusing on, which is the purpose of this  
22 discussion, right, I disagree with, you know, his  
23 findings.

24 Q So it doesn't surprise you that he's created a  
25 seven-page report with 98 citations to academic  
26 literature about COVID?

1 A No. Does it surprise me? No, because -- yeah.

2 Q Your report contains 22 citations to academic  
3 literature; isn't that right?

4 A M-hm. Yes.

5 MR. KITCHEN: Those are my questions.

6 A Thank you. Sorry, for being so long-winded again,  
7 Mr. Kitchen.

8 THE CHAIR: Thank you, Dr. Hu. We will  
9 now turn the floor back to Mr. Maxston for his -- any  
10 redirect.

11 MR. MAXSTON: Thank you.

12 Mr. Maxston Re-examines the Witness

13 Q MR. MAXSTON: I'm just going to start with a  
14 question, Dr. Hu, about the Pandemic Directive, which  
15 is Exhibit C-22 --

16 A Okay.

17 Q I'll let you just get to that, and I'm looking at -- in  
18 specific, I'm looking at page 8. While --

19 A Yeah.

20 Q -- you're getting to that, there was a discussion  
21 between you and Mr. Kitchen about the type of masks  
22 that are -- really, you're referring to, and I think a  
23 discussion about the blue medical clinical mask. I'll  
24 just take you to the heading "PPE Requirements" and --

25 A Yeah.

26 Q -- the first black dot says: (as read)



1           Surgical or procedure masks are the minimum  
2           acceptable standard.

3           And you'd agree that's appropriate?

4    A    Yes.

5    Q    There was a discussion between you and Mr. Kitchen  
6           about how the CMOH orders come about and Cabinet and  
7           other considerations, regardless of the development  
8           process of CMOH orders, they're to be followed, aren't  
9           they?

10   A    Yes. They are legally binding, I believe, so ...

11   Q    There was, I found, a surprising comment, a surprising  
12          question from Mr. Kitchen that chiropractic offices  
13          aren't true health care settings, and I think you  
14          responded pretty vigorously to that, but I just want to  
15          be clear, is there any doubt in your mind that  
16          chiropractic offices are health care settings?

17   A    No.

18   Q    Patients are treated, diagnoses --

19   A    Yes.

20   Q    -- diagnoses are made, and that, in fact --

21          MR. KITCHEN:                   Chair, hold on a second, I --  
22          this was the same line of questioning that I was doing  
23          that Mr. Maxston objected to on the basis that,  
24          ultimately, Dr. Hu doesn't know what goes on in a  
25          chiropractic office, and he's not qualified as an  
26          expert to comment on what goes on in --

1 MR. MAXSTON: I'll skip on, I'll skip on.

2 Q MR. MAXSTON: You made comments about there  
3 being a higher risk -- pardon me, that there are higher  
4 risk settings in the health care world that -- than  
5 there are in the community setting; is that correct?

6 A Yes.

7 Q You talked about things like duration of contact is  
8 important, the number of patients you might see, and  
9 although you're not a chiropractor, you used an example  
10 of eight people a day as a patient load. If any health  
11 care professional, whether it's a chiropractor or a  
12 dentist or whoever, sees 16 or 32 patients, the risk  
13 would go up for COVID transmission, wouldn't it?

14 A Yes.

15 Q So if someone like Dr. Wall was seeing 32 patients a  
16 day would be different -- more risky than if he was  
17 seeing 8 patients, just to use your hypothetical?

18 A Yes.

19 Q You talked about there is a spectrum about what sick  
20 is, and I think, very importantly, you said, And what  
21 people perceive as sick. And I'm going to suggest to  
22 you that people may not know when they're sick; that's  
23 the whole concept of asymptomatic?

24 A Yes, definitely.

25 Q And isn't that why we have things like what are called  
26 universal precautions, so that when someone comes into

1 a dentist's office, the dentist says, I'm going to  
2 assume you've got Hep B, Hep C, or whatever, we always  
3 use universal precautions?

4 A Yes, yeah, that is a term used in infection prevention  
5 and control, just the basics for everybody.

6 Q You made a statement, and I'm going to paraphrase here,  
7 but I think I've got the wording right, the more people  
8 you interact with and the longer you interact with them  
9 and the closer you are, the greater the risk of COVID  
10 transmission; is that correct?

11 A That's correct.

12 Q So if I'm a dentist or a physician or a chiropractor,  
13 and I have closer contact, see more people, have a  
14 longer duration with them, the risk of COVID is going  
15 to increase?

16 A Yes.

17 Q Or transmission, okay.

18 A Yeah.

19 Q There was a discussion you had with Mr. Kitchen about  
20 bacterial infection references and some historical  
21 references in your paper, but I want to be clear, your  
22 paper focuses on masking and COVID and efficacy of  
23 masking?

24 A Yes.

25 Q There was another lengthy exchange between you and  
26 Mr. Kitchen about exemptions to masking, and I just

1        want to be absolutely clear on this point, because I  
2        think the discussion boiled down to one comment on your  
3        part -- or one theme on your part, there should not be  
4        exemptions to masking in health care settings in the  
5        overwhelming majority of situations?

6     A    Yeah, but I will take -- Dr. -- that Mr. Kitchen's  
7        projective for health care workers, right, like a lot  
8        of patients can't wear masks or, you know, their  
9        mental -- like, you know, so I'm not going to deny  
10       treatment to an acutely psychotic person coming into  
11       the emerg without a mask on, right?

12    Q    Yeah, and let me be more clear, there should be no  
13        exemptions for health care workers in health care  
14        settings?

15    A    Yes.

16    Q    You had a discussion with Mr. Kitchen about -- and,  
17        again, I'm going to paraphrase -- it would have been  
18        better if the CMOH orders had provided more detail  
19        about exemptions; is that your recollection?

20    A    Yes.

21    Q    Ideally, you would want, I'm assuming, some criteria  
22        for what a medical exemption is?

23    A    Yes.

24    Q    And a process for getting it, who you get it from, and  
25        who that person is and how qualified they are?

26    A    Yes.

1 Q I think you, would it be fair to say that when you get  
2 a medical exemption, you would want some rigour  
3 involved in that exemption process?

4 A Yes, ideally.

5 Q You would want testing, diagnosis, interaction with the  
6 patient?

7 A Yes, ideally.

8 Q You'd want to avoid quickie, one-line diagnoses or  
9 exemptions?

10 A Yes.

11 Q Would it be fair to say that a physician, for example,  
12 shouldn't self-diagnosis his own or her own exemption  
13 from COVID?

14 A Yes, for various reasons, but yes.

15 Q Okay. And, particularly, let's say if it was a  
16 physiotherapist, a nonphysician, that person shouldn't  
17 be self-diagnosing their medical exemption for COVID?

18 A No.

19 Q And can you tell me why?

20 A Well, I mean, I -- in the same way that I, you know,  
21 generally do not know very much about the practice  
22 of -- you know, like the skill set, knowledge of being  
23 a physiotherapist or a chiropractor, you know, so too I  
24 imagine most physiotherapists don't know as much about,  
25 let's say, providing medical exemptions for masks,  
26 respiratory illness, all those things as compared to at

1 the doctor or a physician, it's just how you're trained  
2 and what you do.

3 Q So if you had someone who thought they might have an  
4 anxiety disorder, they should get that diagnosed by  
5 someone who has knowledge and training and experience  
6 in anxiety disorders?

7 A Yes.

8 MR. MAXSTON: Those are all my questions,  
9 Mr. Chair.

10 MR. KITCHEN: Mr. Chair, there were some new  
11 questions there that weren't in response to my  
12 questions. I'd like a chance, and this is what I'm  
13 going to ask you, I'd like a chance just to ask one or  
14 two questions based on what I saw as new questions that  
15 were not in response to my questions.

16 MR. MAXSTON: I wouldn't have a problem with  
17 that, Mr. Kitchen.

18 THE CHAIR: Okay.

19 Mr. Kitchen Re-cross-examines the Witness

20 Q MR. KITCHEN: Prior to May 14th, 2021,  
21 nothing in the CMOH orders said that a third-party  
22 diagnosis was required for those who felt that they  
23 fell within the exemption clauses in the CMOH orders as  
24 far as masking is concerned; is that correct?

25 A I believe you. I'd have to go into the CMOH orders and  
26 just double-check, but I think you're right from my

1           experience.

2     Q     Why don't I put one to you.

3     A     Sure.

4     Q     I've got to find one here, that's only fair, and I  
5           think May 14th is the right date upon which the CMOH  
6           issued a new order specifying who can grant exemptions  
7           and the criteria for granting them and all of that.  
8           Would you agree with me that it was on or around May  
9           14th that happened?

10    A     Do you have the CMOH order that did that?

11    Q     No, I don't.

12    A     Oh, well, I (INDISCERNIBLE) --

13    Q     But what I have -- but what I do have is CMOH orders  
14           prior to May 14th, 2021. Find one here. So, for  
15           example, CMOH Order 38-2020; are you familiar with that  
16           one?

17    A     Yes, we talked about that one yesterday, I believe.

18           MR. MAXSTON:                   Mr. Kitchen, that's actually  
19           an exhibit, if you want to go to that, it's D-8.

20           MR. KITCHEN:                   It is? Thank you. It's D-8.

21    Q     MR. KITCHEN:                   Yes, we talked --

22           THE CHAIR:                    'D' or 'E'?

23           MR. KITCHEN:                   'D', it should be 'D', should  
24           be D-8, that sounds familiar. I've got my exhibit book  
25           over here. Yeah, it's D-8.

26    Q     MR. KITCHEN:                   Okay, so this is the first

1 CMOH order that brings in province-wide mandated  
2 masking, and Dr. Hu, if I could just take you to, and  
3 you were here yesterday, I believe --

4 A M-hm.

5 Q -- Part 4 says "Masks", if we go down to Section 27, it  
6 says: (as read)

7 A person must wear a mask at all times.

8 Do you see that there?

9 A Yeah, section -- this is on page 6 of 8 of the --

10 Q That's on page 6, and we're at Section 26, it says:  
11 (as read)

12 Subject to Section 27, a person must wear a  
13 mask.

14 And then Section 27 says: (as read)

15 Section 26 does not apply to a person  
16 attending an indoor public place if the  
17 person ...

18 And then there's above, I don't know what, about ten --  
19 eight or ten different exemptions there, one of which  
20 is 'C', it says: (as read)

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

23 You see that there, correct?

24 A Yeah.

25 Q Now, would you agree with me that in this order and  
26 subsequent orders up until around -- on or around May



1       14th, 2021, there was no requirement in the CMOH that  
2       anybody who is unable, pursuant to Section 27(c),  
3       "unable to wear a face mask due to a mental or physical  
4       concern or limitation" get third-party authorization  
5       for that inability?

6       A    Can I ask you a question about this actually?  So my  
7       read of Section 27, like this is a broader thing to  
8       sort of indoor public places, right?  I think we should  
9       look at the CMOH orders that talk about community  
10      health settings as opposed to general --

11      Q    Yes, that's right.

12      A    Yeah, and so 27 is indoor public places, which is not  
13      the same.

14      Q    That's right, that's right.  And so what I'm asking you  
15      about is 38; I'm not asking you about 16.

16      A    Okay.

17      Q    I'm asking you about 38-2020.  So you would agree with  
18      me in 38-2020 and in 40 -- I think it's 40-2020,  
19      42-2020, 02-2021, et cetera, all the way up until May  
20      14th, 2021, you would agree with me that there was no  
21      requirement in the CMOH orders for a person saying  
22      they're unable to wear a mask to get any type of  
23      third-party medical verification of that inability?

24      A    I trust you.  Like, I mean, I -- like I don't -- I  
25      would have to read in greater detail all these orders,  
26      but let's assume I agree with you.  I mean, I -- yeah.

1 Q Well, you did speak at length yesterday about the CMOH  
2 orders, correct?

3 A I did, yes, but they're quite long, and I don't  
4 remember every single clause in the CMOH order.

5 Q I understand, but you did say you are fairly familiar  
6 with them, generally speak --

7 A Yes.

8 Q And you're familiar with the mandatory mask portions of  
9 the CMOH orders?

10 A Yes, and I'm familiar, in particular, with actually the  
11 problems that were caused by not providing guidance  
12 around what constitutes an exemption and how to get  
13 one. I'm more familiar (INDISCERNIBLE) --

14 Q And that's (INDISCERNIBLE) --

15 (INDISCERNIBLE - OVERLAPPING SPEAKERS)

16 A -- yeah.

17 Q Go ahead.

18 A I just don't remember what date, like, that was  
19 changed, but you're right, I'm familiar with the fact  
20 that like in -- on the series -- I agree with you, in  
21 the series of initial CMOH orders, they talk about the  
22 exemption, they didn't provide like criteria for an  
23 exemption or like who to get an exemption from. It was  
24 broadly assumed that people would have to go to their  
25 family doctor to get an exemption. Family doctors were  
26 getting lots of questions about exemptions, and they

1           were confused about what to do, and that caused a bit  
2           of chaos.

3     Q     And by the way, it's okay to answer my questions with,  
4           I don't know. If you --

5     A     Yeah, okay.

6     Q     -- do, I'll leave you alone, if you give me that  
7           answer --

8     A     Yeah, yeah, yeah.

9     Q     -- (INDISCERNIBLE) with you because you know a lot, but  
10           if you do --

11    A     Yeah, no, but I don't know, you're right, I don't know,  
12           so there you go --

13    Q     Okay, so your answer is to -- my question was is there  
14           a requirement in CMOH Order 38-2020 to get the  
15           third-party authorization of that inability to wear a  
16           mask, is your answer yes, no, or I don't know?

17    A     I don't know, but I'm flipping through this, and I'm  
18           going to assume -- like I trust you that I -- I don't  
19           know, but I believe that you -- like I trust you that I  
20           don't think there is one based -- because you're saying  
21           there isn't.

22    Q     Well, no, I'm asking you.

23    A     Well, I don't know, but now I'm just --

24    Q     If your answer is, I don't know, that's okay, but your  
25           answer shouldn't be you trust me.

26    A     Oh, really? Okay, well, I don't know then. But now

1 I'm reading it. Okay, I mean, now I would say, yes,  
2 there's no like specific criteria. I just like  
3 scrolled through the whole order again.

4 Q And you would agree with me that it was in the month of  
5 May 2021 that that new criteria came in?

6 A I don't know. I'm trying to look through the actual  
7 CMOH order that led to that one, but I don't know, and  
8 I'm trying to find the CMOH order specifically.

9 Q I don't know if it's an exhibit in this case. It  
10 wouldn't -- I don't think it would be difficult to make  
11 it one; it's a CMOH order.

12 A Yeah, yeah, it's not. I'm just looking for it in the  
13 list of CMOH orders.

14 Q Well, if you have -- I have a list, but you might have  
15 a better one.

16 A This is from the Alberta Health website.

17 Q I remember the date, but not the number of the CMOH  
18 order.

19 A They're hard to track, just so many of them.  
20 Anyways --

21 MR. MAXSTON: Mr. Kitchen, it's Mr. Maxston,  
22 I'm not going to take issue with this point, the CMOH  
23 orders are the CMOH orders. If I can respectfully  
24 suggest, you can go on with your questions, you're not  
25 going to hear from me later on there wasn't a CMOH  
26 order that spoke at some time, at some date with some

1 type of criteria if you produce that order, so I --  
2 just in the interest of time, I thought I'd make that  
3 comment.

4 MR. KITCHEN: Well, maybe I'll produce it,  
5 because it seems like it's probably going to be good  
6 to. No, that was it. That's all I wanted to ask.

7 A Thank you.

8 THE CHAIR: Okay, Dr. Hu, thank you very  
9 much. I would ask you to just bear with us; we're  
10 going to have a brief recess while the Hearing Tribunal  
11 Members caucus to see if we have any questions of you,  
12 so --

13 A Sure.

14 THE CHAIR: -- just give us a couple  
15 minutes here, and we will be back. Get up and have a  
16 stretch if you want. We'll be back before long. Thank  
17 you.

18 A Thank you.

19 (ADJOURNMENT)

20 Discussion

21 THE CHAIR: Dr. Hu, the Hearing Tribunal  
22 has met, and we do not have any further questions for  
23 you, so I will take this opportunity to thank you very  
24 much for your time and your testimony. I'm sure you're  
25 a busy man, and I'm sure we all wish you continued  
26 success in dealing with this particular problem at this

1       time. And I will also apologize if I mispronounced  
2       your name. I apparently called you Dr. Ho, which is  
3       unforgivable. But anyway, thank you, and you're free  
4       to go, and hopefully we won't need to call you back.

5     A    Yeah, no, no, thank you so much for having me, and I'm  
6       sorry for talking over people, Karoline, and it was a  
7       pleasure to meet you all, and sorry for being  
8       long-winded and all that jazz, but have a good day.

9       THE CHAIR:                   Thank you, take care.

10    A    Bye.

11       THE CHAIR:                   Bye.

12       (WITNESS STANDS DOWN)

13       THE CHAIR:                   So it's 12:15. Mr. Maxston,  
14       is your next witness available for 1:00, or do we know  
15       that?

16       MR. MAXSTON:                He is. I can certainly make  
17       him available for 1, and that would be Dr. Halowski.

18       THE CHAIR:                   Yes, I think that's the next  
19       step; is that correct? So why --

20       MR. MAXSTON:                Yes.

21       THE CHAIR:                   -- don't we meet -- did you  
22       have any thoughts, Mr. Kitchen?

23       MR. KITCHEN:                Well, I prefer an hour for  
24       lunch, but I think most people prefer to have a quick  
25       lunch and get out of here sooner, so I'm fine with  
26       that.

1 THE CHAIR: If we want to take an hour, we  
2 can take an hour, that's ...

3 MR. MAXSTON: I have no problem, neither  
4 does my client with taking an hour break. We had a  
5 pretty intense morning, so we're in your hands,  
6 Mr. Chair.

7 THE CHAIR: Okay, well, let's reconvene at  
8 1:15 with Dr. Halowski. I think you're right, it was a  
9 fairly full morning, and it would be good to get away  
10 from the computer screen and the pen and paper for a  
11 little while. So thanks everybody, we'll see you at  
12 1:15, and we are now in recess until 1:15 for the  
13 record.

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15 PROCEEDINGS ADJOURNED UNTIL 1:15 PM

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

4

5 September 2, 2021 Afternoon Session

6

7 HEARING TRIBUNAL

8 J. Lees Tribunal Chair

9 W. Pavlic Internal Legal Counsel

10 Dr. L. Aldcorn ACAC Registered Member

11 Dr. D. Martens ACAC Registered Member

12 D. Dawson Public Member

13 A. Nelson ACAC Hearings Director

14

15 ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

16 D. Lawrence ACAC Complaints Director

17 B.E. Maxston, QC ACAC Legal Counsel

18

19 FOR DR. CURTIS WALL

20 J.S.M. Kitchen Legal Counsel

21

22 K. Schumann, CSR(A) Official Court Reporter

23

24 (PROCEEDINGS RECOMMENCED AT 1:18 PM)

25 THE CHAIR: This Hearing Tribunal is back

26 in session. It's 1:15, and I believe we are at the



1 point where Mr. Maxston on behalf of the College  
2 Complaints Director will have Dr. Todd Halowski take  
3 the stand to provide testimony.

4 Dr. Halowski, I'm going to ask the court reporter  
5 to swear or affirm you in, whichever is your  
6 preference.

7 A I'm happy to affirm.

8 DR. TODD HALOWSKI, Affirmed, Examined by Mr. Maxston

9 Q MR. MAXSTON: Good afternoon, Dr. Halowski.

10 MR. MAXSTON: Just for the Tribunal's  
11 benefit, I'm going to be asking Dr. Halowski questions  
12 in six areas. The first is some -- the first area is  
13 some very brief questions about his background. The  
14 second area is going to be some questions, again  
15 relatively brief, about his role as Registrar at the  
16 College. Third area I will be asking questions about  
17 is generally the functions of the College. The fourth  
18 area I'm going to ask questions about are the  
19 educational background for chiropractors and to ask  
20 Dr. Halowski to discuss briefly the educational  
21 information the College has on its registration file  
22 for Dr. Wall. The fifth area I'm going to take  
23 Dr. Halowski to are the CMOH orders and the Pandemic  
24 Directive and what I will call the ACAC notices and web  
25 blasts and things that were sent out to the members,  
26 which are Exhibits C-1 to C-22. And then the final

1 sixth area I'll be asking questions of Dr. Halowski  
2 about is his specific involvement in the Wall  
3 complaint.

4 So skipping to the first area then, Dr. Halowski,  
5 I understand that you are the Registrar for the  
6 College. Are you also a licensed practicing  
7 chiropractor?

8 A I am.

9 Q Can you tell me about what your chiropractic education  
10 is and your employment history in the profession?

11 A Yeah, I graduated from Palmer College of Chiropractic  
12 in 2005. Since then, I entered private practice in  
13 September of 2005 and have been a practicing  
14 chiropractor until 2019, when I left full-time practice  
15 and became the Registrar of the College.

16 I am still currently practicing in a part-time  
17 capacity, with my role as Registrar demanding the  
18 majority of my time, and right now I'm practicing part  
19 time in Sherwood Park as an associate in a clinic.

20 Q Thank you. Going to the secondary, I think you  
21 mentioned you became Registrar in 2019 then?

22 A M-hm, yes.

23 Q Okay, can you tell me before you became Registrar, did  
24 you have any positions or other involvement with the  
25 College?

26 A Yeah. I had started volunteering with the College I

1 think in 2007 or 2008 -- or with the ACAC. At that  
2 time, I was on a fee negotiating committee, which is an  
3 association activity versus the College.

4 In 2014, I was asked to become an investigator for  
5 the ACAC, which is a College activity. I received  
6 investigator training with Field Law at the time, and I  
7 think I started into investigations shortly thereafter,  
8 where we would participate as an investigator under  
9 Part 4 of the HPA. In 2015, I was trained also as a  
10 member of a -- to be a member of a hearing tribunal.  
11 During that time, I actively participated in  
12 investigations but never served as a member of the  
13 hearing tribunal.

14 Q Now, I understand you have the title of Registrar and  
15 you carry out Registrar duties, but there is also a,  
16 I'll call it a management or administration function  
17 you carry out as well. Can you tell me what -- first  
18 of all, what your duties are as Registrar?

19 A Yeah, the Registrar, we primarily focus -- that role  
20 primarily focuses on registration and registration  
21 decisions and also membership renewal in a year, so  
22 we're making sure that those people that are joining  
23 the profession meet the requirements that are set out  
24 by council or under the Health Professions Act, and  
25 then we also, for renewal, we perform that same duty,  
26 and that would be very specific to the Registrar role.

1           Beyond that, I'm also the director of regulatory,  
2           and in that capacity, I oversee the regulatory programs  
3           administered by the College. Specifically, I look  
4           at -- I work with the complaints, and I am aware of  
5           what's going on in the complaints department, I work in  
6           the continuing competence. I also oversee things like  
7           professional corporation and some of the other duties  
8           that go on on an ongoing basis like professional  
9           corporation renewal and membership renewal and the  
10          other things that go on in a year that the College  
11          administers on behalf of the members.

12    Q    You've helpfully gone to my second area of questioning  
13          here, which is what your other duties are over and  
14          above Registrar. In your -- I'll call it your  
15          management or administration duties you described, do  
16          you work with council at all?

17    A    Yes, I attend all council meetings, and one of the  
18          roles that I have is, because I am a clinician, I  
19          advise council on clinical matters as well, so for  
20          consideration. Our council is composed right now of  
21          six chiropractors and two public members. We are  
22          waiting for more public members to be appointed so that  
23          that does go to an equal representation.

24                So my role is also in providing practice  
25          information and being a consultant to council on areas  
26          of that and advising council on policy -- recommending

1 policy to support the safe practice of chiropractic in  
2 the Province of Alberta.

3 Q And I take it -- I'm going to take you to Pandemic  
4 Directive in a few minutes, but I take it you were  
5 given assignments from time to time to become involved  
6 on certain projects and things like that?

7 A That is a hundred percent correct.

8 Q Okay, I'm going to go to my third area of questioning,  
9 which is just to talk a little bit about the College.  
10 Can you explain the role of the College and what its  
11 mandate is?

12 A Absolutely. The best -- you know, if we look at it  
13 very high level, a college, a regulatory college has  
14 two duties: Protection of the public and professional  
15 competence. And at a high level, protection of the  
16 public comes down to setting standards, Codes of Ethics  
17 and bylaws that set the guidelines and direction that  
18 members must follow when they're practicing.

19 And then there's the whole aspect of complaints  
20 that a college oversees. So when a complaint or  
21 concern comes from the public, how we address it and  
22 how we respond is one of the primary functions that is  
23 in the Health Professions Act.

24 And then the other is the competence component, is  
25 identifying the competence programs that are there, how  
26 they're operating, is it meeting the intended goals,

1 highlighting what competencies may need extra attention  
2 from members due to -- our practice visit program will  
3 observe patterns or trends in practice, and that may  
4 result in recommendations to counsel on ways that we  
5 can improve the competence requirements that the  
6 profession meets as part of being a regulated member.

7 Q In keeping with your comment about sort of a high-level  
8 view of the College and its role, I don't need you to  
9 go to this section of the HPA, the Health Professions  
10 Act; are you familiar with Section 3 of the HPA?

11 A That is -- that defines specifically the roles that a  
12 college must fulfil or the reason that we exist.

13 Q Is public protection part of the College's role?

14 A That is -- absolutely. That's -- when we talk about  
15 that public protection is our -- the primary mandate  
16 that we have is making sure that we are producing -- or  
17 protecting the public in -- is our primary  
18 consideration.

19 Q You talked a few minutes ago about the College creating  
20 bylaws and Standards of Practice and Codes of Ethics,  
21 is the creation of a Code of Ethics and a Standard of  
22 Practice is that a mandatory duty under the HPA?

23 A Yes, it is. It's mandatory, and they need to be  
24 consulted with members but adopted by council, and once  
25 they are adopted, they do become binding upon the  
26 membership. And it's the standard under which, when we

1       look at it, that we enforce conduct based on the  
2       Standards of Practice. And some people look at  
3       standards are -- you know, really, one of the  
4       considerations there that's really important, and it's  
5       a discussion often is that they're meant to be the  
6       minimal acceptable level of performance that our  
7       members must meet.

8       Q    Okay. I'll get to this later in some more detail,  
9       questioning with you on the Pandemic Directive and some  
10      other things, but are some of those Standards of  
11      Practice, are they mandatory in nature?

12     A    That's a great question. I would say all Standards of  
13      Practice are meant to be mandatory. There is specific  
14      language in them that highlights -- when we see the  
15      word "must", they are mandatory; that is an absolute  
16      that must be followed.

17               Sometimes you'll see the word "may", which is  
18      meant to leave that to the professional judgment of the  
19      member, and so -- but they are meant to define  
20      practice.

21     Q    I'm going to move to then the fourth area of questions  
22      I wanted to chat with you about, and that is, again,  
23      the educational background for chiropractors generally  
24      and what Dr. Wall's education is reflected in the  
25      College's records. So I'll just start off with a  
26      general question, are you familiar with the education

1       generally required to become licensed as a  
2       chiropractor?

3     A   Absolutely.  Yeah, would you like me to describe that  
4       for you?

5     Q   Yeah, if you could.

6     A   Absolutely.  So the majority of chiropractors are  
7       trained here in North America.  Most, who are in the  
8       entry school, have some form of undergrad education  
9       with -- meaning they'll have a Bachelor's degree or  
10      some have advanced degrees in Masters of Science or  
11      other components.

12           A chiropractic program has very set requirements  
13      to go through that are defined by the council -- well,  
14      they're defined by the regulators, but they're put  
15      forward by the council on chiropractic education, and  
16      chiropractic colleges are -- must be accredited, or a  
17      chiropractor that practices must be accredited and  
18      leave an institution that's accredited in order to be  
19      eligible to licence in Alberta.

20           And so -- but those requirements cover over  
21      aspects of delivery of health care and broad ranges of  
22      topics that prepare us to be clinicians.

23     Q   As part of the education that chiropractors receive to  
24       get their degree, is there a required component for  
25       public health education?

26     A   There is, yeah.  So we do have a very, very -- we do



1        have two courses that may apply. We have one in kind  
2        of microbiology, which is a component that is  
3        considered. And then we actually have specific courses  
4        in public health, and more of an introductory -- I  
5        would call an introductory course. They are not meant  
6        for chiropractors to be prepared to manage public  
7        health situations; it's meant to understand kind of the  
8        implications of public health and to understand how our  
9        role is relative to public health.

10    Q    Are there any specific training or educational  
11        requirements then in any of these approved programs  
12        relating to infection prevention and control, for  
13        example?

14    A    There would be, relative to practice, there would be  
15        things like hand hygiene and so on like this. Never  
16        during our training initially would we have been  
17        exposed to things like PPE or personal protective  
18        equipment. It wasn't a consideration because  
19        chiropractors are not typically working with an  
20        infectious population; you know, we're not having  
21        people come in that could be highly infectious or  
22        contagious with different things. So we tend to run  
23        and work from that point of view of -- around  
24        neuromusculoskeletal conditions.

25                And so with that, PPE isn't typically used, nor do  
26        we work with body fluids typically. Gloves may be

1 another thing we're exposed to; i.e., if we're working  
2 in or around the mouth or on the face in treating,  
3 chiropractors may use gloves to work with in the mouth  
4 or in intraoral situations.

5 Q Is there any required training then in these programs  
6 for how to address viral outbreaks or pandemics?

7 A I -- so I'll speak personally, I graduated in 2005. I  
8 took my public health training in 2003 or 2004, and we  
9 were not advised to any such learning during education.  
10 It is something that is, I would say, has been a gap in  
11 our education up to now, and given the current  
12 environment that may adapt, but I can't speak to that.

13 Q I'm going to ask you a question about the chiropractic  
14 profession sort of generally, but are there  
15 chiropractors who take the position that chiropractic  
16 care can strengthen the immune system?

17 A There is. That is an issue within the profession where  
18 some chiropractors do believe that by providing  
19 chiropractic care that they may prevent illness or  
20 prevent infections. We do know that there has been  
21 research focused on that in the last couple of years  
22 that has come out and said that there isn't evidence to  
23 support the position that chiropractic care is an  
24 effective treatment for many immune-based disorders  
25 such as infections or common colds or flus.

26 Q Okay, I'm going to switch gears a little bit here in

1       this fourth area I'm asking you questions about. Have  
2       you been able to review Dr. Wall's registration file  
3       with the College?

4     A    I did go through and look at that just to confirm the  
5       details for this file, yeah.

6     Q    Can you tell me where Dr. Wall was educated?

7     A    Yeah, Dr. Wall was educated at Palmer College of  
8       Chiropractic in Iowa, the same place I was.

9     Q    And do you know when he graduated?

10    A    On his transcripts, it identifies October 18th, 1996.

11    Q    And do you know when he became licensed with the  
12       Alberta College?

13    A    Yeah, that, in our records, indicates that he was  
14       originally -- his initial joining with the College was  
15       December 2nd of 1996.

16    Q    Now, you mentioned before that you were involved in  
17       managing the required continuing competence program for  
18       chiropractors, and I should say that's a mandatory  
19       requirement, to maintain your continuing competence?

20    A    M-hm.

21    Q    And to meet the College's requirements for continued  
22       competence?

23    A    That's correct. Yes, we have set requirements on an  
24       annual basis, and so annually all chiropractors are  
25       required to complete a minimum of 24 continuing  
26       competence credits. That's usually obtained through

1 seeking further development in courses, seminars, or  
2 different things. Those could focus on anywhere from  
3 assessment right through to treatment in that, or they  
4 could be more informationally based in their  
5 presentation.

6 And further, that we also currently have required  
7 recordkeeping, we have a required -- all members must  
8 demonstrate competence in first aid, right? And then  
9 we -- since the introduction of Bill 21, all members  
10 must annually demonstrate that they've taken trauma  
11 informed training.

12 Q When you look through Dr. Wall's continuing -- well, I  
13 should go back, did you look through Dr. Wall's  
14 continuing competence history with the College?

15 A I have reviewed Dr. Wall's continuing competence  
16 history in his profile, and in reviewing that, I did  
17 look back to see what kind of continuing competence,  
18 and there is no record of Dr. Wall completing any  
19 continuing competence around the treatment of  
20 infection, nor anything to do with practicing during a  
21 pandemic or any kind of public health training.

22 Q Okay. I want to go to the next area of my questions  
23 for you, which is the CMOH orders and the Pandemic  
24 Directive. I'm going to take you to the CMOH orders  
25 specifically and the Pandemic Directive specifically,  
26 but I'd just like you to begin with some -- giving me

1       some background, some history about what was happening  
2       with the College in I believe late March of '20, 2020,  
3       and the CMOH orders that were coming out and what the  
4       status of the profession was at that point.

5     A   Absolutely I can talk to that.  So in -- I think it was  
6       right around the middle of March where there -- you  
7       know, there was -- we started to see some notices  
8       coming from Dr. Hinshaw about the presence of the novel  
9       Coronavirus here in Alberta.  As that escalated, we  
10      kind of watched -- on March 27th, CMOH order I think it  
11      was 7 was issued that effectively closed all health  
12      care except to urgent care.

13               Once that came down, that was I think both a very  
14      psychological blow to Albertans but also, speaking to  
15      our profession, was a psychological blow to many of my  
16      colleagues, right?  It was a very tough time to see us  
17      shut down.  You know, it wasn't something that we  
18      planned for, prepared for, would have expected in our  
19      lifetime.

20               One of the things that became very acutely aware  
21      is that our members didn't have any skill set around  
22      practicing in a pandemic, and there was a lot of  
23      confusion.  This was novel.  There was a lot of  
24      discussion around how it -- you know, the risk, the  
25      severity, all those things like this, but one of the  
26      things we set about doing as a college right away, and

1 we advised council and were given direction to go in  
2 that direction is to prepare a guide or directive for  
3 members to follow during the pandemic so that they  
4 would know how to practice safely and have kind of a  
5 guideline to practice during a pandemic.

6 And so we set about doing the research, reviewing  
7 the documents that Alberta Health was publishing, other  
8 information that was available at that time.  
9 Ultimately though, we did look at Alberta Health as a  
10 guide, because they were advising practice and health  
11 care workers in the province on how to practice safely  
12 during a pandemic.

13 Q So that's late -- I think you said March 27, that's  
14 late March where you're starting this effort or looking  
15 at this question, this issue. Did you consult with any  
16 other regulators in the province or outside the  
17 province about what they were doing for the -- their  
18 response to pandemic issues?

19 A Absolutely. During that time, in Alberta, there's  
20 something called the Alberta Federation of Regulated  
21 Health Professions, and that would be kind of like --  
22 it's like a -- I don't want to call it a working group,  
23 but it's a federation, we actually work together and  
24 address issues together. And many regulators face  
25 common issues, and so I know there was discussions  
26 going on amongst Alberta regulators in that group on

1 exactly the impact to the environment introduced by the  
2 novel Coronavirus.

3 Also at that time, the ACAC as a member of the  
4 FCC, which is the Federation of Chiropractic Colleges,  
5 which is all the Canadian chiropractic regulators  
6 across the country. And all provinces were shut down  
7 at that time as a result of Coronavirus, and so why  
8 was -- one of the things that we were doing was sharing  
9 what we were looking at in developing.

10 And during that time, in Alberta, we're really  
11 lucky, we actually have one of our members, who is a  
12 published microbiologist who we were able to consult  
13 with, we consulted with our competence committee,  
14 because we really wanted to contextualize how to  
15 practice safely during the pandemic to chiropractors  
16 and make those considerations.

17 So we consulted with regulators to understand kind  
18 of the environment, the Alberta regulators, which are  
19 not chiropractors, but every other profession, on  
20 practicing safely, and then we consulted with  
21 chiropractic regulators from across the country and  
22 were very proactive in developing kind of a plan and a  
23 guide. And, you know, it took us a lot.

24 What we ended up with is what I would call a  
25 summit of documents. So there was a lot of  
26 information, and we kind of compiled it into different

1 areas, things like hand hygiene, we compiled it into  
2 areas on physical distancing, we compiled it into areas  
3 on personal protective equipment, and, you know,  
4 infection prevention and control. And what would we  
5 require, what would we not require.

6 And then once we developed all of that, we  
7 actually initiated a member consultation where all  
8 members had an opportunity to review what we developed  
9 and provide comments.

10 In addition to that, that was conducted via two  
11 things, we had town halls where we could talk and  
12 listen; we also had a digital consultation, where  
13 members were able to provide responses. And then once  
14 we had those consultations, we took the information  
15 back and prepared revisions to what we put forward. We  
16 listened to the membership, and we had a lot of  
17 information to contextualize, how to inform safe  
18 practice during a pandemic.

19 And then -- so that's kind of where we went to.  
20 That was April 22nd, 23rd, we were consulting. The  
21 next week, by April 29th, we were meeting with council  
22 with what was a plan, which we do call the Pandemic  
23 Practice Directive. And so that was by -- and then  
24 that was published, we reviewed that, council had some  
25 corrections. We came back to them a day later, and  
26 they adopted that, which we were then able to prepare



1           and publish to the membership.

2       Q    Okay, I want to skip back to something you said before  
3           that -- and I think you used the word "direction", that  
4           you felt it was important to give clear direction to  
5           chiropractors. Why was it important to do that?

6       A    Well, one of the things that we experienced and we had  
7           to be really clear with the membership, and I think  
8           some of that goes back to, one, we're not trained to  
9           practice; we were never trained to originally practice  
10          in that environment. It wasn't a consideration of our  
11          training.

12                The second one is that within the profession, we  
13          do see a diversity in membership, where, you know, some  
14          members, even to this day, I think really struggle with  
15          the idea that they shouldn't be offering adjustments to  
16          treat COVID. And so when I look at that, like that  
17          direction was required in order to provide -- and for  
18          us, our primary concern was making sure that what we  
19          were doing was going to be safe for the public to meet  
20          our mandate as a College. We have that obligation to  
21          protect the public, and so we needed to provide a way  
22          for our members to practice as safe as possible for the  
23          public during a pandemic.

24       Q    So before the Pandemic Directive was created, was there  
25           any type of significant training or exposure in PPE  
26           that chiropractors would have had?

1     A     I don't -- not to the degree that was required during  
2           the pandemic. I would say, you know, some  
3           chiropractors were very aware of when to use gloves,  
4           but as far as things like face masks, face shields,  
5           gowns, or other PPE, there was a low level of uptick in  
6           consumption amongst members.

7           Even now, I can speak to members, and some of  
8           them, you know, around some of -- they kind of go, Oh,  
9           this has actually been really helpful. It's really  
10          helped me reframe how I'm going to practice and how to  
11          make considerations for safe practice going forward.

12          And one thing too, Mr. Maxston, that we have to  
13          consider is that a lot of the information we present  
14          here is actually in our standard of practice. Like  
15          there's nothing that we presented that was new. We  
16          just provided direction per the Health Professions Act  
17          on informing practice according to the standard of  
18          practice.

19        Q     I want to skip back. You talked about two  
20           communication modes you used. I think, I'll let you  
21           clarify the time period, but I think it's March and  
22           April of last year being town halls and digital  
23           consultations. What was the purpose of having that  
24           communication?

25        A     We wanted to -- you know, it's really important for us,  
26           like we are a very transparent organization, and you

1 know, like just like our members, this was novel for  
2 us, and so we were doing our absolute best to make sure  
3 we provided a safe environment for the public, but we  
4 also needed to make sure that it's enforceable.

5 Remember, when we talk about Standards of Practice  
6 or practice direction has to meet a minimally  
7 acceptable level. It's not about ideal or being  
8 aspirational; it's a minimal acceptable level of  
9 performance and in the context of practicing safely.  
10 And so, you know, well, we go there, we want that  
11 perspective from all of our membership.

12 And so we did conduct two consultations. We had  
13 town halls that, you know -- where they could actually  
14 ask questions, provide feedback in a live way. We  
15 could go through, listen to them, respond, and all  
16 those kinds of communications.

17 And the second is we used a platform called  
18 ThoughtExchange, which allowed us -- you know, they  
19 could read the whole practice directive and then  
20 provide any feedback they chose to anonymously. We had  
21 a high uptick, we had over 356 unique IP addresses  
22 provide feedback to that. I'd like to think that that  
23 was significant, considering our membership at the time  
24 was probably around between 1150, 1200 members. You  
25 know, so I think that that's at 25 percent of our  
26 membership were actively providing feedback.

1           And it came on a spectrum at that time as well.  
2           It wasn't all like, This is great. Some people really  
3           challenged and helped to inform, you know, and maybe  
4           some of the things, hey, this shouldn't be used now, or  
5           we should do this now.

6           So where we got to after consultation was a place  
7           that really represented -- it was a great way for us to  
8           understand the climate of the membership and also to  
9           advise council on how to adopt a directive that was  
10          going to keep the public safe.

11       Q    I think I want to skip back again, was there a  
12           particularly -- was there a large or significant risk  
13           that you identified when you were putting together the  
14           pandemic derivative?

15       A    The risk for our membership, there was a couple. One  
16           is that, you know, if I speak about it, there's kind of  
17           two ways I can look at this, so even during the  
18           development of it, we would have -- we receive emails  
19           from people going, Oh, this is -- you know, why are we  
20           doing this, we shouldn't be shut down. One of the  
21           biggest concerns for chiropractors, we should be  
22           considered essential services, and essential services  
23           didn't have to shut down during COVID, right? And so  
24           that was -- we got a lot of communication around that.

25           When we started looking at it and asking, well,  
26           what do you mean; you know, a lot of our membership

1        wanted to understand, well, we want to be safe, how do  
2        we practice safe, why weren't we considered to be safe  
3        at this time. And so there was obviously some  
4        questions around that that came in, but a lot of it was  
5        also around things like, you know, like hand hygiene.

6            You know, one of the practices we identified is  
7        that chiropractors really need to be consistent in  
8        their hand hygiene, when they apply it, how to apply  
9        it. PPE was one that we recognized that the membership  
10       really needed to -- we needed to be able to advise a  
11       member on the safe and effective use of PPE according  
12       to the evidence that was available.

13           And so the -- we really went through the stuff  
14       that the Medical Officer of Health was instructing, who  
15       was obviously the lead -- leading the response to the  
16       public health crisis or pandemic that we were  
17       experiencing, so we looked at that kind of feedback.

18    Q    Was close body contact a concern?

19    A    It was for us, because we do work very close -- I mean,  
20       when we're actually delivering care to a patient, the  
21       hands-on care that chiropractic is known for, we're  
22       right over top. We stand and breathe on a patient,  
23       sometimes like less than a foot away from their face.

24           Similar like -- to contextualize it, some members  
25       on the Hearing Tribunal may have been to a  
26       chiropractor, some, they haven't, but think of like

1       when a dental hygienist or a dentist is working on you,  
2       where they're leaning over top, when we're caring for  
3       patients, we're right there, and so that close contact  
4       is there. There's other things where we do work are  
5       maybe not as close or our faces aren't in close  
6       proximity. Sometimes when we do assessments, like  
7       ophthalmological assessments or doing some of the other  
8       things, we're like face to face and mouth to mouth --  
9       well, close to mouth to mouth with patients. So that  
10      was an important consideration we had to make.

11     Q    I should go back, was masking intended to address that  
12           risk?

13     A    Absolutely. Masking was identified in what we were  
14           looking to be a measure that would ensure that we  
15           reduce the risk of transmission of COVID.

16     Q    I'm going to take you to CMOH Order 16-20 [sic] in a  
17           little while, but I'll just stay in this area of the  
18           Pandemic Directive and how it was developed. I  
19           understand that under Order 16-2020, you are required  
20           to or were required to send your directive to  
21           government for review; did that occur?

22     A    That did. We sent that and submitted that to  
23           government on May 1st. So prior to the releasing of  
24           that, we had some opportunities to have phone calls  
25           with Dr. Hinshaw and a couple other representatives. I  
26           believe Martin Tyre [phonetic] was one of them as well,

1       who was head of the emergency operations centre at that  
2       time. And they were very specific to us in the  
3       guidelines that they were looking for, and that we  
4       would need to submit that in order for our  
5       practitioners to be able to return to practice when  
6       things opened back up.

7       Q     Give me a moment, Dr. Halowski.

8       A     Okay.

9       Q     Did you receive any feedback from the CMOH about the  
10       Pandemic Directive before you adopted it then?

11      A     No. We were able to adopt it and advised our  
12       membership that they could return to practice right  
13       away.

14               We did have one follow-up inquiry specific to what  
15       we were advising employers, but we did point them to  
16       the section of the practice directive that covered  
17       that, and they were satisfied.

18      Q     In your consultation with CMOH, did they ever ask about  
19       an exemption for members under the masking requirements  
20       of the Pandemic Directive?

21      A     There was no expectation in any of the Alberta Health  
22       literature we reviewed in developing that us in the  
23       proximity, because we're always going to be breaching  
24       that 2 metre physical distance that has been identified  
25       very early on, that there would be exemptions for that  
26       close of practice.

1           We did recognize, like -- yeah, so there was never  
2           any thought of an exemption, because we are always  
3           going to breach when delivering physical care to a  
4           patient, that 2 metres.

5    Q    I'm going to skip ahead. I'll ask you some more  
6           questions in a little about this, but did the College  
7           recognize or identify in any way that treatment could  
8           be provided outside of that 2 metre space?

9    A    Yeah. So one of the things that we did do in very  
10           early March -- I was so focused on the practice  
11           directive, I forgot to mention it, but we had developed  
12           and council had adopted Telehealth, and so Telehealth  
13           and Telerehabilitation is a practice. It's not  
14           obviously the same as providing physical care, but it  
15           was a way for us to consult with patients, it is a way  
16           for us to instruct patients on movement, exercises, and  
17           shown to be effective for mitigating many common MSK  
18           conditions through education and instruction.

19   Q    And "MSK" means, just for those of us --

20   A    Oh, yeah --

21   Q    -- who aren't chiropractors?

22   A    -- fair enough, I apologize. So "MSK" or NMSK means  
23           neuromusculoskeletal, so the common conditions that  
24           chiropractors do see patients for.

25           MR. MAXSTON:                   Mr. Chair, I'm going to ask  
26           you and your colleagues to turn to Exhibit F-1, which



1 is the government relaunch document. Just wait a  
2 little bit to make sure everybody's literally and  
3 figuratively on the same page, and I'm going to be  
4 looking at the top of page 2 of that 5-page document.

5 Q MR. MAXSTON: Dr. Halowski, are you familiar  
6 with this document?

7 A I am. This document actually -- I'm very familiar with  
8 it, because when they first announced, it was very  
9 contentious because they did not specifically list  
10 chiropractors to be able to return to work on May 4th,  
11 and so we had to seek clarification to provide that for  
12 our members.

13 Q Well, that's right where I was leading you. On the top  
14 of page 2, there's a second bullet. Maybe I'll just  
15 ask you to read that.

16 A (as read)

17 Dental and other health care workers, such as  
18 physiotherapist, speech-language  
19 pathologists, respiratory therapists,  
20 audiologists, social workers, occupational  
21 therapists, dieticians, and more will be  
22 allowed to resume services starting May 4th  
23 as long as they are following approved  
24 guidelines set by their professional  
25 colleges.

26 Q So just two questions. We talked about "and more", I

1 take it you received confirmation that chiropractors  
2 were in the "and more" category?

3 A We did, yes.

4 Q And as long as they were following approved guidelines,  
5 did they tell you that was mandatory then, the CMOH?

6 A Yes, that we had to actually submit that before our  
7 membership could return to practice.

8 MR. MAXSTON: So, Mr. Chair and Tribunal  
9 Members, I'm going to ask you to go to CMOH Order  
10 16-2020, which is Exhibit F-2.

11 Q MR. MAXSTON: Dr. Halowski, you weren't  
12 present for Dr. Hu's testimony, but I took him through  
13 this, but I'm going to ask you some specific questions  
14 about it, given your direct role in the College in this  
15 regard.

16 Are you familiar with this document?

17 A Yes, I am.

18 Q Can you tell me what the second numbered paragraph,  
19 number 2, says?

20 A Would you like me to read it?

21 Q Sure.

22 A (as read)

23 Effective May 4th, 2020, and subject to  
24 Section 6 of this order, a regulated member  
25 of a college established under the Health  
26 Professions Act practicing in the community

1           must comply with the attached workplace  
2           guidance for community health care settings  
3           to the extent possible when providing a  
4           professional service.

5    Q   Does that attached guideline that's attached to this  
6       order, does it require masking?

7    A   It does. There's two references to it in there, and  
8       specifically, I'll just find them and share them with  
9       the Tribunal. On page 3 of Appendix A for that, for  
10      prevention, it does highlight personal protective  
11      equipment. And then on page 9, it does go further into  
12      defining that: (as read)

13           All staff providing direct client/patient  
14           care or working in client/patient care areas  
15           must wear a surgical/procedure mask  
16           continuously at all times and in all areas of  
17           the workplace if they are either involved in  
18           direct client/patient contact or cannot  
19           maintain adequate physical distancing [which  
20           they defined as 2 metres] from  
21           client/patients and co-workers.

22   Q   I'm going to ask you to skip ahead to paragraph 6. Can  
23       you tell me what that says in this CMOH order?

24   A   Yes: (as read)

25           Section 2 of this order [meaning the section  
26           that we just read] does not apply in respect

1           of a regulated member under the Health  
2           Professions Act whose college has published  
3           COVID-19 guidelines as required by Section 3  
4           of this order.

5    Q    So let's go to Section 3 then.  I'll ask you to look at  
6           that, read that in, and tell us what that means to you.

7    A    Yeah:  (as read)

8           Subject to Section 5 of this order, each  
9           college established under the Health  
10          Professions Act must as soon as possible  
11          publish COVID guidelines applicable to the  
12          regulated members of the college that are  
13          substantially equivalent to the guidance set  
14          out in the workplace guidance for community  
15          health care settings developed by Alberta  
16          Health along with any additional guidelines  
17          to the usual practices of the regulated  
18          profession.

19   Q    So the option here was, under item 2, you could use the  
20          guidance document that they have with mandatory  
21          masking, or the College could create its own?

22   A    Yes.

23   Q    And was this a condition to re-opening?

24   A    That was what was indicated to us, and that is the  
25          information we had from the Medical Officer of Health,  
26          so the -- so that was our exact understanding that this

1           was a condition.

2       Q     So was it a requirement to practice then?

3       A     Yes, and it was adopted by council motion.

4       Q     Can you tell me what paragraph 4 -- paragraphs 4 and 5  
5           say?

6       A     Yeah: (as read)

7           Each college must provide the Chief Medical  
8           Officer of Health with a copy of any COVID-19  
9           guidelines published in accordance with  
10          Section 3 of this order.

11       And then Section 5 says: (as read)

12          The Chief Medical Officer of Health may amend  
13          any COVID-19 guidelines created by a college  
14          under Section 3 if the Chief Medical Officer  
15          of Health determines that the guidelines are  
16          insufficient to reduce the risk of  
17          transmission of COVID-19 in the practice of  
18          the regulated profession.

19       Q     I think a few minutes ago, you told me that you  
20           complied with Order Number 4, you provided to the  
21           Minister of Health, and just to be clear, did you  
22           receive amendments from the CMOH; did you get any  
23           amendments from them?

24       A     We did not amend our practice directive due to any  
25           feedback from the CMOH. There was no feedback provided  
26           that we needed to amend anything or make further

1       considerations to reduce the risk of COVID-19 in  
2       chiropractic practice.

3       Q     I'm going to ask you to go to CMOH Order 38-20, which  
4       is Exhibit D-8. This is a November 24, 2020 CMOH  
5       order. I'm going to ask, Dr. Halowski, you and  
6       everyone to go to part 4 on page 4.

7       THE CHAIR:                     Sorry, which number was this?  
8       D --

9       MR. MAXSTON:                   Sorry, Mr. Chair, this is  
10      Exhibit D-8.

11      THE CHAIR:                     Okay.

12      MR. MAXSTON:                   And it's CMOH Order 38-20.

13      Q     MR. MAXSTON:             So, Dr. Halowski, I'm just  
14      going to ask you to go to paragraphs -- well, I've  
15      taken you to page 4, which talks about masks and the  
16      geographic application of this order, but I'm going to  
17      ask you to go to paragraphs 23 and 24, and can you tell  
18      me what those two sections mean or what you interpreted  
19      them to mean?

20      A     Yeah. So we took a very literal look at this: (as  
21      read)

22             For the purpose of part 4 of this order, a  
23             "public place" has the same meaning given to  
24             it in the Public Health Act but does not  
25             include a rental accommodation used solely  
26             for the purpose of a private residence.

1 And then 24 says: (as read)

2 For the purpose of this order, a "face mask"  
3 means a medical or nonmedical face mask or  
4 other face coverings that cover a person's  
5 nose, mouth, and chin.

6 When we saw this and had an opportunity to read this,  
7 one of the things that we did look at is is a  
8 chiropractic office a public space. And at that time,  
9 we were under direction that appointments were by -- or  
10 if we were to control our environment, so who was  
11 coming into the office was by schedule. And we  
12 interpreted this, and the interpretation was that  
13 chiropractic offices are, for the intent of this, a  
14 private space, meaning that we control who's in the  
15 office or can control who receives care at the time.

16 And then face masks under this order, one of the  
17 things when we looked at this, we reviewed and  
18 recognized that, you know, when they start talking  
19 about cloth face masks and the other, we knew that this  
20 didn't specifically apply to chiropractors as the  
21 requirement was that we had to wear at least a Level 1  
22 surgical procedural mask as identified in the practice  
23 directive.

24 So when we saw this section, we saw it as applying  
25 not to our profession but to the public and more of a  
26 guidance for the public on what they should be doing.

1           And I think this is when the Province started to  
2           institute their provincial face mask guidelines and  
3           requirements.

4       Q     So let's go to paragraph 26 of this order, and we there  
5           have a -- I'm going to ask a question -- but it says:  
6           (as read)

7                     Subject to Section 27, a person must wear a  
8                     face mask at all times while attending an  
9                     indoor public place. For greater certainty,  
10                    an indoor public place includes any indoor  
11                    location where a business or an entity is  
12                    operating.

13           Chiropractic clinics would be covered by that?

14       A     Correct.

15       Q     There's an exemption in paragraph 27(c) of this order.  
16           You're aware of that exemption?

17       A     I did read that, yeah. We had read that when it was  
18           published.

19       Q     Okay, I'll have some questions for you later on about  
20           the exemption and the Pandemic Directive ultimately.

21                     I'll get you to now go to and everyone to go to  
22                     Exhibit D-9, which is CMOH Order 42-20, and the date of  
23                     that order is December 11th, 2020. And, Dr. Halowski,  
24                     I will get you to go to paragraphs 23 and 24, which are  
25                     on page 5 of that CMOH order.

26       A     M-hm. Yeah, I'm there.



1 Q I could ask you to read these in, but are these  
2 substantially similar, if not identical, to the  
3 equivalent provisions in the last CMOH order we looked  
4 at?

5 A Yes, they are, on a quick reading, yes.

6 Q And there's the same exemption there in 24(c)?

7 A Correct.

8 Q So we have these two exemptions then or two references  
9 to exemptions. Was there ever any consideration about  
10 whether those exemptions should apply to chiropractors?

11 A We did look at that in consideration. Based on the  
12 guidance that Public Health had provided, that we could  
13 not maintain a physical distance of 2 metres, the  
14 consideration was made that this wouldn't apply because  
15 we can't maintain a physical distance of 2 metres when  
16 providing in-person or close contact care.

17 And I remember communicating this to our members  
18 and using the example that this is probably more meant  
19 for situations like in the public, like if you were  
20 going to a grocery store where you could maintain a  
21 physical distance, or in the public where you can space  
22 yourself appropriately from somebody. But when  
23 we're -- as a practitioner, when we're face to face, we  
24 are not maintaining that distance of 2 metres, which  
25 was identified as one of the risks for transmission  
26 during COVID.

1 Q I'm going to ask you to go to the Exhibits C-20, 21,  
2 and 22, which are the three versions of the Pandemic  
3 Directive. They are dated I believe May 5, 2020, May  
4 25, 2020, and January 6th, 2021. Just broadly  
5 speaking, can you tell me why there are three  
6 directives?

7 A That's a great question. So obviously the first one  
8 was published, this is the one we had originally  
9 submitted to government when they had alerted us that  
10 we would have to provide this for our members to be  
11 able to return to practice on May 4th, and so that was  
12 published and sent to them for review.

13 On May 25th, we had done some review and revisions  
14 and included the practice of mobile chiropractic for  
15 chiropractors to be able to provide chiropractic care  
16 in mobile settings. And for a percentage of our  
17 population, our members, they do provide mobile care,  
18 where they go and provide care in different settings  
19 outside of their office. And, originally, we had not  
20 allowed it, and so council had made the decision that  
21 this would be allowed as long as they were following  
22 the Pandemic Practice Directive. And then --

23 Q Then --

24 A Sorry, yeah, I'll stop.

25 Q No, you go ahead. I was just going to say January 6th.

26 A Yeah, oh, yeah, January 6th, that one was published,

1       that was right in the middle of the second wave of  
2       COVID or the one that was identified as being  
3       significant, and there had been a significant number of  
4       cases. And so we did continue to regularly review the  
5       Pandemic Practice Directive with council.

6               And one of the recommendations we made on this one  
7       was to include the requirements -- or, sorry, include  
8       the recommendation of PPE to include a face shield or  
9       eye protection. And that specifically -- and one of  
10      the unique things about that is this is one of the  
11      first considerations we specifically made for members  
12      to be protected, because it was -- some of the  
13      information that was published in an advisement that we  
14      had had was that eye protection was seen as protective  
15      against the Coronavirus.

16             Up until this time, the practice directive was  
17      focused on public protection. With the introduction of  
18      the eye protection, that was one of the pieces that and  
19      one of the few that we actually specifically put --  
20      meant for the protection of the member only, and that  
21      was to consider the use of eye protection.

22    Q       I'm going to take you through the portions of the  
23       Pandemic Directive in a couple of minutes when we deal  
24       with masking and social distancing and plexiglass  
25       barriers. Through those three versions of the Pandemic  
26       Directive, were there changes about masking and social

1 distancing and the plexiglass barrier requirements?

2 A There was slight -- I believe there were some slight  
3 changes, nothing significant. Some of it may have been  
4 wording.

5 Specifically when we got the last one in January,  
6 we introduced the requirement that patients must be  
7 masked in the clinic as well. And that was in response  
8 to, one, the orders that we received, there was a lot  
9 of confusion from membership, going, well, do my  
10 patients have to mask, the practice directive doesn't  
11 say they have to mask. And so we implemented that  
12 patients are required to mask in that January 6th one,  
13 and then that has -- that persisted through to this  
14 summer.

15 MR. MAXSTON: Mr. Chair, I think as I  
16 mentioned earlier, I'm going to simply use the January  
17 6th, 2021 Pandemic Directive in my questions for  
18 Dr. Halowski and other witnesses, so I'm going to  
19 continue that here.

20 THE CHAIR: Can you give us a reference  
21 number for that?

22 MR. MAXSTON: Yeah, it's C-22.

23 THE CHAIR: Great, thank you.

24 Q MR. MAXSTON: So I'd just like to summarize  
25 I think what are the more -- ask you questions about  
26 what are the more relevant elements of the personal

1 directive -- sorry, Pandemic Directive for today's  
2 hearing in the questions for you.

3 I'd like you to go to page 7 of the Pandemic  
4 Directive. And there's a heading "Physical  
5 Distancing", and I think the comments on this actually  
6 go over to page 8, but can you tell me what the  
7 requirements were in that regard in the Pandemic  
8 Directive?

9 A Yeah, that we were to, as much as possible, in this  
10 space ensure that physical distancing was provided for  
11 in treatment areas.

12 And one of the things that some of our members do  
13 operate is more an open-concept style where they'll  
14 have multiple tables in one area, so we wanted to make  
15 sure that patients receiving care were at least 2  
16 metres apart in those spaces. In waiting areas, that  
17 the patients were provided a place, if they were  
18 waiting indoors, to be 2 metres from the next closest  
19 patient, right; or from staff that may be working  
20 behind the desk, right; in transition areas, i.e., you  
21 know, like hallways or there might be areas where  
22 patients are moving in and out of treatment rooms.

23 Then we did provide an exemption for people who  
24 lived together to be 2 metres, because they're  
25 obviously within the same cohort already, and there are  
26 patients that may present to the office who have care

1       givers or companions with them, and so they were  
2       exempted from that requirement as well. You know, we  
3       didn't feel that it was our place to separate,  
4       especially if somebody that needed a care giver, in the  
5       office environment.

6               And then we did talk about non-clinical employees  
7       in the public, right? So that would be the reception  
8       area. And if 2 metres cannot be maintained, that staff  
9       must be continuously masked, or the installation of a  
10      plexiglass or plastic barrier must occur to protect  
11      reception staff.

12   Q    So, again, the word "must" is used, that's mandatory?

13   A    Yeah, that's correct, "must" is a mandatory  
14      requirement.

15   Q    Okay. I'm going to take you to the heading that says  
16      "Personal Protective Equipment", and I wonder if you  
17      can tell me about the opening paragraph, what it means.

18   A    Yeah. So one is that we -- personal protective  
19      equipment is an essential element for the disease.  
20      Like that was identified early on that it was being  
21      novel and without an effective treatment, personal  
22      protective equipment would be essential in order to  
23      provide as safe an environment as possible.

24               We also wanted to alert members that if they were  
25      not using PPE appropriately, it could fail to prevent  
26      transmission and may facilitate the spread of the

1 disease.

2 Q So the next heading is "Staff and Practitioner PPE",  
3 and there's a quote from an AHS announcement. Can you  
4 tell us what that quote says, what it means?

5 A Yeah. So one of the things we were looking at in the  
6 development stage is what is the requirement or what  
7 are we going to look at around the use of personal  
8 protective equipment. And so this was very clear, it  
9 says: (as read)

10 Effective immediately, AHS is advising all  
11 health care workers [which chiropractors are  
12 considered a health care worker] providing  
13 direct patient care in both AHS and community  
14 settings [chiropractors are in a community  
15 setting] to wear a surgical procedural mask  
16 continuously at all times and in all areas of  
17 their workplace if they are involved in  
18 direct patient contact or cannot maintain  
19 adequate physical distancing from patients  
20 and co-workers.

21 Q Can you take me to the next section "PPE Requirements"  
22 and tell me what those first three bullets say?

23 A Yeah: (as read)

24 Surgical or procedural masks are the minimal  
25 acceptable standard.

26 And that's identified, because there's -- you know, one

1 of the questions that we had during the development is  
2 like do I need an N95 mask, which is a fitted mask  
3 meant for aerosol producing procedures. We wanted to  
4 be very clear that that was not a requirement.

5 Again, we always set minimally acceptable  
6 standards. So a minimal acceptable standard in this  
7 would be a surgical mask.

8 Q Okay.

9 A And then the next one: (as read)

10 Chiropractors and clinical staff must be  
11 masked at all times while providing patient  
12 care.

13 That was very clear. Like if you're providing patient  
14 care, you must wear a mask. It wasn't a suggestion; it  
15 was a requirement.

16 And then the last one is: (as read)

17 Nonclinical staff must be masked when a  
18 physical distance of 2 metres cannot be  
19 maintained.

20 And that would be like some offices are smaller, the  
21 reception desk may not be able to be isolated, the --  
22 you know, or the receptionist is in and out from behind  
23 the desk because they have double duty in bringing  
24 patients to rooms or to cleaning or other aspects. We  
25 wanted to make sure that there was a safety provided  
26 for that person as well.



1 Q So I'm going to ask you to go ahead to page 9.

2 A Okay.

3 Q And at the top of that page, there's some requirements  
4 for donning and doffing masks. But there's a paragraph  
5 right after number 7 under "Doffing of Masks", and it  
6 starts off with: (as read)

7 It is essential that all chiropractors and  
8 staff providing services in a clinic area are  
9 aware of the proper donning and doffing of  
10 PPE.

11 I just want to be clear here, who is responsible for,  
12 in a chiropractic clinic, for ensuring that staff  
13 complies with the Pandemic Directive requirements?

14 A That would be anybody, the chiropractor as a regulated  
15 member has a requirement to provide a safe environment  
16 for themselves and those that work at their direction.

17 Q Okay. I'm going to ask you when the masking  
18 requirement was developed, were you focusing only on  
19 the protection to patients, or were you also  
20 considering your members' protection?

21 A Obviously, there was member protection, but as a  
22 College, our first consideration is always the public  
23 as well. And so anything we could do to reduce the  
24 risk of transmission from a chiropractor who had  
25 acquired a COVID infection was our first consideration,  
26 followed by the safety of the member.

1           And I would say, you know, followed by, it's not  
2           like it was a large gap. You know, both were very,  
3           very important, but as a College, we had a requirement  
4           to definitely consider the needs of the public first.

5    Q    Okay, we talked before about CMOH Order 16-2020 and the  
6           use of the guideline or opting into the Pandemic  
7           Directive and the mandatory guideline on masking or  
8           creating your own Pandemic Directive, in terms of  
9           masking and what you developed for your Pandemic  
10          Directive here, were less restrictive directives than  
11          requiring masking considered?

12   A    We did look at all sorts of things. And I do remember  
13          the final meeting, the second -- on April 29th, when we  
14          met with council, I believe that was the Wednesday,  
15          they had -- that was one of their considerations. Like  
16          they had a question: Should masking be a  
17          recommendation or a requirement.

18               And after discussion, council felt strongly that  
19               masking was and should be a requirement of practice at  
20               that time. So it was discussed, but given the climate,  
21               given that this was novel, and given the risk of being  
22               close contact body workers, council ultimately did  
23               adopt the position that masking is required.

24   Q    I note that -- well, I should ask you, does the  
25          Pandemic Directive contain an exemption for masking,  
26          social distancing, or plexiglass barriers?

1     A     There -- let me see if I understand the question, so  
2           there is no exemption for masking at any time when  
3           we're providing care within 2 metres. The original one  
4           did allow -- the original one introduced did allow for  
5           them to not have a mask on if they were conversing over  
6           2 metres apart, so i.e., on the other side of the room.

7           And the other exemption that was provided is that  
8           if you can't -- if you need to, you could use  
9           Telehealth as a form of care for patients to lessen the  
10          risk of spread for COVID-19.

11     Q     Ultimately, why wasn't there an exemption for masking  
12           like we saw in the CMOH orders?

13     A     You mean in the CMOH 38 and 42?

14     Q     Yeah.

15     A     Yeah, so the reason that we didn't ever consider an  
16           exemption is because we work face to face with a  
17           patient. We're not walking around in parks or open  
18           spaces; we're in closed rooms, sometime poorly  
19           ventilated, and we are breathing right on a patient,  
20           and patients are breathing right on us as well, but  
21           having a mask was meant to be protective for the  
22           patient as well as for the practitioner.

23     Q     Are you aware of any other HPA colleges and their  
24           pandemic directives?

25     A     Yeah. So one of the things that we did do after is we  
26           had an opportunity to read and review other colleges

1       and what they were directing. And to my knowledge,  
2       every college adopted a position of masking is a  
3       requirement.

4               I know recently that, talking to one of the  
5       registrars, who -- for I think it was ACSLPA, which is  
6       the Alberta College of Speech-Language Pathology [sic]  
7       and Audiologists. They had indicated that that had  
8       been very stressful for their members to practice  
9       during the pandemic when masking was required, because  
10      they need to observe the mouth and visualize it in  
11      order to respond or appropriately teach or provide  
12      interventions, but they also, in some of their  
13      interventions, identified that they produced more  
14      aerosols because they're -- of speaking and causing  
15      that, and so they had to maintain masking. And then up  
16      until the end of June or beginning of July this year,  
17      they amended it to become a recommendation. And that  
18      was one that had indicated it was stressful.

19             Physiotherapists from when I reviewed, the  
20      physicians when I reviewed, everybody else was  
21      requiring masking for providing that close care.

22    Q       So I'm going to ask you to go a little bit backwards in  
23             this document. I'd like to go to page 1 -- actually  
24             page 2 of the Pandemic Directive.

25    A       Okay.

26    Q       And right after the introduction, the first paragraph,

1       there's a second paragraph that says -- actually it's  
2       an indent after the second paragraph: (as read)

3               Note to chiropractors, this directive is  
4               current as of the date of publication and  
5               reflects the rules and requirements for  
6               chiropractors. In the event of a discrepancy  
7               between this information and the directives  
8               of Provincial Public Health authorities, the  
9               directions of the Provincial Public Health  
10              authorities take precedence.

11      Can you tell me what you meant by that language and --

12   A   Absolutely.

13   Q   -- what would or wouldn't take precedence, I guess?

14   A   Absolutely. So when we look at that, one of the things  
15       that -- I think the word we could describe around COVID  
16       is it was a very fluid environment, and it seemed that  
17       information was consistently and constantly shifting or  
18       changing, or new information would come to light.

19              And so one of the things we wanted to make sure  
20       that our members were aware that, say, this was in  
21       place, and something came out from the Chief Medical  
22       Officer of Health that had a more stringent  
23       requirement, i.e., that maybe all practitioners were  
24       required to wear an N95 mask or were required to wear a  
25       face shield, that our members would know that they  
26       should follow that direction, that they should wear

1 something more stringent.

2 Q So -- sorry.

3 A No, go ahead.

4 Q So that comment is directed to chiropractors then?

5 A Yes.

6 Q Health care professionals?

7 A Yeah.

8 Q If we go a little further down, it says: (as read)

9 As regulated health professionals,  
10 chiropractors are required to: 1. Follow all  
11 mandates and recommendations from Public  
12 Health and Government of Alberta regarding  
13 your personal and professional conduct. As a  
14 regulated -- [Mr. Kitchen, there is a  
15 question coming] -- regarding your personal  
16 and professional conduct. As a regulated  
17 health professional, you have a fiduciary  
18 responsibility to follow all civil orders  
19 that originate from any level of government.

20 And then number 2: (as read)

21 Read to and adhere to all communication from  
22 the ACAC.

23 So what message are you sending to chiropractors there?

24 A Yeah, that's a great question. This was introduced for  
25 our regulated members, because, at one time, we were  
26 getting a lot of members calling in and going, hey, you

1 know, the City of Calgary has a masking mandate, or  
2 this city has a masking mandate; and what we were  
3 finding is people were calling us to interpret local  
4 legislation, so we wanted to inform them that they  
5 actually also have a responsibility to be aware of and  
6 follow legislation or requirements or orders, civil  
7 orders, that are introduced in the location where they  
8 practice.

9 You know, one of the ones I remember dealing with  
10 specifically was the City of Chestermere had ordered  
11 all clinics closed at one time, and our members that  
12 were there were calling and saying, But we're  
13 regulated. I said, You need to follow the civic orders  
14 that are introduced by your local government.

15 And so that was the intent of that, because those  
16 may change or have a crossover, an impact for the  
17 direction that we're providing. And we continually  
18 also informed members that we wanted them to follow the  
19 more stringent requirements. So that would be the part  
20 of it as well.

21 Q Okay, so I want to just explore that a little bit with,  
22 so if a local bylaw, for example, was more stringent,  
23 you were required to follow that?

24 A Correct.

25 Q If a Pandemic Directive was more stringent, you were  
26 required to follow that?

1 A Correct.

2 Q Dr. Halowski, you were not part of the discussion or  
3 not present when we talked about entering some new  
4 exhibits relating to Alberta Health Services, but I  
5 have provided those to you, and I'm just going to ask  
6 you to go through them briefly. They are again three  
7 documents.

8 MR. MAXSTON: And, Mr. Chair, you'll have  
9 those I believe in your File H [sic], and they're the  
10 AHS Guidelines for Continuous Masking, the AHS Personal  
11 Protective Equipment document, and the Alberta Health  
12 Services Directive Use of Masks During COVID-19.

13 A Mr. Maxston, I don't have those documents available  
14 right now. Can I obtain them? I apologize, I just  
15 don't have them here.

16 Q I wonder if Ms. Nelson can send those to you in the  
17 Dropbox, or we can have her forward them to you by  
18 email.

19 A Okay, I'll wait for her to provide those.

20 MS. NELSON: Yeah, I will email those out  
21 right now. Just the three AHS docs?

22 MR. MAXSTON: Mr. Chair, I wonder if this  
23 isn't a good time to just take a 5- or 10-minute break,  
24 just to allow some time for those documents to make  
25 their way to Dr. Halowski, and we'll make sure he's got  
26 them, and then we'll resume.



1 THE CHAIR: I was about to suggest the  
2 same thing. It's 25 after 2, so let's take a 10-minute  
3 break, and we'll come back at 25 to 3 and resume, and  
4 hopefully by then, Dr. Halowski, you'll have received  
5 and had a chance to look at the three documents.  
6 They're not lengthy.

7 MR. MAXSTON: And, Mr. Kitchen, I'm aware of  
8 the fact that I can't speak with Dr. Halowski about his  
9 testimony, but I am going to chat with him just briefly  
10 to make sure he's got the right documents if you're  
11 okay with that.

12 THE CHAIR: Okay, I'm okay with that.  
13 Mr. Kitchen, any comment?

14 MR. KITCHEN: I was muted, I'm sorry.  
15 Blair, it looks like we're going to have time for me to  
16 do my whole cross, and that's probably going to be it  
17 for the day. Is that what you're thinking?

18 MR. MAXSTON: Yeah, I'll see how far I've  
19 got to go. I still have to go through Exhibits C-1 to  
20 C-22 with Dr. Halowski. I'm not going to through every  
21 line of them; I'm going to highlight some things, but,  
22 yeah, I think we're making some good progress. So I'm  
23 just going to make sure he's got these documents,  
24 James. I won't talk to him about his testimony, but I  
25 want to make sure he's on the literally the same page,  
26 so --

1 MR. KITCHEN: That's fine, yeah.

2 MR. MAXSTON: -- okay, thanks, yeah.

3 THE CHAIR: Okay, we're in recess now, and  
4 we'll reconvene in 10 minutes, thank you.

5 (ADJOURNMENT)

6 THE CHAIR: The Hearing Tribunal is back  
7 in session, and Mr. Maxston is continuing with his  
8 direct examination of Dr. Halowski.

9 EXHIBIT G-1 - AHS - Directive Use of Masks  
10 During COVID-19

11 EXHIBIT G-2 - AHS - Guidelines for Continuous  
12 Masking

13 EXHIBIT G-3 - AHS - Personal Protective  
14 Equipment (PPE)

15 Q MR. MAXSTON: So, Dr. Halowski, you've got  
16 these three AHS documents in front of you?

17 A Yes, I do.

18 Q I'm not going to be very long with these with you. You  
19 talked before about the fact that council was  
20 monitoring the situation in terms of the Pandemic  
21 Directive. Were you and council considering AHS  
22 documents?

23 A We were considering them. That was one of the  
24 resources, one of the primary resources we used when  
25 evaluating the practice directive.

26 Q So I'm just looking at the first document, which is AHS

1 Guidelines for Continuous Masking, and the middle of  
2 the page, it says: (as read)

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

5 I take it that supports the Pandemic Directive from  
6 your perspective?

7 A It does, and it -- one of the things in reading this,  
8 and I remember having conversations with council about  
9 it is we would see these documents, and, you know,  
10 obviously these were developed specifically for the AHS  
11 environment, but we did pay close attention to them  
12 because they're advising how to keep their staff safe  
13 and how to limit the risk of spread between patients  
14 and between patients and staff.

15 Q The next document is the Personal Protective (PPE)  
16 document, and really I'm just going to take you to page  
17 2, under the heading "AHS Guidelines For Continuous  
18 Masking and Use of Eye Protection". Again, there's a  
19 statement about AHS has a continuous masking directive  
20 in place, and, again, that would have been consistent  
21 with the directive?

22 A Correct.

23 Q The final document is the AHS directive on use of  
24 masks, and I'll take you to the principle section, and  
25 the first sentence there, I wonder if you can just read  
26 that, the one beginning with "Continuous".

1 A Yeah: (as read)

2 Continuous masking can function either as a  
3 source control, being worn to protect others,  
4 or part of personal protective equipment to  
5 protect the wearer to prevent or control the  
6 spread of COVID-19. Working collaboratively,  
7 we shall ask all individuals to assist us in  
8 limiting the spread of COVID-19 through the  
9 use of procedure masks in AHS  
10 facilities/settings.

11 Q So we talked --

12 A Okay, next paragraph? Okay, sorry.

13 Q No, that's fine. So we talked a little bit about this  
14 before. They're talking here about two things, source  
15 control protecting others and protecting the wearer;  
16 was that a consideration for the development of the  
17 Pandemic Directive?

18 A That is the consideration that we made to protect our  
19 patients and also to provide that protection for our  
20 members as well.

21 Q To your knowledge, has AHS ever granted an exemption  
22 from masking for the health care workers they regulate?

23 A No, and specifically during the pandemic, I did speak  
24 to members who raised concerns, i.e., one had a severe  
25 allergy to latex and was reacting to the mask. And I  
26 did reach out to AHS and had a conversation with them

1 about that, and they indicated that there was no  
2 substitution for a procedural mask available. And so  
3 even in the case of somebody that was having that  
4 reaction and actually having a like constant contact  
5 dermatitis reaction, there was no exception provided to  
6 masking.

7 Q I'm going to talk now about the manner in which the  
8 Pandemic Directive was communicated or distributed to  
9 members, and I'm going to, in a couple of minutes, I'm  
10 just going to ask you to go through some of the  
11 highlights of the documents C-1 to C-22, but I'll  
12 just -- I'll ask you to call those up.

13 When we look at C-1 to C-22, they are a series  
14 of -- they're entitled "Notice to Member", "Registrar's  
15 Report", "Council Updates". Can you tell me generally  
16 how the Pandemic Directive was communicated and what  
17 the purpose of these notices was?

18 A Yeah, no, and that's great. So a lot of -- I looked  
19 back, during COVID, we were highly communicative with  
20 our members, right from the time there was an  
21 identified pandemic declared, all the way up and to --  
22 including the provision of the Pandemic Practice  
23 Directive, we were sending communications to members or  
24 notices to members once, sometimes twice a day, to make  
25 sure they had the most current information for their  
26 consideration.

1           And that would have been a blend of -- because we  
2           are a dual-mandate organization currently, that would  
3           have been a blend of both Association communications  
4           and College communications. And often they may -- that  
5           communication may have come from one, like clearly the  
6           Association or the College, or made a blended  
7           communication where we would have covered topics of  
8           both in that communication.

9       Q    Okay, so when we look at these notices and the, again,  
10           Registrar's report, who sends them; how do they go out  
11           to chiropractors?

12      A    Yeah, so those are sent specifically out of our  
13           patient -- or not our patient but our member database.  
14           So those are in there. We have -- we can see who we're  
15           sending to. They would have distributed to all of the  
16           regulated members at the same time.

17           One of the requirements of the College, of the  
18           ACAC is that members must receive our electronic  
19           communications because we're an electronic  
20           communicator.

21      Q    So are you confident that Dr. Wall would have received  
22           all of these notices and updates?

23      A    I am confident. It is our members' responsibility to  
24           ensure that their email address is up to date and on  
25           the College database. And I am confident, because when  
26           I did contact Dr. Wall, I did so using the email

1 address that's provided to the College when I first  
2 reached out to Dr. Wall in December of 2020.

3 Q We talked about the -- I'm going to take you through  
4 some of these, of course -- or take you through them in  
5 a minute. We talked about the fact that the Pandemic  
6 Directive had mandatory language for masking. Do these  
7 notices all have mandatory language in terms of  
8 masking?

9 A I would say that it depends on each notice. Some will  
10 say "must", some will say "may", but whenever we were  
11 being direct with members of what they were required to  
12 do, we always used the word "must". If they were  
13 allowed to -- professional discretion in a situation,  
14 then we used the word "may".

15 Q So I'm going to (INDISCERNIBLE) --

16 THE COURT REPORTER: That was all -- you were  
17 turned away from the camera. I did not hear a word of  
18 that, sorry.

19 MR. MAXSTON: I'm sorry, Madam Court  
20 Reporter.

21 Q MR. MAXSTON: Dr. Halowski, I'm going to  
22 take you or ask you questions about Notices C-1, C-10,  
23 and C-13, and they are the Telehealth notices.

24 MR. MAXSTON: I don't need, Mr. Chair, you,  
25 and the Tribunal Members, to go to all of them.

26 Q MR. MAXSTON: But I just wonder if you can

1 tell me what these Telehealth notices to members are,  
2 when they came out, and what they were intended to  
3 achieve.

4 A Absolutely. So C-1 specifically we sent to members.  
5 We had developed a framework for our members to be able  
6 to provide Telehealth, but one of the things that we  
7 were getting questions on was billing. And I say "we",  
8 often they would call me in looking to do that. The  
9 College cannot advise on billing matters, so then this  
10 would have been a communication that came from the  
11 Association but specific to needs identified, where  
12 they were asking, well, how do I bill for Telehealth,  
13 how do I, you know. And so they were looking for a  
14 way. So this was our advisement provided to members on  
15 how to bill when they're providing Telehealth services.

16 Q Okay. Was this something new for the profession, to be  
17 allowed to do Telehealth?

18 A Absolutely. This -- we had never provided Telehealth  
19 as a profession before, and so this was something that  
20 we developed as soon as -- we started working on this  
21 right away when things were -- when we saw where this  
22 was going so that we could offload or offset the risk  
23 for in-person care at that time. And so this was  
24 developed and adopted by a motion from council as a  
25 temporary Telehealth solution, which was intended to be  
26 reviewed in June of that same year.



1 Q Is Telehealth now a permanent allowed modality for  
2 treatment for chiropractors?

3 A It is a permanent allowed modality, and it's the  
4 intention of the ACAC to take and turn that into a  
5 standard of practice as time permits. Some of that's  
6 been restricted due to other legislative challenges  
7 within the system and introduction of other bills. So  
8 that is our intention to make that a standard of  
9 practice down the road.

10 Q Okay, I'm going to be mindful of the court reporter's  
11 caution to me, I'm going to keep looking at the camera  
12 here when I go to the next documents. I'd like to take  
13 you to C-2, which is an April 21, 2020 Notice to  
14 Members.

15 A Yeah.

16 Q Broadly speaking, when I look at paragraph 2, this  
17 addresses, at least in part, the return to practice  
18 plan. Can you tell me what paragraph 2 is talking  
19 about in terms of consultation or feedback?

20 A Yeah. So when we developed this, you know, we had done  
21 a lot of work to develop, but we wanted to inform  
22 members how we developed it, that we weren't pulling it  
23 out of a hat, we had spoken to other regulators, we had  
24 spoken to members of the competence committee, to  
25 specialists within the profession, and other regulators  
26 across Canada so that we had a framework for

1           chiropractors to reasonably practice during a pandemic.

2           And then what we did is that we were advising  
3           members that as -- we've done the work, but we're not  
4           just going to say here it is, we wanted consultation,  
5           we wanted their feedback.

6       Q   The second paragraph talks about the platform you  
7           referred to before as ThoughtExchange, and there's a  
8           final sentence in that paragraph: (as read)

9           This is your opportunity to engage in the  
10          development of this plan, so please  
11          participate.

12       Were you hoping for participation?

13      A   Absolutely. We wanted feedback, and I believe we  
14           received robust feedback from members in the form of  
15           participation in the ThoughtExchange, during the town  
16           halls, and then also with direct communication from  
17           members to myself or to council during the time that we  
18           were developing that.

19      Q   If you go to paragraph 3 in this notice, it talks about  
20           virtual member meetings on COVID-19 to be held next  
21           week, and the final sentence: (as read)

22          There will be an opportunity for members to  
23          submit questions related to COVID-19 during  
24          the meeting.

25       Did you receive questions?

26      A   I do, we did receive questions. During that, there was

1 a lot of questions ranging from like everything in the  
2 practice directive and other questions that were also  
3 other than College questions, there was Association  
4 questions, people worried about different aspects of  
5 practice and when could we go back.

6 As indicated when I spoke earlier, one of the  
7 concerns that chiropractors continued to voice was  
8 around the idea of why aren't we considered an  
9 essential worker, and so that was a question that was  
10 also raised during that meeting.

11 Q When we go to document C-3, which is a Notice to  
12 Members, the first line after that says: (as read)

13 Participate in the member consultation on the  
14 draft return to practice plan.

15 Is this the mechanics of getting that access we were  
16 just talking about?

17 A Yeah, absolutely. We published it, which is what  
18 step 1 was so they could review the draft return to  
19 practice plan, and step 2 was to provide anonymous  
20 feedback to that draft practice plan.

21 Q There is a statement just above the heading  
22 "Registration for ACAC", and it says: (as read)

23 If you have any questions or concerns about  
24 the plan or survey, please email Dr. Todd  
25 Halowski.

26 Were you available to take questions then about the

1 plan for re-entry?

2 A Absolutely. In addition to that, I received I would  
3 say upwards of a hundred emails from members, ranging  
4 and weighing in of topics of concern or consideration  
5 in regard to the Pandemic Practice Directive as  
6 presented -- as the draft was presented.

7 Q I'm going to ask you more about this in a moment, but  
8 do you recall if you received any communications or  
9 questions from Dr. Wall?

10 A I did review my email to see if Dr. Wall had submitted  
11 any feedback to the practice directive, and in all the  
12 emails that I reviewed, I did not see any feedback  
13 received from Dr. Wall.

14 Q I'm going to ask you to go to document C-4, "Our  
15 Clinics are Adjusting to Keep You Safe". What is that  
16 document?

17 A Yeah, so this is one of the things, this would be an  
18 Association style communication that was produced, and,  
19 again, this is more meant for marketing to patients,  
20 but it's also highlighting what chiropractors are going  
21 to be doing to keep them safe when patients return to  
22 practice.

23 And so this was developed and prepared, and you'll  
24 see the date on it was April 29th. That's when we knew  
25 that we were going to be going ahead, and this had been  
26 approved for distribution, so members could get these

1 posters prepared for use in their clinics when we had  
2 the opportunity to re-open.

3 Q Did this also go to chiropractors then, just so I'm  
4 clear?

5 A Yeah, yes, that was distributed to all members of the  
6 Alberta College and Association of Chiropractors.

7 Q Okay. I'm looking at the next document, C-5, it's a  
8 Notice to Members, and item 1, numbered paragraph 1,  
9 the last paragraph says: (as read)

10 Chiropractors will not be able to open until  
11 the ACAC has received Public Health approval  
12 of the return to practice plan.

13 This is referring to the Pandemic Directive approval  
14 process we talked about before?

15 A That is correct, we wanted to make members very aware  
16 that that was a part of that.

17 Q If you go to number 5 on the next page, it's dealing  
18 with PPE, and can you tell me what the first sentence  
19 says and what it means?

20 A Yeah: (as read)

21 The initial information from Alberta Health  
22 Services is that the appropriate use of PPE  
23 will be a requirement of return to practice  
24 for close contact practitioners. As  
25 mentioned in the --

26 Oh, sorry, I'll stop.

- 1 Q Sorry. This would have gone to all chiropractors?
- 2 A This was distributed to all chiropractors of the  
3 Alberta College and Association of Chiropractors.
- 4 Q Okay, I'll go to document C-6, which is a May 1, 2020  
5 Notice to Members. And I'll just ask you to tell me  
6 what the first paragraph -- first couple sentences in  
7 paragraph 1 say.
- 8 A Is that starting with "Yesterday"?
- 9 Q No, numbered paragraph 1, I'm sorry --
- 10 A Oh, sorry.
- 11 Q -- "Status on".
- 12 A Yes: (as read)
- 13 Status on the return to practice plan.  
14 Council approved the ACAC COVID-19 Pandemic  
15 Practice Directive today, which can be  
16 accessed here. This directive has been  
17 submitted to Public Health for review and  
18 approval as required by the Government of  
19 Alberta.
- 20 And then: (as read)
- 21 Public Health must approve the directive  
22 before chiropractors can proceed with  
23 re-opening, and chiropractors can remain  
24 limited to urgent, critical, and emergency  
25 care until otherwise notified by the ACAC.
- 26 Q So was this the first communication of the Pandemic

1 Directive to members?

2 A It absolutely was, yes. And we did that because we  
3 wanted members to be able to review it so they could be  
4 prepared to implement it, because they weren't allowed  
5 to return to practice till they could implement it.

6 Q So that sort of takes us to the next document, C-7,  
7 which is a May 3, 2020 notice.

8 A Yeah.

9 Q And I wonder if you can just read the first three  
10 paragraphs, it begins with "We are", and tell me what  
11 this means.

12 A Yeah: (as read)

13 We are excited to report that Alberta Health  
14 notified all regulated health professions  
15 today that effective May 4th, 2020, regulated  
16 health professions who are ready to execute  
17 all requirements of their respective  
18 regulatory college pandemic practice  
19 directives can return to practice.

20 Q And the next, I've got a question, tell me about the  
21 next two paragraphs, if you can read those.

22 A Yeah: (as read)

23 The ACAC COVID-19 Pandemic Practice Directive  
24 is approved. Chiropractors who can  
25 completely implement the directive may  
26 re-open. Chiropractors who are unable to

1           fully implement the ACAC Pandemic Practice  
2           Directive may not proceed with re-opening  
3           until all measures are in place.

4    Q    So compliance was a condition to re-opening?

5    A    Absolutely.

6    Q    And was that mandatory compliance, just to be clear?

7    A    Mandatory, yes.

8    Q    I'll go to the next document C-8, which is a May 25,  
9           2020 Notice to Members.

10   A    Yeah.

11   Q    And in specific, I'll get you to go to page 2, and  
12           there is a heading "Why do Chiropractors need to wear  
13           masks". I'm wondering if you can just explain why this  
14           is being sent to members?

15   A    Yeah, and so we did have some questions from members  
16           once we originally returned to practice who were  
17           wondering why we were required to wear masks, and so we  
18           wanted to make sure that we were answering that for  
19           members, and that that was that proper -- the observing  
20           PPE requirements protects chiropractors from mandatory  
21           self-isolation if they treat an asymptomatic patient  
22           who later tests positive for COVID-19.

23           So when we returned to practice, what we did start  
24           to see is that members that were being deemed close  
25           contacts would have to isolate, and it was communicated  
26           via Public Health that chiropractors that were wearing



1 masks at the time would not be required to self-isolate  
2 if they were masked when exposed to a pre -- what  
3 Alberta Health termed a presymptomatic patient.

4 Q Okay, if we go to Notice C-9, it's July 24, 2020 Notice  
5 to Members, there's a reference on page 1 to the City  
6 of Calgary's mandatory face bylaw, but I'd like to take  
7 you to the top of page 2, and there's a bullet that  
8 starts off with "Exemptions", I wonder if you can just  
9 read that.

10 A Yeah. So: (as read)

11 Exemptions to any bylaw are designated by  
12 each municipality.

13 And I should give context to that, at that time, only  
14 the cities were providing exemptions; there was no  
15 provincial exception -- our provincial bylaw requiring  
16 masking, sorry, not exemptions: (as read)

17 A medical diagnosis that leads to an  
18 exemption may only be provided by  
19 practitioners who have the authority to grant  
20 exemptions.

21 So currently, chiropractors are not entitled to offer  
22 exemption from face covering to their patients.

23 Q So I'm going to stop you. Are you telling  
24 chiropractors there that they can't grant exemptions?

25 A Absolutely correct. One of our concerns was that  
26 chiropractors may attempt to write exemptions once

1       these were introduced, and so we wanted to be very  
2       clear that that is not in our scope of practice to  
3       exempt patients from a face covering when required by a  
4       bylaw.

5       Q   And there's a sentence you read:  (as read)

6               A medical diagnosis that leads to an  
7               exemption may only be provided by  
8               practitioners who have the authority to grant  
9               exemptions.

10       The College was requiring a medical diagnosis then?

11       A   No, so I think in the initial stages of the bylaw  
12       introduction, one of the things we were trying to be  
13       clear to our members is if a medical -- "that leads to  
14       an exemption may only be" -- so if there was a medical  
15       diagnosis, i.e., that somebody was -- because I -- like  
16       Edmonton required an exemption card, Calgary had a  
17       different way, but we wanted our members to know that  
18       they weren't authorized to provide any sort of --  
19       exemption for a member of the public from a masking  
20       bylaw.

21       Q   I'm going to ask you a question, but was -- did you  
22       ever -- that's okay.

23               I'll go to the next notice, C-10 -- sorry, we've  
24       talked about C-10, that's the Telehealth notice, my  
25       apologies.

26               I'd like to go to C-11, which is your August 2020

1 Registrar's report.

2 A Yeah.

3 Q And more specifically, I'm going to ask you to go to  
4 page 9.

5 A Okay.

6 Q And under the heading "Return to Practice Feedback  
7 Survey, I wonder if you could read that sentence.

8 A Yeah: (as read)

9 We want to hear how implementation of the  
10 return to practice plan is going in your  
11 clinic. Please submit your feedback to us  
12 using this survey.

13 And that was another ThoughtExchange survey that was  
14 sent out for members to be able to make comments on.

15 Q So you had a line of communication for positive  
16 comments or negative comments?

17 A For any comment, and comments received could have been  
18 both positive or negative.

19 I can take a second and explain how  
20 ThoughtExchange works. So in ThoughtExchange, what  
21 happens is somebody gets to make a comment, and they  
22 could say, I love masking, or they could say, I hate  
23 masking. And when then they do that, then what happens  
24 is, once you get enough thoughts in there, people get  
25 to go and read the thoughts that are currently in it,  
26 and they can rank them; they can go this is actually

1       really important, or, oh, this is garbage, or they may  
2       flag inappropriate comments. So ThoughtExchange is  
3       meant for a much more interactive response than, say,  
4       the idea of a yes/no survey.

5     Q    Okay. Let's go to document C-12, which is an August  
6       11, 2020 Notice to Members.

7     A    Okay.

8       MR. MAXSTON:                   Mr. Chair and Tribunal  
9       Members, I'm planning on going through these quickly.  
10      I'm assuming that once you're in that C file, you're  
11      able to click ahead fairly easily too. If any of you  
12      are not at a document, please let me know.

13    Q    MR. MAXSTON:                So, Dr. Halowski, I'm looking  
14      at C-12 again, and numbered paragraph 1 says: (as  
15      read)

16           Chiropractors must adhere to the ACAC  
17           COVID-19 Pandemic Directive regardless of  
18           local bylaws.

19      What are you intending to communicate there?

20    A    Yeah. So one of the questions that members were going,  
21      say -- they were asking what's the interplay between  
22      bylaws and what's the interplay between this. And so  
23      when we said this, that "Chiropractors must adhere to  
24      the ACAC COVID" ... "regardless of local bylaws", local  
25      bylaws only expand practice requirements. They do not  
26      remove the requirements of the practice directive.

1           And so we're saying like they may add things in,  
2           but they can't diminish the minimally acceptable level  
3           of performance that's put out by the practice  
4           directive.

5    Q    Okay. We've already talked about C-13, that's one of  
6           the Telehealth directives, so I'm going to go ahead to  
7           C-14, which is a November 23, 2020 Notice to Members,  
8           and I'd just like you to, I'm on page 1, if you could  
9           read the last couple of sentences on that page, "As  
10          always".

11   A    (as read)

12           As always, as soon as we know more, we will  
13           advise you. If you have questions, please  
14           contact us at the ACAC office.

15          So we -- again, we were always very open and  
16          communicative with members, especially when questions  
17          were coming up. You know, speaking as a -- as the  
18          Registrar, I was often communicated to with questions.  
19          And speaking as a practitioner, this time, I think this  
20          is when we started to see kind of the development of  
21          that second wave, and practitioners were getting  
22          nervous, that, hey, we're going to get shut down again  
23          like we did when the first wave happened. And so they  
24          were often seeking clarification. We wanted to make  
25          them very aware that they could reach out and speak to  
26          us at any time.

1 Q Okay. So C-15 is a November 25, 2020 document.

2 A Yeah.

3 Q I'd like you to read the last sentence on the bottom of  
4 that page "As a health professional", that's what it  
5 begins with.

6 A Oh: (as read)

7 As a health professional, it is your  
8 obligation to be informed of and to uphold  
9 all restrictions, bylaws, or other decisions  
10 that impact your clinic and the health and  
11 well-being of staff, patients, and visitors.

12 Q And then if you go to the next page, can you read the  
13 last sentence, "If you have"?

14 A Yeah: (as read)

15 If you have questions, please contact the  
16 ACAC office.

17 Q So this is an opportunity for members to contact you  
18 again?

19 A Yes, it is.

20 Q Again, these would go to all members?

21 A Yes.

22 Q If we go to the next document, C-16, which is a  
23 November 25, '20 FAQ or frequently asked questions, I'm  
24 going to ask you to go to page 7.

25 A Okay.

26 Q And there's a heading "Do we need barriers for our

1 reception desks", and can you tell me what it talks  
2 about in that next paragraph?

3 A Yeah, I will read it, and then interpret it, if that's  
4 okay: (as read)

5 Employees in the public should be 2 metres  
6 from each other. If 2 metres cannot be  
7 maintained at reception/payment area, other  
8 noncontact electronic payment means can be  
9 used or installed, or installation of a  
10 plexiglass or plastic barrier can be used to  
11 protect reception staff. Many local  
12 companies are retooling to do installations  
13 of barriers in local businesses.

14 One of the things that we wanted to make sure is that  
15 members knew how to obtain and provide for barriers for  
16 their staff, especially with the uptick in cases, that  
17 that was made available for members as a resource and  
18 also just to remind them that they have a duty to keep  
19 barriers in place when the physical distance of 2  
20 metres can't be maintained or to separate them from the  
21 general public that was receiving care.

22 Q Just below that, there's a heading "Personal Protective  
23 Equipment (PPE), and it has some Q and As again about  
24 wearing masks, et cetera. Is this a reminder to  
25 members of your profession?

26 A Yeah, absolutely, because we were getting not only

1        questions about that but questions around things like,  
2        Do I have to wear a mask, or, Do I have to wear gloves  
3        or gowns when treating. So we wanted to just be very  
4        mindful and remind them of the duty that a  
5        surgical/procedure mask must be worn by the member when  
6        treating patients and a physical distance of 2 metres  
7        cannot be maintained.

8        Q    If we go to page 10 of that document, there is a  
9        heading "Who should I contact if I have questions", I  
10       wonder if you can read that paragraph?

11       A    (as read)

12                If you have questions, please contact the  
13                ACAC at office@albertachiro.com, and we will  
14                respond to you as quickly as possible. If  
15                you have a question, it's likely that other  
16                chiropractors are having the same question.  
17                We'll answer your question if we can. Follow  
18                up with the Government on anything that  
19                requires further investigation, and continue  
20                to update you on any news.

21        And that's one of the patterns that we saw, like if we  
22        started to get one member asking a question, usually  
23        we'd get three or four questions. That's one of the  
24        ways we identified some of our FAQs, because if  
25        somebody was asking it, we'd get multiple questions  
26        along the same line around topics like that.



1 Q And there's a reference here to an email address so  
2 members could communicate with you by email as well  
3 then?

4 A That's correct.

5 Q I'd just like to go to the next document very briefly,  
6 C-17, which is I think an ACAC website update, and it's  
7 entitled "Adjusting for you". I'm assuming this is  
8 something that was intended to go to the public or more  
9 for public consumption?

10 A Yes, yeah, this is more of an Association style  
11 communication relative versus a College style.

12 Q And the second page has a heading called "Wearing  
13 Masks", can you tell me what that is telling the  
14 public, members of the public who might read this?

15 A Yeah, so if you look like -- like if we -- and for a  
16 second, if you juxtapose this to the practice  
17 directive, this language is meant to be clear, like  
18 everyday language so that chiropractors are wearing  
19 personal protective equipment such as masks during  
20 treatments.

21 We're letting the public know that that's what  
22 chiropractors are doing, because in the directive,  
23 we're very clear that that's a requirement, and we  
24 thought it was reasonable to alert the public that  
25 chiropractors are wearing masks.

26 Q I'd like to go to the next document, which is C-18, a

1 Notice to Members dated December 9, 2020.

2 A Yeah.

3 Q And about halfway down the page, maybe two-thirds of  
4 the way down the page, there's a paragraph that begins  
5 with "Masking is mandatory", and there is a sentence  
6 sort of about a third of the way down or half of the  
7 down that paragraph that says: (as read)

8 There are no exemptions to chiropractors and  
9 staff masking.

10 Was that consistent with the Pandemic Directive?

11 A That was a hundred percent consistent with what we had  
12 indicated to our members.

13 Q So this is another reminder to members?

14 A Yes.

15 Q If you go to page 2, there's an impacts -- sorry,  
16 "Impacts on ACAC operations", and there's a paragraph  
17 that begins, it's the third one: (as read)

18 If you experience a COVID-19 emergency.

19 Can you tell me what that paragraph says?

20 A Yeah, so at that time, with the -- right now, the  
21 province was in the full, like kind of a ramp-up up to  
22 that second wave of COVID-19, and we were shutting down  
23 operations, and so we wouldn't be answering the phones  
24 live, so we wanted to make sure that our members knew  
25 how to reach us and how to contact us and that we were  
26 there to receive their communications.

1           And so when you look at that, they could email the  
2 Registrar, email directly. Under that, this contact  
3 information, where you see the underlined in blue,  
4 where it says "Dr. Todd Halowski" or "Sheila Steger",  
5 those lines, that provided a direct link to our  
6 personal emails. And then also that was the extension  
7 of the phone number, if they called the College office,  
8 it would come to us, and we received all voice mails  
9 electronically at that time.

10 Q   So they can communicate by email or by phone?

11 A   We were available to be communicated to at all times.

12 Q   C-19 is a Notice to Members, and I'm just going to get  
13 you to go to the third page of that three-page  
14 document, and I'd like you to read the last sentence  
15 literally above your signature. It says "We are here  
16 to support you: Can you read that sentence?

17 A   Yeah: (as read)

18           We are here to support you. If there are  
19 COVID topics that will benefit the profession  
20 that you believe the ACAC should cover,  
21 contact me.

22 Q   So this is another opportunity for members to contact  
23 you?

24 A   Yes.

25 Q   I just have to grab a binder, just bear with me for one  
26 moment.

1 I'm looking -- I'd like to take you to File F,  
2 File Folder F and, in specific, F-3, the ACAC Registrar  
3 report from July 5 of 2020, and more specifically, I'll  
4 just get you to go to page 5 -- sorry, 2021, thank you.  
5 Mr. Lawrence just reminded me.

6 And on page 5, there's a reference to a simple  
7 rule. Can you read that sentence?

8 A I'm just going to pull it up on the 'K' drive here.

9 Q And, again, that's the --

10 A Registrar's report.

11 Q -- yeah, July 2021, yeah.

12 A Yeah, okay.

13 Q So I've asked you to go to page 5, and the second  
14 complete paragraph has a sentence about the "simple  
15 rule". Can you just tell me what the "simple rule" is?

16 A Yeah: (as read)

17 The simple rule to follow to maintain  
18 compliance is that the more stringent  
19 requirement applies to chiropractic practice  
20 in Alberta.

21 And that's -- we communicated that: (as read)

22 For example, if Public Health relaxed a  
23 restriction, but your local municipality  
24 maintained their bylaw, then the bylaw would  
25 be considered more stringent and would need  
26 to be followed. If your local --

1 Q Okay -- yeah, I'm sorry.

2 A Oh, so, yeah, this is part of that line of  
3 communication. Like it's the more strict. The  
4 baseline, the minimal accepted level is the practice  
5 directive. If there was a more strict requirement  
6 introduced, it was the requirement of the member to  
7 follow the more strict requirement.

8 Q And just finally, very quickly, the next document, F-4,  
9 is an FAQ from July 7. I'll just let you get to that.  
10 I'm not sure if you have it handy or have to go through  
11 your computer to --

12 A I have it, I have it handy.

13 Q Okay. There's a question on the first page: (as read)  
14 Why are we still required to do all this when  
15 the rest of the province is back to normal.  
16 Can you tell me what the answer is?

17 A Yeah, we are a regulated health profession. We're  
18 not -- not to diminish the work or role that anybody  
19 else plays, but we have a responsibility as a health  
20 care provider to act first for the safety and  
21 protection of our patients and to consider their health  
22 needs.

23 And so when we're looking at that, we have a duty  
24 to maintain the privilege that we're offered as a  
25 regulated health profession, and part of that is to  
26 make sure that we're following the highest standard in

1       ensuring public health and safety.

2       Q     So I've taken you through a number of documents --

3       MR. MAXSTON:                   Thank you, Mr. Chair, for your  
4       patience, and Tribunal Members --

5       Q     MR. MAXSTON:            -- that have talked about the  
6       communication efforts and the feedback efforts from the  
7       College.

8               I asked you this question before, but I'm just  
9       going to confirm, you did receive feedback from the  
10      membership?

11     A     I did receive feedback from the membership.

12     Q     I'm going to talk with you in a couple of minutes about  
13      your communications with a lady named Ms. Ho and how  
14      the Dr. Wall complaint arose.

15             After -- or in April and May, when the Pandemic  
16      Directive was being created and thereafter, did you  
17      receive any communication from Dr. Wall?

18     A     I received -- in preparing for this, I was reviewing  
19      and I didn't see any communication via email directly  
20      to myself or the College from Dr. Wall. And all  
21      communication around COVID was always forwarded to me  
22      for a response and -- and review and response of the  
23      College, and I have no record of Dr. Wall emailing the  
24      College.

25     Q     Just so I'm clear, no emails or phone calls?

26     A     No phone calls either.

1 Q Before the introduction of the Pandemic Directive, did  
2 Dr. Wall contact you about pandemic concerns?

3 A I didn't -- prior to this, I didn't have any  
4 communication from Dr. Wall about the pandemic.

5 You have one communication in my record that I had  
6 received from Dr. Wall in early March, just when the  
7 thought of the pandemic was coming.

8 Council had recently introduced some direction on  
9 discussion of vaccines and that -- chiropractors, we  
10 wanted to be very clear with our members that, you  
11 know, we don't have it in our scope of practice to  
12 administer, educate on vaccinations, and so we had  
13 tightened up a position statement that directed our  
14 regulated members to send questions direct -- send  
15 patients with questions directly to Public Health or  
16 their medical doctor in order to receive the  
17 appropriate answer and education.

18 One of the things that we know is that vaccine  
19 misinformation or -- can elevate vaccine hesitancy and  
20 put the public at risk especially in the times of  
21 communicable disease. And Dr. Wall had written a  
22 letter saying that, you know, that he was -- he said  
23 that he recognizes that chiropractors are governed  
24 under the Health Professions Act, and he intends to  
25 follow any guidelines and rules put forth to our  
26 profession through Standards of Practice and bylaws.

1           But then he was also expressing frustration that  
2           chiropractors couldn't speak up about vaccines, that he  
3           indicated that he doesn't believe in vaccines to the  
4           same extent that Public Health does and that he thinks  
5           that, you know, it's a shame that we were being limited  
6           in our ability to communicate about vaccination. So he  
7           provided feedback to a policy that council had put  
8           forward that he disagreed with.

9    Q    And that was before the Pandemic Directive though?

10   A    Absolutely.

11   Q    I'm not going to take you to these documents to look  
12           at, but Exhibits D-3 to D-7 are a series of CMOH  
13           orders, and I'll just ask you, are you generally  
14           familiar with those?

15   A    I believe so, yes.

16   Q    And just to close off a discussion on the Pandemic  
17           Directive, did the College review CMOH orders as they  
18           came out?

19   A    We did, we did review them and consider them in our  
20           policies that we were maintaining and the direction  
21           that council was providing.

22           CMOH orders were an essential part in looking at,  
23           reviewing, and advising council so that council had the  
24           best information when they were making their decisions.

25   Q    Was the Pandemic Directive a fluid document?

26   A    It was fluid in the sense that when a change was



1       required, we would make a change. As we reviewed that,  
2       there was no need to change the directive relatively --  
3       when it first came out, we were very -- we wanted to  
4       think big picture with it, so we wanted to have a  
5       document that would stand during a pandemic. I didn't  
6       want the idea of tinkering it. It's difficult for  
7       members to have to adapt if we were reviewing it every  
8       two weeks and going, What about this and what about  
9       that.

10               So we really did develop a document that was able  
11       to stand during a pandemic and provide and inform  
12       members' practice relative to the standard of practice.

13    Q    I understand that there was change to the Pandemic  
14       Directive in early July of 2021; is that correct?

15    A    I think -- oh, this year, yeah, sorry. There was.  
16       That was changed -- sorry, I was thinking back to last  
17       year. I don't think anything happened in 2020, but  
18       2021, that's correct, we did introduce new direction  
19       for the members based on the current environment and  
20       current information and the medical orders that were in  
21       place from the Medical Officer of Health at that time,  
22       so ...

23    Q    So mask --

24    A    Yeah, we amended specifically, we changed and we  
25       maintained requirements around infection prevention and  
26       control in the office, but specifically, you know, hand

1 washing and some of the other measures in around  
2 screening as well.

3 We did remove the requirement for masking and eye  
4 protection but did maintain a strong recommendation  
5 that members consider to continue to use the masking  
6 for themselves and the eye protection for themselves as  
7 well.

8 Q So, Dr. Halowski, a while ago when we were first  
9 talking, I think you mentioned to me that the Pandemic  
10 Directive, at least in part, was based on Standard  
11 4.3 --

12 A Yes.

13 Q -- that was already in place. I'd like you to go to  
14 and the Tribunal Members to go to Exhibit A-11, which  
15 is an excerpt from the -- or, pardon me, it is the  
16 Standards of Practice for the College, and I'd like  
17 everyone specifically to go to page 15 and Standard  
18 4.3, which is "Infection Prevention and Control". So,  
19 again, that's Exhibit A-11, and I'd ask all of you to  
20 go to page 15.

21 Dr. Halowski, this is a bit of a lengthy standard.  
22 I'm more interested in -- most interested in the  
23 opening statement and then the bullets that appear on  
24 page 16. I'm wondering if you can take me through this  
25 with as much detail as you need to. Can you tell me  
26 what the standard of practice says?

1     A     Yeah, so this is our infection, prevention, and control  
2           standard. It was adopted in 2010 and revised in 2014  
3           specifically.

4           And, again, one of the things that, Mr. Maxston  
5           and the Hearing Tribunal, is that I cannot stress  
6           enough that Standards of Practice represent our  
7           minimally acceptable level of performance. These are  
8           not aspirational; they're meant to designate the low  
9           bar for practice.

10          And so when we look at that -- and that's the same  
11          in every profession, that's not unique to us as  
12          chiropractors or unique to physicians or  
13          physiotherapists, dentists, or anybody; Standards of  
14          Practice are the minimal acceptable level of  
15          performance, and it's kind of how we measure if  
16          somebody has met the threshold of professional conduct.  
17          And if they're at or exceed the standards, then that's  
18          one of the considerations.

19          So when we look at that and go through this, the  
20          standard does lay out specifically what the  
21          requirements are for our members to be minimally  
22          acceptable, to: (as read)

23                 Remain current in generally accepted routine  
24                 practices and infection control protocols  
25                 relative to their current practice context.

26          And practice context can be what's internal in the

1 environment and what's external to the environment.

2 In the case of something like a novel Coronavirus,  
3 none of us have practiced that in that environment, and  
4 so that's where we saw a need that we would have to  
5 provide direction for membership, right?

6 The next one: (as read)

7 Develop, incorporate, and keep up to date  
8 infection control policies to promote the use  
9 of infection control measures, which may be  
10 unique to their personal professional  
11 practice style.

12 That's a -- so that's incorporating that they need or  
13 are required to have an infection prevention control  
14 policy in their office that highlights how they execute  
15 and practice to keep in consideration of infection and  
16 infectious disease, right?

17 (as read):

18 Ensure that their clinic is fully equipped,  
19 operated, and maintained to meet generally  
20 accepted infection control guidelines.

21 And that's a really important one is the "generally  
22 accepted". You know, it's not -- we're not looking to  
23 set a bar higher for the chiropractic profession than  
24 any other profession; these are measures that are  
25 generally accepted.

26 Like, you know, hand washing is a great example.

1 The World Health Organization continues to identify  
2 that hand washing is the single most effective way to  
3 break the transmission of disease. Every standard of  
4 practice I review from other professions highlights the  
5 importance of hand hygiene before and after care.

6 And so that's -- and you look at that in our  
7 practice directive: (as read)

8 Hand hygiene, which must include the use of  
9 hand cleaner or a hand washing -- or hand  
10 washing before and after each patient  
11 contact.

12 We're very consistent as a generally accepted measure:  
13 (as read)

14 Use of protective barriers as standard  
15 practice whenever contact with blood and body  
16 fluids is likely to occur during patient  
17 contact. Barriers must also be used when a  
18 patient's personal care equipment is likely  
19 to have been contaminated with potentially  
20 infected fluids, like wheel chairs or  
21 walkers.

22 So protective barriers, and that's defined specifically  
23 in here as personal protective equipment: (as read)

24 Specialized equipment or clothing used by  
25 health care workers to protect themselves  
26 from direct exposure to client's blood,

1           tissue, or body fluids. Personal protective  
2           equipment [and here's where we leave it to  
3           practitioner discretion in the standard of  
4           practice] may include gloves, gowns,  
5           fluid-resistant aprons, head and foot  
6           coverings, face shields or masks, eye  
7           protection, and ventilation devices, for  
8           example, mouth pieces, respirator bags,  
9           pocket masks.

10       And the reason that it's left to practitioner  
11       discretion in a standard of practice is -- and if we  
12       required our practitioners to wear gloves, to wear a  
13       gown, fluid-resistant aprons, and head and foot  
14       coverings for every patient interaction would be  
15       significantly oppressive to practice and to the  
16       practice style that we practice in. You know,  
17       chiropractors tend to work with non-infectious  
18       patients, we tend to work with patients that are coming  
19       in with neuromusculoskeletal conditions or NMSK as I  
20       indicated earlier.

21           We go on to talk about: (as read)  
22           Internal environmental cleaning, disinfecting  
23           and sterilizing equipment and facilities, and  
24           managing waste and materials contaminated by  
25           body fluids [which we use Appendix A to  
26           define all of that].

1 And I'm happy to review that as part of this, right?

2 And highlights of that is measures practiced in  
3 appendix -- I'm going to jump over to that, and then  
4 I'll come back to the bullets. But: (as read)

5 Measures practiced by health care  
6 practitioners intended to prevent spread,  
7 transmission, and acquisition of agents or  
8 pathogens between patients, from health care  
9 practitioners to patients, from patients to  
10 health care practitioners in the health care  
11 setting. Infection control measures  
12 instituted are based on how an infectious  
13 agent is transmitted and includes standard,  
14 contact, droplet, and airborne precautions.  
15 Cleaning is really the physical cleaning of a space,  
16 right? Disinfection is using different things that we  
17 know are -- during contact time are meant to kill or --  
18 kill the pathogen, right? Sterilization is a two-step  
19 process not typically applied in practice, but there  
20 may be some practitioners who use metallic pinwheels,  
21 and those require sterilization versus, say, a disposal  
22 one.

23 And then we really highlight as well as part of  
24 Appendix A that we have to consider our policies in  
25 light of both external and internal practice  
26 environments. External would be: (as read)

1 Any locale beyond the internal practice  
2 environment and may extend to municipal,  
3 provincial, national, or international  
4 borders, depending on the nature of the  
5 infection risk being considered.

6 Specifically when I look at that, that just  
7 specifically speaks about a novel infection. There was  
8 so much information that was lacking at the onset of  
9 the pandemic that we -- this is where we again  
10 identified that we really need to be -- get the  
11 information and provide the information that's relevant  
12 to practice.

13 And then when you come back, we are adamant that  
14 our members must: (as read)

15 Adopt appropriate -- [and this is a minimal  
16 level] -- but adopt appropriate infection  
17 control measures, including contact  
18 management protocols and monitor their use  
19 and effectiveness to identify problems,  
20 outcomes, and trends; provide infection  
21 prevention and control training for clinical  
22 staff and monitor implementation of that.

23 So, again, they are highlighting, to a question you had  
24 asked earlier, Mr. Maxston, part of this standard is  
25 that our members have a responsibility to make sure  
26 their staff are trained and monitored in their use of



1 infection prevention and control procedures, which --  
2 excuse me for a sec -- which does include the use of  
3 personal protective equipment.

4 And then to: (as read)

5 Conduct ongoing assessments of current risk  
6 of infections and transmissions to patients,  
7 staff, colleagues, and other health  
8 professionals, and take appropriate remedial  
9 action in a timely manner consistent with  
10 professional requirements --

11 Right? And when I look at that word "professional  
12 requirements", you know, that is the Pandemic Practice  
13 Directive, that was the professional requirement that  
14 council put in place in respect of the novel  
15 Coronavirus that -- pandemic: (as read)

16 -- and the applicable law based on  
17 consideration of the following: The  
18 assessment of the treatment [so this is  
19 speaking to, you know, assessing what's going  
20 on]; the health condition of the patients;  
21 the degree of infection and risk currently  
22 present in the internal practice environment;  
23 the degree of risk presently in the external  
24 practice environment; and current best  
25 practice infection prevention control  
26 protocols relative to his or her practice.

1 Again, going back to, you know, if -- what they're  
2 doing with patients.

3 For instance, we have some practitioners that work  
4 intraoral or do work inside of somebody's mouth,  
5 they're going to wear gloves. There's a risk that they  
6 could be closer or developing aspirations or -- from  
7 the patient or where they would need face shields. So  
8 that was a significant portion of that.

9 And then, you know, so this standard of practice  
10 is there -- there isn't a requirement in our Pandemic  
11 Practice Directive that isn't already considered in our  
12 standard of practice, but the Pandemic Practice  
13 Directive was contextualized to the information  
14 provided by Alberta Health and Public Health to  
15 practicing during the novel Coronavirus outbreak and  
16 was meant to -- as a requirement for our members to  
17 follow. Hence, why we use the word "directive" instead  
18 of "suggestions".

19 Q Okay.

20 MR. MAXSTON: Mr. Chair, it's about 3:30.  
21 The -- I have my last section of questions for  
22 Dr. Halowski is about his involvement in the complaint  
23 concerning Dr. Wall and a couple of I guess  
24 housekeeping questions after that, not many.

25 I understand from the College that the Hearings  
26 Director at 4:00 would need to hand over control of the

1 meeting hosting to someone else. I think I would  
2 propose to go another half an hour unless you need a  
3 break, and I don't think, unfortunately, we're going to  
4 get to cross-examination today by Mr. Kitchen, but I  
5 think I can finish with Dr. Halowski today. And then  
6 next Tuesday, we would resume with Mr. Kitchen. I, of  
7 course, wouldn't talk to Dr. Halowski about his  
8 testimony during that break.

9 Do you want to take a quick break now though for 5  
10 or 10 minutes, or do you want me to just go ahead, and  
11 I'm fine either way?

12 THE CHAIR: No, I think my body doesn't  
13 like sitting in front of a computer screen eight hours  
14 a day, so I'd like to get up and stretch. So let's  
15 just -- I mean 5 minutes is fine, and then we'll --

16 Mr. Kitchen, does that sound fair to you in terms  
17 of a plan for the rest of today and for next week?

18 MR. KITCHEN: That's fine, yeah. We're not  
19 going to have time to do my cross, so that's fine.

20 THE CHAIR: Okay, very good. All right,  
21 well, if that's the case, let's break for -- come back  
22 at 20 to 4, and then we'll plow through the rest of the  
23 direct examination. So we're in -- session is in  
24 recess for now, reconvene at 3:40. Thank you.

25 (ADJOURNMENT)

26 THE CHAIR: The hearing is back in

1 session, and, Mr. Maxston, it's your floor to continue  
2 with Dr. Halowski.

3 MR. MAXSTON: Thank you, Mr. Chair.

4 I'm now going to turn to the sixth and final area  
5 that I wanted to have questions for Dr. Halowski on,  
6 and that is his involvement in the complaint concerning  
7 Dr. Wall. I'm going to ask you, Mr. Chair and your  
8 colleagues, to go to Exhibit A-2, which is a December  
9 1, 2020 email from a lady named Heidi Ho at Alberta  
10 Health Services that was sent to Dr. Wall and was  
11 copied to Dr. Halowski, so I'll just let everybody get  
12 to that document, and then I'll -- I've got a few  
13 questions on that.

14 THE CHAIR: And, Dr. Halowski, do you have  
15 a copy?

16 A Yes, I do, thank you.

17 Q MR. MAXSTON: So, Dr. Halowski, I really, as  
18 I said, going to want to talk to you here about your  
19 involvement with this complaint and how things started.  
20 Can you tell me who Heidi Ho is at Alberta Health  
21 Services?

22 A Yeah. Heidi Ho is a community medical specialist, so  
23 she's like a ground-worker for Public Health, and so  
24 when Public Health complaints are received, then she  
25 would go out and investigate.

26 During the pandemic in the initial phase, we

1 received many contacts specifically from Public Health  
2 about the conduct of our membership, where we would  
3 investigate. That was something that I would often  
4 receive, initiate, and then follow up and let me them  
5 know that we'd investigated and any action taken.

6 So for Heidi Ho to reach out and communicate to me  
7 directly was an occurrence that wouldn't have raised on  
8 my radar from time to time, but it was a signal that  
9 Public Health had something that they wanted us to look  
10 into and be able to respond to them that our member  
11 was, in fact, doing what they should do, or if there  
12 was concerns, then we would raise them back to Public  
13 Health as well.

14 Q So the December 1, 2020 email, you're copied with it,  
15 it's going to Dr. Wall. Can you tell me what Ms. Ho is  
16 communicating to you in this email?

17 A Yeah. So she says: (as read)

18 Alberta Health Services received a complaint  
19 indicating that the administration staff and  
20 yourself are not masking even when within 2  
21 metres distance with patients. As per our  
22 phone conversation, you indicated you were  
23 mask-exempted as per CMOH 38-2020. Please  
24 indicate which exemption you would fall  
25 under; otherwise, you are required to be  
26 masking when within 2 metres distance with a

1 patient. As for your administrative staff,  
2 you indicated that there is no plexiglass  
3 barrier at the reception and that staff are  
4 not masking. Patients could be within 2  
5 metres' distance when making payments. This  
6 is in violation of the CMOH Order 26-2020,  
7 where every person attending an indoor or an  
8 outdoor location must maintain a minimum of 2  
9 metres distance from every other person.  
10 Your clinic must have control measures,  
11 physical barriers -- for example, physical  
12 barriers to promote physical distancing at  
13 all times; otherwise, the administrative  
14 staff must be masked as per CMOH Order  
15 38-2020.

16 And then she just informs that she's copied me, and  
17 when I received this email, I was quite concerned that  
18 Dr. Wall was not following the practice directive,  
19 because we were very clear about what the requirements  
20 are, and masking was one of them, and Ms. Ho was also  
21 aware of that.

22 Q Okay. I'll ask you to go and everyone else to go to  
23 Exhibit A-3, which is your December 2, 2020 letter to  
24 Mr. Lawrence, in his capacity as Complaints Director.  
25 And I'll just -- you quote Ms. Ho's email in there in  
26 your letter, I'll just ask you to read the first

1 paragraph in your letter to Mr. Lawrence.

2 A (as read)

3 It has come to the attention of the Registrar  
4 through Public Health on December 1st, 2020,  
5 at 4:17 PM that Dr. Curtis Wall is not  
6 following the ACAC Pandemic Directive and the  
7 CMOH orders regarding masking and the  
8 requirements to maintain 6 feet of social  
9 distance.

10 And I included that body of the email just for  
11 Mr. Lawrence's consideration.

12 Q Okay, and can you read the last two paragraphs -- I'm  
13 going to have questions for you on these, but can you  
14 read the last two paragraphs in your letter,  
15 beginning --

16 A Yeah.

17 Q -- with "Further to"?

18 A (as read)

19 Further to the email from Public Health, in  
20 conversation with Dr. Wall, he indicated that  
21 he does not mask, and he has not provided  
22 for barriers in his clinic.

23 So I did, once I had this, send an email to Dr. Wall,  
24 letting him know I would need to speak with him. We  
25 did have a conversation on December 2nd.

26 And so that's what that's referencing, that, in

1 conversation, he had communicated that he wasn't doing  
2 it and nor do he have intention to: (as read)

3 I have serious concern for public safety as  
4 Dr. Wall refuses to mask when he breaches the  
5 physically distance of 6 feet with the  
6 public. He is not providing for or requiring  
7 his staff to mask when they are within 6 feet  
8 of distance.

9 Q Okay, so I want to turn back to this phone conversation  
10 you had with Dr. Wall, and can you just refresh my  
11 memory, what day did that happen?

12 A December 2nd.

13 Q And did he call you?

14 A I can't remember the exact -- I did imply that we would  
15 need to converse, and I believe that I did call him at  
16 his clinic, but I don't know off the top of my head.

17 Q Okay, I want to just be very clear about your  
18 conversation with him and what he said to you. You  
19 said in your letter he indicated that he does not mask?

20 A Yeah.

21 Q And that's accurate?

22 A That's what he indicated at the time, that he was not  
23 masking, and I also remembered he indicated he had no  
24 intention to mask because -- yeah, well, he did, for a  
25 brief moment in that conversation, describe how he  
26 didn't think that COVID was serious, and that it was --



1 we were overreacting with the Pandemic Practice  
2 Directive. And so he was indicating that he was not  
3 going to because he did not believe that he needed to  
4 follow this, that he would be just fine.

5 And somewhat at -- somewhat at the time, I think  
6 they've come to be known as COVID deniers in the  
7 public, that there was rhetoric, there was speech about  
8 how COVID's not real, how it's not serious, that it's  
9 no more than a mild flu, and some of that language that  
10 was common and has continued to be common about COVID  
11 during the pandemic.

12 Q Did he talk to you about his exemption from masking or  
13 his alleged exemption?

14 A He had talked about how he had originally worn a mask  
15 but then decided that he didn't like to wear it and  
16 that he -- you know, I think he said, you know, he just  
17 didn't feel comfortable wearing it, so he had been  
18 wearing it since May. And so at the end of May, I  
19 think, is when he indicated that he had removed the  
20 mask from what I recall of that conversation.

21 Q And, I'm sorry, what did he identify as the reason for  
22 not masking?

23 A He said he didn't like how he felt when he wore it, you  
24 know, he just didn't feel comfortable wearing it, which  
25 I believe were the words he used in that conversation.

26 Q Okay. Did he identify any other reasons for not

1           wanting to wear the mask?

2     A     Other than, you know, I asked why, and I think that's  
3           when some of the conversation around COVID not being  
4           real and that this is, you know, we're just  
5           overreacting, and, in this environment, to have to wear  
6           a mask and that he wasn't comfortable doing that.

7     Q     Did he mention any religious objections?

8     A     I don't believe he did at that time; not that I can  
9           recall.

10    Q     Did he argue that he couldn't practice because of the  
11           Pandemic Directive then?

12    A     No, he didn't raise anything. You know, I tried to  
13           encourage him that masking is required, and he said  
14           that he wouldn't be masking, that he -- I think he then  
15           was -- yeah, I think, you know, part of it he was  
16           claiming he was now exempt from masking because of the  
17           City bylaws allowed him to be exempt. And I do  
18           remember having a conversation that that's not the  
19           intent of the bylaws, and the practice directive  
20           applies to you.

21           Hence, the follow-up communication to  
22           Mr. Lawrence, that we have a member that's not  
23           following the Pandemic Practice Directive.

24    Q     We talked before about the Telehealth directives; were  
25           there some options for practice available to Dr. Wall  
26           if he didn't want to mask?

1     A     Dr. Wall could have practiced Telehealth. Dr. Wall  
2           could have -- at that time, he could have had  
3           conversations with his patients to only mask when he  
4           was going to be within 6 feet, but Dr. Wall indicated  
5           that he wouldn't do that either.

6     Q     I'm going to ask you some closing questions here just  
7           about I guess the regulatory function of the College  
8           and, more specifically, the regulatory roles that you  
9           occupy or have involvement with as Registrar.

10           Does the College have mandatory practice visits?

11    A     Yes, that is a part of our practice. That's part of  
12           the rights given in our regulations that our competence  
13           committee has mandatory practice visits.

14    Q     And can a chiropractor choose to opt out of practice  
15           visits?

16    A     They cannot.

17    Q     Does the College have a required continuing competence  
18           program?

19    A     We do have a continuing competence program that  
20           requires a certain number of CC hours. Council has  
21           also directed that members have to maintain currency in  
22           first aid, that right now we have a requirement for a  
23           recordkeeping course that must be completed annually,  
24           and that members also must complete trauma-informed  
25           training on an annual basis.

26    Q     Can a member choose to opt out of those requirements?

1 A Not if they would like to renew their practice permit.

2 Q So I take it that means, no, if they want to practice?

3 A That's correct, yes.

4 Q In his questions with a prior witness, Mr. Kitchen  
5 asked a question about whether chiropractic clinics are  
6 or are not health care settings; how would you respond  
7 to that?

8 A The way I would look at that is we're a regulated  
9 profession underneath the Health Professions Act, and  
10 we are health professionals, health care workers.  
11 We're regulated members of a health care profession,  
12 and that's what the Health Professions Act establishes.  
13 That's the level of expertise.

14 When people come to us, they're coming to us for  
15 health care problems. They're coming to us because  
16 they're seeking our care for conditions that impact  
17 their health. So I would say, in every sense of the  
18 word, we are health care workers.

19 Q Dr. Halowski, since the COVID-19 pandemic began, have  
20 any chiropractors died from COVID-19, to your  
21 knowledge?

22 A Yes. We've had two of our members that passed away as  
23 a result of COVID-19. We had one practitioner in his  
24 early 50s in Calgary that passed way as a result of it.  
25 We had one of our members in their early 60s passed  
26 away as a result of it. And during that time, I've had

1 an opportunity to speak to many of our members who  
2 acquired COVID as well.

3 MR. MAXSTON: Dr. Halowski, those are all my  
4 questions for you.

5 I see we're just coming to 4:00, so Ms. Nelson is  
6 still involved. I take it, based on our previous  
7 discussion, Mr. Chair and Mr. Kitchen, that what the  
8 intention will be is that next Tuesday, when we resume,  
9 Dr. Halowski's testimony would continue, and  
10 Mr. Kitchen would commence his cross-examination, I  
11 would do my redirect, if any, and the Tribunal would  
12 ask any questions of Dr. Halowski?

13 THE CHAIR: That's my understanding. I  
14 think that's the path that we shall follow.

15 The Chair Questions the Witness

16 THE CHAIR: But before we break for today,  
17 I had one quick question that I would like to ask  
18 Dr. Halowski, and this goes to the complaint that was  
19 received.

20 Q THE CHAIR: So the complaint was made by a  
21 patient to Alberta Health?

22 A It was made by one of Dr. Wall's patients specifically  
23 to Alberta Health, but Alberta Health communicated it  
24 back to us. They indicated that that patient would  
25 like to stay anonymous, as they had a -- often  
26 patients -- and that's very standard for a patient not

1 to want to be identified -- but when they made that  
2 complaint and with that follow-up conversation to  
3 Dr. Wall where I became aware of it, that's when we  
4 decided to action further.

5 Q Okay, so there was no further communication with the  
6 patient?

7 A No, at no time did we communicate with the patient;  
8 that came to Alberta Health from a patient.

9 Q Okay, I just was curious as to how -- what the path was  
10 for that complaint to end up where it did.

11 THE CHAIR: Did any other Members of the  
12 Tribunal have questions they wanted to talk about  
13 today? We can caucus and discuss those, or we can --  
14 you have a chance to think about this and certainly  
15 raise them next week when we meet.

16 Okay, I think the Hearing Tribunal Members are  
17 fine; I'm fine.

18 So thank you very much, Dr. Halowski, for your  
19 time and your testimony today. Much appreciated.

20 Thank you, counsel, both counsel for your efforts.  
21 They are long days, but there's a lot to cover, and we  
22 shall pick this up at 9:00 on September 7th and  
23 continue, at that point, with Mr. Kitchen's  
24 cross-examination of Dr. Halowski.

25 And I would just ask, Mr. Pavlic, do we need to  
26 caution Dr. Halowski not to discuss his testimony, or

1 is that not an issue?

2 MR. PAVLIC: He should be provided the  
3 usual caution, but I think Mr. Maxston has already  
4 indicated that he will not be discussing any matters  
5 with him, so I think that will cover it off.

6 MR. KITCHEN: Okay, your comment, mine, and  
7 Mr. Maxston's.

8 THE CHAIR: Okay, that's great. Okay,  
9 thanks everybody. We will call this hearing to close  
10 for today, and we'll see everybody on the 7th. Have a  
11 good long weekend.

12 \_\_\_\_\_  
13 PROCEEDINGS ADJOURNED UNTIL 9:00 AM, SEPTEMBER 7, 2021

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1 CERTIFICATE OF TRANSCRIPT:

2

3 I, Karoline Schumann, certify that the foregoing  
4 pages are a complete and accurate transcript of the  
5 proceedings, taken down by me in shorthand and  
6 transcribed from my shorthand notes to the best of my  
7 skill and ability.

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

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Karoline Schumann

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Karoline Schumann, CSR(A)

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Official Court Reporter

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Exhibits	1			
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## Y

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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

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DISCIPLINARY HEARING

VOLUME 3

VIA VIDEOCONFERENCE

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Edmonton, Alberta

September 7, 2021

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

4

5 September 7, 2021 Morning Session

6

7 HEARING TRIBUNAL

8 J. Lees Tribunal Chair

9 W. Pavlic Internal Legal Counsel

10 Dr. L. Aldcorn ACAC Registered Member

11 Dr. D. Martens ACAC Registered Member

12 D. Dawson Public Member

13 A. Nelson ACAC Hearings Director

14

15 ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

16 B.E. Maxston, QC ACAC Legal Counsel

17

18 FOR DR. CURTIS WALL

19 J.S.M. Kitchen Legal Counsel

20

21 K. Schumann, CSR(A) Official Court Reporter

22

23 (PROCEEDINGS COMMENCED AT 9:08 AM)

24 THE CHAIR: Good morning, everybody.

25 Thank you, Dr. Halowski, for coming back this morning.

26 A Thank you for having me back.

1           THE CHAIR:                   Just to remind everybody, we  
2           concluded on September 2nd with the direct examination  
3           of Dr. Halowski, and we will start this morning -- I  
4           should, first of all, remind everybody that the Hearing  
5           Tribunal is back in session, and we will start this  
6           morning with the cross-examination of Dr. Halowski.

7                   And, Dr. Halowski, I would just remind you that  
8           you are still under oath.   Very good.

9                   Mr. Kitchen, I'll turn the floor over to you.

10          MR. KITCHEN:                Thank you, Chair.

11          DR. TODD HALOWSKI, Previously affirmed, Cross-examined  
12          by Mr. Kitchen

13   Q     MR. KITCHEN:                Good morning, Dr. Halowski.

14           Is it all right, if I call you Dr. Halowski?

15   A     Yeah, that works for me.

16   Q     Thank you.   Well, I'm going to start with just a few  
17           questions about some of the things you had to say on  
18           Thursday, and I might refer to last Thursday, and  
19           that's just a reference to your direct examination with  
20           Mr. Maxston.

21                   Now, Dr. Halowski, the primary form of care  
22           provided by chiropractors is physical manipulation of  
23           the musculoskeletal system of their patients; isn't  
24           that right?

25   A     That is one form of treatment provided.   There's also  
26           consultation.   There's education.   There's also soft

1 tissue immobilization. There's exercise instruction.

2 And so one of the modalities of treatment that is used  
3 is physical manipulation as well as many others.

4 Q So you disagree that the primary form of care is  
5 manipulation?

6 A That is one of the modalities of treatment that we are  
7 taught. It may be that many chiropractors employ it.  
8 There are chiropractors that don't use that. So for me  
9 to speak for every chiropractor and the treatment plan  
10 they provide would be inappropriate in this setting,  
11 but it is one of the treatment forms that chiropractors  
12 utilize and are trained to utilize and recognized as a  
13 restricted activity that we are able to perform under  
14 the Health Professions Act.

15 Q Okay, and I appreciate that answer, but can you just  
16 confirm for me that you disagree that it's the primary;  
17 in other words, you would say it is only one form of  
18 treatment, it is not the primary; would you agree with  
19 that statement?

20 A I would say that historically, manipulation was the  
21 primary means of treatment. I would say in today's  
22 chiropractic. There are many approaches; chiropractors  
23 also provide acupuncture, they provide all sorts of  
24 different treatments that are physical or meant as for  
25 intervention. So I think that having me agreed to that  
26 statement or disagree to that statement, doesn't



1       provide the full context of care provided by  
2       chiropractors.

3     Q     And I appreciate that you feel that way --

4     A     No, that's the truth; it's not my feeling.

5     Q     Okay, and I appreciate that you think that's the truth,  
6       but you are required to answer my question, and my  
7       question is do you agree that physical manipulation of  
8       the musculoskeletal system is the primary form of care?  
9       If you disagree, I'd ask that you tell me.

10    A     I think I have answered that that is one of the forms  
11       of care, and it may be the most --

12    Q     I didn't --

13    A     -- commonly --

14    Q     -- ask you if it's one form of care; I asked you if  
15       it's the primary.

16    A     Again, then --

17    Q     Do you agree it's the primary, or do you disagree?

18    A     I would say I can't answer that question the way you're  
19       asking it.

20    Q     So do you agree that you don't know the answer to that  
21       question?

22    A     No, I think I do understand that that applies, and I  
23       did inform you as well as the Hearing Tribunal of the  
24       many different options that are available for treatment  
25       as offered by chiropractors.

26    Q     I didn't ask you if you understood. I asked you if you

1       don't know. So is your answer to the question whether  
2       you agree that musculoskeletal manipulation is the  
3       primary form, is your answer I don't know?

4     A    The answer is that would depend on each practitioner,  
5       and while that is we are trained and experts in  
6       providing manipulation as you're describing, or if we  
7       talked about osseous manipulation, then, yes, that is a  
8       primary treatment that we're trained to offer.

9     Q    So you would agree that physical manipulation is a  
10       primary form but not the primary form?

11    A    That's correct.

12    Q    Well, do you agree that the physical manipulation of  
13       the musculoskeletal system is called an adjustment?

14    A    That is one word that's used for it. Adjustment and  
15       manipulation are used interchangeably by practitioners,  
16       often recognizing that, you know, manipulation is what  
17       would be recognized by the majority of health  
18       professions. Adjustment is the term used by some  
19       chiropractors when they're describing manipulation.

20    Q    Well, I'll use the word "manipulation" because it seems  
21       to be the one favoured by you. Now, manipulation is  
22       done by chiropractors by either touching patients with  
23       their hands or with small manipulation devices; isn't  
24       that right?

25    A    That are -- yes, that would be the two, typically  
26       either instrument-assisted or hand-based adjustment or

1 manipulation as you call it.

2 Q Well, I'm calling it that, because you called it that.  
3 Adjustments cannot be done -- okay, sorry, let's call  
4 them manipulation. Manipulation cannot be done over  
5 the phone, can it?

6 A That is correct.

7 Q Manipulation cannot be done if a chiropractor is  
8 physically distanced from their patients by 2 metres;  
9 isn't that correct?

10 A That's correct.

11 Q You stated last Thursday that Telehealth is not the  
12 same as physical care, did you not?

13 A It is not the same.

14 Q I don't think you said last Thursday that Telehealth is  
15 shown to be effective, but you have produced no  
16 independent evidence of this effectiveness in the form  
17 of studies or reports, have you?

18 A I think I did report on a study that's forthcoming  
19 that's not yet published, but there is evidence and  
20 there is published evidence that treating  
21 musculoskeletal conditions with Telehealth has been  
22 shown for specific conditions to be effective, that  
23 depends on the condition.

24 Q You haven't produced that evidence for the purposes of  
25 this hearing, have you?

26 A I didn't -- no, we didn't produce that evidence. It's

1 not submitted as one of the articles.

2 Q Chiropractors don't generally work with people that  
3 have infectious illnesses, do they?

4 A They -- not typically, we don't. We don't seek out to  
5 treat patients with infections. Some patients may show  
6 up because they have an infection -- well, with an  
7 infection as a comorbidity.

8 Q But you said last Thursday, did you not, that  
9 chiropractors don't generally work with people that  
10 have infectious illnesses, didn't you?

11 A Yeah, we're not a primary treatment for those patients.

12 Q When the ACAC decided to include mandatory masking for  
13 chiropractors in the Pandemic Directive in May of 2020,  
14 it did not consider the statutory human rights and  
15 constitutional rights of chiropractors regarding  
16 mandatory masking, did it?

17 A We were taking the direction of Public Health around  
18 the requirements to protect patients. So if you're  
19 asking about it in that situation, it was one of the  
20 discussions; however, the primary decider was that we  
21 have a responsibility to practice in the safest way  
22 possible for our patients.

23 Q Thank you for that answer, but you didn't answer my  
24 question. My question was when you were deciding what  
25 to put in the Pandemic Directive, and you decided to  
26 include mandatory masking, this is in May of 2020, you

1        did not consider the human rights and constitutional  
2        rights of chiropractors, did you?

3     A    I would say that the rights of the patient and our  
4        responsibility to provide a safe environment were  
5        considered above those rights. So it's not that it was  
6        not considered, the consideration was specifically that  
7        the patient's safety in a situation like that should  
8        come first at this time.

9     Q    Sir, you agree that the human rights and constitutional  
10        rights of patients are very important?

11    A    I do agree that we have a responsibility. I don't know  
12        if I'm an expert -- able to speak about constitutional  
13        and human rights. I do know that we had a  
14        responsibility to provide a way for our practitioners  
15        to deliver safe care. So while you're asking me about  
16        that, I don't feel that I'm qualified to speak about  
17        the human rights here in the aspect that you're  
18        pursuing. And what you're seeking is my opinion, and I  
19        don't know if my opinion really matters in the regard  
20        of making a decision of what's best and safest for a  
21        patient.

22    Q    But you would agree, just to confirm what you just  
23        said, you would agree that the rights of patients are  
24        paramount over the rights of chiropractors?

25    A    That the safety of patients is paramount in making a  
26        decision about how to provide for safe practice.

1 Q Right, but what you just said is that the rights of  
2 chiropractors are less important than the rights of  
3 patients; is that not what you just said?

4 A I don't believe it is.

5 MR. KITCHEN: Well, Madam --

6 A I think I spoke about the safety of the patient.

7 MR. KITCHEN: Madam Reporter, can you help  
8 us out with that? Can we just go back to what  
9 Dr. Halowski said there just a moment ago?

10 COURT REPORTER: (by reading)

11 A I would say that the rights of the  
12 patient and our responsibility to provide  
13 a safe environment were considered above  
14 those rights. So it's not that it was  
15 not considered, the consideration was  
16 specifically that the patient's safety in  
17 a situation like that should come first  
18 at this time.

19 MR. KITCHEN: Thank you.

20 Q MR. KITCHEN: So, Dr. Halowski --

21 A Yeah.

22 Q -- you would agree can with me that, from your  
23 perspective, the rights of the patients are paramount  
24 to the rights of chiropractors?

25 A When you say "paramount", can you give me the  
26 definition of how you're describing "paramount"?

1 Q You would agree with me that you just said that the  
2 rights of patients are more important to you in your  
3 role as the Registrar than the rights of chiropractors?

4 A I would say that the rights -- if you're going to use  
5 those words, the right or the responsibility of the  
6 College is to ensure public protection, public safety,  
7 and practitioner competence, and I believe we met those  
8 requirements by the decisions that were made in May  
9 last year.

10 So we did say that paid practitioners must be  
11 masked to provide care, because the evidence at that  
12 time was that masking was an effective way to limit the  
13 transmission of COVID-19 to patients that were  
14 receiving care.

15 Q So you would agree with me that the Pandemic Directive  
16 does a good job of prioritizing the rights of patients  
17 over the rights of chiropractors?

18 A I would agree with that.

19 Q When the ACAC decided to include mandatory masking for  
20 chiropractors in its Pandemic Directive in May of 2020,  
21 it did not consult a scientist who was independent of  
22 the Alberta Government, did it?

23 A We were -- we did not, other than the advice and  
24 recommendations of Public Health, consult anybody  
25 outside of that organization.

26 Q And by "Public Health", you mean the Public Health of

1 the Government of Alberta?

2 A Correct, and also the recommendations of the Public  
3 Health Agency of Canada.

4 Q Now, when the ACAC reviewed and revised the Pandemic  
5 Directive in January of 2021, it didn't then consult a  
6 scientist who was independent of Government Public  
7 Health to review the mandatory masking, did it?

8 A No, we continued to put our trust in the  
9 recommendations and direction received from Public  
10 Health in Alberta as well as that from Public Health of  
11 Canada.

12 Q Exclusively, correct?

13 A Yes, correct.

14 Q You said last Thursday, that it would be, quote,  
15 oppressive for the ACAC to mandate too much PPE too  
16 often; isn't that right?

17 A In the context of reviewing the standard of practice, I  
18 believe that is correct. When we talked about all of  
19 the different things, i.e., having to wear gowns,  
20 having to wear gloves, having to wear splash shields,  
21 all those different things would have been an excessive  
22 amount of PPE in the context of what we knew about  
23 COVID at the time.

24 Q Now, I'm going to take you and the Tribunal to Exhibit  
25 F-2. If you could just let me know when you have that  
26 in front of you. This is CMOH Order 16-2020.



1 A I will let you know as soon as I have it. Okay.

2 THE CHAIR: Does everybody have it?

3 MR. KITCHEN: Thank you.

4 Q MR. KITCHEN: Dr. Halowski, you're there?

5 A Yeah.

6 Q Now, Section 2 of this order, CMOH Order 16-2020,  
7 Section 2 never applied to Dr. Wall, did it?

8 A You're saying Section 2 of the actual order or Section  
9 2 of Appendix A? Because when I read Section 2 of the  
10 order: (as read)

11 Effective May 4th and subject to Section 6 of  
12 this order, a regulated member of a college  
13 established -- [so Dr. Wall is a regulated  
14 member of a college] -- established under the  
15 Health Professions Act practicing in the  
16 community must comply with the attached  
17 Workplace Guidance for Community Health Care  
18 Settings to the extent possible when  
19 providing a professional service.

20 I would say that does apply to Dr. Wall.

21 Q Let me take you over to the next page then. You see  
22 Section 6 there?

23 A Yeah.

24 Q Now, I'm going to read it to you, and then I'm going to  
25 ask you a question: (as read)

26 Section 2 of this order does not apply in

1           respect of a regulated member under the  
2           Health Professions Act whose college has  
3           published COVID-19 guidelines as required by  
4           Section 3 of this order.

5    A    Yeah.

6    Q    You would agree that the ACAC Pandemic Directive was  
7           implemented on May 4th?

8    A    It was -- that's when members could return to practice  
9           under the CMOH order. It was -- that's when it was  
10          effected. It was provided to members before that.

11   Q    All right. Okay, so let me ask you again -- let's go  
12          back to Section 2 --

13   A    Okay.

14   Q    You would agree with me then that Section 2 never  
15          applied to Dr. Wall?

16   A    Section -- the way you're reading it, yes.

17   Q    And that's because of Section 6 and the fact that the  
18          ACAC implemented the Pandemic Directive on May 4th,  
19          correct?

20   A    Correct.

21   Q    So at no time did Dr. Wall ever contravene Section 2 of  
22          CMOH Order 16-2020, did he?

23   A    I am answering; I'm just reading to make sure my answer  
24          is consistent with what I'm reading right now.

25   Q    That's fine.

26   A    Yeah, at that time, he would be under the direction of

1       the College. So your answer -- I think the way you --  
2       can you restate your question, and then I will answer  
3       it specifically?

4     Q   At no time did Dr. Wall ever contravene Section 2 of  
5       CMOH Order 16-2020; isn't that correct?

6     A   He would have been -- so, yes, he would have been under  
7       Section 6 of the CMOH -- of this order at 16-2020,  
8       because the College had its own guide, but the answer  
9       is, yes, that said that.

10    Q   Thank you. I'll take you to Exhibit D-8, please. D-8,  
11       and that is CMOH Order 38-2020.

12    A   Okay.

13    Q   You're familiar with this? I believe we discussed this  
14       last Thursday.

15    A   Yes.

16    Q   And I'll take you over to page 6. Now, Section 27(c)  
17       of this CMOH Order 38-2020 orders that individuals are  
18       exempt from wearing a mask if they are: (as read)

19           Unable to due to a mental or physical concern  
20           or limitation.

21       Isn't that right?

22    A   That's what that says right there.

23    Q   Just going to go back to the Pandemic Directive, and  
24       just so everybody knows, there's three versions of the  
25       directive, of course, I think it's C-20, C-21, and  
26       C-22. C-22 being the January 6th version.

1           Now, Dr. Halowski, none of these three versions of  
2           the Pandemic Directive requires that patients wear a  
3           mask, do they?

4    A    I think the first and second did not. I believe in the  
5           third version, we did start speaking to the direction  
6           that was provided in the CMOH orders. I would have to  
7           confirm that.

8    Q    Well, why don't you do that.

9    A    In here, we did not speak to patients. I do know we  
10           did -- and so that's why I had to review. I do know we  
11           communicated to the ACAC around patients and how to  
12           manage and handle patients that were not masking  
13           because those were at the time Provincial or Municipal  
14           orders.

15   Q    I appreciate that, but you'll confirm for me that never  
16           in the directive, in the Pandemic Directive, did you  
17           mandate that patients must wear a mask?

18   A    No, we don't regulate patients. We did not mandate it  
19           in there.

20   Q    And none of the three versions of the directive  
21           required chiropractors to enforce that their patients  
22           wear a mask, does it?

23   A    That was -- no, we don't have anything in the Pandemic  
24           Practice Directive around enforcement for chiropractors  
25           to make their patients mask in the clinic.

26   Q    Now, I'm at that Personal Protective Equipment section,

1       okay, which stays largely the same for the three  
2       versions. Now, you would agree with me that nowhere in  
3       the PPE or the Personal Protective Equipment section in  
4       the directive, you would agree with me that nowhere  
5       does it say anything about chiropractors contacting the  
6       ACAC regarding masking if they think they have a human  
7       rights concern regarding mandatory masking?

8     A   We don't have anything in there about our practitioners  
9       contacting us. We do -- and this directive didn't  
10      include anything about them contacting, because the  
11      expectation was that they would always mask when  
12      providing close contact care.

13    Q   I heard you say quite a few times in your answers to  
14      Mr. Maxston on Thursday that the protection of the  
15      public is the top priority and primary consideration  
16      for the ACAC?

17    A   That is what directs our policy decisions, yes, that  
18      is -- when council meets and council makes decisions,  
19      that is the consideration that's made is what is best  
20      for the public. That is that council -- both  
21      between -- so I would say, yes, that is an appropriate  
22      assessment that we do speak to the need for regulating  
23      members with the perspective of public safety first.

24    Q   You agree that a key aspect of protecting the public is  
25      protecting their health, do you not?

26    A   Yes.

1 Q You agree that the principle of, first, do no harm is a  
2 vital part of protecting the health of members of the  
3 public; do you not?

4 A That would be part of what we do and aim to do with the  
5 provision of care as chiropractors.

6 Q You agree that each patient of every chiropractor is a  
7 member of the public, do you not?

8 A Yes.

9 Q You agree that the interests of each patient, each  
10 forms a part of the broader public interest; do you  
11 not?

12 A I would say I guess so if we're going down this --  
13 where you're going is that each patient's, you know --  
14 but again there, I'm trying to understand the reason of  
15 the question, other than, yeah, we have that each  
16 patient's safety is paramount, but we only interact  
17 with a patient that's in the office.

18 Q You agree from the perspective of the ACAC, because  
19 that's -- I'm not asking this question, I'm not asking  
20 any of these questions about you as a chiropractor. I  
21 know you've practiced; you mentioned that on Thursday.

22 A Yeah.

23 Q But you're here in your role as Registrar.

24 A Yeah.

25 Q Okay, so that's what I'm talking about.

26 A Okay.

1 Q So you would agree from the perspective of the ACAC  
2 that the interests of each patient, each chiropractor,  
3 each forms a small part of the broader public interest,  
4 correct?

5 A Yes. I would say the public as a whole, yes.

6 Q Do you think -- would you agree that if the interests  
7 of one individual patient were impacted, that in some  
8 small way the broader public interest as a whole is  
9 impacted?

10 A Perhaps. I mean, can you give me an example of a  
11 situation that you're thinking of? Because I can think  
12 there would be positive and negative for impact, I  
13 think that's a consideration.

14 Q If I did that, Mr. Maxston would tell me I can't ask  
15 you a hypothetical, so I'm not going to do that.

16 A Okay.

17 Q You would agree that the public interest is not merely  
18 an ideal, correct?

19 A The public interest, I think that's the  
20 decision-making, it's not -- it's meant to be realistic  
21 for the public and how they receive care or how we  
22 interact or how we provision for the -- it's meant to  
23 be realistic, yes.

24 Q Exactly, and the public is made up of many individuals,  
25 correct?

26 A It would be, yeah, everybody, like I said, the --

1 society in its entirety.

2 Q So the interests of each individual chiropractic  
3 patient, a conglomeration of those interests make up  
4 the public interest, correct?

5 A Perhaps, yes, that would be -- I guess so, yes.

6 Q The ACAC expects chiropractors to prioritize the  
7 protection of the health of their patients above all  
8 other priorities; isn't that right?

9 A That we do expect that they practice with safety as  
10 their primary concern, whether it's safety to deliver  
11 the care at that time, whether it's safe to -- safer to  
12 not provide care, whether it's safer to refer the  
13 patient. All of those are considerations that an  
14 individual chiropractor must make based on the  
15 presentation of the patient. So in the full context,  
16 yes.

17 Q Okay, thank you, but I didn't ask you about safety, so  
18 please try to listen to the words that I use.

19 A Okay.

20 Q And if you don't agree with me, that's okay, just say  
21 so, say, I don't agree with that, or just say, That's  
22 not right. You can give whatever answer you want, but  
23 I am asking you, and you are required to answer the  
24 question that I ask you.

25 A Okay.

26 Q The ACAC expects chiropractors to prioritize the



1 protection of the health of their patients above all  
2 other priorities; is that right or is that wrong?

3 A Yes, that's right.

4 Q Even above their own interests, correct?

5 A That would be -- I'm going to say there is context --  
6 no, yes, that would be true.

7 Q You agree that the principle -- again I'm asking you in  
8 your capacity as the Complaints Director, okay? I'm  
9 not asking your personal opinion --

10 A I'm not the Complaints Director, but I'm the --

11 Q Sorry.

12 A -- Registrar, yeah.

13 Q Forgive me. That's exactly --

14 A That's okay. No, that's okay, I just wanted to make  
15 sure that that was clear that I'm not pretending to be  
16 the Complaints Director.

17 Q So you agree, from your perspective as the Registrar of  
18 the ACAC, that the principle of chiropractors  
19 protecting the public from harm is more important than  
20 the principle of protecting the reputation of the  
21 chiropractic profession, do you not?

22 A Public safety is what is the key and essential in the  
23 decision-making, so I don't know if I would separate  
24 the two because I do believe that protecting the  
25 patients protects the reputation of the profession. So  
26 that would be I disagree with the way you stated the

1 question.

2 Q Okay. As far as you're concerned, those two things  
3 could never come in conflict?

4 A So when you say "those two things", you're talking  
5 about patient safety and the public reputation. They,  
6 at times, they do come in conflict, and patient safety  
7 would be above the professional reputation at the time  
8 in the sense that, you know, we actually -- when we  
9 govern or when council governs under the Health  
10 Professions Act, their consideration is the public  
11 above the profession.

12 Q So you've agreed that public safety is above the  
13 reputation -- or above the interest of protecting the  
14 reputation of the profession. Do you agree that  
15 protecting the public from harm is also above  
16 protecting the reputation of the profession?

17 A I think that, in my mind, the protecting the public and  
18 protecting them from harm is very similar. I don't  
19 know if I understand the distinction you're trying to  
20 make there.

21 Q Well, again, I asked the question, and I didn't use the  
22 word "safety", but you used the word "safety" in  
23 answering, which --

24 A Okay, you said public -- versus public, protecting the  
25 public and protecting the public from harm, is that  
26 what you used?

1 Q That's exactly what I used.

2 A And so what's the distinction? To me, I see them as  
3 the same.

4 Q You see safety and protection from harm as the same  
5 things?

6 A Again, you put the word "safety" in there, I didn't.  
7 When I was restating your question, I said public and  
8 public harm. And so when you're saying protecting the  
9 public, I think that encompasses protecting them from  
10 harm as one of the components. So I guess I would say,  
11 yes, in that aspect.

12 Q You agree that there are other threats to the overall  
13 health and safety, health and well being of  
14 chiropractic patients besides COVID-19, do you not?

15 A Absolutely, yeah. You know, that is -- I would a  
16 hundred percent agree that COVID-19 is not the only  
17 health threat that our patients face at this time or  
18 the public faces, because I'm not speaking about my  
19 years as a practitioner.

20 Q You agree that chiropractors are obligated to comply  
21 with the ACAC's requirements of practice even if those  
22 requirements are harmful to the chiropractor, do you  
23 not?

24 A I would say that the -- that the chiropractor must  
25 deliver care in a safe way, which is that to reduce the  
26 risk of harm.

1 Q I appreciate that, but that's not what I asked you.

2 A Okay.

3 Q You agree, do you not, that chiropractors are obligated  
4 to comply with the ACAC's requirements of practice even  
5 if those requirements are harmful to the chiropractor?

6 A I disagree with the way you've asked the question, and  
7 I know you're going to tell me I have to answer the  
8 question, and so I would agree that the patient's  
9 safety comes -- is paramount in the delivery of  
10 chiropractic care, and we would not set it up so that  
11 our chiropractors were in a position to be in physical  
12 danger when providing the care.

13 Q Dr. Halowski, if you don't agree with my questions,  
14 it's perfectly acceptable for you to answer and say you  
15 don't agree.

16 A Okay.

17 Q But you don't get to ask yourself a different question.  
18 I'm the one asking questions. I'm asking you  
19 questions, and if you disagree with the question that I  
20 have asked you, if I ask you if you agree with  
21 something, I'm asking you to tell me whether or not you  
22 agree. I'm not asking for you to ask yourself a new  
23 question.

24 A Okay.

25 MR. MAXSTON: Mr. Chair, I've got to make a  
26 comment. Mr. Kitchen is phrasing his responses to

1 Dr. Wall's [sic] answer in the format of, You're not  
2 answering a question. He may not like the answer that  
3 Dr. Halowski has given, but this constant repeating of  
4 you have to answer my question, Dr. Halowski is  
5 answering. It's not a question of does Mr. Kitchen  
6 like the answers. Dr. Halowski is providing his  
7 answer, and I just -- I would ask Mr. Kitchen to  
8 refrain from the repeated rephrasing of a question when  
9 the answer has been given.

10 MR. KITCHEN: And I appreciate that. The  
11 problem is that what we're seeing is the witness is  
12 making up his own questions and answering them; he's  
13 not even attempting to answer my questions.

14 MR. MAXSTON: Mr. Kitchen, you and I  
15 disagree, but when I think when Dr. Halowski gives an  
16 answer, he gives an answer, and you don't have to like  
17 it. You can press him on it. But I think you're going  
18 beyond that in reminding him repeatedly about what his  
19 obligations are. He's answering questions.

20 MR. KITCHEN: Well, I'll refrain from that,  
21 and I won't give that reminder again.

22 THE CHAIR: I think, Mr. Kitchen, that  
23 and, Mr. Maxston, that Mr. Kitchen's questions are  
24 being asked to solicit a certain answer from  
25 Dr. Halowski, which -- and Dr. Halowski, from my  
26 perspective anyway, is trying to provide the

1 information in his answer the best way he can, and I  
2 think perhaps there is disagreement on how the answer  
3 should be worded between Mr. Kitchen and Dr. Halowski.

4 But I agree, let's try and move forward with this.  
5 We seem to be hung up on splitting hairs about the use  
6 of a particular word. Thank you.

7 MR. KITCHEN: Thank you.

8 Q MR. KITCHEN: Dr. Halowski, I'm just going  
9 to ask this question one more time, and whatever answer  
10 you give, we're going to move on.

11 I'm simply asking you whether or not you agree, do  
12 you agree that chiropractors are obligated to comply  
13 with the ACAC's requirements of practice even if those  
14 requirements are harmful to the chiropractor? Do you  
15 agree with that, or do you not?

16 A Patient safety comes first in the delivery of care, so  
17 I would say that if there's the risk for harm for a  
18 practitioner in providing care, they shouldn't be  
19 providing care at that time. If providing safe patient  
20 care is going to harm the practitioner, that  
21 practitioner should not be providing that care at that  
22 time.

23 Q And you would agree that it's impossible for the ACAC  
24 requirements of practice to ever result in a lack of  
25 safety to the patients?

26 A Can you repeat the question once more?

1 Q You would agree it's impossible that the ACAC's  
2 requirements of practice would be or would result in a  
3 lack of safety to patients?

4 A Can I -- I'm going to say how I heard your question,  
5 and so that the way we require care may result in an  
6 unsafe environment for patients?

7 Q No, I'm asking you, you in your role as the Registrar,  
8 you regard it as impossible that the requirements of  
9 practice from the ACAC could ever result in a lack of  
10 safety for patients?

11 A I think the Standards of Practice -- so I'm going to  
12 contextualize this, the way the Standards of Practice  
13 are established and direction is meant to provide the  
14 safest way for a patient to receive care. If  
15 somebody's not following that, it may introduce an  
16 environment where the patient is not safe in receiving  
17 care.

18 Q The ACAC is obligated by law to only impose  
19 requirements of practice that are lawful; isn't that  
20 right?

21 A So I would, listening to that, I think that there's  
22 more meaning behind the words than I would be able to  
23 speak to. I do know our responsibility is to set  
24 Standards of Practice and to govern the profession --  
25 and Codes of Ethics and govern the profession according  
26 to the mandate that the legislation provides.

1           So when we do that, the consideration is to be  
2           lawful in how we set up our direction as well as  
3           Standards of Practice and Code of Ethics.

4   Q   Well, since you take objection to the words, let me get  
5           a little more specific.

6   A   Okay.

7   Q   You would agree with me that the ACAC is obligated to  
8           only impose requirements of practice that are  
9           consistent with the Alberta Human Rights Act, correct?

10   MR. MAXSTON:                   Mr. Chair, I'm going to object  
11           to that. Dr. Halowski has no knowledge of Alberta  
12           human rights legislation or requirements. This may be  
13           a question for another witness but not Dr. Halowski.

14           And, I'm sorry, and I might add that's the  
15           ultimate question that may be before -- or one of the  
16           questions that may be before the Tribunal.

17   THE CHAIR:                    I think Mr. Maxston makes a  
18           good point. Dr. Halowski is an expert on the College's  
19           work; however, I don't think he should be held to be an  
20           expert on human rights legislation.

21   MR. KITCHEN:                   And I would agree, and I  
22           wasn't asking about the content.

23   Q   MR. KITCHEN:                   I was merely asking do you  
24           agree, Dr. Halowski, that the ACAC is bound by the  
25           statutes of Alberta?

26   A   To the extent that we have authority under the



1       legislation, we have a responsibility to -- council has  
2       a responsibility to govern, given the -- what the  
3       legislation provides for us to govern.

4               So I think that, yes, but there's context there  
5       that's really important to consider. Like I don't get  
6       to decide what happens in somebody's personal life  
7       but -- or our director or -- I say "us", the ACAC  
8       doesn't get to.

9               What we actually have to specifically consider is  
10       how the legislation should be applied for chiropractors  
11       that are practicing in Alberta, and "legislation" being  
12       specifically the Health Professions Act.

13    Q       The ACAC is bound to act according to the Constitution  
14       of Canada; isn't that correct?

15    A       Again, there I wouldn't be an expert in that. I think  
16       we are bound -- we are entitled with the legislation  
17       under the Health Professions Act and act according to  
18       the direction provided in that document.

19    Q       So would you agree with me that the ACAC is bound by  
20       other pieces of legislation besides the Health  
21       Professions Act?

22    A       There are other pieces of legislation that do speak to  
23       the chiropractic profession, specifically things like  
24       the Health Information Act. We also are responsible  
25       for PIPA in our own conduct. Our members are  
26       responsible PIPA in their own conduct. So there are

1       other pieces of legislation that direct the conduct of  
2       what we have an opportunity to provide guidance,  
3       direction, or regulation on.

4     Q   Thank you.  Now, last Thursday, in response to  
5       questions from Mr. Maxston, you discussed what was said  
6       in an initial call between yourself and Dr. Wall.  This  
7       occurred in early December; you would agree?

8     A   December 2nd from my records.

9     Q   Thank you.  Now, you told Dr. Wall, during that call,  
10       that a decision may be made that he either wear a mask  
11       or sit out from practicing for the rest of the  
12       pandemic, didn't you?

13    A   I don't believe I made that.  I said that we would have  
14       to go further in inquiry at that time.  I don't  
15       actually get to make the decisions, but that would be  
16       one of the decisions that would have been possible to  
17       be raised, so -- I don't have the transcript nor a  
18       memory of every word that was said in that  
19       conversation.

20    Q   Well, Dr. Wall remembers the conversation, and I'm just  
21       going to put it to you that he is going to say that you  
22       said to him in that phone call that he either wear a  
23       mask or sit out from practicing?

24    A   I think that if it was prefaced that way, it would have  
25       been an ask not a demand:  So would you consider not  
26       practicing at this time if you're not willing to mask.

1 Q Well, I'm going to put it to you, Dr. Wall is going to  
2 say that you made that as a statement.

3 A All right.

4 Q So let me ask you: Do you confirm or deny that you  
5 said to him on that phone call that he either wear a  
6 mask or sit out from practicing?

7 A I don't -- I would disagree that I said it that way.

8 Q And, Dr. Halowski, you said that COVID killed two  
9 Alberta chiropractors; you said that, correct?

10 A That is what was reported to us from their families,  
11 so, yes, I did report what was communicated from my  
12 family out to our colleagues, so that our colleagues  
13 were aware of the impact of COVID on these families and  
14 fellow colleagues.

15 Q So you haven't viewed the death certificates of these  
16 two individuals, have you?

17 A I did view the death certificate of one; the other, I  
18 received the obituary from the -- and it wasn't a death  
19 certificate, like the Government death certificate; it  
20 was the one, like a -- I don't know what it's called,  
21 but a certificate of death, but like the notice that a  
22 funeral home or a mortuary would provide, confirming  
23 that they are in possession of this body is what we  
24 received, and we require that for some form of  
25 confirmation -- or we require some form of  
26 confirmation, and that is what we received in that

1 case, and the other was the obituary.

2 Q That document that you viewed, you haven't produced  
3 that as an exhibit in this case, have you?

4 A No.

5 Q You have no evidence of what comorbidities these two  
6 chiropractors had at the time of their death, do you?

7 A I don't. I didn't. It wasn't my place to ask these  
8 families specifically what comorbidities or health,  
9 that's their personal health information. They just  
10 informed me that COVID had killed their -- one was  
11 their husband, and the other was their father.

12 Q So you don't have personal knowledge that COVID was the  
13 primary cause of death in these two people, do you?

14 A I have what was reported to me. Is that not considered  
15 personal knowledge before the -- like I don't know what  
16 your -- is "personal knowledge" is a legal word or not?  
17 Like I would call that personal when I spoke to the  
18 wife and said that her husband was in the hospital for  
19 close to six -- I think four weeks, six weeks, received  
20 care at both the Rockyview and the Foothills, but  
21 eventually succumbed to complications due to COVID.

22 And the other, there was reports that there was --  
23 from them, not from that person directly, somebody else  
24 who knew them, indicated that they may have had  
25 comorbidities and -- but the son said, Yeah, no, COVID  
26 is what killed my father.

1           So I mean, that's information. I didn't enter  
2           that as exhibits, other than the fact that both those  
3           families declared to me, in different ways, that their  
4           loved ones had been killed by COVID or as a result of  
5           COVID-acquired infection.

6    Q    The basis of your belief that these two individuals  
7           died of COVID is based on what you were told by other  
8           people, correct?

9    A    Correct.

10   Q    And you don't know how these two people contracted  
11          COVID if they did; isn't that correct?

12   A    I didn't ask. It was moot to the conversation, and I  
13          didn't feel it was my place to ask that question, so  
14          that is correct.

15   Q    But you did feel it was your place to say, as part of  
16          your testimony, that you believe that two Alberta  
17          chiropractors died of COVID?

18   A    I believe the reports that were provided by those  
19          people, so, yes, I did. And I think, again, for our  
20          profession, it only illustrated to me, as well as to  
21          our colleagues, the severity of COVID in our community.

22   Q    Dr. Halowski, how many chiropractors are there in  
23          Alberta?

24   A    It -- that goes up or down. Do you want an exact  
25          number today or just an estimate?

26   Q    Is it greater than 1100?

1     A     Yes, it is, and it would have been, at the time, it  
2           would have been 1150 to 1180.

3           MR. KITCHEN:                   Those are all my questions.

4           THE CHAIR:                    Thank you, Mr. Kitchen. I'll  
5           ask, Mr. Maxston, if you have any questions in redirect  
6           for Dr. Halowski?

7           MR. MAXSTON:                 Mr. Chair, I do, I have a few,  
8           but I wonder if we could just take maybe a 10-minute  
9           break; I just need to go through my notes and organize  
10          my questions a little bit.

11          THE CHAIR:                    Okay, it's 10:00. I think  
12          that's a good idea. Let's come back, we'll give you 15  
13          minutes, Mr. Maxston, so we'll reconvene at 10:15.  
14          We'll take a recess for now and see everybody in 15  
15          minutes.

16          (ADJOURNMENT)

17          THE CHAIR:                    The hearing is back in  
18          session, and, Mr. Maxston, it's your opportunity for  
19          any redirect with respect to Dr. Halowski.

20          MR. MAXSTON:                 Yeah, I have about maybe five  
21          or six questions for Dr. Halowski. It will be pretty  
22          brief.

23          Mr. Maxston Re-examines the Witness

24     Q     MR. MAXSTON:                 Mr. Kitchen engaged you in a  
25           discussion about chiropractors, and his statement to  
26           you was chiropractors don't generally work with

1 patients with infectious illnesses, and your response  
2 was I believe that chiropractors are not a primary  
3 treatment for those types of patients.

4 When it comes to COVID though, chiropractors don't  
5 know whether a patient is or isn't infectious, even if  
6 they're coming to you for an adjustment for their back;  
7 is that correct?

8 A That is correct. We do have the screening questions as  
9 part of our thing, because we were concerned, right  
10 from the get-go, with chiropractors trying to triage  
11 patients coming in with infections that they shouldn't  
12 be in the clinic in the first place, and then we were  
13 concerned that practitioners may try and triage their  
14 symptoms and go, Well, this sounds like a cold or this  
15 sounds like something else.

16 So we were very prescript to begin with and had  
17 maintained that for the duration of the pandemic that  
18 those screening questions are important in part of the  
19 consideration of whether it would be safe to provide  
20 care at that time and --

21 Q And -- sorry.

22 A Sorry. Or have that patient in the clinic environment.

23 Q Is it fair to say --

24 MR. KITCHEN: Mr. Maxston, that was a  
25 leading question, and this is a redirect. So if  
26 there's any more leading questions, I am going to

1 object.

2 MR. MAXSTON: Sure.

3 Q MR. MAXSTON: Dr. Halowski, patients can be  
4 asymptomatic when they attend, asymptomatic for COVID  
5 when they attend at a chiropractor's clinic?

6 A That is correct.

7 Q I'll take you to a discussion you had with Mr. Kitchen  
8 where he commented that the Pandemic Directive contains  
9 no requirements for patients to mask. You don't have  
10 jurisdiction over patients, do you?

11 A Correct.

12 MR. KITCHEN: I object to that; it's  
13 leading.

14 Q MR. MAXSTON: Oh, I'm sorry, I'll rephrase  
15 that. Does the College have jurisdiction over  
16 patients?

17 MR. MAXSTON: You're quite right,  
18 Mr. Kitchen.

19 A We have no jurisdiction over patients. We regulate  
20 chiropractors.

21 Q MR. MAXSTON: Would the CMOH orders enforce  
22 a time that required patients to mask?

23 A Yes, there was times where either municipalities and  
24 CMOH orders required masking.

25 Q For patients?

26 A For patients, for the public, which patients are a part



1 of.

2 Q Including Dr. Wall's patients?

3 A Including Dr. Wall's patients.

4 Q Mr. Kitchen took you through a part of the PPE section  
5 of the Pandemic Directive and mentioned that it said  
6 nothing about the chiropractor having a human rights  
7 concern. Do you recall last week, last Thursday, when  
8 I took you through the Chiropractic College notices,  
9 Exhibits C-1 to C-22?

10 A I do remember.

11 Q Are there comments in those notices --

12 A I could review and look off the top of my head. I am  
13 not sure. I do know, if that's what I -- you would  
14 like me to do, I can definitely look through and give a  
15 quick look about that.

16 Q My question was going to be --

17 MR. KITCHEN: Mr. Maxston --

18 Q MR. MAXSTON: -- were chiropractors invited  
19 to contact the College if they had questions or  
20 concerns?

21 MR. KITCHEN: Mr. Maxston --

22 A Oh, yes.

23 MR. KITCHEN: -- you asked that in direct,  
24 okay, last Thursday, okay? So this is not new, and  
25 redirect is for new issues and --

26 MR. MAXSTON: Well, you raised the human

1 rights concern, Mr. Kitchen, and I'm responding to  
2 that.

3 MR. KITCHEN: Okay, but then the question's  
4 going to have to be phrased to be specifically dealing  
5 with the human rights concern that I raised in cross,  
6 not going back and re-asking the same question you  
7 asked last Thursday.

8 Q MR. MAXSTON: Well, I'll ask another  
9 question. Dr. Halowski, could a chiropractor contact  
10 the College about a human rights concern?

11 A At all times, chiropractors were able to contact the  
12 ACAC.

13 Q Dr. Halowski, you engaged in a discussion with  
14 Mr. Kitchen and his reference to I think a generally  
15 accepted principle of, first, do no harm; do you recall  
16 that?

17 A I remember that.

18 Q Who does the "harm" refer to in that, first, do no  
19 harm?

20 A That would be in consideration of the patient, that our  
21 plans and our treatment is specifically around ensuring  
22 that the care we're providing is safe, that our -- how  
23 we're providing that we're making those considerations  
24 that patients can, one, in our treatment be safe but  
25 also in the environment we provide that they're safe.

26 Q And what was the College's determination about

1 practitioners not masking?

2 A The determination, based on the guidance from Public  
3 Health and the evidence that we had in making those  
4 decisions, was that masking posed a risk to the public  
5 because there was the risk for transmission from the  
6 practitioner to the patient if the practitioner was not  
7 masked inside of that 2 metres distance.

8 Q Okay. Thank you for that. Mr. Kitchen asked you a  
9 question, and I'll paraphrase here, does the College  
10 expect chiropractors to prioritize the health of  
11 patients above all other priorities. Why does the  
12 College create Standards of Practice or Code of Ethics?

13 A Standards of Practice and Codes of Ethics, look, the  
14 Standards of Practice represent the minimal acceptable  
15 level of performance for our practitioners in  
16 delivering care. It's meant to provide that framework  
17 so that the obligations for the practitioner is spelled  
18 out that the public knows what they're reasonably going  
19 to receive when they receive care. It makes  
20 considerations for public and patient safety in the  
21 provision of care.

22 And Code of Ethics represents the conduct or the  
23 ethical conduct that's expected out of regulated  
24 members of the chiropractic profession in Alberta.

25 Q You engaged in a discussion with Mr. Kitchen about his  
26 comment or question that preventing public harm is

1       above the reputation of the profession. I just want to  
2       be clear, where does the reputation of the profession  
3       come into the College's functions?

4       A   The way that -- the reputation of the profession is  
5       paramount. Practicing in a safe way is how we protect  
6       that. If we made decisions that put the public at  
7       risk, that would damage the reputation of the  
8       profession.

9               And that also comes in in the reputation of the  
10       profession in the way that council deliberates and  
11       discusses. Our council currently is comprised of 25  
12       percent public members, 75 percent practitioners. That  
13       is going to be expanding to 50/50 representation once  
14       the Government's provided enough public members of  
15       council.

16              But that reputation -- and reputation is based on  
17       the idea that, you know, the College is providing a  
18       safe way, and we've spent a considerable amount of  
19       effort to ensure that things like advertising have been  
20       in line -- you know, and that's significant because  
21       some of the things that members of our profession say  
22       publicly have and potentially damaged the profession in  
23       Alberta, have damaged it in other provinces, and so the  
24       reputation is really, really key, and we do that by  
25       regulating the members to practice safely and practice  
26       within the guidelines of what we're given to do under

1 the Health Professions Act.

2 Q I just have one final question. You talked with  
3 Mr. Kitchen about the initial phone discussion you had  
4 with Dr. Wall I think in early March of last year, I  
5 might have the date wrong, my apologies, but it was --

6 A December last year.

7 Q Pardon me, thank you --

8 A Oh, sorry, March was the one that I had with you,  
9 Mr. Maxston, but December was the one I had with Mr. --  
10 or was the email that I had with, prior to the  
11 pandemic, with Dr. Wall, and December 2nd was the  
12 conversation after we became aware that he was not  
13 masking in his practice.

14 Q Yeah, and I'm referring to that December 2 --

15 A Yeah.

16 Q -- conversation, and I think a difference of opinion or  
17 a different recollection that Mr. Kitchen explored with  
18 you between your recollection of that conversation and  
19 what Dr. Wall's anticipated testimony is. During your  
20 phone conversation with Dr. Wall, did you explain the  
21 risks to him of not complying with the Pandemic  
22 Directive?

23 A I did. I said, realistically, if he's not willing to  
24 comply, I would have to refer him to -- on to the  
25 Complaints Director and make the Complaints Director  
26 aware, and the Complaints Director would -- may

1 proceed.

2 And we -- I am very specific with that in my  
3 language, and we don't use -- I can't determine the  
4 outcome of something ahead of time, but I do inform  
5 members that this may happen. So, for instance, you  
6 may be suspended, you may not be able to practice, you  
7 may -- all of those would be the language. So those  
8 would have been the warnings provided to Dr. Wall in  
9 that phone conversation, that if we proceeded down this  
10 path, those are things that may happen or could happen  
11 as a result of his decision to not wear a mask.

12 MR. MAXSTON: Those are all my questions,  
13 Mr. Chair.

14 THE CHAIR: Okay, do Members of the  
15 Tribunal have any questions for Dr. Halowski?

16 MR. MAXSTON: Mr. Chair, I don't mean to  
17 tell you what to do, but do you need a break to canvass  
18 that? I don't know if you had done that before.

19 THE CHAIR: I am going to see if we do  
20 need a break. I actually may have a question, so I  
21 think we will recess for a couple of quick minutes just  
22 to check on if there's any further questions for you,  
23 Dr. Halowski, so please bear with us. If we could put  
24 the members of the Hearing Tribunal into a break-out  
25 room. Thank you.

26 (ADJOURNMENT)

1 THE CHAIR: We're back in session. The  
2 Hearing Tribunal has discussed the testimony of  
3 Dr. Halowski, and a couple of questions have come to  
4 mind, and I will ask Dr. Aldcorn to present these  
5 questions to Dr. Halowski.

6 The Tribunal Questions the Witness

7 Q DR. ALDCORN: Thank you. Dr. Halowski, you  
8 referred to the ThoughtExchange as an opportunity for  
9 members to perhaps share, discuss concerns that they  
10 had. My question for you is that ThoughtExchange  
11 anonymous?

12 A It is anonymous, yeah, we don't keep a record of  
13 anybody. The only thing that shows up in a  
14 ThoughtExchange is IP addresses, but we don't keep a  
15 record of anybody's personal IP address, and so we  
16 don't know who is there or who is commenting. We  
17 assume, because it's distributed to members, that it's  
18 regulated members of the profession in Alberta.

19 Q Thank you. And the second question I have is just a  
20 quick comment that was made by you on Thursday, and you  
21 had commented, we were going through the Alberta Health  
22 Services G-3 personal protection report, and you had  
23 commented that, at some point, you had reached out to  
24 Alberta Health Services to find out if there was any  
25 exceptions, but my question to you is just when did  
26 that happen?

1     A     That would have been in and around the fall.  Actually  
2           we started speaking about PPE with Alberta Health I  
3           would say in August, and part of that was driven at the  
4           time because we started hearing reports of members that  
5           didn't have eye protection being required to isolate,  
6           which wasn't in our practice directive.

7           And when they had originally issued the practice  
8           directive, they said masking would be adequate, and  
9           then we saw this shift in what was being communicated.  
10          So I continually tried to inquire around there and  
11          looking for guidance and, specifically, was eye  
12          protection required for our profession.

13          And then we did have one member of our profession  
14          last -- who's on mat. leave and, last summer, inquiring  
15          about, you know, they were finding it increasingly  
16          difficult to practice while pregnant and wearing a  
17          mask.  And so, you know, we were looking for ways, and  
18          the same guidance was given, that there isn't a safe  
19          way for you to provide care to a patient without a mask  
20          within 2 metres.

21     Q     So that was August approximately you would say?

22     A     That member, I would say about August, because I think  
23           they're just getting ready to come back to practice  
24           now.

25           DR. ALDCORN:                    Thank you, that's all I have.

26     Q     THE CHAIR:                    And just to follow up,



1 Dr. Halowski. You said it started in August. This was  
2 an exchange of consultation?

3 A Yeah, we continued consultation until December, when  
4 Alberta Health said that they wouldn't provide any  
5 guidance on the requirement for the eyewear, so we did  
6 make the -- and that's why we only ever made the  
7 recommendation; there was no indication it would be a  
8 requirement for practitioners to wear eyewear.

9 And for context, other professions had at the  
10 time, but we had not.

11 THE CHAIR: Thank you. Thanks,  
12 Dr. Halowski.

13 I would ask counsel, are there any questions  
14 arising from these most recent responses? None.

15 Okay, Dr. Halowski, thank you very much for your  
16 testimony over the past two days. Your presence here  
17 is no longer required, and we very much appreciate your  
18 expertise, and you can leave at this time.

19 A Thank you very much, Mr. Chair. I do appreciate the  
20 opportunity to have spoken, and for the care and  
21 concern and attentiveness of the Hearing Tribunal, as  
22 well as Mr. Maxston and Mr. Kitchen in their  
23 questioning as well. So thank you for the opportunity  
24 to be here as a witness for this Tribunal.

25 THE CHAIR: Okay.

26 (WITNESS STANDS DOWN)

1 Discussion

2 THE CHAIR: Mr. Kitchen, we were just  
3 hearing from Mr. Maxston that Mr. Lawrence will require  
4 5 minutes just to get himself set up computer-wise  
5 prior to his starting his direct, so if we could just  
6 ask people to hold. I think -- it's quarter to 11; is  
7 5 minutes enough?

8 MR. MAXSTON: I think so, Mr. Chair, and, of  
9 course, Mr. Lawrence will be on the screen when he's  
10 ready to go, but I think that will be fine.

11 I'll just mention as well, I see that Dr. Halowski  
12 is no longer with us, but, of course, since his  
13 testimony is finished, he's free to listen in for the  
14 remainder of the hearing if he wants to. I don't see  
15 him here, but he may join us at some time.

16 THE CHAIR: Yes, I think, in fact, that  
17 might happen, but in any event. Okay, well, we'll just  
18 ask everybody to stay on mute and hold until David  
19 Lawrence is ready, and then we will continue with his  
20 direct examination.

21 MR. KITCHEN: Mr. Maxston, can I just ask  
22 you about timelines?

23 MR. MAXSTON: Yeah, that's a good question.  
24 I anticipate probably being about an hour-and-a-half  
25 with Mr. Lawrence. So I would think I'd be going maybe  
26 a little bit into the lunch hour, or we'd break at

1 noon, and then I resume after lunch and, of course,  
2 won't be talking to Mr. Lawrence about his testimony.

3 I don't know how long you anticipate being. And I  
4 should be candid, I may be longer with Mr. Lawrence,  
5 just depending on how things go.

6 I don't know, Mr. Kitchen, what your thoughts are  
7 about starting Dr. Wall's -- I believe that's your  
8 witness, as my case will be closed. I don't know what  
9 your thoughts are about starting with Dr. Wall today or  
10 whether you'd prefer to start with him tomorrow.

11 MR. KITCHEN: I'd prefer to start with him  
12 tomorrow just because I do think I'm going to be quite  
13 a while, I imagine you're going to be quite a while.  
14 And I know from experience the last couple days,  
15 particularly with Dr. Halowski, you went quite long, I  
16 have no issue with that, but you went on for a while,  
17 and then -- because I fully expected to do the cross,  
18 and then we just cut into the afternoon, and we ran out  
19 of time.

20 So, you know, I thought a realistic goal today was  
21 the direct of Mr. Lawrence, my cross, and then we'd  
22 probably be done 3, 3:30, 4, 4:30, somewhere around  
23 there. That was what I thought was realistic for  
24 today, so -- and I'm flexible about lunch, because I  
25 know if you don't want to break that up with him, and  
26 we're -- and we don't lunch till 12:30, 12:45, that's

1 fine with me.

2 MR. MAXSTON: Maybe we can just see where we  
3 get and invite comments from the Chair and the Tribunal  
4 Members. Oh, and Mr. Lawrence is just going into  
5 another room now.

6 I'm thinking as well, and I'm not going to, of  
7 course, hold you to this, Mr. Kitchen, do you have any  
8 sense about how long you'll be with Dr. Wall? Because  
9 I'm going to be a while with him, and I don't know if I  
10 want to start my cross-examination, let's say, at 2:00  
11 tomorrow and leave it hanging. I want to use our time  
12 as effectively as possible. Having said that, maybe  
13 you can just give me a sense of what you think our day  
14 might look like tomorrow while we're on a break here.

15 And maybe we can ask -- we can go off the record,  
16 so Madam Court Reporter doesn't have to be --

17 MR. KITCHEN: I -- yes --

18 MR. MAXSTON: -- taking this down.

19 MR. KITCHEN: -- let's do that.

20 (DISCUSSION OFF THE RECORD)

21 THE CHAIR: Thank you very much.

22 Mr. Lawrence, we will turn you over to  
23 Mr. Maxston, but, first, I would ask that you be sworn  
24 in as a witness, and our court reporter will take you  
25 through that process.

26 DAVID LAWRENCE, Affirmed, Examined by Mr. Maxston

1 MR. MAXSTON: Give me one minute, Mr. Chair,  
2 I just have to locate a document. Thank you,  
3 Mr. Chair.

4 Q MR. MAXSTON: Good morning, Mr. Lawrence. I  
5 understand that you're the Complaints Director for the  
6 College. Can you tell me since when you've occupied  
7 that position?

8 A I am the Complaints Director since March of 2020.

9 Q And can you briefly describe your employment history or  
10 professional background before coming to the College?

11 A So educationally, I hold a Masters in Business  
12 Administration from Athabasca University, I have  
13 certification in Business and Human Resources from the  
14 University of Alberta, and I've spent 25 to 30 years in  
15 the management field in both public and private  
16 businesses.

17 Q Thank you, Mr. Lawrence.

18 MR. MAXSTON: Mr. Chair and Hearing Tribunal  
19 Members, for your benefit, I'm going to be asking  
20 Mr. Lawrence questions in three areas. The first area  
21 will be general questions about the College and its  
22 regulatory functions in the context of the Complaints  
23 Director's duties. The second area will be to, very  
24 briefly, review the two primary CMOH orders we've been  
25 talking about and, very briefly, review the Pandemic  
26 Directive. The third area I'll be asking questions on

1 is his involvement in terms of the Section 56 complaint  
2 that he made, the investigation, and the referral to  
3 hearing.

4 Q MR. MAXSTON: So I'll just go to the first  
5 area of my questions then, Mr. Lawrence, can you  
6 generally describe the College's regulatory function?

7 A Certainly. So under the Health Professions Act, the  
8 College duties set out by council is to establish Codes  
9 of Ethics, Standards of Practice, policies, directives  
10 for members to follow. And as part of the Complaints  
11 Director, my role is to hold members accountable when  
12 there are breaches of compliance.

13 So when standards, Codes of Ethics, or the HPA is  
14 not complied with, then my role is to, under Part 4 of  
15 the HPA, is to take appropriate action and -- rather,  
16 open, and if that is a complaint, an investigation,  
17 referral to hearing, whatever action that's required  
18 under the HPA.

19 Q Okay, thank you for that. I'll just get back and go  
20 back to the College's regulatory function. Are you  
21 familiar with Section 3 of the Health Professions Act?

22 A I am.

23 Q Can you tell me what that says, and I'll just ask you  
24 to tell me what that says?

25 A So under Section 3, it talks about the regulation of  
26 health professions; they're governed by legislation by

1 Codes of Ethics, by Standards of Practice, the  
2 directives that are set by government or the governing  
3 bodies; and in the ACAC's case, that's the ACAC  
4 council.

5 Regulated health professionals are mandated to  
6 comply with the section when delivering health services  
7 to patients. And certainly for any medical  
8 professional, it is about compliance and protecting the  
9 public from harm. And, you know, the most important  
10 thing is there is mandated compliance; it is not a  
11 question for members whether they do comply or not.

12 Q You spoke a little bit before about your role as  
13 Complaints Director and the handling of complaints.  
14 Are you familiar with Section 55 of the Health  
15 Professions Act?

16 A I am.

17 Q Can you tell me what that says in terms of your role as  
18 Complaints Director?

19 A Under Section 55 of the HPA, it lays out the  
20 responsibilities of what can and can't be acted on when  
21 a complaint is opened. So it talks about, you know,  
22 after you treat something as a complaint, there's a  
23 30-day window in which to notify the members, notify  
24 the member of the action being taken, and then lays out  
25 the options available to the Complaints Director in  
26 managing a complaint.

1 Q I'm going to turn now to the second area of my  
2 questions for you, and I'm going to just very briefly  
3 take you through the CMOH orders. Are you generally  
4 familiar with Exhibits D-8 and D-9, which are CMOH  
5 Orders 38-20 and 42-20?

6 A I am.

7 Q Can you tell me, generally, what your understanding is  
8 of those CMOH orders?

9 A So in the -- the CMOH Order 38-2020 talked about the  
10 private social gatherings, talked about the masking,  
11 and talked about the areas of the province in Section  
12 21, which was the Calgary metropolitan area, and the  
13 requirements for masking. It went on to the Edmonton  
14 area and talked about face masking.

15 Q And I'll talk with you about this in a little more  
16 detail in a few minutes, but you're aware of an  
17 exemption under paragraph 27(c)?

18 A I am.

19 Q When it comes to CMOH Order 42-20, can you tell me what  
20 your understanding of that order is? And that's  
21 Exhibit D-9.

22 A So under 42-20, Section 5 is appropriate to this, talks  
23 about masking as well, and the requirement for masking,  
24 as the previous order did.

25 Q So we talked about the exemption in CMOH Order 38-2020.  
26 There's a similar exemption, it might be word for word,



1 in paragraph 24(c) of CMOH Order 42-20, and it speaks  
2 of medical conditions.

3 When you were determining -- I'll get to this in  
4 greater detail in a few minutes -- but when you were  
5 determining what action to take concerning this  
6 complaint, did that exemption apply to Dr. Wall?

7 A I didn't feel so at the time. The -- I didn't -- I  
8 didn't believe Dr. Wall had an exemption, at least none  
9 was provided to the College. And also I do think that  
10 there was never an expectation for exemptions for  
11 medical health professionals, especially in close  
12 contact with patients. And the chiropractors are in  
13 very close contact with them during treatment, and so I  
14 don't think this exemption would apply in this case.

15 Q Mr. Lawrence, I'm going to take you, again very  
16 briefly, to the College's Pandemic Directive, and,  
17 again, I'm going to use the January 6, 2021 one as the  
18 reference document.

19 Can you tell me what your understanding was of the  
20 Pandemic Directive in terms of requirements on relating  
21 to chiropractors and how they would practice?

22 A So when the Pandemic Directive was initiated, the  
23 profession was closed -- or, sorry, shut down for  
24 practice except for emergency situations only. And  
25 when Public Health enabled chiropractors to return to  
26 practice, part of the expectation was that there would

1 a Pandemic Directive in place approved by Public  
2 Health, and so the Pandemic Directive was established  
3 so that chiropractors could return to practice in a  
4 safe manner to protect the public.

5 In regards to the masking, the PPE requirements  
6 were clear that chiropractors and clinic staff must be  
7 masked at all times while providing patient care, and  
8 so the masking requirement was very clear as part of  
9 the re-opening strategy to allow chiropractors to  
10 return to practice.

11 Q Dr. Halowski commented on the Pandemic Directive  
12 extensively, so I'm not going to take you through this  
13 in any great detail, but were there requirements for  
14 social distancing and plexiglass barriers?

15 A There were. And I should say for plexiglass barriers  
16 that was for, you know, clinic staff if they weren't  
17 masking.

18 Q Did the Pandemic Directive contain an exemption for  
19 masking when a chiropractor was providing patient care  
20 and was within 2 metres?

21 A It didn't provide any exemption for there. It gave  
22 some options for other modalities of care but not a  
23 direct exemption when you're within the 2 metres, no.

24 Q And to your understanding, why was there no exemption?

25 A The close proximity that chiropractors have with their  
26 patients at times is -- puts them in close contact and

1       can be a -- can cause transmission of the COVID-19  
2       pandemic.

3               So similar to, you know, your dentist working  
4       around your mouth, chiropractors are very close, face  
5       to face. They can be very close to their patients, and  
6       so for patient safety, the masking was required.

7   Q   So I'll go to the third area now that I want to ask you  
8       questions about, and that is your involvement in terms  
9       of the complaint relating to Dr. Wall, and I'll ask you  
10      to go to Exhibit A-3, which is a December 2, 2020  
11      letter to you from Dr. Halowski.

12   A   Okay.

13   Q   I'll just wait a minute to make sure all the Tribunal  
14      Members have located that, and it's Exhibit A-3.

15       MR. MAXSTON:                    So, Mr. Chair, I'll just  
16      continue then.

17   Q   MR. MAXSTON:                    Mr. Lawrence, can you tell me  
18      when you received this letter?

19   A   So this was referred to me from the Registrar, dated  
20      December 2nd, and the Registrar said sent this to me as  
21      the Complaints Director.

22   Q   And I'd like to ask you to go to Exhibit A-5, which is  
23      your December 21, 2020 letter to Dr. Wall.

24   A   Okay.

25       MR. MAXSTON:                    Let everyone catch up and make  
26      sure we're there, that we're all on that same document.

1 Q MR. MAXSTON: So, Mr. Lawrence, the opening  
2 paragraph refers to Section 56 of the HPA. Can you  
3 tell me what that paragraph means?

4 A So under Section 56 of the HPA, if information is  
5 received by the Complaints Director that is deemed to  
6 be a complaint when there is no -- if there is no  
7 complainant, the Complaints Director can open a  
8 complaint and become the de facto complainant under  
9 this section.

10 Q And is that what happened here?

11 A It is.

12 Q If you look at paragraph 2, can you just explain the  
13 first sentence?

14 A So on the referral from the ACAC Registrar, so the  
15 Registrar sent me the December the 2nd letter. We  
16 received information that Dr. Wall was in breach of  
17 CMOH orders and the Standards of Practice, as well as  
18 the COVID-19 Pandemic Practice Directive, and that  
19 Dr. Wall would not be taking steps to come into  
20 compliance, so I had treated that as a complaint and  
21 opened the Complaint Number 20-20 under Section 56 of  
22 the HPA.

23 Q The second sentence in that paragraph says, and there's  
24 a question coming: (as read)

25 On December 2, 2020, you advised the  
26 Registrar, and on December 3, 2020, advised

1           the Complaints Director that you would not be  
2           taking steps to become compliant with these  
3           requirements.

4           And those requirements are the COMH orders and  
5           Standards of Practice as mentioned above.

6           There's a reference to a December 3, 2020  
7           communication or interaction between you and Dr. Wall;  
8           can you tell me what happened there?

9    A    So after I received a referral from the Registrar, I  
10       called Dr. Wall to discuss the issue with him, and I  
11       let him know that this would be proceeding to a  
12       complaint and certainly, I'm sure we'll get to it, a  
13       request under Section 65.

14       And Dr. Wall had asked me if there was sort of any  
15       alternatives to that, which I let him know that he  
16       certainly, you know, could start complying and begin  
17       masking. And we had discussed the information that was  
18       received from Alberta Health about the discussion he  
19       had had with Heidi Ho.

20    Q    What did he say about any steps he was taking to comply  
21       with the CMOH orders?

22    A    He said, at that time, that he had an exemption, and he  
23       also said that, you know, the -- it's just -- it's like  
24       the flu or words to that effect, and either the  
25       recovery rate or the survival rate was I think he said  
26       99 percent, but I'm not quoting directly.

1 Q Did he indicate whether he was masking?

2 A He said he was not.

3 Q Did he --

4 A And --

5 Q -- indicate whether -- oh, I'm sorry, go ahead.

6 A Yeah, he said he had tried originally and had feelings  
7 of anxiety and claustrophobia, and that he felt he was  
8 exempt from it.

9 Q Did he mention any other reasons for not masking at  
10 that time?

11 A I don't believe he did. I think he might have  
12 mentioned about human rights in that call, but like it  
13 was more about the low risk of COVID and that he was  
14 exempt.

15 Q Did he say anything about his staff masking?

16 A I think he had said -- no, I don't have a recollection  
17 of that, sorry, no.

18 Q Did he say anything about observing social distancing,  
19 the 2 metre requirement?

20 A He did not.

21 Q Did he say anything about his use of plexiglass  
22 barriers?

23 A Not that I recall, no.

24 Q I'm going to stop here, because you are -- pause for a  
25 second, because, as you alluded to, there's a bunch of  
26 things that are happening now in conjunction with the

1 complaint itself. We've talked about your choice to  
2 rely on Section 56 to initiate a complaint.

3 The second thing that was happening was also the  
4 Section 65 interim suspension request. Can you explain  
5 what Section 65 is, what it's designed for?

6 A So under Section 65 of the HPA, if there is a -- if the  
7 Complaints Director believes that there is a risk to  
8 the public, they can make application for a suspension  
9 of practice permit or restrictions placed on the  
10 practice of the member.

11 Q Sorry, Mr. Lawrence, I was just reaching for a document  
12 there.

13 I'll ask you to go to Exhibit B-1, as in Bob dash  
14 one, and that is a December 3, 2020 letter to a  
15 Dr. Linford.

16 A Yes.

17 Q And I'll just make sure everybody on the Tribunal has  
18 skipped ahead to B-1.

19 So can you explain to me who Dr. Linford is?

20 A So part of council's role is to identify and nominate  
21 people who can hear -- or members of the profession who  
22 can hear these types of requests and make decisions  
23 with legal counsel when these are provided, so  
24 Dr. Linford was one of the members that had been  
25 appointed by council to hear these requests.

26 Q Okay, and what are you asking for from Dr. Linford?

1     A     So in the Section 65 request, I asked for an interim  
2           suspension of the practice permit until the completion  
3           of the complaint process.

4     Q     And why were you asking for an interim suspension?

5     A     Because I believed that there was a danger to the  
6           public for members to practice in close proximity  
7           without a mask as outlined by Public Health at that  
8           time.

9     Q     I'll take you to the second page of the letter, and  
10           there's a Section entitled "Background".

11    A     Yes.

12    Q     And there's a couple of arrows that are indented. Can  
13           you explain what the background information is in those  
14           arrows?

15    A     So at the time, there was no plexiglass barrier at the  
16           reception area, and the staff were not masking. And so  
17           in the Pandemic Directive, if people come in that if  
18           they breach the 2 metre distance, other clinical staff,  
19           they are to be masked or have a barrier protecting or  
20           separating them from the patients.

21           And the other point is that Dr. Wall was not  
22           masking during patient treatment even though he's in  
23           close proximity to his patients.

24    Q     There's a paragraph a couple of -- well, I'll skip a  
25           paragraph and go to the next one, it says: (as read)

26           In my view, Dr. Wall was in violation.



1 Can you tell me what violation you were concerned about  
2 there?

3 A So in regards to the Pandemic Directive, when --  
4 without masking, there were I believe Standards of  
5 Practice and Codes of Ethics that were being breached,  
6 as along with the Pandemic Directive, and so that's  
7 what that refers to.

8 Q There's a second sentence in that paragraph that  
9 begins: (as read)

10 If there is a medical exemption applicable to  
11 Dr. Wall.

12 Can you tell me what you're saying there?

13 A It says: (as read)

14 If there is a medical exemption applicable to  
15 Dr. Wall, there is no requirement for him to  
16 mask in his personal activities. However, to  
17 continue in his chiropractic treatment, the  
18 pandemic protocols of the ACAC and AHS must  
19 be followed.

20 And what I meant there was, you know, in a regulated  
21 member's personal life, that's their own business and  
22 their own decisions. The compliance in my role has  
23 just to do with practice and interaction with patients.  
24 So where I don't regulate, nor where the College  
25 doesn't regulate anything outside of practice while  
26 you're practicing chiropractic, you are responsible for

1 the mandates.

2 Q There are a couple of other exhibits after that, B-3  
3 and B-4; I'll just ask you to identify those. Those  
4 are Mr. Kitchen's letters in relation to the Section 65  
5 request you made?

6 A Correct.

7 Q If we go to Exhibit B-5, there's a December 18, 2020  
8 letter to Dr. Wall from Dr. Linford. I'll just let  
9 everybody get caught up and be at B-5, and then I've  
10 got a couple of questions for you about that document.

11 So is this Dr. Linford's decision letter  
12 concerning your Section 65 request?

13 A It is.

14 Q On page 2, it's the third complete paragraph, it begins  
15 with "I have decided"; can you tell me what  
16 Dr. Linford's decision was ultimately?

17 A So Dr. Linford decided that, at that time, the  
18 suspension wasn't justified, and he instead decided to  
19 put conditions on Dr. Wall's practice permit to try to  
20 address the risk to the public.

21 Q Can you tell me what the -- I think there are four  
22 numbered orders, can you tell me what those orders were  
23 that Dr. Linford made?

24 A So number 1 was that Dr. Wall was to inform each client  
25 or patient that he sees that Dr. Wall has a medical  
26 exemption from the Public Health order that all persons

1 in a public place must wear a face mask.

2 He also ordered that Dr. Wall should obtain  
3 written confirmation that each patient would sign and  
4 the patient agrees to be seen and treated by Dr. Wall  
5 without wearing a face mask or a face shield, and that  
6 copies of those would be sent to the Complaints  
7 Director, to me, by 5 PM on Friday of each week, and  
8 that this stays in effect until the public order and  
9 face masks are in effect.

10 Number 2 talked about Dr. Wall directing any staff  
11 person assisting in his office, whether that's a  
12 volunteer, paid or unpaid, that they also comply with  
13 the current orders and that physical barriers must be  
14 up, social distancing must be adhered to, or they wear  
15 a face mask. The -- and then if anybody brings in an  
16 exemption for that, Dr. Wall was to consult with  
17 Alberta Health.

18 Dr. Wall was to maintain a log of screening  
19 questions asked and answered by all patients and daily  
20 screening of his staff and himself. And in the event  
21 that Dr. Wall has any symptoms or answers positively to  
22 screening questions, he would not see patients.

23 Q To your knowledge, did Dr. Wall comply with those  
24 orders?

25 A To my knowledge, he did.

26 Q So I'm going to ask you specifically, he was to send

1       you written confirmation by 5 PM on Friday of each week  
2       about certain matters. Did you receive written  
3       confirmations weekly?

4     A    I did by email.

5     Q    In terms of your statement, that you believe he  
6       complied with the other aspects of the order, on what  
7       information are you basing that?

8     A    So the -- Dr. Wall had provided pictures that,  
9       following the request from Alberta Health, the barriers  
10      were put in place in the clinic, the protective  
11      barriers. And based on the screening questions that  
12      they were -- that was also part of the information he  
13      sent to me. And as I don't have any evidence that  
14      Dr. Wall had any symptoms or was answering positively  
15      on the screening questions, then I believe he was  
16      compliant with that one as well.

17    Q    So the -- I talked with you about the fact that you  
18      initiated this Section 65 complaint. We talked about  
19      the Section 65 interim suspension request. As for the  
20      same time, there was a third thing going on, and  
21      Alberta Health Services became involved in terms of the  
22      operation of Dr. Wall's clinic; is that correct?

23    A    It is.

24       MR. MAXSTON:                   Bear with me, Mr. Chair. I'm  
25      going to ask everyone to go to Exhibit D-1, which is an  
26      AHS Order of an Executive Officer Notice of Public

1 Access Closure.

2 Q MR. MAXSTON: So, Mr. Lawrence, are you able  
3 to tell me how this came into the possession of the  
4 College?

5 A So following the information provided to Alberta  
6 Health, they also do site visits and also the Alberta  
7 Health had discussion with Dr. Wall as well and had  
8 decided that, as the practitioner at that time was not  
9 wearing a face mask and was well within 2 metre  
10 distance from the patient and that could contribute to  
11 the spread of COVID-19, they also found that staff  
12 worked at the clinic were not continuous masking, and  
13 no barriers were up, they initiated a closure order  
14 against the clinic, and shut the clinic down under  
15 the -- from the Executive Officer of Public Health.

16 Q And if we go to page 2 of that document, paragraph 2  
17 talks about: (as read)

18 The owner [meaning Dr. Wall] immediately  
19 undertake to diligently pursue completion of  
20 the following work.

21 Can you describe what Dr. Wall was supposed to do?

22 A So Dr. Wall was the practitioner, which is Dr. Wall:  
23 (as read)

24 ... must be masked when treating patients  
25 within 2 metre proximity to help prevent the  
26 spread of COVID-19; patients must be masked

1           when receiving a treatment from the  
2           practitioner; staff not working alone at the  
3           station must be masked at all times while  
4           working an indoor public space; staff working  
5           alone at a work station must also be  
6           observing physical distance, the 2 metre  
7           distance, from all other persons, otherwise,  
8           they must mask or a barrier must be up; and  
9           the complete the relaunch plan template  
10          [which is an Alberta Health document].

11    Q    And I'm just going to digress for a moment.  
12           Exhibit A-4, I don't need you to go to this, is an ACAC  
13           Notice of Closure of Clinic. Can you tell me what that  
14           document is just very briefly?

15    A    So once we received the closure order from Alberta  
16           Health, there was a statement put out to the rest of  
17           the membership about the closure of the clinic.

18    Q    So I said before, a few minutes, ago I was going to  
19           pause because there was a lot happening, and I went  
20           through three areas with you, the complaint, the  
21           Section 65 request, and AHS's involvement.

22           I'm now going to take you back to your direct  
23           involvement and specifically the investigation that was  
24           conducted under Part 4 of the HPA. Did you act as the  
25           investigator?

26    A    I did.

1 Q I'd ask you to go to and the Tribunal Members to go to  
2 Exhibit A-7, which is your investigation report.

3 MR. MAXSTON: Mr. Chair, I'll just assume  
4 that everybody is at document A-7 or is getting there  
5 very, very quickly.

6 Q MR. MAXSTON: Mr. Lawrence, did you write  
7 this report?

8 A I did.

9 Q Can you tell me when you wrote it?

10 A I'm going to say late January. I don't know the exact  
11 date, I'm sorry.

12 Q And is it your belief that it's an accurate reflection  
13 of your investigation?

14 A It is.

15 Q Okay, I'm going to ask you some questions about it. In  
16 the second paragraph of your investigation report,  
17 beginning with the phrase "On December 2, 2020",  
18 there's a reference to the discussions between the  
19 Registrar and you with Dr. Wall on December 2 and  
20 December 3, 2020. I'm not going to go through that in  
21 any greater detail, except the tail end of the  
22 paragraph. There's, about the fifth line down, there's  
23 a sentence beginning with: (as read)

24 He indicated that he thought this was a human  
25 rights violation and that he was exempt from  
26 wearing a mask.

1 Does that refresh your memory in terms of your  
2 conversation with him?

3 A Yes.

4 Q And can you tell me what he might have told you then  
5 about a human rights violation?

6 A So when he had an exemption, the -- and I had talked  
7 about initiating the Section 65 and the following  
8 complaint, he thought his -- it was his -- under the  
9 human rights that he would be allowed to continue to  
10 practice and that the College was violating this right  
11 by taking these actions.

12 Q The next sentence says: (as read)

13 He was informed that, as this was unsafe  
14 practice, it was the responsibility of the  
15 College to take action to protect the public.

16 Was it you who informed him?

17 A Yes.

18 Q The next --

19 A Oh, sorry.

20 Q I'm sorry.

21 A I think the Registrar had that discussion as well, but  
22 certainly I did, yes.

23 Q The next sentence begins: (as read)

24 He indicated that he did not believe ...

25 Can you just read that sentence, read to the end of the  
26 paragraph and then tell me what you're conveying here?



1     A     (as read)

2             He indicated that he did not believe he was  
3             endangering the public as the recovery rate  
4             from COVID is so high and asked if there  
5             could be any discussion on alternatives. He  
6             was informed that public safety is not for  
7             debate and that if he would not mask, we  
8             would proceed with a Section 65 request.

9             So as I said before, during the discussion, Dr. Wall  
10            had talked about the recovery rate from COVID, and I  
11            seem to remember it was 90, he might have even said 99  
12            percent, I can't remember exactly, but very high, and  
13            that, you know, because the recovery rate was so high,  
14            he didn't think he was endangering people.

15            And the -- in my comment was that, you know,  
16            public safety is a requirement of the College, we're  
17            mandated to follow the legislation, and that we would  
18            need to proceed to a Section 65, which is the  
19            suspension request if he didn't mask.

20     Q     The next couple of paragraphs talk about the --  
21            Dr. Salem's letter and those types of things, and I'll  
22            get to those in a few minutes, but there's a paragraph  
23            that begins: (as read)

24            On December 16th, 2020, Dr. Wall provided a  
25            follow-up letter to David Linford indicating  
26            plexiglass barriers had been installed at the

1 front counter of the clinic.

2 How did you get that information?

3 A That was sent over by Mr. Kitchen, and Dr. Wall had  
4 provided pictures of the installed plexiglass barriers.

5 Q After you had initiated the complaint, I believe you  
6 received an undated response letter from Dr. Wall, and  
7 I'm going to ask you to go to Exhibit A-6.

8 A Okay.

9 Q And I'll ask the Tribunal Members to go to A-6 as well.  
10 This is a four-page letter, so I'm not going to ask you  
11 to go through it line by line, but could you summarize,  
12 to the best of your ability, what Dr. Wall was saying  
13 to you in this letter?

14 A So it starts out where that Dr. Wall had originally put  
15 on a face mask, and he believed that it was causing him  
16 anxiety and symptoms of claustrophobia, he said he  
17 decided to wear -- or to try a face shield, and he  
18 found that the same symptoms persisted and thought that  
19 this negatively impacted his dialogue with patients,  
20 and that he had decreased concentration levels.

21 So he said: (as read)

22 After enduring this for several weeks, I  
23 decided in late June of 2020 to not wear a  
24 mask or a face shield.

25 He went on to say that in his conclusion, the Pandemic  
26 Directive could not reasonably be interpreted to demand

1 the wearing of a face mask if doing so was harmful to a  
2 member, and it negatively impacted the member's ability  
3 to provide the best patient care.

4 So he said that patients had asked him about, you  
5 know, why he wasn't masking, and he said because he had  
6 mental concerns and limitations and said that the  
7 patients were understanding.

8 He said: (as read)

9 At the time I did not think that I should or  
10 needed to obtain any sort of exemption to  
11 wearing a mask or shield such as -- from  
12 another health care practitioner such as a  
13 medical doctor.

14 He said: (as read)

15 As time progressed, it seemed to me that my  
16 decision was reasonable in the circumstance.

17 So I think as we go through, what he's saying is that  
18 he has concerns of concentration levels, he has  
19 concerns of anxiety and feelings of claustrophobia, and  
20 thought that the Pandemic Directive wasn't accurate in  
21 mandating face masks, so he made the decision to  
22 discontinue wearing one.

23 Q When you received this letter from Dr. Wall, did it  
24 cause you to change your decision about referring the  
25 matter to investigation?

26 A It did not.

1 Q Can you tell me why?

2 A I think that when I look at the requirements of the  
3 legislation, the mandates or the compliance is not a --  
4 it's not really an optional what you choose to comply  
5 with and what you choose not to comply with.

6 The legislation, the Standards of Practice, Codes  
7 of Ethics, whatever mandates under that, the  
8 chiropractors that are members of the profession are  
9 mandated to comply with them. And so what I saw here  
10 was the member deciding that he wouldn't comply, and so  
11 I didn't see anything that would prevent -- would  
12 change my mind on proceeding with the investigation.

13 Q On page 2 of your investigation report, there is a  
14 statement, it's the third complete paragraph: (as  
15 read)

16 On January 25, 2021, Dr. Wall was interviewed  
17 by David Lawrence. ACAC Complaints Director,  
18 Dr. Todd Halowski, ACAC Registrar, Dr. Wall  
19 and his legal counsel were present for this  
20 interview.

21 I'm going ask you to skip a couple pages ahead here to  
22 page 4 of your investigation report, there's a  
23 statement at the top of that page that says: (as read)

24 The key points of the interview.

25 And I'll just let everyone get to that page, again page  
26 4 of the investigation report. So when you say "The

1       key points of the interview", was that your interview  
2       of Dr. Wall that occurred on January 25?

3     A    It is.

4     Q    And again, during that interview, Dr. Wall had legal  
5       counsel present?

6     A    He did.

7     Q    Okay, I'm going to ask you to go through each of these  
8       arrows or bullets and just tell me what occurred during  
9       the interview. And I know this may be a little bit  
10      lengthy but I think it's important to get a flavour for  
11      what was going on during the interview.

12    A    Certainly. So as it indicates, the interview was done  
13      on January 25th, 2021. It was myself, Dr. Halowski,  
14      Mr. Kitchen, and Dr. Wall.

15                So we talked about that Dr. Wall said he had  
16      originally tried masking and that he had feelings of  
17      anxiety or claustrophobia and that he had also tried  
18      using a face shield but had the same feelings, and so  
19      at the end of June, he made the decision to stop  
20      masking. He said he felt the mask interfered with his  
21      concentration and his ability to interact with  
22      patients.

23                He's indicated that he felt the risk to him in  
24      wearing a mask was greater than not wearing one, as his  
25      feelings of claustrophobia and anxiety were something  
26      that he didn't want to deal with.

1           We asked him about if he had had these feelings  
2           previously, and he said he had not experienced these  
3           feelings prior to masking, he had no diagnosis of any  
4           condition, and the decision to not mask was made by  
5           Dr. Wall on how he felt and his comfort.

6           He indicated the ACAC Pandemic Directive does not  
7           give any room for exceptions, and so he made the  
8           decision to stop masking based on the feelings he was  
9           having. As he was -- as there was no exemptions in the  
10          Pandemic Directive, he talked about the CMOH orders  
11          that he was using for exemption.

12          His -- he indicated that his son was the only  
13          other person that was working at the clinic at the  
14          time, he had no other employees, and that -- yeah,  
15          since March of 2020, so during the COVID pandemic. He  
16          also indicated that he did not require his son to be  
17          masked and did not think it necessary to install any  
18          barriers. He said his son was -- completed  
19          transactions, he did not mingle with anyone and so did  
20          not think it necessary, and that his son was 17, he's  
21          young, healthy, and so he didn't think his son was at  
22          risk from COVID. He also responded that his son was  
23          not able to maintain physical distance at all times.

24          Dr. Halowski asked Dr. Wall if his son was  
25          provided the opportunity to mask, and Dr. Wall  
26          reiterated that he was a healthy individual and that he

1 did not want to wear one. When asked if he was  
2 presented with the facts and varying points about  
3 COVID, Dr. Wall indicated he was aware that he told his  
4 son about the Pandemic Directive.

5 When talking about compliance with the Standards  
6 of Practice or the Codes of Ethics, Dr. Wall indicated  
7 that the only area he believes he did not comply with  
8 was the ACAC Pandemic Directive. He believes it is  
9 unreasonable not to provide exceptions to allow him not  
10 to mask with his patients, and he indicated that he had  
11 a medical note regarding his mental limitation and  
12 concern.

13 Dr. Wall further indicated that under CMOH Order  
14 38-2020, there is an exemption to mask wearing that he  
15 used to discontinue wearing a mask. Dr. Wall had  
16 indicated he stopped masking in June, and his medical  
17 exemption he did not get till December of 2020 from  
18 Dr. Salem.

19 The same order also indicates that physical  
20 distance must be maintained, so further down in the  
21 "Exceptions to masking", it does indicate that the 2  
22 metre barrier must be maintained.

23 When we talked if Dr. Wall had talked to his  
24 patients about the dangers of him not being masked, he  
25 replied that people are aware of the dangers, and he  
26 did not need to explain any of the dangers to the

1 patients from him not masking. And Dr. Wall said that  
2 the people he sees, they either understand they are at  
3 high risk of getting COVID or they are not at risk. He  
4 said people fill out the screening questions, and if  
5 they answered "no" were considered low risk.

6 Dr. Wall stated that the feelings of anxiety he  
7 experienced were the only reasons that he chose not to  
8 mask, and there are no other reasons that he does not  
9 mask.

10 Dr. Wall discontinued masking in June, however,  
11 did not get a medical exemption until December 2020  
12 when the public closure order was given. During that  
13 time, he sought no treatment for his condition,  
14 provided no communication to the ACAC and has no  
15 charting to show that he was advising patients of the  
16 risk they were facing by seeing an unmasked doctor.  
17 Dr. Wall indicated that he made the decision to stop  
18 masking due to the feelings of anxiety he was having.

19 Q I'll just ask you a couple of questions. During this  
20 interview with Dr. Wall, did he mention any objections  
21 to masking about his religious beliefs?

22 A He did not.

23 Q Did he mention anything, and we may have covered this,  
24 did he mention any about whether he thought masks  
25 weren't medically effective against spreading COVID?

26 A No.



1 Q Did he discuss whether he thought masks were or weren't  
2 necessary?

3 A He said that -- he said that he thought that they  
4 interfered with his ability to concentrate, and that he  
5 felt that it was giving him anxiety and claustrophobia  
6 but not unnecessary, no.

7 Q Okay, I'm going to switch gears a little bit here, and  
8 ask you about the letters from Dr. Wesam Salem. They  
9 are referenced -- this is referenced in your  
10 investigation report on page 3. So again the  
11 investigation report is Exhibit A-7, and page 3 has a  
12 heading "Dr. Wesam Salem".

13 MR. MAXSTON: And I'll just get everybody to  
14 turn to that.

15 Q MR. MAXSTON: At the same time, I'm going to  
16 ask you a question about Exhibit A-8, which is  
17 Dr. Salem's December 12, 2020 letter to Dr. Wall. So  
18 I'll just ask you, how did you get Exhibit A-8, the  
19 letter from Dr. Salem?

20 A So this was provided by Dr. Wall.

21 Q And do you remember roughly when it was provided to  
22 you?

23 A I think it was shortly after the date that it was dated  
24 on the letter.

25 Q And it's quite brief, so I'll ask you what does the  
26 letter say?

1     A     The letter is dated December 12, 2020, and it says:  
2           (as read)

3           To whom it may concern, this letter serves to  
4           confirm that I have assessed Mr. Curtis Wall  
5           in my office today. Please be advised that  
6           due to medical reasons, he has been deemed to  
7           be exempt from mask wear and the use of a  
8           face shield.

9     Q     When you saw that letter, how did you respond to it?

10    A     I sent a follow-up request to Dr. Salem's office for  
11       more information.

12    Q     And why did you do that?

13    A     I found that it was a very just a general note that  
14       didn't really have a lot of detail to it, and I was  
15       looking for more information.

16    Q     And if we go to Exhibit A-9, there's a January 8, 2021  
17       letter on Dr. Salem's letterhead. Just let everybody  
18       get to document A-8.

19       THE CHAIR:                   A-8 or A-9, Mr. Maxston?

20       MR. MAXSTON:                Oh, I'm sorry, A-9. Thank  
21       you, Mr. Chair.

22    Q     MR. MAXSTON:            So, Mr. Lawrence, was this the  
23       response you got from Dr. Salem?

24    A     It is.

25    Q     And if we look -- I'm sorry, I'm skipping around a  
26       little bit here, if we go back to page 3 of your

1 investigation report, it says: (as read)

2 Dr. Salem provided a written response related  
3 to the medical exemption. The following  
4 outlined the key points in the information  
5 from Dr. Salem.

6 MR. MAXSTON: And forgive me, Mr. Kitchen,  
7 here, I'm going to ask a bit of a leading question.

8 Q MR. MAXSTON: I'm assuming the outline of  
9 the key points you referred to are the key points from  
10 this January 8, 2021 letter?

11 A That's right.

12 Q Okay, I'll just ask you then to go through your  
13 investigation report on page 3, and those four stars,  
14 and there's a little bullet point at the bottom that  
15 says "Note", and if you can tell me what the key points  
16 were.

17 A So the -- Dr. Salem had provided the written responses  
18 we went through, so he indicated that, at his  
19 appointment on December 29th, that Dr. Wall harboured  
20 significant anxiety about masking and his inability to  
21 breathe. Then in his letter, he indicates that there  
22 were no other documents or tests conducted or any  
23 diagnostic information.

24 In my letter to him, I had asked for, you know,  
25 how did he confirm the diagnosis? Was there tests or  
26 any diagnostic information, of which he said there's

1 not.

2 Dr. Salem provided some medical history regarding  
3 Dr. Wall, which included that Dr. Wall takes no  
4 medication and is in good health. He indicated  
5 Dr. Wall tried to wear a mask and developed a tickle in  
6 his throat and felt anxiety and claustrophobia after  
7 wearing a mask. Dr. Salem further cites that Dr. Wall  
8 is pushing for exemption given his mental health  
9 impact.

10 Q You also have a note at the bottom, can you tell me  
11 what you're saying there?

12 A I'm sorry, where are you looking?

13 Q Just on your investigation report after those four  
14 bullets, there's an indented note, literally N-O-T-E:  
15 (as read)

16 It should be noted that.  
17 I'm just wondering what you're saying there.

18 THE CHAIR: I'm not following. This is  
19 after the four bullet points regarding Dr. Salem?

20 MR. MAXSTON: Yes, that's -- oh, I'm sorry,  
21 that's my mistake, Mr. Chair. Yes, I'm sorry, that's  
22 my mistake.

23 Q MR. MAXSTON: After your investigation was  
24 completed, did you decide to refer this to a hearing?

25 A I did.

26 Q And can you tell me why?

1     A     I do think there was significant breach of both the  
2           Standards of Practice and the Codes of Ethics, and  
3           these were I think most appropriate to be presented to  
4           a Hearing Tribunal for a decision on the disposition of  
5           the complaint, and so for that reason, I referred it to  
6           the hearing on the 4th of February.

7     Q     We talked a little bit about this before at the  
8           beginning of your testimony, and I believe you  
9           indicated that when you talked with Dr. Wall on I think  
10          it was December 3, you said that compliance wasn't  
11          optional. What was your expectation if a member  
12          couldn't comply or was thinking of not complying with  
13          the Pandemic Directive?

14    A     So if there's questions about compliance, I would  
15          expect that they would -- usually what members do is  
16          they reach out to the Registrar, and they talk about,  
17          you know, what the -- what options may be available or,  
18          you know, a question about, you know, if they're not  
19          sure about something, usually the Registrar fields  
20          those types of questions, and they reach out about  
21          that.

22                 In my role, it's -- you know, compliance is  
23          mandatory, and so that -- usually the -- when there is  
24          questions about that, whether it's, you know, sometimes  
25          they'll reach out about is this advertising compliant,  
26          is this compliant, can I do this or can I do that, so

1       we get those questions quite frequently. And so my  
2       expectation would be that you usually contact the  
3       Registrar or that you comply until you question, or you  
4       step back from practice until you resolve the issue

5    Q    So I'm just about finished with my questions for you,  
6       Mr. Lawrence. I just want to ask you about some other  
7       obligations at the College.

8               If there is a complaint sent to you, and you  
9       choose to investigate it, is a member required to  
10      cooperate with your investigation?

11   A    They are.

12   Q    And can a chiropractor choose to not cooperate?

13   A    Well, they could choose to, but that is actually --  
14      that would be an example of unprofessional conduct  
15      defined in the Health Professions Act.

16   Q    Dr. Wall's conduct doesn't involve any sexual  
17      misconduct. This is a theoretical question I'm going  
18      to pose to you. Are you aware of Bill 21 Standards of  
19      Practice that the College has about prohibiting sexual  
20      relationships with patients?

21   A    I am.

22   Q    Is that part of your role, or enforcing that part of  
23      your role as Complaints Director?

24   A    It is.

25   Q    Are those standards mandatory?

26   A    They are.

1 Q Are there any exemptions to them?

2 A No. There are -- there are guidelines provided about  
3 how to discharge from a patient care to enable a  
4 relationship to begin, but they are not -- they're not  
5 optional while a patient is under doctor care.

6 Q Are you familiar with the phrase "ungovernability" or  
7 "ungovernable professional"?

8 A I am.

9 Q Can you tell me what that means to you?

10 A So the mandate of the College is to hold regulated  
11 members in compliance with the mandates of practice and  
12 the self-regulation. Council is the deciding body on  
13 the conduct that members must adhere to in practice.

14 And so the role of the College or my role is to  
15 hold members accountable when they're not compliant,  
16 and when they are what's termed "ungovernable", it is  
17 when they are purposefully or deciding not to comply  
18 with the requirements of their practice.

19 Q How would ungovernability affect the profession?

20 A Well, I think if members are picking and choosing about  
21 what they comply with and what they won't, it doesn't  
22 really become compliance then; it's -- everything's  
23 just becoming a recommendation or a suggestion, so the  
24 profession basically isn't self-regulating at that  
25 point.

26 Discussion

1 MR. MAXSTON: Mr. Chair, those are all my  
2 questions for Mr. Lawrence.

3 I welcome Mr. Kitchen's comments, but I doubt he  
4 wants to start his cross-examination at 10 to 12. I  
5 wonder if this might be a good time to take a break for  
6 lunch, and come back perhaps at 10 to 1 or 1:00, and  
7 then Mr. Kitchen could conduct his cross-examination, I  
8 can do my redirect, and you can ask any questions that  
9 you have.

10 MR. KITCHEN: I prefer a slightly longer  
11 break for lunch. I'd like to come back at 1:15, one of  
12 the reasons being I don't think we are in jeopardy of  
13 not finishing today at a very reasonable hour. If we  
14 come back at 1:15, I suspect we'll still be out of here  
15 at 3:30 at the latest. So if that's acceptable to the  
16 Chair, that's what I would propose.

17 THE CHAIR: Mr. Maxston, any ...

18 MR. MAXSTON: Sorry, that's fine, and I  
19 think, Mr. Kitchen, we'd be moving ahead on the  
20 understanding we wouldn't start with your evidence then  
21 until tomorrow morning?

22 MR. KITCHEN: That's right.

23 MR. MAXSTON: Yeah, I'm fine with that  
24 approach.

25 THE CHAIR: Okay, if both parties are okay  
26 with that plan, we will now break until 1:15, so see



1       everybody back at 1:15. And, Mr. Lawrence, we just  
2       caution you not to discuss the case while not giving  
3       testimony.

4     A    Yes, that's fine.

5       THE CHAIR:                               Thank you and see you at 1:15.

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7       PROCEEDINGS ADJOURNED UNTIL 1:15 PM

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

4

5 September 7, 2021 Afternoon Session

6

7 HEARING TRIBUNAL

8 J. Lees Tribunal Chair

9 W. Pavlic Internal Legal Counsel

10 Dr. L. Aldcorn ACAC Registered Member

11 Dr. D. Martens ACAC Registered Member

12 D. Dawson Public Member

13 A. Nelson ACAC Hearings Director

14

15 ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

16 D. Lawrence ACAC Complaints Director

17 B.E. Maxston, QC ACAC Legal Counsel

18

19 FOR DR. CURTIS WALL

20 J.S.M Kitchen Legal Counsel

21

22 K. Schumann, CSR(A) Official Court Reporter

23

24 (PROCEEDINGS RECOMMENCED AT 1:21 PM)

25 THE CHAIR: We are now back in session,

26 and we will ask Mr. Kitchen to start with his

1 cross-examination of Mr. Lawrence.

2 MR. KITCHEN: Thank you, Chair.

3 DAVID LAWRENCE, Previously affirmed, Cross-examined by  
4 Mr. Kitchen

5 Q MR. KITCHEN: Good afternoon, Mr. Lawrence.

6 A Hello.

7 Q You are not a chiropractor, correct?

8 A I am not.

9 Q And I have it right that you started in this position  
10 as Complaints Director in March of 2020, correct?

11 A That's correct.

12 Q So you did not do this job prior to the onset of COVID?  
13 Is that --

14 A I did not.

15 Q -- (INDISCERNIBLE)? You agree that the most important  
16 principle for chiropractors to adhere to is the  
17 principle of protecting the public from harm, do you  
18 not?

19 A I do.

20 Q You agree that each patient of a chiropractor is a  
21 member of the public, do you not?

22 A I do.

23 Q You agree that each patient of every chiropractor is --  
24 sorry, let me start again. You agree that the  
25 interests of each patient, each forms a part of the  
26 broader public interest, do you not?

1 A I'm not sure about public interest, but public safety,  
2 yes.

3 Q So you agree that the safety interests of each patient  
4 forms a part of the broader public safety interest,  
5 correct?

6 A That would follow, yes.

7 Q So then would you agree that the interests of each  
8 individual patient make up together the broader public  
9 interest?

10 A As it applies to the practice of chiropractic, each  
11 patient is part of the public.

12 Q You agree that chiropractors should protect members of  
13 the public from harm no matter what, do you not?

14 A Yes.

15 Q You agree, do you not, that the principle of  
16 chiropractors protecting the public from harm is more  
17 important than the principle of protecting the  
18 reputation of the chiropractic profession, do you not?

19 A More important. It's difficult I think from a  
20 compliance perspective. I think the priority of the  
21 College is the protection of the public, and so in that  
22 regard, yes.

23 Q You agree that there are other threats to the overall  
24 health and well being of chiropractic patients besides  
25 COVID-19, do you not?

26 A Yes.

1 Q You agree that there are other threats to the overall  
2 health and well being besides COVID-19 that are more  
3 severe than COVID-19, that are a greater threat, do you  
4 not?

5 A I'm not sure. It probably would be per threat, but,  
6 you know, a threat's a threat.

7 Q Do you think all threats are the same?

8 A I would think that there's many different kinds of  
9 threats, so I don't know where COVID would be in  
10 compared to a threat of something else. So in regards  
11 to legislation and compliance, public safety threats  
12 are public safety threats.

13 Q But you would agree some threats are more serious than  
14 others?

15 A If you could give me an example of what threats you're  
16 talking about.

17 Q Well, I don't want to give you a hypothetical, but let  
18 me ask you this: You believe that the threat of  
19 COVID-19 is more of a threat than the threat posed by  
20 wearing a mask; is that correct?

21 A I think the legislation in regards to COVID-19 is clear  
22 on the expectation of masking.

23 Q Okay, I didn't ask that, so I'll try again. You would  
24 agree with me -- sorry, you believe, do you not, that  
25 the threat of COVID-19 is greater -- that the threat of  
26 COVID-19 to a person's health is greater than the

- 1 threat to a person's health posed by a mask?
- 2 A I think, you know, my personal beliefs on --
- 3 Q I didn't ask you your personal beliefs.
- 4 A You did you asked me what -- if I believe that.
- 5 Q Right, but you are here as the Complaints Director.
- 6 A Correct, so my response is is that the legislation is
- 7 what guides, not my personal beliefs.
- 8 Q You have discretion as the Complaints Director, do you
- 9 not?
- 10 A I do.
- 11 Q You used the word "danger" to describe Dr. Wall not
- 12 wearing a mask while treating his patients earlier
- 13 today; is that correct?
- 14 A I believe so, yes.
- 15 Q So let's use the word "assessment", okay? Let's not
- 16 use the word "belief", because you didn't use the word
- 17 "belief". In your assessment, COVID-19 is more of a
- 18 threat to a patient's health than wearing a mask,
- 19 correct?
- 20 A In my assessment, the legislation and guidelines
- 21 indicate it is more of a threat than wearing a mask.
- 22 Q So I want to make sure I have your position correct.
- 23 You're saying that the legislation -- well, let me ask
- 24 you this: By "legislation", do you mean the Health
- 25 Professions Act?
- 26 A I mean all the mandates of practice.

1 Q And you would say the mandates of practice are  
2 legislation?

3 A I would refer to them -- and I use the term broadly,  
4 but I'm referring to whether the Code of Ethics, the  
5 Standards of Practice, directives, policies,  
6 legislation, and perhaps mandates would have been a  
7 more appropriate word than "legislation" to use in that  
8 context.

9 Q So you believe that the ACAC mandates state that  
10 COVID-19 is a greater threat to a patient's health than  
11 masks?

12 A I think the Pandemic Directive states that wearing a  
13 mask can reduce the risk of transmission between doctor  
14 and patient.

15 THE CHAIR: Mr. Kitchen, I was just going  
16 to say Mr. Lawrence is not a medically trained  
17 individual, so I'm wondering if we're asking him for  
18 medical opinions or medical --

19 MR. KITCHEN: I'm not. I'm not searching  
20 for a medical opinion.

21 THE CHAIR: Okay.

22 MR. KITCHEN: But I'm -- this question is --  
23 he has said -- and I don't think he's trying to claim a  
24 medical opinion, and I'm not claiming that he is, he  
25 has said, I think Dr. Wall not wearing a mask and  
26 treating patients was dangerous to the public, that's

1     why I took action. That's what he said.

2             So what I'm trying to figure out -- and that  
3     wasn't a medical determination, that was a Complaints  
4     Director determination about public safety, which he  
5     has to make. So I'm asking him if he thinks one danger  
6     is more than another danger, and I think that's within  
7     his purview, not as an expert, not as an opinion, but  
8     simply he has to assess that, and he has been assessing  
9     that.

10            And I've asked the question four times, and he's  
11     refused to answer, so I don't see any point in asking  
12     it again; however, I will ask you, Mr. Chair, to either  
13     direct that he answer the question, or that he not, and  
14     I continue on because --

15     THE CHAIR:                     Well --

16     MR. KITCHEN:                  -- (INDISCERNIBLE) again.

17     THE CHAIR:                     Well, I think he did reply  
18     that he couldn't compare one to the other without  
19     knowing what they were and asking for examples, and I  
20     know you won't provide hypotheticals. Is there a  
21     possibility you could reword your question?

22     MR. KITCHEN:                  Sure. No, I did -- the  
23     example I provided was masking. I asked if he thought  
24     COVID was more of a danger to the health of patients  
25     than wearing a mask, and he has refused to answer.

26     THE CHAIR:                     I don't know. To me, that



1 would require some medical knowledge.

2 MR. KITCHEN: Okay.

3 THE CHAIR: I mean, in some cases, COVID  
4 is fatal, so there's all kinds of different ways to  
5 assess how dangerous COVID is. I don't want to get  
6 into your direct -- your cross-examination,  
7 Mr. Kitchen, I just wanted to just clarify that  
8 Mr. Lawrence is there in an administrative rather than  
9 a medical position.

10 Q MR. KITCHEN: Mr. Lawrence --

11 THE CHAIR: (INDISCERNIBLE)

12 MR. KITCHEN: Oh, sorry.

13 Q MR. KITCHEN: Mr. Lawrence, in assessing  
14 Dr. Wall as a danger to the public and not wearing a  
15 mask, are you not making something of a medical or  
16 scientific determination?

17 A The comment there is in regards to the Standards of  
18 Practice that apply by not masking that -- when you are  
19 not compliant, that is the danger. So when I look at  
20 the practice directive, and it says chiropractors and  
21 clinic staff must be masked at all times while  
22 providing patient care, when a member of the profession  
23 does not comply with that, then they are a risk.

24 Q All right, so if I have your position correct then,  
25 what you're saying -- and if you don't agree with me,  
26 tell me -- the source of the danger to the public in

1 Dr. Wall's actions are simply that he wasn't complying  
2 with what the ACAC said to do?

3 A In my position as Complaints Director, when members are  
4 not compliant with what they're supposed to do, my role  
5 is to hold them accountable to comply.

6 Q Okay. I didn't ask you what your role is. I thought I  
7 was asking a simple question because I was trying to  
8 repeat what you had said, I was just trying to clarify.  
9 Wasn't trying to trick, I was trying to clarify what  
10 you had just said just so I understood your position.

11 I thought you just said that the source of the  
12 danger to the public from Dr. Wall was that he was not  
13 complying with what the ACAC said to do; do you agree  
14 with that?

15 A I would say not complying with the ACAC and Public  
16 Health, yes.

17 Q So the noncompliance is the source of the danger,  
18 correct or not correct?

19 A Noncompliance -- noncompliance is the -- what's the  
20 term -- the noncompliance is the issue in the  
21 complaint. The actions are the danger.

22 Q And so and the action --

23 A Dr. Wall's actions, yes.

24 Q You would agree that by referring to Dr. Wall's  
25 actions, you mean his actions in not wearing a mask  
26 while treating patients?

1 A Correct.

2 Q You agree that chiropractors are obligated to comply  
3 with the ACAC's requirements of practice even if those  
4 requirements are harmful to the chiropractor, do you  
5 not?

6 A I wouldn't say that, no.

7 Q Okay. The ACAC is obligated to comply with the  
8 statutes of Alberta; isn't that correct?

9 A The statutes that apply to the profession, yes.

10 Q The ACAC is obligated to only impose restrictions on  
11 chiropractors that are consistent with the Canadian  
12 Constitution; isn't that right?

13 MR. MAXSTON: Mr. Chairman, I'm going to  
14 object there. We don't have a constitutional law  
15 expert. Mr. Lawrence is the Complaints Director, and I  
16 objected this question or line of questioning with  
17 Dr. Halowski, and I'll object again.

18 MR. KITCHEN: Sure. If I was asking whether  
19 or not Dr. Lawrence [sic] thought, in his opinion, that  
20 wearing a mask could possibly be a violation of Section  
21 2(a) of the Canadian Charter of Rights and Freedoms,  
22 I'd be asking for his legal opinion. I'm not asking  
23 for his legal opinion. I'm asking for his  
24 confirmation, as Complaints Director, whether or not  
25 the Canadian Constitution applies to the body that he  
26 is the Complaints Director of. That is requisite

1 knowledge to do his job. It's not an opinion. That  
2 either does or doesn't, and he, by virtue of his  
3 position, must have that knowledge. I'm asking for him  
4 to confirm that knowledge, not to provide me a legal  
5 opinion.

6 MR. MAXSTON: I'm only going to make one  
7 other comment, and then you'll decide whether the  
8 question can be asked. That again is one of the  
9 ultimate questions that this Tribunal is going to be  
10 deciding on, what does and doesn't apply to the  
11 College's Pandemic Directive and other mandates, so ...

12 MR. KITCHEN: So, Chair, my question is I'm  
13 asking Mr. Lawrence to confirm that the Canadian  
14 Charter of Rights and Freedoms, being part of the  
15 Canadian Constitution, applies to the College; so I'm  
16 asking you to let me know if you're going to allow the  
17 question.

18 THE CHAIR: My thoughts on this are that  
19 we could recess and take advice from independent legal  
20 counsel, and I think Mr. Maxston's indicated his  
21 concern that this could be a central issue, so I think,  
22 as much as I'd like to keep things moving, we will take  
23 a brief recess so that the Hearing Tribunal and myself  
24 can take advice from counsel, so please bear with us  
25 for a few minutes. Thank you.

26 MR. KITCHEN: Okay, thank you.

1 (ADJOURNMENT)

2 THE CHAIR: Okay, we are back. We are  
3 still in session. We've had a couple of internet  
4 hiccups, a couple of freezing screens, so we'll just  
5 hope that this doesn't re-occur.

6 We have discussed the question you've proposed,  
7 Mr. Kitchen, and spoken to our independent legal  
8 counsel, and our decision is that we do not allow you  
9 to ask this question. We believe you're asking for an  
10 opinion from this witness, and as you've pointed out,  
11 this is likely -- or Mr. Maxston has pointed out it's  
12 likely to be a central issue in this hearing, so that  
13 question is not allowed.

14 MR. KITCHEN: Thank you, Chair.

15 Q MR. KITCHEN: Now, Mr. Lawrence, I'm going  
16 to take you to the Pandemic Directive.

17 A Okay.

18 Q Once again, there's three versions, so it's Exhibits  
19 C-20, C-21, and C-22, C-22 being the January 6th  
20 version.

21 Now, there's a Personal Protective Equipment  
22 section in the directive. Of course, that's what we've  
23 been talking about. Now, in that section, there is  
24 nothing discussing chiropractors contacting the ACAC if  
25 they have human rights concerns regarding the mandatory  
26 masking directive, is there?

1 A There is not.

2 Q And the ACAC has never had in place a process in which  
3 to reach a possible resolution whereby a chiropractor  
4 could practice without a mask; isn't that right?

5 A I think depending on the modality. So certainly I know  
6 when council had decided to make Telehealth a permanent  
7 modality for chiropractors going forward, and we  
8 received communication from I believe it was Green  
9 Shield and Blue Cross about how to bill for it. There  
10 certainly is practice under that which wouldn't require  
11 masking.

12 And in the earlier pandemic, there was if you can  
13 maintain 2 metres of distance while conversing with a  
14 patient, there was exception -- or there wouldn't be a  
15 required to mask.

16 Q The ACAC has never had in place a process by which  
17 there's a possible resolution that would allow a  
18 chiropractor to physically treat patients without a  
19 mask; isn't that right?

20 A In close contact, that's correct.

21 Q You called Dr. Wall December 4th, 2020, to inform him  
22 you were making a request to suspend his practice  
23 permit, did you not?

24 A I think it was December 3rd.

25 Q Okay.

26 A But yes.

1 Q Thank you for that. Dr. Wall asked you during that  
2 call about human rights accommodations, didn't he?

3 A I think he said something to the effect of, Isn't there  
4 a human rights part of this. I don't know exact words,  
5 but something to that effect, yes.

6 Q Okay. Dr. Wall said to you that the literature doesn't  
7 support mandatory masking, didn't he?

8 A I think he said that in his response letter. I don't  
9 know if it was during our call, but something to that  
10 degree, yes.

11 Q And you responded to him by saying that you were not  
12 going to debate the issues, didn't you?

13 A I said the patient's safety isn't up for debate, yes,  
14 and that compliance wasn't up for discussion -- or  
15 compliance wasn't up for debate, and that if he wasn't  
16 going to comply, I was going to initiate the Section 65  
17 request.

18 Q But it wasn't public safety that you refused to debate,  
19 was it?

20 A Well, it's compliance.

21 Q It was the scientific efficacy of masks that you  
22 refused to debate, wasn't it?

23 A No, that's sort of beyond my purview. It's, you know,  
24 this is a compliance issue, so the mandates of practice  
25 were masking, and if Dr. Wall wasn't going to comply  
26 with the requirements, then I initiated the request.

1 Q Now, I'm going to put it to you that Dr. Wall is going  
2 to say that what you refused to debate was the  
3 scientific efficacy of masks; that's what he's going to  
4 say.

5 A Okay, I disagree with that, but okay.

6 Q And I'm talking in the context of this call, not  
7 talking anywhere else. In the context of this call,  
8 Dr. Wall's going to say that you said to him that you  
9 refused to debate the efficacy of masks.

10 A I don't believe -- "efficacy" isn't a word I would  
11 usually use. I think I probably talked more in  
12 compliance. I note he did talk about the recovery rate  
13 of COVID, and like I said before, I think he said  
14 something to the effect of it's 99 percent recovery or  
15 something to that regard, but it's not -- this was  
16 about compliance.

17 Q Do you disagree that Dr. Hu said that the recovery rate  
18 is 99 percent?

19 A I don't remember specifically, but I wouldn't disagree  
20 with that.

21 Q So you don't disagree that what Dr. Wall said when he  
22 told you the recovery rate is 99 percent is truthful?

23 A I don't know either way, so, no, I wouldn't disagree  
24 with that.

25 Q So you don't know if the recovery rate is 99 percent or  
26 not?



1     A     I know it's quite high.  I don't know what the exact  
2           percentage is, so -- but I know it's quite high.

3     Q     But you did just say -- so you don't remember what  
4           Dr. Hu said; is that correct?

5     A     I'm -- what I said was I believe he said something like  
6           that, and I have no reason to disagree with that  
7           comment.

8     Q     So you have no reason to disagree with Dr. Wall when he  
9           said that the recovery rate's 99 percent?

10    A     I don't.

11    Q     You said in that call that you cannot make Dr. Wall  
12           wear a mask and that he was free to not wear a mask,  
13           didn't you?

14    A     I think I was talking about in regards to, you know, in  
15           both his public life and in work.  I can't, you know,  
16           make him do anything; all I can do is hold  
17           chiropractors compliant when their mandates of practice  
18           are not complied with and proceed in that way.

19    Q     You said he was free to not wear a mask, didn't you?

20    A     I think I was talking about in his private life.

21    Q     Dr. Wall is going to say that there was no discussion  
22           in that call about anything to do with his private life  
23           but that the discussion was focused on his professional  
24           life.

25    A     Okay.

26    Q     So let me ask you again:  You said in that call to

1 Dr. Wall that he was free to not wear a mask; isn't  
2 that correct?

3 A I think what I said was in regards to his private life.  
4 If we -- if I interpreted it differently, or he  
5 interpreted it difficulty, or there's misunderstanding  
6 there, or I don't know, I think what I was talking  
7 about was like I can't -- you know, I can't put a mask  
8 on him; all I can do is if he won't comply, I can take  
9 an action.

10 Q So you disagree with me that you said in that call that  
11 Dr. Wall --

12 A I don't have the transcript here, so I wouldn't  
13 disagree or agree at all because I'm not -- I don't  
14 know exactly the wording that was used.

15 Q So is your answer that you don't remember?

16 A No, my answer is that I believe what we were saying was  
17 in his personal life, and also that I can't make him do  
18 anything. My job is if he refuses to comply, then I  
19 take an action in regards to noncompliance.

20 Q So when Dr. Wall says that there was no mention of  
21 private life in that conversation, you're going to  
22 disagree with him?

23 A I don't have an answer to that. Like I said, I don't  
24 have a transcript. I don't have the call transcript  
25 here. I don't have a record of it, so, you know, it's  
26 based on what I remember, and that's it.

1 Q But you are convinced, are you not, that you --

2 THE CHAIR: Mr. Kitchen, if I could just  
3 interrupt, I believe Mr. Lawrence has indicated what he  
4 believes the conversation was about, and you've  
5 indicated that you have a witness that will testify  
6 differently. I don't know that we can get any more  
7 clarification than that.

8 MR. KITCHEN: Thank you, Chair. The only  
9 reason I continue to keep going is I keep getting  
10 contradictory answers, so I'm just trying to give the  
11 witness an opportunity to remove the contradictory  
12 answers.

13 THE CHAIR: I think he's been consistent  
14 in saying what he recalls the conversation was about.  
15 Thank you.

16 MR. KITCHEN: Thank you.

17 Q MR. KITCHEN: Mr. Lawrence, when Dr. Wall  
18 was faced with a choice of either wearing a mask or  
19 sacrificing his ability to earn an income as a  
20 chiropractor, his choice was not a free choice absent  
21 of a coercion, was it?

22 A I think there were alternatives he could have followed.  
23 He could have practiced Telehealth and -- which would  
24 have enabled him to continue practice and not wear a  
25 mask.

26 Q When Dr. Wall was faced with a choice of either wearing

1 a mask or treating his patients in a way that he  
2 thought was the only good way to treat them, his choice  
3 between those two things was not a free choice absent  
4 of coercion, was it?

5 A I don't agree with the way you're stating that. I  
6 think there's, in any mandate of practice, the  
7 compliance is obligatory. I think that in probably  
8 most cases in the legislation and in all the standards,  
9 there may be chiropractors that agree with some and  
10 disagree with others, but the obligation is to comply.

11 Q So that obligation imposes no coercion?

12 A That would be up to the drafters of the legislation. I  
13 think, you know, the compliance is not an option, so if  
14 non-optional compliance is coercion, then it's  
15 coercion.

16 Q By requesting the suspension of Dr. Wall's practice  
17 permit, you were, in fact, attempting to make Dr. Wall  
18 either wear a mask or stop treating patients in person,  
19 were you not?

20 A I think the purpose of that was to safeguard the public  
21 and protect the public from harm.

22 Q And the way that you protect the public from harm in  
23 that scenario is by making Dr. Wall either wear a mask  
24 when he's treating patients or stop treating patients  
25 in person?

26 A Correct.

1 Q Now, it was on December 3rd, 2020, that you submitted a  
2 request to suspend the practice permit of Dr. Wall;  
3 isn't that right?

4 A Correct.

5 Q Now, you said earlier it was on the same day, December  
6 3rd, that you called him, correct?

7 A Yes.

8 Q So when Dr. Wall told you on that call that he was  
9 exempt from wearing a mask on medical -- he was  
10 medically exempt, you didn't believe him, did you?

11 A No, I don't believe that -- under the regulations, the  
12 health care workers aren't exempt from masking.

13 Q You didn't believe that he had a medical condition that  
14 exempted him, did you?

15 A I think that in regards -- from Public Health and the  
16 Pandemic Directive, I think that he was noncompliant  
17 with his requirements, and there was never an  
18 expectation for exemptions for medical health  
19 professionals.

20 Q Didn't ask you that. You didn't believe that he had a  
21 medical condition that exempted him from wearing a  
22 mask, did you?

23 A "Believe" is not really an appropriate term. It's  
24 compliance with or noncompliance with, and that's what  
25 guides the direction.

26 Q In your assessment, he wasn't being truthful with you?

1 A That's not what I said, no.

2 Q So you did believe him; you thought he was being  
3 truthful?

4 A I believe that there was never an expectation for  
5 medical health professionals to be exempt, and I  
6 believe Dr. Wall was noncompliant with his mandates of  
7 practice. You know, truth and not truth, that's not  
8 really appropriate I think.

9 Q Isn't it your job as Complaints Director to assess  
10 whether or not chiropractors are telling the truth?

11 A My job is to apply the legislation and the mandates of  
12 practice and hold them accountable when they've been  
13 breached.

14 Q And when you do that, you have to make assessments of  
15 whether or not chiropractors are telling you the truth  
16 about something; isn't that right?

17 A I have to look at their actions about what they're  
18 doing and whether their actions are compliant or  
19 noncompliant with the standards. Whether they lied to  
20 me or not, I -- you know, it's more on the actions  
21 towards compliance.

22 Q Isn't lying to the -- isn't lying to you in your  
23 capacity as Complaints Director in and of itself  
24 something worthy of investigation?

25 A Potentially, yes.

26 Q So in your work, you have to make determinations

1 occasionally on whether or not somebody's telling you  
2 the truth, correct?

3 A Yes.

4 Q So you made an assessment on December 4th, when  
5 Dr. Wall and you had that conversation on the phone,  
6 you made an assessment of whether or not he was telling  
7 you the truth about his medical exemption?

8 A No. And I think you're misquoting that. It's not  
9 about truth or lying or -- it's about compliance, and  
10 so the mandates of practice say, you know, this should  
11 happen, and if the actions don't follow those mandates,  
12 then that's the direction or the actions they take  
13 accordingly. It's not whether Dr. Wall was telling the  
14 truth or not. It's about whether he was compliant or  
15 not.

16 Q Well, and he clearly wasn't.

17 A Wasn't compliant? I agree.

18 Q Right.

19 A I agree he was not compliant.

20 Q So you don't think he had a medical condition that made  
21 him medically unable to wear a mask, did you?

22 A I think the question about the -- whether that is an  
23 exemption or not, it will be up to the Tribunal to  
24 decide. My position is he was not compliant, and as  
25 the Complaints Director, my job is to act when members  
26 are not compliant.

1 Q And I appreciate that, but I didn't (INDISCERNIBLE) --

2 A I understand what --

3 Q -- (INDISCERNIBLE) about --

4 A I understand what you wanted to say was Dr. Wall  
5 telling the truth or not, and it's compliance, so it's  
6 about whether he was compliant or not.

7 Q So you believed he was not compliant?

8 A I believe he was not compliant with his mandates of  
9 practice, correct.

10 Q And you believed he had no medical condition that made  
11 him unable to wear a mask?

12 A I don't know the answer to that.

13 Q Okay. You thought he was just saying that he was  
14 exempt because he didn't want to wear a mask, and he  
15 was being ungovernable, didn't you?

16 A I believe that he was not being compliant because what  
17 he was supposed to be doing, and when they're not  
18 compliant, members of every regulated health profession  
19 are to be held accountable. So this is a compliance  
20 question.

21 Q And you thought he had no medical basis for  
22 noncompliance?

23 A I believe there is no -- there wasn't an expectation  
24 for medical health professionals to have an exemption,  
25 and he was noncompliant with his expectations of  
26 practice.



1 Q Which is fine, I didn't ask you anything about  
2 exemptions.

3 Now, you received a letter from Dr. Salem, a  
4 Calgary medical doctor, stating that Dr. Wall was  
5 deemed by that doctor to be medically exempt from  
6 wearing a mask; isn't that right?

7 A Yes.

8 Q And you would have received that by December 14th;  
9 isn't that right?

10 A Do you mean the letter in follow-up or his December the  
11 12th note?

12 Q The December the 12th note, you received that by  
13 December 14th, did you not?

14 A Correct.

15 Q And upon receiving that letter, you decided not to  
16 withdraw your request to suspend Dr. Wall's licence;  
17 isn't that right?

18 A Correct.

19 Q You doubted the accuracy of Dr. Salem's December 12th  
20 medical note, didn't you?

21 A I asked for more information about the condition in a  
22 follow-up letter to Dr. Salem.

23 Q That's not what I asked. So you didn't doubt the  
24 accuracy of that note?

25 A I don't know what you mean by "accuracy". Dr. Salem  
26 sent me this note, so I have no doubt to believe it

1           came from Dr. Salem, and he meant what he said.

2    Q    So you don't doubt the accuracy of that note?

3    A    I think that's accurate.

4    Q    So when you received that note, you just said you  
5           decided not to withdraw your request to suspend, it  
6           didn't matter to you that Dr. Wall was medically unable  
7           to wear a mask, did it?

8    A    At the time, I, as I said before, I don't think there  
9           was an expectation for exemptions for people in  
10          front-line medical health workers, and Dr. Wall was  
11          still not compliant with the Pandemic Directive and the  
12          Standards of Practice, so I continued, yes.

13   Q    It didn't matter to you that Dr. Wall had a medical  
14          disability that potentially triggered the duty to  
15          accommodate in the human rights legislation, did it?

16   A    I'm not familiar enough with human rights legislation  
17          to answer that.

18   Q    So you didn't think about potential human rights  
19          accommodation after you received that letter?

20   A    I think that in regards to proceeding with the  
21          investigation and the complaint, there was still  
22          concern about the risk to the public, so I continued  
23          with the complaint.

24   Q    Great, that's greet. I didn't ask you that. I asked  
25          you if you thought about human rights --

26   A    I --

1 Q -- (INDISCERNIBLE) --

2 A -- you -- this is --

3 Q -- either you did or you didn't.

4 A This is nine months ago. I don't know what -- every  
5 thought that went through my head then.

6 Q That wasn't important then; must not have been, you  
7 forgot about it. So was it important to you to  
8 consider human rights at that time or no?

9 A The consideration was in the protection of the public  
10 and the compliance of a regulated member to the  
11 mandates of the legislation. So, you know, that's what  
12 led to the complaint, that's what led to the Section 65  
13 request, and that's what led to the continuation of the  
14 complaint.

15 Q And nothing else matters, right?

16 A Well, that's not what I said either, but ...

17 Q Okay.

18 A I'll agree with you. How about that?

19 Q When your December 3rd request for an interim  
20 suspension of Dr. Wall's practice permit was denied by  
21 Dr. Linford on December 18th, Dr. Linford relied upon  
22 Dr. Salem's December 12th doctor note, didn't he?

23 A You would have to ask Dr. Linford, but that would be a  
24 good assumption I think.

25 Q It's not an assumption. Let's take you over to the  
26 December 18th decision of Dr. Linford. That's Exhibit

1 B-5. I'll give you a chance to pull it up.

2 MR. MAXSTON: Mr. Kitchen, while  
3 Mr. Lawrence is looking for that, I'm going to tell you  
4 that I'll object to any questions about what  
5 Dr. Linford was thinking. I don't expect you're going  
6 to ask those questions because that's not within this  
7 witness's knowledge.

8 MR. KITCHEN: Right, you and I are on the  
9 same page there.

10 THE CHAIR: You said E-5, Mr. Kitchen?

11 MR. KITCHEN: B-5, 'B' as in Bob.

12 Q MR. KITCHEN: Now, Mr. Lawrence, do you have  
13 that in front of you?

14 A I do.

15 Q Now, do you see there, this is the very first  
16 paragraph, do you see where Dr. Linford says: (as  
17 read)

18 I have also considered the following?

19 A Yes.

20 Q And there's a list there of six things, okay? Then  
21 there's a paragraph that starts "I have also  
22 considered". Now, so at the very bottom of the page  
23 there, it says "Dr. Wall has provided". Do you see  
24 that there?

25 A Yes.

26 Q Now, this thing that Dr. Wall provided, was it a letter

1 from a physician, Dr. Salem?

2 A Yes.

3 Q And does Dr. Linford describe there what that note was  
4 about?

5 A Yes.

6 Q Dr. Linford states, I'm reading it here: (as read)

7 Dr. Wall has a medical condition that  
8 prevents him from wearing a mask or a face  
9 shield as required under the CMOH orders.

10 A Yes.

11 Q You would agree that I've just read that accurately,  
12 correct?

13 A Yes.

14 Q So Dr. Linford referred to that note in making his  
15 decision; is that correct?

16 A Yes.

17 Q Now, in this December 18th decision, I guess we can  
18 call it Section 55 request for interim suspension of  
19 Dr. Wall's practice permit. So Dr. Linford didn't call  
20 it anything in particular, but, it's you would agree  
21 with me, that this December 18th document from  
22 Dr. Linford is Dr. Linford's written decision on your  
23 request, right?

24 A Yes.

25 Q So Dr. Linford decided December 18th to permit Dr. Wall  
26 to continue to practice in a manner that was

1 noncompliant with the ACAC Pandemic Directive, didn't  
2 he?

3 A He did until the completion of the complaint under Part  
4 4 of the HPA, so until the complaint is completed, and  
5 that, in this case, will be the decision of the  
6 Tribunal, so once that is completed, he provided him an  
7 avenue to continue to practice.

8 Q So because of Dr. Linford's decision, Dr. Wall has  
9 practiced in a manner noncompliant with the ACAC  
10 Pandemic Directive for the last eight months since  
11 Dr. Linford's decision; isn't that right?

12 A Correct.

13 Q Now, the only two CMOH orders referred by Dr. Linford  
14 in his written decision on December 18th are CMOH  
15 Orders 38-2020 and 42-2020; isn't that right?

16 A That's correct.

17 Q Now, you would agree with me that in early December,  
18 December 7th, AHS issued a closure order to Dr. Wall's  
19 office, correct?

20 A That's correct.

21 Q And that was an oral order, it was followed up by a  
22 written order on December 8th; you wouldn't contest  
23 that, would you?

24 A No.

25 Q Now, you would agree with me that the only CMOH order  
26 referred to in that closure order is CMOH Order

1 38-2020; isn't that right?

2 A That's correct.

3 Q You might not have it in front of you, so I'll take you  
4 to Exhibit D-2, 'D' as in Deborah, D-2. This is the  
5 rescind notice, and I don't know that it has a date on  
6 it. It was issued on January 5th. Here it is, January  
7 5th, it's right in the first paragraph.

8 Now, in that notice re-opening Dr. Wall's office,  
9 Dr. Wall was permitted by AHS to practice, to treat  
10 patients in person without a mask; isn't that correct?

11 A That's correct.

12 Q That January 25th interview that was conducted by  
13 phone, you questioned Dr. Wall, was there a transcript  
14 or recording of that interview?

15 A There is.

16 Q But it hasn't been entered as an exhibit as part of  
17 this case though, has it?

18 A No.

19 Q So in your investigation report, you discuss at length  
20 what Dr. Wall said to you. Those are your own words to  
21 describe what Dr. Wall said; isn't that right?

22 A I lot of it, yes.

23 Q Forgive me, I'm going to take you back to Dr. Linford's  
24 decision just one last time. I don't think you'll have  
25 to go there, but we can if we need to. Dr. Linford, in  
26 his written decision of December 18th, he did not order

1           that patients of Dr. Wall must be masked, did he?

2     A     He did not.

3     Q     Mr. Lawrence, you are the de facto complainant in this  
4           case; isn't that right?

5     A     That's correct.

6     Q     You appointed yourself as the lead investigator in this  
7           case; isn't that right?

8     A     It's correct. Under the Health Professions Act, the  
9           Complaints Director becomes the lead investigator, and  
10          when other investigators are used, they are assistant  
11          investigators, but for this case, yes, I was lead  
12          investigator.

13    Q     There's no assistant investigators in this case, is  
14          there?

15    A     There is not, no.

16    Q     And just to be clear, you made that appointment,  
17          appointing yourself as lead investigator, after opening  
18          the complaint and becoming the de facto complainant;  
19          isn't that right?

20    A     Yes.

21    Q     Dr. Wall has not harmed any member of the public or any  
22          one of his patients by treating them in person without  
23          wearing a mask, has he?

24           MR. MAXSTON:                   I'm going to object to that,  
25           Mr. Chair, that's beyond Mr. Lawrence's knowledge.

26           THE CHAIR:                     Agreed.



- 1 Q MR. KITCHEN: Mr. Lawrence, do you have any  
2 evidence that Dr. Wall has harmed any of his patients?
- 3 A I do not.
- 4 Q Do you have any evidence that Dr. Wall has harmed a  
5 member of the public by not erecting a plexiglass  
6 barrier in his office?
- 7 A I do not.
- 8 Q And just to be clear, you don't have any evidence that  
9 any of his patients have been harmed by him treating  
10 his patients in person, up close without wearing a  
11 mask, do you?
- 12 A I do not.
- 13 Q No member of the public has complained to the ACAC  
14 regarding the conduct of Dr. Wall in the period of time  
15 between March 2020 and today; isn't that correct?
- 16 A I believe the original concern that came from Public  
17 Health was initiated by a patient of Dr. Wall, but the  
18 ACAC has not received any, no.
- 19 Q The complaint you just referenced went to AHS, correct?
- 20 A Correct.
- 21 Q Not to the ACAC, correct?
- 22 A Correct.
- 23 Q And you've received no other complaints to the ACAC  
24 about Dr. Wall in the last 18 months, correct?
- 25 A Correct.
- 26 Q In fact, as far as you're aware, there had never been

1           any complaints to the ACAC about the conduct of  
2           Dr. Wall; is that correct?

3     A     Not that I know of, that's correct.

4           MR. KITCHEN:                     Just give me one second.

5           Those are all my questions.

6     A     Thank you.

7           THE CHAIR:                     Okay, Mr. Maxston, any  
8           redirect, or would you like a few minutes? We can  
9           break for 5 or 10 minutes.

10          MR. MAXSTON:                    You know, I think I'm okay.  
11          I've got a pretty good idea of what I'm going to ask  
12          Mr. Lawrence, but I don't know if Mr. Lawrence needs a  
13          break or if the Tribunal needs a break. We've been  
14          going for just about an hour, so I'm in your hands. I  
15          think I will be 15 or 20 minutes, but, again, I'm in  
16          your hands.

17          THE CHAIR:                     I think that why don't we just  
18          break for 10 minutes, and then we can check to see if  
19          the Tribunal has any questions arising from the direct  
20          and the cross-exam, and we can do both those things  
21          while you prepare for your follow-ups, okay?

22          So it's 20 after. Let's take a brief recess, and  
23          we'll reconvene at 2:30, and Members of the Tribunal,  
24          let's go to a break-out room with our esteemed counsel,  
25          and we'll just see if there's any questions arising  
26          that we can discuss. Thanks.

1 (ADJOURNMENT)

2 THE CHAIR: Okay, we're all back. Just a  
3 reminder everybody, the hearing is in session, and  
4 Mr. Maxston has some follow-up on the -- following the  
5 cross-examination of Mr. Lawrence by Mr. Kitchen.

6 MR. MAXSTON: Thank you, Mr. Chair.

7 Mr. Maxston Re-examines the Witness

8 Q MR. MAXSTON: Mr. Lawrence, you had a  
9 discussion with Mr. Kitchen, and his question was would  
10 you agree that chiropractors should protect patients  
11 from harm no matter what, and I believe your answer was  
12 yes. In your role as Complaints Director, do you  
13 decide those kinds of issues?

14 A No.

15 Q Who does?

16 A It's the legislation governs what our actions is, and  
17 so I'm led by the regulations or mandates of practice.  
18 So the drafters of the legislation, and then council  
19 also directs the Standards of Practice, Codes of  
20 Ethics, the Pandemic Practice Directive, any policies.  
21 The council of the ACAC determines how chiropractors  
22 will conduct themselves.

23 Q And a similar question, Mr. Kitchen asked you would you  
24 agree that the threat of COVID-19 is more than the  
25 threat posed by wearing a mask. Again, as Complaints  
26 Director, in your role under Section 55 of the HPA, do

1           you decide that?

2     A     No.

3     Q     And, again, who does?

4     A     Again, that would be, in this case, I would assume  
5           Public Health, and they would set the direction for  
6           managing the pandemic during -- or managing COVID  
7           during the pandemic, and then council would apply  
8           practice directives or practice mandates to the  
9           members.

10    Q     Mr. Kitchen asked you a question about when you are  
11           assessing whether Dr. Wall was a danger to the public,  
12           aren't you making a medical or scientific judgment. Is  
13           that the Complaints Director's role, to make a  
14           judgment?

15    A     The judgment really is whether the mandates of practice  
16           have been complied with or not, and the -- apply the  
17           appropriate actions if noncompliance occurs.

18    Q     Do you as Complaints Director make findings of  
19           unprofessional conduct?

20    A     I do not.

21    Q     Is that prohibited under the HPA?

22    A     So the -- in this case, the Hearing Tribunal makes the  
23           determination of that. I don't assign guilt or  
24           innocence. That would be the purview of the Hearing  
25           Tribunal.

26    Q     Does a Complaints Director assess a threshold of

1 evidence?

2 A No. I think really the role of the investigation is to  
3 gather evidence and then present the evidence to the  
4 Tribunal, and the Tribunal will determine its value and  
5 weight.

6 Q Okay. Mr. Kitchen asked you or stated there was --  
7 asked you a question about there was no process for a  
8 chiropractor to practice without a mask. Were you ever  
9 asked by Dr. Wall as Complaints Director about that by  
10 Dr. Wall?

11 MR. KITCHEN: Hold on, hold on.  
12 Mr. Maxston, you asked that exact question in direct,  
13 and now you're asking it again. That's not a new  
14 issue. You're just re-going through your direct when  
15 you're asking that question.

16 MR. MAXSTON: Well, I think you asked  
17 whether there was a process for a chiropractor to  
18 practice without a mask --

19 MR. KITCHEN: Yes.

20 MR. MAXSTON: -- and I'm asking Mr. Lawrence  
21 whether he was ever asked --

22 MR. KITCHEN: Right.

23 MR. MAXSTON: -- about that process.

24 MR. KITCHEN: But you've already asked that  
25 question. Now you're just asking it again.

26 MR. MAXSTON: Well, I'm asking whether

1 Mr. Lawrence was ever asked about that. I'm not asking  
2 whether there was one or wasn't. I'm asking was  
3 Mr. Lawrence ever asked about the process.

4 MR. KITCHEN: You're asking if Mr. Lawrence  
5 was ever asked by Dr. Wall if there was a process?

6 MR. MAXSTON: I'll be even -- yeah, I'll be  
7 even more precise then.

8 Q MR. MAXSTON: Were you ever asked by  
9 Dr. Wall if there was a process?

10 MR. KITCHEN: Right, but you asked that in  
11 direct. This isn't new. This is redirect; it's new  
12 only. That's not --

13 MR. MAXSTON: Well --

14 MR. KITCHEN: -- new. You asked him; we  
15 have the answer to it.

16 MR. MAXSTON: Well --

17 MR. KITCHEN: You're going to get the same  
18 answer now, I don't dispute that, but I have an issue  
19 with you using redirect as Direct 2.0.

20 MR. MAXSTON: Well, your question was in the  
21 context of a human rights concern, and you then asked  
22 whether there was a process to address human rights  
23 concerns, and I'm going to ask Mr. Lawrence whether he  
24 was ever asked by Dr. Wall if there was a process to  
25 address human rights concerns, and that's new.

26 MR. KITCHEN: Well, I guess -- I don't think

1       it is. I think you asked something almost identical to  
2       that, maybe the exact words were different, but you, in  
3       substance, asked that question on the record.

4       MR. MAXSTON:                   Yeah, I asked him -- I asked  
5       him, Mr. Kitchen, about whether there was an exemption  
6       process. I didn't ask him whether someone had raised a  
7       human rights concern and asked about an exemption  
8       process.

9       THE CHAIR:                    I think we've been allowing  
10      some latitude in terms of these questions. I think I  
11      will allow this question with the inclusion of the  
12      specific reference to human rights, if that wording was  
13      not part of the first time this was raised.

14      MR. MAXSTON:                  So I'll ask a very precise  
15      question then.

16    Q   MR. MAXSTON:                  Mr. Lawrence, did Dr. Wall  
17       ever ask you about whether there was a process to  
18       address any human rights concerns he had?

19    A   No.

20    Q   In fairness to Mr. Kitchen and his last comment, I'm  
21       going to ask a question, but if he thinks it was asked  
22       and answered, I'll invite him to refresh my memory.

23               Did Dr. Wall ever ask you for an exemption?

24    A   No.

25      MR. KITCHEN:                  Again, we know the answer to  
26      that, but I --

1 MR. MAXSTON: I'm content to move on,  
2 Mr. Kitchen. I'm not going to pursue that any further.

3 MR. KITCHEN: Okay. Well, I have no issue  
4 with new questions, but you're asking the same  
5 questions you asked in direct. So regardless of  
6 whether we know the answer, whether it's controversial,  
7 I take issue with simply asking the same questions.

8 Q MR. MAXSTON: Mr. Lawrence, Mr. Kitchen  
9 asked you whether you refused to debate scientific  
10 efficacy of masking with Dr. Wall. Is debating that  
11 part of your role under the HPA as Complaints Director?

12 A It is not.

13 Q Mr. Kitchen asked you about the 99 percent recovery  
14 rate. Is recovery rates part of a charge in the notice  
15 of hearing?

16 A It is not.

17 Q Mr. Kitchen and you engaged in a discussion about your  
18 comment, alleged comment, to Dr. Wall during your  
19 telephone conversation where you allegedly said that  
20 Dr. Wall was not free to mask, and I believe you  
21 responded couldn't comment about his private life.  
22 Does the College have jurisdiction over a regulated  
23 member's private life in masking?

24 A It does not.

25 Q Were you concerned about Dr. Wall's private life and  
26 masking?



1 A No.

2 Q Mr. Kitchen made some comments to you about Dr. Wall  
3 being placed in a position where he could either choose  
4 between masking or earning an income, and that wasn't a  
5 free choice. Order 16-2020, about the relaunch of the  
6 profession, had required masking; is that correct?

7 A Yes.

8 Q Was this about a free choice for you as Complaints  
9 Director, Dr. Wall's alleged free choice?

10 A As the Complaints Director, compliance is a necessity  
11 or an obligation.

12 Q Mr. Kitchen engaged in a discussion with you about  
13 Section 65, and his words were that you were attempting  
14 to require masking or requiring Dr. Wall to force  
15 practice -- to stop practicing. Does Section 65 allow  
16 for interim suspensions for a member to stop  
17 practicing?

18 A Section 65 allows for an interim suspension, yes.

19 Q Mr. Kitchen talked about you coercing Dr. Wall into  
20 masking or, I guess his alternative, he did not  
21 practice; who made the Section 65 decision?

22 A Dr. Linford.

23 Q Did you have any involvement in Dr. Linford -- direct  
24 involvement talking to Dr. Linford about this decision?

25 A No.

26 Q You had a discussion with Mr. Kitchen about whether you

1           believed that Dr. Wall had a medical exemption. Was  
2           your belief relevant?

3     A     No.

4     Q     Can you tell me why?

5     A     The -- my beliefs aren't relevant. The legislation is  
6           what's relevant, and so the -- and, sorry, I should  
7           clarify, when I say "legislation", what I'm talking  
8           about is the mandates of practice, and I just use that  
9           term as a catch-all, I guess. So I'm referring to the  
10          Standards of Practice, the Code of Ethics, directions  
11          that are provided by council for the members to adhere  
12          to, and my role is to ensure there is compliance to  
13          those requirements.

14    Q     Mr. Kitchen brought you back to the Linford decision  
15           after leaving it for a few minutes, and he brought you  
16           back to it, do you ultimately decide whether a member's  
17           noncompliance is unprofessional conduct?

18    A     I do not.

19    Q     Who does that?

20    A     In this case, it would be the Hearing Tribunal.

21    Q     Did you have to make a determination about exemptions  
22           to refer this to hearing?

23    A     No.

24    Q     I'll ask you to go to Dr. Linford's decision letter and  
25           specifically page 2. And that again is Exhibit B-5,  
26           'B' as in Bob, dash 5.

1 A Okay.

2 Q Just while you're finding that, Mr. Kitchen asked you  
3 to confirm a number of statements in this letter by  
4 reading them out to you and asking is that  
5 Dr. Linford's statement, and I'm going to ask you to go  
6 to the paragraph in the middle of page 2 that begins:  
7 (as read)

8 I have decided that the interim suspension of  
9 Dr. Wall's practice permit is not justified  
10 at this point in time.  
11 I'm going to read the next sentence to you, and there's  
12 a question coming: (as read)

13 I have decided the conditions on Dr. Wall's  
14 practice permit will be sufficient to address  
15 the risk to the public by Dr. Wall not  
16 wearing a face mask or face shield when  
17 seeing and treating patients.

18 Is that Dr. Linford's statement?

19 A Yes.

20 Q Does he mention a risk to the public?

21 A Yes.

22 Q I'm going to ask you to go to the AHS rescind notice,  
23 that's the rescinding of the closure of  
24 (INDISCERNIBLE), and that is Exhibit D-2, 'D' as in  
25 dog.

26 A Okay.

1 Q So while everyone is finding that, Mr. Kitchen took  
2 you, I believe, to paragraph 3 of the rescind notice.  
3 There is a question coming, but paragraph 3 says: (as  
4 read)

5 Prior to booking an appointment, Dr. Wall  
6 must inform the patient he will be unmasked  
7 [and so forth].

8 I'm going to ask you to read Order Number 1 in the  
9 rescind notice.

10 A (as read)

11 Dr. Curtis Wall must follow the current  
12 re-opening practice guidance as set out by  
13 the Alberta College and Association of  
14 Chiropractors, as well as all future  
15 iterations of this guidance.

16 Q So the Pandemic Directive, the guidance, did it require  
17 masking?

18 A It did.

19 Q Is there a contradiction between Order 1 and Order 3 in  
20 your mind?

21 A I believe there is, yes.

22 MR. MAXSTON: Mr. Chair, this isn't a  
23 question, but I'll leave this as a final comment, I  
24 want to come back to something about the transcript and  
25 discuss that.

26 Q MR. MAXSTON: Mr. Lawrence, Mr. Kitchen

1       discussed with you how you decided to, after utilizing  
2       Section 56 to create a complaint, that you also acted  
3       as investigator. Do you have Section 55(2) of the HPA  
4       handy? And it's not crucial that you do, but if you  
5       do --

6     A    55(2)?

7     Q    Yeah.

8     A    Yes.

9     Q    And I'm really looking -- I'm sorry?

10    A    I do, yes.

11    Q    And can you tell me what Section 55(2)(d) as in dog  
12       says? And I think you'll have to read the opening line  
13       on 55(2) for it to make grammatical sense.

14    A    So 55(2) says: (as read)

15               The Complaints Director may ...

16       And (d) of that says: (as read)

17               May conduct or appoint an investigator to  
18       conduct an investigation.

19    Q    Did you rely on this section when you conducted the  
20       investigation yourself?

21    A    Yes.

22    Q    Is that allowed under the HPA?

23    A    It is.

24    Q    Mr. Kitchen asked you whether you were aware of any  
25       other complaints about Dr. Wall's conduct in terms of  
26       masking.

1 MR. KITCHEN: Hold on, that's not what I  
2 asked. I did not qualify it in terms of masking.

3 MR. MAXSTON: Okay, well --

4 MR. KITCHEN: I left it unqualified.

5 MR. MAXSTON: Fair enough, well, I'm going  
6 to ask the question then a little bit differently.

7 Q MR. MAXSTON: Mr. Kitchen asked you about  
8 whether there were any complaints against -- other  
9 complaints against Dr. Wall; is that correct?

10 A Yes.

11 Q And I think your response was that you relied on  
12 Section 56. Do you need more than one complaint to  
13 direct that an investigation occurs?

14 A I do not.

15 Q Mr. Kitchen asked you a series of questions about  
16 whether you have any evidence of Dr. Wall harming  
17 patients because of not masking or social distancing or  
18 using plexiglass barriers; is that relevant?

19 A I don't believe so. I think in a -- when we're looking  
20 at compliance, it's not about the outcome, it's the  
21 action.

22 Q When you look at the Notice of Hearing -- the Amended  
23 Notice of Hearing, are there any charges about causing  
24 harm to patients?

25 A There is not.

26 MR. MAXSTON: So, Mr. Chair, I want to go

1 back to something I was going to address sort of in the  
2 tail end of my questions, in the middle of my tail end  
3 of my questions.

4 Q MR. MAXSTON: Mr. Kitchen asked questions  
5 about a transcript or a recording of the I believe it's  
6 the December 3 telephone conversation and --

7 A Sorry, I think it was about the interview that  
8 Dr. Halowski and I conducted with him.

9 Q Pardon me, thank you.

10 MR. MAXSTON: I think, and this is open to  
11 the Tribunal more than anything, but -- well, first,  
12 you're not bound by the formal Rules of Evidence. If  
13 Mr. Lawrence has a recording or a transcript, I think  
14 it's open to this Tribunal to ask that he produce it,  
15 and that we finish his testimony tomorrow by reviewing  
16 that with him.

17 And I don't think that's unusual or extraordinary.  
18 My friend brought up the matter of the transcript. And  
19 if you're concerned about what was or wasn't said, and  
20 I think Mr. Kitchen is, I think it's fair to ask that  
21 that transcript be or recording, whatever it is, be  
22 entered as an exhibit, and we finish with Mr. Lawrence  
23 tomorrow morning.

24 So I'm going to ask Mr. Kitchen if he has any  
25 comments on that, but my sense is it might clear up a  
26 lot of questions.

1 MR. KITCHEN: I disagree. I don't think it  
2 would clear up hardly any questions. I don't object to  
3 it coming in as an exhibit. I do object to Mr. Maxston  
4 having another opportunity to do a direct examination.  
5 That ship has sailed. He's had his opportunity. He's  
6 done it. He did not introduce that as an exhibit as  
7 part of that or inquire to that. He should not be  
8 permitted, it's procedurally unfair to permit him to  
9 have another chance to have a direct examination of  
10 this witness. We've had a direct, we've had a cross,  
11 we've had a re-direct, let's put in the transcript and  
12 leave it there.

13 MR. MAXSTON: I'm not really -- I don't  
14 think my re-re-direct, if I was to ask Mr. Lawrence  
15 questions about it tomorrow, would be anything other  
16 than, Is this a recording, did you make it, or is this  
17 a transcript, did you type it up or have someone  
18 prepare it. That's all I would want to do. If you're  
19 consenting to it being entered as an exhibit,  
20 Mr. Kitchen, then I don't intend to ask any further  
21 questions about it because I've asked those questions.  
22 But it occurred to me that if it's a concern for the  
23 Tribunal, they can certainly have it as an exhibit.

24 MR. KITCHEN: Yeah, I'm fine with it being  
25 an exhibit, just not with any further questioning.

26 MR. MAXSTON: I think what I would -- again,



1     what I would suggest is that I ask Mr. Lawrence, if  
2     that transcript or recording is provided, you know, Is  
3     it something you created. And I'd leave that today. I  
4     just don't want there to be any question about the  
5     bona fides or source of that exhibit. I don't intend  
6     to ask him any questions about it other than that.

7     MR. KITCHEN:                     Well, you can ask him that  
8     question now I mean. If there is a transcript, if  
9     one's produced, you can ask him how it was produced,  
10    who produced it. I've got no issue to go ahead and ask  
11    it now.

12    MR. MAXSTON:                    Yeah, and I think I'm only  
13    going to do that if we have, (a), the consent from you,  
14    Mr. Kitchen, that this can go in and, (b), the Tribunal  
15    wanting it to go in. It just struck me, as I was  
16    listening to your questions about, you know, what said  
17    and what wasn't said, and I heard Mr. Lawrence indicate  
18    that there was either a transcript or a recording, I  
19    thought, well, why wouldn't we put that to the  
20    Tribunal. Not intending to re-examine, that's why I  
21    stopped right there and didn't ask a question.

22    MR. KITCHEN:                    Well, I tell you what, if  
23    there's a transcript, there's a recording. I think the  
24    fair thing to do, if the Tribunal agrees, is we put in  
25    the transcript as an exhibit but that you provide to me  
26    a copy of the audio recording. That sounds fair to me.

1 MR. MAXSTON: Why don't we do this: I'm  
2 going to --

3 Q MR. MAXSTON: We're digressing here,  
4 Mr. Lawrence, with some legalese questions, and they're  
5 good questions, but maybe I can ask you a couple of  
6 questions, with my friend's consent, about the  
7 transcript and the recording, and then we can see how  
8 that might or might not go in.

9 MR. MAXSTON: Would that be fair,  
10 Mr. Kitchen?

11 MR. KITCHEN: Yeah, I think that's okay.

12 A Can I make one comment about --

13 Q MR. MAXSTON: Sure.

14 A -- that? It is a recording not a transcript.

15 Q Okay. Well, I'll ask you a couple of quick questions  
16 about it. Did you make that recording when you had the  
17 conversation?

18 A I did.

19 Q Has it been altered in any way, to your knowledge?

20 A It has not.

21 MR. MAXSTON: Okay, subject to Mr. Kitchen,  
22 and I think, in fairness, he should have a chance to  
23 ask you some very basic questions about it as well, I  
24 think we should provide the recording to the Tribunal  
25 and go from there.

26 THE CHAIR: Can I ask -- and I'll be

1     frank, we discussed this at our last break and the  
2     question as to why it wasn't entered.  If it's a  
3     recording, is it -- are you proposing, Mr. Maxston,  
4     that it be played, or are you proposing that it be  
5     transcribed?

6     MR. MAXSTON:                     Well, I'm in Mr. Kitchen's  
7     hands because I really want to be fair to him.  To be  
8     honest with you, I think it might be better to have it  
9     transcribed and put the recording in so everybody has a  
10    chance to look at, you know, both versions of it.

11         I'm really concerned here with getting this  
12    information into your hands.  There's nothing devious  
13    here.  I'm not -- again, in fairness to Mr. Kitchen,  
14    I'm not going to ask questions about it.  I've asked  
15    questions about the discussion before.  It just  
16    occurred to me that, particularly when I heard his  
17    cross-examination, and there were questions about what  
18    was said and what wasn't said in this particular  
19    conversation, I thought, well, let's just put it in  
20    front of you.

21         And to the extent that helps or hurts my case or  
22    helps or hurts Mr. Kitchen's case, well, so be it.

23    THE CHAIR:                     It's kind of out of order in  
24    terms of normally we get that, and then there's  
25    questioning direct and cross.  So --

26    MR. MAXSTON:                     Well, again, Mr. --

1 THE CHAIR: Are --

2 MR. MAXSTON: Oh, I'm sorry.

3 THE CHAIR: -- we at the point where we've

4 agreed that it could be entered tomorrow morning and

5 that Mr. Maxston and Mr. Kitchen can ask a very -- very

6 pointed questions to establish what it is, it's

7 provenance, and then -- but not its subject?

8 MR. MAXSTON: I think I probably already did

9 that with Mr. Lawrence. I'm not sure I need to redo

10 that again.

11 MR. KITCHEN: What about this? We're going

12 to have to come back to hear more evidence at some

13 point, we don't know when, but that's -- we're probably

14 looking at at least a few weeks I'd imagine, unless we

15 can get ourselves all together again soon. Why not --

16 Mr. Maxston, let me know what you think of this -- why

17 not, in that span of time, because it should be quite a

18 bit of time, the recording is transcribed, and then

19 when that transcription is ready, it gets -- you know,

20 you can send it to me for me to have a look.

21 Presumably, I won't object to it, I don't intend to,

22 unless I see something fishy, which I don't expect to

23 see. It can go in by consent -- well, it can go in by

24 consent from counsel. We can, by consent, suggest that

25 the Tribunal accept it when we reconvene a few weeks

26 down the road to hear the rest of the evidence.

1           THE CHAIR:                           I would prefer that. I would  
2           much prefer to see a transcription. Then there is  
3           no -- since it's not going to be directly the topic of  
4           questioning at this point, then there's no panic to get  
5           it in tomorrow. Is that fair?

6           MR. MAXSTON:                        I didn't think it was  
7           providable tomorrow, if that's a word. I'm just  
8           suggesting that, you know, it's something that you  
9           might be interested in. And I'll be --

10          THE CHAIR:                           Who would transcribe it?

11          MR. MAXSTON:                        We could send it to a court  
12          reporter. We could ask someone internally at the  
13          College to do it. I'm a -- I want to make sure that  
14          Mr. Kitchen is comfortable with that process. Again --

15          THE CHAIR:                           I don't know --

16          MR. MAXSTON:                        -- I'm in your hands.

17          THE CHAIR:                           -- who has -- who has  
18          possession? The College?

19    A       The College.

20          MR. MAXSTON:                        I don't --

21          THE CHAIR:                           Yeah. Okay, can we leave it  
22          with the College to make arrangements to have a  
23          transcription prepared?

24          MR. MAXSTON:                        (NO VERBAL RESPONSE)

25          THE CHAIR:                           Okay.

26    A       Yes.

1 MR. KITCHEN: Now, I have to raise  
2 something. This was Mr. Maxston's idea, I've consented  
3 to it. In the event months from now, we get to a point  
4 where we're discussing costs, I'm going to object now,  
5 make it known, that I will object to the College  
6 claiming any costs for this transcription. Because as  
7 much as I'm consenting to it going in, it was not my  
8 proposal, it was not my idea, it was the College's idea  
9 to put it in.

10 So in the event the Tribunal rules against  
11 Dr. Wall, and the College, the Complaints Director  
12 seeks costs, I don't consent to the cost of this  
13 transcription being added --

14 THE CHAIR: Okay, that --

15 MR. KITCHEN: -- to those costs.

16 THE CHAIR: -- that's a -- your point's  
17 made. I think we're getting ahead of ourselves.

18 MR. MAXSTON: Yeah, and, Mr. Kitchen, let me  
19 be honest with you, if you don't think you want this  
20 in, then -- I mean it's really for your benefit in a  
21 sense, because you haven't questioned your client yet.  
22 I'm content to leave it out. I wanted to raise it.  
23 You seemed to, rightly so, have some questions about  
24 the interaction. If you don't want it to go in for  
25 either cost reasons or other reasons, I'm content to  
26 just leave things as is.

1 MR. KITCHEN: I'm indifferent. I'm content  
2 to leave it out as well. It sounded like it was your  
3 idea to bring it in.

4 MR. MAXSTON: Well, can I suggest this?  
5 Mr. Lawrence is in the sort of awkward position of  
6 being both witness and the client who gives me  
7 directions. Without discussing the contents of that  
8 tape at all or any questions about the discussion,  
9 because I can't do that, can I get instructions from  
10 him and let you know tomorrow what his preference is?

11 MR. KITCHEN: That's fine, yeah.

12 THE CHAIR: Okay, we'll table it till  
13 tomorrow.

14 MR. MAXSTON: Sure.

15 THE CHAIR: Mr. Maxston, were you finished  
16 with your examination -- your redirect?

17 MR. MAXSTON: Yes, I am. So I don't know if  
18 you want to take a break, Mr. Chair, and decide whether  
19 you have questions for Mr. Lawrence or you want to go  
20 ahead right now, but fine either way.

21 MR. KITCHEN: Mr. Chair, I propose I have a  
22 couple questions for recross. That was a pretty  
23 extensive redirect. That was a pretty extensive  
24 redirect that I think raised some new issues that I  
25 should be entitled to cross on.

26 MR. MAXSTON: I'm not going to object to

1           that, Mr. Chair, provided that I get the same courtesy  
2           if I have a couple of quick follow-ups on something  
3           down the road with my friend's witnesses.

4           THE CHAIR:                               Okay, let's proceed.

5                       Mr. Kitchen.

6           Mr. Kitchen Re-cross-examines the Witness

7    Q   MR. KITCHEN:                       Mr. Lawrence, just to confirm,  
8           you would not initiate an investigation unless there  
9           was at least a possibility of professional misconduct;  
10          isn't that correct?

11   A   Yes.

12   Q   In your discretion, before you initiate a complaint,  
13          you decide if there's actually any likelihood of a  
14          finding at the end of professional misconduct; do you  
15          not?

16   A   I don't know about if there's a finding, but if --  
17          because there might be what I would consider evidence  
18          of professional misconduct and then not a finding, but  
19          generally that's correct, yes.

20   Q   You said in answer to Mr. Maxston that you're not  
21          concerned about the private life of Dr. Wall; is that  
22          correct?

23   A   That's correct.

24   Q   Then it's not likely, given that lack of concern, it's  
25          not likely that your comments in the call to Dr. Wall  
26          about being free to wear a mask were actually about his



1 private life?

2 A What I meant by that when I said that is the concern  
3 is, because I don't have any legislative authority over  
4 his private life, so that's what I mean, in his private  
5 life, he's free to do whatever he chooses; my concern  
6 is only as a member of the College.

7 Q Right, so considering you're only concerned with the  
8 professional life of Dr. Wall, it's not likely you  
9 would have made that comment about being free to wear a  
10 mask only in the context of his private life; it's not  
11 likely you discussed his private life at all, correct?

12 A I don't agree with that, but I believe what I was  
13 talking about was, you know, in his private life, he's  
14 free to do whatever he decides he wants to do.

15 Q Dr. Linford disagrees with the ACAC on how to respond  
16 to the alleged risk to the public of not wearing a  
17 mask, correct?

18 A I think Dr. Linford's decision was to allow practice  
19 with restrictions until the completion of the complaint  
20 so that the Tribunal could make a decision on how best  
21 to proceed.

22 Q That's not what he said in his December 18th decision  
23 though, is it?

24 A Well, he said that he directs Dr. Wall's practice  
25 permit is subject to the following conditions pending  
26 the completion of the process under Part 4 of the

1 Health Professions Act, and Part 4 is dealing with  
2 complaints.

3 MR. MAXSTON: Mr. Kitchen, I wasn't going to  
4 object before, but we are now going back to things you  
5 directly asked my client about. This isn't anything  
6 new, so --

7 THE CHAIR: Yeah, I agree.

8 MR. KITCHEN: I think I just have one more.

9 Q MR. KITCHEN: So I'm going to the rescind  
10 notice. My learned friend asked you a question  
11 about -- a redirect question about a contradiction  
12 between 1 and 3, between paragraph 1 and paragraph 3 of  
13 that rescind notice. Do you recall him asking you that  
14 just a few minutes ago?

15 A Yes.

16 Q Contradiction being, paragraph 1 says: (as read)

17 Dr. Wall must follow the current reopening  
18 practice guidance as set out by the ACAC.

19 And then Section 3 says: (as read)

20 Prior to booking an appointment, Dr. Wall  
21 must inform the patient he will be unmasked  
22 while providing services.

23 So just to confirm, you think there's a contradiction  
24 there, correct?

25 A Yes.

26 Q Would you agree that, at least in the short-term, at

1       least for the last eight months, Dr. Linford does not  
2       see a distinction there? That's based on his written  
3       decision. I'm not asking about his thought process.  
4       Based on his written decision, Dr. Linford doesn't see  
5       a distinction there?

6       MR. MAXSTON:                   I'm not sure that question can  
7       be asked, because that's not something that is even  
8       addressed in the Linford decision. So, Mr. Kitchen, I  
9       think we've gone about as far as we can here with your  
10      recross-examination. I think that goes beyond  
11      Dr. Linford -- what Dr. Linford was even talking about,  
12      so I'm going to object to that.

13      MR. KITCHEN:                   That's fine. That's fine.

14    Q   MR. KITCHEN:                   Last question, and I only  
15       raise this because there seems to be some confusion  
16       about how many complaints to the ACAC that have been  
17       submitted on behalf of -- or about Dr. Wall.

18               Mr. Maxston said it doesn't take any more than one  
19       complaint against Dr. Wall for there to be a finding of  
20       professional misconduct, but just to be clear, there  
21       are zero complaints to the ACAC about Dr. Wall's  
22       conduct; is that correct?

23    A   Except the one presently opened, that's correct.

24    Q   So the only complaint is the one from yourself,  
25       correct?

26    A   That's correct.

1 Q Okay, good, we're on the same page.

2 MR. KITCHEN: All right, that's it for me.

3 Discussion

4 THE CHAIR: Okay, then that will conclude  
5 our session for today. We will resume, we'll convene  
6 for today and resume 9:00 tomorrow morning.

7 And I believe Mr. Maxston is finished with his  
8 witnesses, so you will have your at least one witness  
9 tomorrow morning, Mr. Kitchen?

10 MR. KITCHEN: I'm going to be calling  
11 Dr. Wall tomorrow morning, yes.

12 THE CHAIR: Okay.

13 MR. KITCHEN: Just to go back, so maybe I  
14 misheard, you don't have any questions then for  
15 Mr. Lawrence as the Chair, as the Tribunal?

16 MR. MAXSTON: I was just going to ask that  
17 actually.

18 THE CHAIR: We have -- we discussed that  
19 in the 15-minute break, and, at this point, I will say  
20 no.

21 MR. MAXSTON: Mr. Chair, I just want to make  
22 one other comment, Mr. Lawrence was the College's final  
23 witness, but you will recall, and I think this is --  
24 there's an understanding amongst everyone here, but I  
25 want to just put it on the record again, I believe the  
26 Hearing Tribunal gave my client the ability to call a

1 response witness or response evidence to Mr. Schaefer's  
2 expert report. I don't know if that will happen,  
3 frankly, but I just want to put on the record that,  
4 although the College's -- the Complaints Director's  
5 case is closed, there's that one caveat. I don't know  
6 if we'll be calling anyone, but I wanted to remind  
7 everyone of that.

8 THE CHAIR: I don't think we'll be doing  
9 that tomorrow.

10 MR. MAXSTON: No, I'm not in a position to  
11 do that tomorrow. It would be, frankly, out of order.  
12 To use a phrase my friend and I are familiar with, at  
13 some point, I might say, Well, before we go on to the  
14 next witness, we have to finish up with a Complaints  
15 Director witness concerning Mr. Schaefer. Again, I'll  
16 let Mr. Kitchen know as soon as we've made any  
17 determination on that, but, typically, I'd be saying  
18 now, well, the Complaints Director's case is closed,  
19 that's accurate with that one caveat.

20 THE CHAIR: Okay --

21 MR. KITCHEN: That's fine.

22 THE CHAIR: -- fair enough. Okay, on  
23 behalf of all of us, Mr. Lawrence, thank you very much  
24 for your attendance and your testimony today.

25 A Thank you.

26 THE CHAIR: You are discharged or

1 dismissed, I'm not sure which is the appropriate term.

2 (WITNESS STANDS DOWN)

3 THE CHAIR: And we will, for the rest of  
4 those on the hearing call, we will see everybody 9:00  
5 tomorrow morning.

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7 PROCEEDINGS ADJOURNED UNTIL 9:00 AM, SEPTEMBER 8, 2021

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1 CERTIFICATE OF TRANSCRIPT:

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3 I, Karoline Schumann, certify that the foregoing  
4 pages are a complete and accurate transcript of the  
5 proceedings, taken down by me in shorthand and  
6 transcribed from my shorthand notes to the best of my  
7 skill and ability.

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

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Karoline Schumann

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Karoline Schumann, CSR(A)

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Official Court Reporter

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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

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DISCIPLINARY HEARING

VOLUME 4

VIA VIDEOCONFERENCE

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Edmonton, Alberta

September 8, 2021

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

4

5 September 8, 2021 Morning Session

6

7 HEARING TRIBUNAL

8 J. Lees Tribunal Chair

9 W. Pavlic Internal Legal Counsel

10 Dr. L. Aldcorn ACAC Registered Member

11 Dr. D. Martens ACAC Registered Member

12 D. Dawson Public Member

13 A. Nelson ACAC Hearings Director

14

15 ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

16 B.E. Maxston, QC ACAC Legal Counsel

17

18 FOR DR. CURTIS WALL

19 J.S.M. Kitchen Legal Counsel

20

21 K. Schumann, CSR(A) Official Court Reporter

22

23 (PROCEEDINGS COMMENCED AT 9:03 AM)

24 THE CHAIR: Good morning everybody. We  
25 will start this morning with Mr. Kitchen's examination  
26 of Dr. Wall, and before we do that, we will have

1 Dr. Wall sworn by Karoline.

2 Discussion

3 MR. MAXSTON: Chair, it's Blair Maxston. I  
4 have a quick housekeeping matter to attend to from  
5 yesterday. When we concluded our -- if I could just  
6 deal with that very briefly -- when we concluded our  
7 discussion yesterday, there was a discussion about  
8 whether the Complaints Director would seek to have the  
9 recording of the interview entered and placed before  
10 you. I have received instructions from Mr. Lawrence to  
11 not to do that, so that won't be placed then before  
12 you.

13 THE CHAIR: Okay, thank you for clarifying  
14 that.

15 DR. CURTIS WALL, Sworn, Examined by Mr. Kitchen

16 MR. KITCHEN: Just to confirm, everyone can  
17 hear me.

18 Q MR. KITCHEN: Dr. Wall, you can hear me?

19 A (NO VERBAL RESPONSE)

20 Q Good. Dr. Wall, just to confirm, can you give us your  
21 full name for the record?

22 A Curtis Wall.

23 MR. KITCHEN: My fault, I apologize. Like I  
24 said, I think we can make this work; I'm just going to  
25 have to be diligent.

26 Q MR. KITCHEN: Now, Dr. Wall, when did you

1 first become a chiropractor?

2 A I attended Palmer College of Chiropractic in Davenport,  
3 Iowa, and I graduated with a Doctor of Chiropractic in  
4 1996.

5 MR. KITCHEN: Now, I apologize, I notice  
6 that produced some feedback as well, so if this  
7 continues, we might have to devise a separate way of  
8 doing this, but I'm going to just keep trying it a  
9 little bit longer. I had no way to really to test this  
10 prior to doing this.

11 THE CHAIR: Mr. Kitchen, would it help if  
12 there was maybe a couple of seconds pause between the  
13 end of your question and Dr. Wall's replying? I gather  
14 you're muting after you've spoken?

15 MR. KITCHEN: Yes, so that's what we're  
16 going to try to do is have more of a time lag in  
17 between each one. Just give me a second. Okay.

18 Q MR. KITCHEN: I'm just going to confirm,  
19 because of that issue, it was, in fact, Palmer College  
20 that you went to?

21 A That's correct.

22 Q All right, and, Dr. Wall, tell me why did you choose to  
23 go to that particular college amongst all the  
24 chiropractic colleges you could have gone to?

25 A That could be a long drawn-out answer. I'll give you a  
26 few of the salient points. I have a Bachelor of

1 Religious Education degree from a Canadian college, and  
2 in order to attend a Canadian chiropractic college,  
3 CMCC, I would have needed to take quite a few more  
4 credits in the social science end of things, and so I  
5 began looking at American colleges to attend because  
6 they did recognize my social science credits from the  
7 college I had attended in Canada.

8 And also I went to a chiropractor who had gone to  
9 Palmer College in Davenport, Iowa, and my wife attended  
10 a -- went to see a chiropractic who also went to Palmer  
11 College in Iowa. Another chiropractic friend, who --  
12 whose practice I actually purchased, attended Palmer  
13 College in Iowa. And so all those recommendations to  
14 attend Palmer were the reasons why.

15 And Palmer College in Davenport is considered a  
16 fountainhead. It was the original college that was  
17 started by B.J. Palmer. And so it has a very strong  
18 reputation for academic excellence, strong in  
19 philosophy, the philosophy of chiropractic, so the  
20 science, philosophy, and art were very strong  
21 components of Palmer College. So those are some of the  
22 specific reasons why I attended Palmer.

23 Q Thank you. Now, I heard you mention the philosophy of  
24 chiropractic, which is interesting. I don't know that  
25 I would have expected to hear that word. Can you just  
26 elaborate a little bit on what the philosophy of

1 chiropractic was when you went there?

2 A Quite basically, I would say that the philosophy of  
3 chiropractic is based on the fact that the body has an  
4 innate ability to heal itself and that the nervous  
5 system is a very strong component in the body's healing  
6 capabilities.

7 At times, there are interferences to the nervous  
8 system through spinal misalignments, and so the  
9 chiropractic adjustment just removes those  
10 interferences and helps the body to heal itself in a  
11 manner.

12 And so those are some of the philosophical  
13 understandings. Innate intelligence, the body was  
14 created or made with an ability to heal itself, and so  
15 yeah.

16 Q Thank you. Were there any core principles of  
17 chiropractic that were taught to you when you were at  
18 Palmer?

19 A Yes, core principles, basically stated what I was just  
20 referring to, some of those principles being that the  
21 body has innate intelligence, that there is a science  
22 component to chiropractic. So that core understanding  
23 is that the body is physical, and that, at times, we do  
24 have spinal misalignments that interfere with the  
25 nervous system and that chiropractic, through an  
26 adjustment, can remove those interferences and help the

1 body to heal in a natural way.

2 Q Thank you. Now, let's back up a little bit. Why did  
3 you want to become a chiropractor in the first place?

4 A Excuse my long answer. My initial intention with a  
5 career path was to become a youth pastor. In the  
6 process of doing that, my wife and I spent four years  
7 in lay work in a church doing youth ministry work.

8 And in so doing, I was working at the University  
9 of Calgary in the phys. ed. department, and I played  
10 quite a bit of squash at the time. And at one point, I  
11 was playing squash, and I ruptured my achilles tendon.  
12 That put me in the hospital, and while I was in the  
13 hospital for surgery, a friend of mine, a very close  
14 friend of mine was in his first year at Palmer College  
15 of Chiropractic in Davenport, and he sent me a  
16 prospective student packet.

17 And I looked at that packet while I was in the  
18 hospital, and I said to myself I wish I could do that.  
19 I was very much interested in health, natural healing  
20 processes, lifestyle choices. And I looked at that  
21 packet, and I thought I would love to be a  
22 chiropractor.

23 And all I can say is that the pieces of the puzzle  
24 were being put together very specifically and  
25 amazingly, which I won't go into detail, but that  
26 unfolded the desire to pursue becoming a chiropractor,

1           and there's so much to the story, but, yeah, that's  
2           basically how I got into it.

3       Q    Thank you. Do you feel like then that chiropractic is  
4           more than a mere occupation for you?

5       A    Yes, I thoroughly enjoy what I do. I thoroughly enjoy  
6           the privilege of helping assist people in their health  
7           care goals. Yes, it is an occupation, but I love  
8           coming to work. I love coming to work to help people  
9           and to assist people in lifestyle choices, and the  
10          basic understanding of removing nervous system  
11          interference so that their bodies can carry out health  
12          in the best possible way, so, yes, it is more than an  
13          occupation, but that is one component of it.

14      Q    Thank you. When did you first start practicing as a  
15          chiropractor in Alberta?

16      A    I first started practicing in Alberta in 1996, shortly  
17          after graduation, perhaps early '97. I saw a few  
18          patients in a colleague's office, began that way, and  
19          then I started doing locums for a year or two, and then  
20          I purchased a practice in 1998.

21                I had a young family. I decided that perhaps that  
22          was a better way to go to have a patient base to start  
23          with, and so in 1998, I purchased a practice, and  
24          that's how I've practiced ever since.

25      Q    When you started practicing in Alberta, did you think  
26          the chiropractic profession in Alberta held to the same



1 principles emphasized at Palmer College when you went  
2 to Palmer College?

3 A Yes, generally I would say so, yes.

4 Q When it comes to those principles, do you think things  
5 have changed here in Alberta since then?

6 A I have seen, over the last 20 years, a slow but steady  
7 change in chiropractic. I've seen a stronger role of  
8 governance from the College of less perhaps freedom to  
9 do some of the things that some chiropractors would  
10 prefer to do. I understand some of the reasoning that  
11 the College uses to create some of these restrictions  
12 perhaps or boundaries, but I have seen a steady  
13 decrease in the ability to do certain things that  
14 perhaps 20 years ago would not have been an issue.

15 Q Do you know roughly how many patients you've seen over  
16 the years that you've been a chiropractor?

17 A Very hard to tell, but several thousand for sure,  
18 multiple thousands, yeah.

19 Q Wow. Okay, do you have any patients that you have been  
20 treating for many years or even decades?

21 A Yes, yes, I have several patients that have started and  
22 stayed with me right from the beginning, so up to 25  
23 years, yes.

24 Q Now, let's go to the spring of 2020. Were  
25 chiropractors ordered by the Alberta Government to stop  
26 practicing in March of 2020?

1     A     There were, yes, restrictions on our ability to  
2           practice. We were told that we could only practice if  
3           the situation was an emergency, and so that was a  
4           regulation by the College to restrict only those people  
5           who had an emergency situation.

6     Q     And did the restrictions only come from the College, or  
7           did they also come from any other sources?

8     A     I believe the College placed that restriction in place  
9           due to Alberta Health Services. I'm sure they worked  
10          in collaboration with each other, so that's my  
11          understanding.

12    Q     And what was it like for you during that time that you  
13          could only treat emergencies?

14    A     Very challenging. My -- I support my family strictly  
15          through chiropractic, and I have a large family, many  
16          needs, and so when that happened, essentially my  
17          practice load went just about to zero, and I perhaps  
18          might see a patient in a day, maybe not. Some days  
19          were blank for sure, but, yeah, it was a stressful  
20          time.

21    Q     Do you have any sense of what it was like for your  
22          patients during that time?

23    A     I had several people say that it was difficult because  
24          they needed care, they needed to receive an adjustment  
25          to relieve their discomfort or their ailment. And so,  
26          yeah, many people were certainly -- had to wait, had to

1        wait it out or take painkillers or some other thing,  
2        but, yeah, it was challenging for everybody I think.

3        Q    And were you permitted to -- or were chiropractors  
4        permitted to re-open and start practicing again?

5        A    Yes, I believe -- I can't remember the exact date, but  
6        I believe it was sometime in May that that occurred.

7        Q    And did the College implement a directive in May that  
8        imposed extra requirements for chiropractic practice  
9        related to practicing under COVID?

10      A    Yes, they did.

11      Q    And do you recall the name of the document, and this is  
12      in the record, but I'll ask you anyways, do you recall  
13      the name of the particular document that contained all  
14      these requirements and restrictions?

15      A    It was called the Pandemic Practice Directive.

16      Q    Thank you. And I'm just going to call it the Pandemic  
17      Directive. Did the Pandemic Directive contain a  
18      requirement that chiropractors wear a mask?

19      A    Yes, it did.

20      Q    And do you recall specifically what types of masks were  
21      mandated in the directive to be worn?

22      A    Yes, it would have been a surgical style mask, so the  
23      blue type of mask, not a cloth mask, no homemade  
24      materials, a surgical mask.

25      Q    Now, we've heard a lot about how the Pandemic Directive  
26      was not optional. Did you regard the Pandemic

1 Directive as optional?

2 A No, I did not.

3 Q Okay, thank you. Now, did you start wearing a mask  
4 while treating patients once you became aware of the  
5 mandatory mask requirement in the Pandemic Directive?

6 A Yes, I did off and on. It was very apparent to me  
7 right from the start when I put on a mask that I did  
8 experience mental concerns, and so -- but I did put the  
9 mask on to treat patients, again off and on. It was  
10 very quickly that I realized my mental concern.

11 Q And just to confirm, the Pandemic Directive at the  
12 time, so this is spring of 2020, May of 2020, did you  
13 have to wear the mask all the time, or was there only  
14 certain times that you had to wear it according to the  
15 directive?

16 A According to the directive, we were supposed to wear a  
17 mask at all times unless we kept the physical distance  
18 barrier of 2 metres.

19 Excuse us, sorry, we forgot to lock the door.

20 Q Now, I'm curious, did you have any prior experience to  
21 regularly wearing a mask?

22 A None whatsoever.

23 Q So you didn't have any prior experience with being  
24 required to wear a mask then, I take it?

25 A That's correct.

26 Q Now, did you eventually stop wearing a mask while

1       treating patients, and by that, I mean being within 2  
2       metres of them?

3     A    Yes, I did.   Probably by the end of June, I made the  
4       decision that, with my mental concern and limitation, I  
5       decided that it was not productive for me to continue  
6       wearing a mask, and so I did stop by the end of June  
7       2020.

8     Q    And did you try wearing a face shield after you stopped  
9       wearing a mask?

10    A    Yes, I actually went out and purchased a face shield to  
11       see if that was also a problem, and when I put the face  
12       shield on, I also experienced the same symptoms.   And  
13       so, yes, I did purchase a face shield and tried that  
14       for several times.

15    Q    Now, why was it that you decided to try that as opposed  
16       to just taking off the mask and leaving it at that?

17    A    A face shield, I would think, provides a little more  
18       breathing room and space, and so that was my reasoning  
19       behind that, and so that's why I went to the face  
20       shield.

21    Q    Did you attempt to -- at that time, did you attempt to  
22       obtain a doctor's note that would provide you with a  
23       medical exemption to wearing a mask?

24    A    No, I did not.

25    Q    Did you think there was any requirement that you do so?

26    A    No, I didn't.

1 Q Did you understand the Pandemic Directive to include  
2 any direction about reaching out to the College if you  
3 were having problems with wearing a mask?

4 A No, I didn't see anything in the directive that stated  
5 that. I initially -- my thought was that my health  
6 information is private, between me and my doctor, and  
7 so I didn't decide that that was privy information to  
8 discuss with anybody at the time.

9 Q Did the College give you any reason to think that it  
10 would be supportive and work with you if you had  
11 reached out and told them your concerns about wearing a  
12 mask?

13 A No, they did not. Of course, the College is always of  
14 the stance that we should reach out if we have concerns  
15 and -- but on the same note, from my calls with  
16 Dr. Halowski and with Mr. Lawrence, it was apparent to  
17 me that, even as I expressed my concerns, there was no  
18 option with respect to the mask wearing.

19 Q Dr. Halowski mentioned an email that you had written to  
20 him I think just a few months before all this. Did you  
21 ever receive a response to that email?

22 A No, I did not.

23 Q Did that contribute to your apprehension about whether  
24 or not the College would be supportive?

25 A Yes, it did. In fact, in addition to sending an email  
26 to Dr. Halowski, I sent an email to a trusted, tenured

1       chiropractor, whom I've known for 30 years, and the  
2       response I received back was also very vague and  
3       disheartening when I expressed my concerns in that  
4       email. So I was reluctant that the College was going  
5       to have any, you know, understanding with my situation.

6       Q   During this time, in the spring of 2020, did you have  
7       some doubts or fears about the College penalizing you  
8       or punishing you for what was going on?

9       A   Yes, I did.

10      Q   Did you think in the spring of 2020, so around this  
11      time, that the so-called surgical or blue or medical  
12      masks were effective at preventing the transmission of  
13      respiratory viruses such as the COVID virus?

14      A   I had done my own research, and it's not -- again, I  
15      don't want to say that this is my word, this is  
16      research that I -- as doctors, we all look into various  
17      research, and so having researched this issue with  
18      respect to masks, yes, I did have some very strong  
19      concerns that they were effective at reducing the  
20      transmission of viral particles, specifically COVID in  
21      this situation, and I also had concerns about their  
22      health risks to the person wearing them.

23      Q   So you started being concerned about what you just  
24      called the health risks right away then?

25      A   Yes, I did.

26      Q   And can you describe for me what some of those health

1 risks are?

2 A Specifically, when one wears a mask, there's decreased  
3 oxygen that you're taking in, and there is an increase  
4 in carbon dioxide intake. And whether perceptible or  
5 not, these physical facts are certain, and, at varying  
6 degrees, people will experience symptomatology, so,  
7 yes, I'm very aware of these physical issues.

8 Q Now, have you, since the spring of 2020, developed any  
9 other concerns or personal objections to wearing a  
10 mask?

11 A Yes, I have. I would say that I do have religiously,  
12 sincerely held religious beliefs that would preclude me  
13 from wearing a mask. Specifically, I'm a Christian,  
14 and that means that I am a born-again follower of Jesus  
15 Christ. And as such, I adhere to the teachings and  
16 requirements of the Holy Bible. And in Genesis 1:27,  
17 it states that: (as read)

18 God created mankind in his own image, in the  
19 image of God he created them, male and female  
20 he created them.

21 So I believe that, number one, my face is sacred and  
22 sacred to me and sacred to God, because it is -- it's a  
23 manifestation of his image. So for me to cover up my  
24 face, essentially places a barrier between me and  
25 Jesus.

26 And for someone to require me to wear a mask,



1 who's in a position of authority, when there's no other  
2 reason to put that mask on other than the fact that  
3 they are telling me to, when I don't exhibit any  
4 symptoms or any upper respiratory issue, to me, is  
5 essentially fearing man and not God, and so that's one  
6 aspect of it.

7 Also, as a Christian, I believe that I am to live  
8 my life in the fullest measure and expression of faith.  
9 And just to clarify that, I just want to read a couple  
10 of, again, passages of the Bible that support my  
11 religious conviction. Hebrews 11:6 says: (as read)

12 And without faith, it is impossible to please  
13 God: for whoever comes to God must believe  
14 that he exists and that he rewards those who  
15 diligently seek him.

16 The 2nd Corinthians 5:7 says: (as read)

17 For we walk by faith and not by sight.

18 And Romans 14:23 says: (as read)

19 For whatever does not proceed from faith is  
20 sin.

21 And so when I have to wear a mask, I am not living by  
22 faith; I am living because someone in a position of  
23 authority has told me, Put that mask on, whether it's  
24 fear-based or whether it's for some other reason, it  
25 violates my life of faith, and so that's one of the  
26 aspects of my religious convictions.

1           Also, I would have to clarify to say that the  
2           Canadian Charter of Rights and Freedoms and the Alberta  
3           Human Rights Act protect my expression of my  
4           religiously held beliefs, and it guards against anybody  
5           discriminating against those beliefs, and so that's  
6           kind of all wrapped up into that section.

7       Q    Thank you. Why do you think it took you time to come  
8           to that conclusion instead of that being instantly  
9           apparent?

10     A    Sometimes you don't know the significance of an issue  
11           until or the significance of a freedom until it is  
12           taken away, and this would apply in this situation.  
13           Until our freedoms have been -- our health freedoms  
14           have been slowly chipped away, you don't realize what  
15           it is that you have or the significance of it, and so  
16           that's how I would answer that question. It took some  
17           time to formulate that and to recognize, listen, this  
18           is going on.

19     Q    Had you ever in your life before this thought about  
20           masking or mandatory masking in the context of your  
21           religious beliefs as a Christian?

22     A    Never.

23     Q    You just never had any reason to; is that it?

24     A    That's correct.

25     Q    Do you think mandatory masking interferes with bodily  
26           autonomy?

1     A     Yes, I do when it's mandated. I believe that, as a  
2           chiropractor, I have been and we have all been trained  
3           to respect the principles of, first, do no harm and the  
4           principle of informed consent; extremely important  
5           principles that we are required to carry out in our  
6           profession every day.

7                 So mandatory masking does violate those things.  
8           Specifically, the College has never performed informed  
9           consent to the issue of mask mandating, and this is a  
10          medical procedure, wearing a mask is a medical  
11          procedure because there is an imminent risk of mental  
12          or physical harm by putting the mask on. And so I  
13          believe that, essentially, the College has violated  
14          that aspect of informed consent and the right to bodily  
15          autonomy and, first, do no harm.

16                 Putting on a mask harms me, and it harms my  
17          patients. And so as a doctor, which means teacher, I  
18          have to educate my patients; I have to tell them the  
19          specific harms of a treatment, risks of potential  
20          harms, and so that's all wrapped up in mandatory  
21          masking. It's not following informed consent, and it's  
22          not following, first, do no harm

23     Q     Do you seek to obtain informed consent when you do your  
24           treatments with patients?

25     A     From every patient at the outset of their becoming a  
26           patient, that is required, and if there's any changes

1 in treatment protocol or in their health picture, yes,  
2 we have to keep informed consent updated.

3 And informed consent is not implied; it has to be  
4 expressed, and so that's a very specific thing, it has  
5 to be communicated. We have to say here are the risks  
6 to this treatment, here are the benefits to this  
7 treatment, and here are some alternatives that you can  
8 do if you would like to investigate those. So these  
9 are core principles for sure.

10 Q And are there some treatments -- generally speaking,  
11 are there some treatments where the risks become quite  
12 high and the benefits become quite tenuous, and there's  
13 a difficult decision to make about whether you actually  
14 proceed with that treatment?

15 MR. MAXSTON: Mr. Kitchen, I'm sorry to  
16 interrupt, I've been a little bit liberal here; I think  
17 you're asking some fairly leading questions --

18 MR. KITCHEN: Okay --

19 MR. MAXSTON: -- so I'm a little concerned  
20 about that. Just thought I'd mention it.

21 MR. KITCHEN: That's fine. That one was ad  
22 hoc, and it was a little leading, I'll admit. That's  
23 fine.

24 Q MR. KITCHEN: Do you think wearing a mask  
25 also impacts psychological illness?

26 A Yes, I do. It can.

1 Q I'm going to take you to -- talk a little more about  
2 your patients. When you stopped wearing a mask, how  
3 did your patients react?

4 A Most of my patients never said a thing. They were very  
5 understanding. I would express to several patients,  
6 who did ask me if I would be wearing a mask, that I did  
7 have an exemption. And I would say 99 percent of those  
8 patients were very understanding and unconcerned, and  
9 there was the odd person who requested, you know, more  
10 information, and if I was at liberty to discuss that, I  
11 would. But, yes, 99 percent of my patients were  
12 unconcerned and were okay with my not wearing a mask.

13 Q So for those who wanted more information, was there any  
14 kind of discussion about why you weren't wearing one?

15 A Yeah, I -- for somebody that I felt in a trusted  
16 position, I would talk about my mental concern, but  
17 others, I would just, you know, give a very generalized  
18 answer.

19 Q Why do you think so many of your patients were so  
20 understanding?

21 A My patients know who I am. They know my character.  
22 They know who I am as a chiropractor, that I believe in  
23 their health. They trust me with their health. They  
24 trust me as somebody who understands the health  
25 process. And so I believe that it was a doctor/patient  
26 trust relationship that enabled people to feel

1 comfortable and to understand that they were coming  
2 into an office that was safe, and there was no risk of  
3 harm from them by me not wearing a mask.

4 Q Now, let's jump forward six, seven months to December  
5 of 2020. Did AHS close down your chiropractic office?

6 A Yes, it did.

7 Q Now, I'm going to take you and everybody else to that  
8 closure order, which is Exhibit D as in dog, D-1. Now,  
9 was there a CMOH order that was specified in that  
10 closure order?

11 A Yes, there is.

12 Q And which one was it?

13 A That is CMOH Order 38-2020.

14 Q Now, I'm going to come back to all the things that  
15 happened in December, but let's forward to early  
16 January; did AHS permit your chiropractic office to  
17 re-open?

18 A Yes, it did.

19 Q And was that done through another document that  
20 rescinded the closure order?

21 A Yes, it was. I had to complete a re-opening template  
22 and meet some of the requirements that were specified  
23 with that template.

24 Q Okay, so I'll bring you to that notice; it's Exhibit  
25 D-2. Now, did AHS permit you to continue treating  
26 patients in person without wearing a mask?

1 A Yes, they did.

2 Q Did you provide AHS with a doctor's note verifying your  
3 medical exemption from wearing a mask?

4 A I believe I did.

5 Q And why did -- looking at this rescind notice, why did  
6 AHS permit you to practice without wearing a mask?

7 A I believe they recognized the doctor's -- the medical  
8 doctor's note and decided that was sufficient grounds  
9 to permit me to treat patients.

10 Q You said earlier that it was CMOH Order 38-2020 that  
11 was mentioned in the closure order, so I'm going to  
12 take you to CMOH Order 38-2020. Just got to get the  
13 exhibit number. 38-2020 is Exhibit D-8. Now, I know  
14 we've been over this, but let me ask you is there  
15 anything in that order that provides for medical  
16 exemptions to wearing a mask?

17 A Yes, there is. Yes, there is.

18 Q All right, let's go back now to December. Did you hear  
19 from the College in early December?

20 A Yes, I did.

21 Q Did you receive a call from the Registrar, Todd  
22 Halowski?

23 A Yes, I did.

24 Q And did Dr. Halowski say anything in that call about  
25 how a decision may be made that you either wear a mask  
26 or sit out from practicing?

1 A Yes, he did.

2 Q Did you receive a call from the Complaints Director,  
3 David Lawrence?

4 A Yes, I did.

5 Q And did he say anything in that call about suspending  
6 your licence?

7 A Yes, he did.

8 Q Did you ask him any questions about accommodation?

9 A Yes, I did. I asked him, I said I knew the College was  
10 in a difficult place because of their desire to protect  
11 the public, and I also said but they also had a role in  
12 protecting its members; and so I discussed my mental  
13 concern, that I was exempt, and left that on the table  
14 and asked if there would be accommodation for that.

15 Q Did you mention anything about human rights?

16 A Yes, I did.

17 Q Did you say anything to him about how the literature  
18 does not support wearing a mask?

19 A Yes, I did.

20 Q What was Mr. Lawrence's response when you made that  
21 comment about the literature?

22 A I believe his response was that he didn't want to  
23 debate me on the issues. He felt he just had a  
24 responsibility to protect the public. He also said  
25 that he disagreed with me, and he said that I was a  
26 danger to the public and that he was going to initiate



1           this investigative process.

2       Q    Did you say anything to Mr. Lawrence about the  
3           percentage of the COVID recovery rate?

4       A    Yes, I did. I stated that there was a 99.97 percent  
5           recovery rate for people who were infected with COVID.

6       Q    Did Mr. Lawrence say anything to you about making or  
7           not making you wear a mask?

8       A    Yes, he said he couldn't make me wear a mask, but that  
9           if I was not going to wear a mask, he would have to  
10          initiate this practice suspension, suspending my  
11          licence.

12      Q    And did Mr. Lawrence say anything to you about you  
13          being free to not wear a mask?

14      A    Yes, yeah, he said I was free to wear a mask, but there  
15          would be the consequence, of course, of my licence  
16          being suspended.

17      Q    Did you understand this comment about "free" from  
18          Mr. Lawrence to mean that the College's masking mandate  
19          was actually optional?

20      A    No, this mandate was not optional.

21      Q    Do you think "mandate" and "optional" are contradictory  
22          terms?

23      A    I don't know the answer to that.

24      Q    Did Mr. Lawrence say anything to you about your private  
25          life or what you do in your private time during that  
26          call?

1 A No, not to my knowledge. I can't remember him talking  
2 about me and my private life or what I do with that.

3 No, I can't remember that. I don't think he did.

4 Q Now, after talking to Mr. Lawrence, did you feel like  
5 you were free to decide whether or not to wear a mask?

6 A No, I did not feel like I was free. I felt that there  
7 was a very strong arm of the College that was about to  
8 step in and stop my practice.

9 Q And was this call with Mr. Lawrence around December 3rd  
10 or 4th?

11 A That's correct.

12 Q Did Mr. Lawrence submit a request to suspend your  
13 licence?

14 A Yes, he did.

15 Q Now, you said earlier that you did not attempt, in the  
16 spring of 2020, to obtain a doctor's note in support of  
17 your inability to wear a mask. Did you now at this  
18 time, in December, attempt to obtain a doctor's note?

19 A Yes, I did. It seemed that there was an unspecified  
20 requirement from the College that verification of a  
21 mental or physical limitation or concern was required,  
22 and so I did try to obtain one at that time, yes.

23 Q When you first told Mr. Lawrence that you had a medical  
24 exemption, did you have doubts about whether or not he  
25 believed you?

26 A M-hm, yes, I did have doubts.

1 Q Did you end up receiving a medical note from a medical  
2 doctor regarding your inability to wear a mask?

3 A Yes, I did.

4 Q And do you recall when you received that?

5 A I can't remember the exact date in December, but  
6 sometime after December 5th.

7 Q It's an exhibit in the records, so I could give it to  
8 you to refresh your memory about when, but is it your  
9 recollection that you provided this note to him before  
10 Dr. Linford made a decision about Mr. Lawrence's  
11 request?

12 A I can't remember the exact timeline, but, yes, I  
13 believe it was before, but I'm unclear on the specific  
14 dates.

15 Q Were you at all surprised that Dr. Lawrence forged  
16 ahead with the request even though you gave him this  
17 medical note?

18 A No, I wasn't surprised. Dr. Lawrence was very clear  
19 that his role was to protect the public and that he  
20 needed to initiate this process, and so, yeah, he was  
21 going to do that, and so I wasn't surprised.

22 Q Did you feel like your medical concerns mattered at all  
23 to the College?

24 A No, I didn't feel like they mattered.

25 Q And what actually were your medical reasons for not  
26 being able to wear a mask?

1     A     When I put on a mask, I experience feelings of anxiety  
2           and a sense of claustrophobia, like somebody's cutting  
3           off my air supply. And so what that does is it  
4           decreases my concentration level, and it makes it  
5           difficult for me when I am treating patients and  
6           note-taking to maintain proper concentration and  
7           provide the best possible care to my patients, and so  
8           that specifically is what my mental concern was.

9     Q     And were those things reflected in the medical  
10           documentation you received from the doctor that you  
11           saw?

12    A     Yes, that was reflected in that doctor's note.

13    Q     Now, of course, there's this original note from  
14           Dr. Salem. Did the College ask -- I shouldn't say the  
15           College, forgive me. Did the Complaints Director,  
16           Mr. Lawrence, did he ask for further details from  
17           Dr. Salem?

18    A     Yes, he did.

19    Q     And did Dr. Salem provide those?

20    A     Yes, he did.

21    Q     Was a decision made regarding Mr. Lawrence's request to  
22           suspend your practice permit?

23    A     Yes, a decision was made.

24    Q     And who made that decision?

25    A     I believe Dr. Linford had to make that decision.

26    Q     And as part of Dr. Linford's written decision, did he

1           consider your medical note from Dr. Salem?

2     A     Yes, he did.

3     Q     So then were you permitted by Dr. Linford to continue  
4           practicing without wearing a mask?

5     A     Yes, I was permitted. There were further conditions  
6           and restrictions placed on me at the time, but, yes, I  
7           was permitted.

8     Q     Did the College ever raise the possibility of you  
9           practicing without a mask but with conditions?

10    A     Yes, it did, after Dr. Linford's decision came out.

11    Q     What about before?

12    A     No, there -- no.

13    Q     Let's just talk a little bit about your office. Have  
14           you had any staff at your office since the spring of  
15           2020?

16    A     Yes, I employ members of my family in my office  
17           occasionally, and so, yeah, my son was working in the  
18           spring of 2020 up until December of 2020.

19    Q     How old was he at that time?

20    A     He was 17.

21    Q     And as of December, just before he stopped working with  
22           you in your office, was he wearing a mask when he was  
23           working in your office?

24    A     No, he wasn't.

25    Q     And why is that?

26    A     He has religious concerns and beliefs that preclude him

1 from wearing a mask.

2 Q Are those similar to yours?

3 A Yes, they are.

4 Q Yesterday, Mr. Lawrence read into the record as part of  
5 his testimony that you did not tell him, during the  
6 January 25th, 2021 interview, that you had any other  
7 reasons that you did not mask. Did you tell  
8 Mr. Lawrence you had other reasons for not masking  
9 besides your issues with anxiety and claustrophobia in  
10 that interview?

11 A I don't believe I did. Yeah, I'm unclear, but I don't  
12 think I did.

13 Q And you had by now, by January 25th, you had made some  
14 conclusions about your religious beliefs around  
15 masking?

16 A Absolutely.

17 Q So why didn't you tell Mr. Lawrence about those beliefs  
18 during that interview?

19 A I believe that the primary issue was my mental concern  
20 and limitation. The religious beliefs are very strong,  
21 but I didn't believe that that was to come into play at  
22 the moment, so I left it at the mental concern, because  
23 it appears to me, from the CMOH order, that the only  
24 real exemptions that are provided are through physical  
25 or mental concerns or limitations.

26 Q Just want to ask you a few questions about the

1 treatments you provide your patients. What is the  
2 standard treatment you provide your patients when they  
3 come in to see you?

4 A The standard type of treatment that I provide is a  
5 chiropractic manual adjustment. And "chiropractic" is  
6 a term that means chiro, it means hand, and practice,  
7 which means work done by hand, and so that is my --  
8 from day one, that's been my primary form of treating  
9 patients.

10 Q Forgive my ignorance as a non-chiropractor, but did you  
11 just tell me that "chiro" means hand, and the reason  
12 it's chiropractic is because "practic" is a reference  
13 to practice, is that what you just said?

14 A Yes.

15 Q So the name itself means using your hands to treat the  
16 body of another?

17 A That is correct.

18 Q What system of the body does this treatment intend to  
19 impact or improve?

20 A That's a loaded question. There are many aspects to a  
21 person's body, many different systems, and so  
22 essentially when you adjust a person, you're physically  
23 adjusting the skeletal structure, but there are  
24 far-reaching implications to that, because in the  
25 chiropractic philosophy and science aspect of it,  
26 you're also removing nervous system interference, and

1       you're also causing soft tissues to perhaps relax and  
2       come into better function.

3               So you're dealing with multiple systems of the  
4       body, but you're primarily adjusting, you know, the  
5       skeletal soft tissue component from an outward  
6       perspective.

7       Q    This treatment, this physical manipulation, is this the  
8       primary form of care you provide?

9       A    Yes, it is.

10      Q    Can you provide this treatment from a distance?

11      A    No, you cannot.

12      Q    Can you provide it over the phone?

13      A    I wish, but no.

14      Q    Can your patients providing this treatment to  
15       themselves?

16      A    No, they cannot.

17      Q    Are there any treatments you can provide your patients  
18       that are as effective as manual manipulation that do  
19       not require you to be within 2 metres of your patients?

20      A    No, there is not.

21      Q    Do you think Telehealth is effective?

22      A    It may have its place, but it doesn't -- it's not  
23       effective in my situation for what I do.

24      Q    Do you think your patients find it effective?

25      A    I haven't had a single patient tell me that they've had  
26       a Telehealth experience or treatment.



1 Q Do you think you'd be properly caring for your patients  
2 if you could only provide them with Telehealth?

3 A Absolutely not.

4 Q Do you think it likely that some of your patients would  
5 eventually have to seek care from a different  
6 chiropractor if you could only provide Telehealth to  
7 them?

8 MR. MAXSTON: Mr. Kitchen, I hate to  
9 interrupt, but the last two questions in particular  
10 aren't questions; they're leading questions in my view.  
11 I'm sorry to interrupt you, but I've raised this  
12 concern before, but those are loaded questions, they're  
13 not a regular question.

14 MR. KITCHEN: All right, I'll rephrase.

15 THE CHAIR: Mr. Kitchen, this might be an  
16 appropriate time to ask you how much longer you  
17 anticipate your examination will be in terms of a  
18 possible break. We've been going for an  
19 hour-and-a-quarter, and we'd just like to get an idea.

20 MR. KITCHEN: Well, I might be about  
21 halfway, so a break would make sense to me. I'm pretty  
22 sure I'm on track here to finish by the lunch hour, as  
23 you can see, Dr. Wall is not a big talker. So I --  
24 yeah, I think now is fine for a break, and we should  
25 not be in any jeopardy of not finishing by the lunch  
26 hour.

1 THE CHAIR: Okay, I think that would be a  
2 good idea. So let's take a break. It's 10:14 by my  
3 watch. Let's come back at 10:30, and we'll continue  
4 with Dr. Wall's testimony. So we'll convene for now,  
5 and we'll see everybody in 15 minutes.

6 MR. KITCHEN: Thank you.

7 (ADJOURNMENT)

8 THE CHAIR: Okay, we're back in session,  
9 and, Mr. Kitchen, the floor is yours.

10 MR. KITCHEN: Thank you. We're having some  
11 technical difficulties. Just bear with me. Let's turn  
12 your mic on.

13 (DISCUSSION OFF THE RECORD)

14 MR. KITCHEN: Sorry, my apologies.

15 Q MR. KITCHEN: Dr. Wall, before the break,  
16 I'd asked you if you think you were properly caring for  
17 your patients if you could only provide Telehealth, and  
18 you answered no, and then the next question was  
19 objected to.

20 So let me ask you this: Do you think your  
21 patients are receiving the care they need from you if  
22 you're only providing them with Telehealth?

23 A No, they would not.

24 Q Do you think your patients would need to seek manual  
25 adjustment treatment from another private chiropractor  
26 if they couldn't get it from you?

1 A Yes, I believe they would.

2 Q How do you think your ability to keep practicing and  
3 earning an income would be impacted if all you could do  
4 was provide Telehealth?

5 A I believe it would be severely impacted. Again,  
6 hands-on procedure for me is the primary form of care  
7 that I provide. Patients would go elsewhere, and so,  
8 yeah, it would be severely impacted.

9 Q Do you care about more than just the musculoskeletal  
10 health of your patients?

11 A Yes, I do. I believe that a person is not just  
12 physical, there is an emotional and spiritual component  
13 to it, so if that's what you're referring to, but --  
14 so, yes.

15 Q Thank you. Do you feel like you owe any other duties  
16 to your patients other than a duty to provide good  
17 adjustments to their musculoskeletal system?

18 A That's a very good question. I'm sure there are other  
19 duties. I would have to give that some thought, but  
20 that would be a primary duty is to provide safe and  
21 effective chiropractic care to my patients, so yeah.

22 Q When it comes to treating your patients, are there any  
23 principles that come to mind that are important to you?

24 A Again, I touched on this earlier, but the principle of,  
25 first, do no harm is an oath that we take when we  
26 graduate, become chiropractors, and so that

1 encapsulates the principle of we are to very cautiously  
2 and carefully and thoughtfully examine what we are  
3 doing with our patients and teach and instruct them,  
4 you know, lifestyle issues, but -- so that's a primary  
5 principle. And, again, the principle of informed  
6 consent is also paramount when it comes to dealing with  
7 treating our patients.

8 Q Do you think those principles are engaged when it comes  
9 to masking or the masking of your patients?

10 A I believe they're engaged in my office, so, yes, I  
11 instruct my patients. If I see there's a potential for  
12 something to cause harm, many times I'll have to  
13 educate my patients on that, and so yes.

14 Q Do you permit your patients to not wear a mask in your  
15 office?

16 A Yes, I do.

17 Q Why?

18 A I believe everybody has the responsibility to make  
19 their own health choices. Health freedom is very  
20 important to me, and, again, that is a decision that  
21 has to be between that person and their personal health  
22 belief, personal bodily autonomy, and so that's an  
23 extremely important aspect of how I treat my patients.  
24 So, yes, everybody that comes in has the freedom to  
25 wear a mask or not to wear a mask based on their  
26 personal decision.

1 Q Do you feel like the College's stance regarding  
2 mandatory masking has placed you in a difficult  
3 position regarding your patients?

4 A A very difficult position, yes.

5 Q Do you feel AHS's stance on mandatory masking has put  
6 you in a difficult position?

7 A It appears that the Alberta Health Services has left  
8 some room for people who have physical or mental  
9 concerns to exercise those concerns and not wear a  
10 mask.

11 It appears that the College has no wiggle room for  
12 that expression. If somebody has a mental or physical  
13 concern or disability, yeah, there's no wiggle room for  
14 the College when it comes to that and the members of  
15 the College.

16 Q Does the College require patients to wear a mask?

17 A No, it does not.

18 Q And you've given some thoughts on masks, you gave some  
19 thoughts back in the spring of 2020, and, you know,  
20 you've given some religious objections, but have your  
21 thoughts changed at all regarding masks in the last 18  
22 months?

23 A No, they have not.

24 Q Do you think, if you did require your patients to wear  
25 a mask while you treated them in your office, that you  
26 would be causing harm to them?

1     A     Yes, I do. I believe that wearing a mask does decrease  
2           oxygen levels, increase CO2 levels, and that, again,  
3           whether perceptive to that person or not, the physical  
4           fact remains, and it's to the extent physically that it  
5           imposes a real imminent physical harm and danger.

6     Q     Have you read or heard anything, whether in this  
7           hearing or before, that has caused you to change your  
8           mind on the ineffectiveness of masks?

9     A     No, nothing I've heard would cause me to change my  
10          mind.

11    Q     Let's just discuss your office a little more. Are you  
12          aware of any instance where COVID was transmitted in  
13          your office?

14    A     No, I am not.

15    Q     Do you think you ever put any of your patients at a  
16          higher risk of contracting COVID than they would  
17          otherwise regularly encounter by treating them without  
18          wearing a mask?

19    A     No, I don't. I am asymptomatic. I come to work; I  
20          have to adhere to the very same prescreening questions  
21          that all patients must adhere to.

22                 When it comes to treatment, I treat patients one  
23          on one. There is no one else in the office but that  
24          patient and myself. And so, no, I don't believe that  
25          there is an increased risk.

26    Q     Have you ever treated patients while being symptomatic

1 with COVID symptoms?

2 A No, I have not.

3 Q Do you think you've done anything since COVID that has  
4 in any way threatened the health or safety of your  
5 patients?

6 A Absolutely not.

7 Q Do you think your actions since March of 2020 have  
8 caused any harm to any of your patients?

9 A No, I do not.

10 Q Just a quick side question here, did you ever receive a  
11 ticket for not wearing a mask, contrary to the Calgary  
12 mask bylaw?

13 A No, I did not.

14 Q Do you think you are a health care worker?

15 A Yes, I do.

16 Q Do you think there are different types of health care  
17 workers?

18 A Yes, I do.

19 Q Do you think health care workers fall on the spectrum?

20 A Can you explain that question?

21 MR. MAXSTON: Mr. Kitchen, I hate to keep  
22 interrupting, but that's a fairly leading question, a  
23 fairly leading couple of questions, "Do you think".  
24 I'd just ask you to rephrase that. I know where you're  
25 going, but I think the introduction presupposes an  
26 answer.

1 Q MR. KITCHEN: Now, Dr. Wall, you said that  
2 you do think there are different types of health care  
3 workers. Please explain, in as much detail as you can,  
4 what you think those differences are?

5 A I would say that there are emergency room doctors,  
6 there are paramedics, there are pathologists, all could  
7 be classified, there are chiropractors, naturopaths,  
8 all could be classed as health care workers, facing all  
9 kinds of different situations and treatments and  
10 patient needs. So, yes, there is a very wide spectrum  
11 of health care workers.

12 Q And how would you say, you as a chiropractor, how would  
13 you say that's different than, for example, being a  
14 doctor in an ER?

15 A Quite different in the sense that, number one, I'm  
16 seeing people one on one, I'm seeing people who have  
17 been prescreened in this last year-and-a-half, and I am  
18 seeing people who are asymptomatic obviously. And I  
19 would say that somebody in the ER, a doctor, is seeing  
20 more emergency types of situations with significant  
21 potential for bodily fluid contact and so on. So I  
22 would say it's a much different experience than what  
23 I'm doing in my office.

24 Q Do you think your chiropractic office is a health care  
25 setting?

26 A Yes, I do.



1 Q Do you think all health care settings are the same?

2 A No, I don't.

3 Q Could you describe for me how you think the health care  
4 setting in your office is different than the health  
5 care setting of a hospital?

6 A I believe the setting in my office is much more  
7 personable if you're looking at it from an emotional  
8 component perhaps, so it's much more welcoming; it's a  
9 homier feel; it's I would say much smaller; there's  
10 less fear involved in my office compared to perhaps a  
11 hospital or an ER setting.

12 So -- and I'm treating people with chiropractic  
13 care; I'm not treating people for cuts and stitches and  
14 broken bones and these types of situations, so I would  
15 say there's quite a big difference.

16 Q Is making your patients feel comfortable really  
17 important to you?

18 A Yes, it is; it establishes a sense of trust and, yes,  
19 so people want to come to my office. It's a very  
20 important part.

21 Q Do you directly treat infectious illnesses?

22 A No, I do not.

23 Q Do patients come to you for you to directly treat  
24 infectious illness?

25 A No, they do not.

26 Q Do you agree with Dr. Halowski that, generally, as a

1       chiropractor, you don't see people with infectious  
2       illnesses?

3       A   No, people will have infectious illnesses.  So I will  
4       see people with infectious illnesses, but I am not  
5       treating them for infectious illnesses.  If I could  
6       clarify that also.

7       Q   Go ahead.

8       A   That's not a norm; that's a very rare thing.  And,  
9       again, in the last year-and-a-half, we have to  
10      prescreen people.  So if they are exhibiting any  
11      symptoms, we are not allowed to treat them; you have to  
12      reschedule them.  And so in this last year-and-a-half,  
13      I have not seen anybody that has exhibited a  
14      symptomatic infectious illness.

15      Q   You mentioned "prescreening" a lot; is it your  
16      understanding that prescreening is something that's  
17      quite important to the College?

18      A   Yes, it is very important.

19      Q   Have you received any communication from the College  
20      that indicates which is more important between  
21      prescreening and masking?

22      A   No, I have not.

23      Q   I'm going to shift gears a little bit here.  Do you  
24      think it's possible to know the scientific truth about  
25      things like viruses?

26      A   Yes, I do.

1 Q Including COVID?

2 A Yes.

3 Q Do you think there's a large amount of scientific  
4 information now available about COVID?

5 A Yes, a lot of information.

6 Q Do you think it's enough to actually make an informed  
7 determination on whether or not certain measures are  
8 effective at preventing the transmission of COVID?

9 A Yes, I do.

10 Q And would that include masking as a measure?

11 A Are you asking if masking is an effective measure at  
12 preventing COVID?

13 Q No, I'm just wondering if you think there's enough  
14 scientific knowledge to actually make an informed  
15 determination on whether or not masking is effective or  
16 not?

17 A Yes, I do believe that.

18 Q Do you think there's enough scientific information to  
19 make an informed determination on whether or not  
20 physical distancing is effective?

21 A Yes, I do.

22 Q Do you think there's enough scientific information  
23 available now to make an informed determination on  
24 whether or not masking as a restriction is harmful to  
25 the health of individuals?

26 A There is enough information, yes.

1 Q Would you agree with Dr. Hu that COVID Public Health  
2 restrictions have probably killed more people than  
3 COVID itself?

4 A Yes, I would agree with that. Yes, I would agree with  
5 that.

6 THE CHAIR: I'm sorry, Mr. Kitchen, I  
7 missed your question; would you mind repeating it,  
8 please.

9 MR. KITCHEN: Sure, yeah.

10 Q MR. KITCHEN: Dr. Wall, do you agree with  
11 Dr. Hu that COVID Public Health restrictions have  
12 probably killed more people than COVID itself?

13 A Yes, my answer is yes.

14 THE CHAIR: Thank you.

15 Q MR. KITCHEN: And just to confirm, do you  
16 agree with Dr. Hu that the COVID survival rate is 99  
17 percent?

18 A Yes, I agree with that.

19 Q Do you think the College is making scientific knowledge  
20 the top priority when they make decisions about  
21 restricting the behaviour of chiropractors?

22 A I believe the College thinks they have. I think they  
23 have consulted with Alberta Health Services, and they  
24 believe that they are using information that is  
25 accurate, but I believe it is inaccurate. And there's  
26 too much conflicting scientific evidence that comes

1 from very credible, credible sources that would  
2 contradict the measures that have been put in place.

3 I am not a lone wolf stating some of those  
4 scientific issues. These scientific facts come from  
5 people much more knowledgeable and skilled to be able  
6 to represent that information in their fields of  
7 expertise, and so, yeah.

8 Q Well, in fact, some of those people are going to  
9 provide expert testimony.

10 Do you find it surprising that the College seems  
11 so unwilling to consider other viewpoints like yours?

12 A Not really, because I understand that our College is  
13 regulated by the Health Professions Act, which has a  
14 strong medical model, and there is a certain mindset  
15 about how legislation is formulated. So I can -- I'm  
16 not surprised by it, but I wish it were different.

17 Q Do you think Alberta Public Health has generally gotten  
18 it wrong when it comes to masking?

19 A Yes, I do.

20 Q Do you think Alberta Public Health has generally got it  
21 wrong when it comes to other COVID restrictions?

22 A Yes, I do, and I wouldn't say that's just my opinion.  
23 As we know, that will be backed up by our expert  
24 witness, and it is a testimony of so many others in so  
25 many different fields, not only health care, but  
26 emergency preparedness within the military, it's been

1       demonstrated that what has happened in the last  
2       year-and-a-half has not followed the methods that would  
3       be acceptable for an emergency situation such as COVID.

4       Q   Do you think there is fear to challenge the perspective  
5       of Government Public Health?

6       A   Yes, I do.  Fear is a very big motivator in this  
7       situation, always has been.  And in this situation,  
8       yes, if you stand up to the Public Health authority or  
9       your regulatory body, you risk -- you risk being  
10      censured, you risk your licence being suspended, and  
11      nobody wants that, nobody wants to experience what I'm  
12      experiencing right now.  There are other chiropractors  
13      out there who believe as I do, but they are afraid of  
14      being in my situation.

15                I am the -- I would say one of the least likely  
16      people to be in this situation right now.  From the  
17      standpoint that, if I can say, I am a very compliant  
18      person, generally speaking.  I do not like to make  
19      waves.  I do not like conflict.  But a barrier was  
20      crossed, my health freedoms were crossed, and I have to  
21      say something, and I know I'm not the only one.  I know  
22      there are many others out there, but they're afraid.  
23      And so, yes, that is a very accurate statement:  Fear  
24      is a huge motivator to not step out.

25      Q   Do you feel like, as a professional, you have an  
26      ethical obligation to speak the truth?

1     A     Absolutely.

2     Q     You described just a few minutes ago COVID being an  
3           emergency, did you think it was an emergency last  
4           spring?

5     A     It was put out that way, but, no, I did not think it  
6           was an emergency.

7     Q     Do you think it's an emergency now?

8     A     No, I do not.

9     Q     Is your integrity something that's really important to  
10           you?

11    A     Extremely important.

12    Q     If you were told that there was going to be an  
13           application to suspend your licence, why didn't you  
14           just put the mask on?

15    A     Well, number one, as I've said, wearing a mask causes  
16           me anxiety and the inability to concentrate properly to  
17           do my -- the best work I can. So that's reason number  
18           one.

19           But I also understand it to affect my physical  
20           health. I know there's -- there are physical  
21           limitations and harms about putting a mask on, and so I  
22           had to -- I had to go with a personal health choice and  
23           freedom, bodily autonomy. No informed consent was  
24           provided to me by the College, and I had to stand up  
25           for those basic rights and freedoms.

26    Q     Even though doing so might risk your licence?

1 A Yes, that's correct. I would emphasize character over  
2 reputation.

3 Q Do you think the College has violated your legal rights  
4 over the last year-and-a-half?

5 A Yes, I do.

6 Q Do you think the College's mandatory masking directive  
7 is unreasonable?

8 A Yes, I do insofar as other mandates, orders have  
9 allowed provisions for exemptions, and the Pandemic  
10 Directive has not allowed for any exemptions.

11 Q Do you think you've done anything unethical by  
12 permitting your patients to leave their faces uncovered  
13 when you treat them?

14 A No, I do not.

15 Q Who do you believe you owe your first loyalty to?

16 A First loyalty is to my patients. It's -- that's who I  
17 come to see every day, and they're my priority. And  
18 so, yeah, my ethical and moral responsibility is to my  
19 patients primarily, not to the College.

20 Q What about government?

21 A Well, the same would go for that. Ethically and  
22 morally, it's first to my patients, and if there's  
23 something I see from the government that violates that,  
24 I have to speak up, and I have to stick to treating my  
25 patients and treating them with the utmost respect  
26 first.



1 Q Do you think you've done any unethical by not wearing a  
2 mask yourself when treating your patients?

3 A No, I don't.

4 Q Do you have any concerns about the future of the  
5 chiropractic profession in Alberta?

6 A Yes. I have spoken about this to my wife. Over the  
7 last ten years, I have seen the steady increase in  
8 regulatory control, which has a veneer of protecting  
9 the public with decreased freedom for the chiropractor,  
10 and I've seen it occurring, and so, yes, I do have  
11 concerns for the chiropractic profession at this time,  
12 yes.

13 Q Do you think increased freedom for chiropractors to do  
14 lawful things is good for patients?

15 A Yes, I do.

16 Q Do you think if chiropractors were less constrained by  
17 the College that they would be more likely to engage in  
18 sexual impropriety with their patients?

19 A No, I don't. Somebody who's going to engage in sexual  
20 impropriety, whether there are restrictions or not, is  
21 likely going to commit that offence.

22 Q Why do you think the College has done all that it's  
23 done to you since December of 2020?

24 A I understand the College has a responsibility to  
25 protect the public, and that, again, is what they  
26 consider to be their highest mandate over protecting

1       the rights and freedoms of its members. And so I  
2       think, based on the legislation that has come down from  
3       the Public Health and the collaboration that has  
4       happened to create our Health Professions Act has  
5       created a difficult situation for the College whereby  
6       they cannot make this distinction between protecting  
7       the public and protecting the rights of its members.

8               And it's a very fine line. I think there needs to  
9       be some renegotiating that occurs to balance that out.  
10       I am not against rules and regulations, but I believe  
11       in this situation, there has been a line that has been  
12       crossed, so ...

13    Q    Do you think mandating that chiropractors wear masks  
14       while treating patients is in any way actually  
15       protecting the public?

16    A    No, I don't.

17    Q    Do you think the College is trying to protect the  
18       public?

19    A    Yes, I do.

20    Q    Do you think the College is very concerned with  
21       pleasing the Chief Medical Officer of Health?

22    A    Yes, I do. Again, I believe that much that has been  
23       collaborated with the Alberta Health Services and the  
24       College of chiropractic has created this dynamic, this  
25       relationship whereby the College does want to please  
26       authority, and so yeah.

1 Q Do you think when it comes to COVID, there is a tension  
2 between the desire to please government and the duty to  
3 protect patients?

4 A Are you referring to the College or to myself?

5 Q I'll ask it again. Do you think, in the context of  
6 COVID and when it comes to the College, there is a  
7 tension there between desiring to please the government  
8 and desiring to protect the interests of patients?

9 A I don't think I'd be able to speak to that because I'm  
10 not part of council, I'm not part of those people that  
11 make those decisions. That would be a tough decision  
12 for me to say. I don't think I could say that.

13 Q I asked you earlier if you ever received a ticket for  
14 not wearing a mask contrary to the Calgary bylaw; did  
15 you ever receive a ticket for not wearing a mask  
16 contrary to a CMOH order?

17 A No, I have not.

18 Q Do you think you've actually breached any CMOH orders?

19 A No, I don't.

20 Q Have your patients expressed any thoughts to you about  
21 the fact that you have -- that you're not wearing a  
22 mask?

23 A Did you ask have they expressed any concerns that I'm  
24 not wearing a mask?

25 Q No, I asked if your patients have expressed any  
26 thoughts about the fact that you're not wearing a mask

1           when you treat them?

2     A     Yeah, I've had a few patients express their thoughts,  
3           so we have engaged in some discussion, and there are  
4           some people that believe in mask wearing, there are  
5           some people that don't believe in mask wearing, and so,  
6           yeah, I have definitely interacted with both sides of  
7           the fence with respect to that.

8     Q     Do you think the fact that masks are mandated in spaces  
9           like chiropractic offices, do you think that interferes  
10          at all with that, an attempt by you to create an  
11          emotionally welcoming environment?

12    A     Yes, I do. I believe when you cover the face with a  
13          mask, you are taking away a significant portion of  
14          communication ability. You're not able to read lips.  
15          You're not able to see facial expression as well. And  
16          not only that, your voice is muffled. So many times  
17          you can't hear or distinguish what the person is  
18          saying. So, yeah, it definitely creates a less  
19          welcoming environment, an environment for potential or  
20          greater misunderstanding between you and the patient,  
21          and, yeah.

22          MR. KITCHEN:                   Thank you, Dr. Wall. Those  
23          are my questions.

24    A     Thank you.

25          MR. KITCHEN:                   Now, I note we're at 11:20,  
26          which is a little early for lunch, so, you know, I

1     guess we'll have to hear from Mr. Maxston what his  
2     thoughts are about his cross. I doubt he wants to  
3     break it up with a lunch break, so -- but I'm very  
4     flexible.

5     THE CHAIR:                     Okay, thank you, Dr. Wall,  
6     thanks, Mr. Kitchen.

7             Mr. Maxston, what are your thoughts on next steps?

8     MR. MAXSTON:                 Well, I'm going to propose  
9     this potentially: Maybe we take a break for 10 or 15  
10    minutes. What I -- because I'd like to press on with  
11    Dr. Wall in just one respect.

12            I've been making notes of the direct examination,  
13    and I have questions arising from that. I wonder if  
14    it's a good idea for me to try and get through those  
15    questions now while Dr. Wall's testimony is fresh in  
16    everyone's mind, and then -- and I hope I can do that  
17    before lunch. And then at 1:00 or 1:15, whatever  
18    works, then I would start my planned questions if I can  
19    describe it that way.

20            I'm just a little reluctant to -- I think  
21    Mr. Kitchen's nodding his head -- I'm a little  
22    reluctant to start lunch at 11:30. Maybe I can make  
23    some headway at least with Dr. Wall in a good way in  
24    terms of asking those questions now. I just need a  
25    little bit of time to prep for that and consult with my  
26    client.

1 THE CHAIR: Okay, Mr. Kitchen, I'll take  
2 your nodding as agreement with that approach, so --

3 MR. KITCHEN: Yeah, if we could just have 10  
4 minutes, because we've got to work on the technology on  
5 our end too, so ...

6 MR. MAXSTON: I think even 15 minutes to be  
7 honest, yeah.

8 THE CHAIR: It's 11:20, let's recess until  
9 11:35. We'll reconvene then, and Mr. Maxston can start  
10 his cross-examination.

11 (ADJOURNMENT)

12 THE CHAIR: We're back in session, and,  
13 Mr. Maxston, the floor is yours.

14 MR. MAXSTON: I just want to be sure, is  
15 Mr. Dawson in attendance? I don't know if he's gone --  
16 if he's activated his camera.

17 THE CHAIR: Okay, yeah, we were having a  
18 caucus during the break, so he might be a minute or two  
19 late. Thank you, I didn't notice that. Let's just  
20 wait for Mr. Dawson. He won't be long I'm sure.

21 (ADJOURNMENT)

22 THE CHAIR: Okay, not to interfere in the  
23 exchange, but Mr. Dawson is back, so we'll resume the  
24 session with Mr. Maxston and his cross-examination.

25 MR. MAXSTON: So again, Mr. Chair, what I'm  
26 going to do now is I'm going to go through my questions

1       that I noted during Mr. Kitchen's direct examination,  
2       and I'm going to stop at 12, regardless of where I'm  
3       at, whether I'm finished or not. I'll finish after  
4       1:00, if need be, with those questions, and I'll then  
5       begin my more structured questions after that.

6       Mr. Maxston Cross-examines the Witness

7       Q     MR. MAXSTON:                Dr. Wall, in the beginning of  
8       your questions with Mr. Kitchen, you talked about the  
9       fact that, in your mind over 20 years, you've seen a --  
10      I think you said a slow and steady decrease -- slow and  
11      steady change, pardon me, in the College and I think an  
12      increase in restrictions. Wouldn't it be fair to say  
13      though that professions evolve and grow, and we become  
14      better at regulating professionals over time?

15     A     I would say we evolve and grow but not necessarily  
16     better.

17     Q     You had a discussion with Mr. Kitchen, and in fairness  
18     to him, you talked about restrictions coming from the  
19     College, and you said, well, they also came from  
20     government; and you were talking there about the CMOH  
21     orders and I think the re-opening order, that type of  
22     thing. You're aware that all professions have to have  
23     a re-opening plan and have to have some type of  
24     restriction on masking; is that correct?

25     A     Yes, I'm aware of that.

26     Q     So it wasn't just this college or you as a

1           chiropractor?

2     A     That's right.

3           MR. KITCHEN:                         Sorry, Mr. Maxston, I  
4           sincerely apologize. I have another headset, and I'm  
5           going to go quickly get that and put that on, because I  
6           just want to make sure that there's no feedback that's  
7           interfering with you; is that all right if I just run  
8           and do that?

9           MR. MAXSTON:                         Oh, I don't I can continue  
10          without that, Mr. Kitchen, so you've got to hear the  
11          question, so, yeah, sure thing.

12          (ADJOURNMENT)

13          THE CHAIR:                             All right, we're back on the  
14          record. Mr. Maxston.

15     Q     MR. MAXSTON:                         Dr. Wall, you had a discussion  
16          where Mr. Kitchen asked you did the Pandemic Directive  
17          include direction to reach out to the College if there  
18          were problems with masking, and I think your answer was  
19          no.

20                 Isn't it fair to say though that you can always  
21          reach out to the College? You don't need, a standard  
22          of practice, for example, doesn't have to say, Call us  
23          if you have a question or a policy on this or that; you  
24          can always reach out though, can't you?

25     A     That's right.

26     Q     You had an exchange with Mr. Kitchen about the



1 requirement to obtain a doctor's note, and you said  
2 there was nothing in the Pandemic Directive requiring  
3 that, and I think you also mentioned that your health  
4 information is private between you and your doctor. If  
5 you were to disclose that information to the College  
6 though, it wouldn't become public, would it?

7 A Insofar as addressing it to the College is addressing  
8 it to the public. The College is not my doctor, and so  
9 I believe that's public.

10 Q But I guess what I'm getting at is if you send that  
11 information to the College and you say, Look, I've got  
12 a medical condition, that information is not  
13 distributed to the public at large; it goes to the  
14 College; isn't that correct?

15 A That would be correct.

16 Q You had a discussion about your March 3 email to  
17 Dr. Halowski, and I believe you said you didn't receive  
18 a response. This isn't a gotcha question, I just want  
19 to say to you that Dr. Halowski, his recollection, is  
20 that there was, in fact, a response, and it was a March  
21 4 email to you, where he essentially said, Thank you  
22 for your note, I'm going to send this to counsel. I'm  
23 just asking if that refreshes your memory about getting  
24 a response.

25 A Yes, that is very correct, but no further follow-up to  
26 that.

1 Q Just wanted to be clear that it wasn't unanswered.

2 You had a discussion about I think your  
3 apprehension with coming forward to the College, and  
4 you said you were reluctant to do so because you felt  
5 the College would not be supportive, but isn't it fair  
6 to say from June until December, you really didn't  
7 reach out to test the College's temperature, so to  
8 speak, on this?

9 A That is correct, but I also, as previously stated, did  
10 not believe that it was the College's position to hear  
11 my private health information, and so that is another  
12 reason why I didn't reach out to the College.

13 Q I think you'd agree with me though when you do your  
14 annual practice permit renewal, there are questions  
15 that go to your personal and private information. You  
16 have to disclose fitness to practice issues and those  
17 types of things, and you would routinely send that to  
18 the College, wouldn't you?

19 A Did you say "fitness practice issues"?

20 Q Sorry, fitness to practice is what I said.

21 A Yes.

22 Q You had a discussion with Mr. Kitchen at a number of  
23 points about consent and informed consent regarding  
24 masking, and I think you said that the College's  
25 mandatory masking requirement for you violated consent,  
26 and I'm going to suggest to you that that's the wrong

1 way about looking at consent, and that patient consent  
2 is the proper way to frame that phrase, and it's about  
3 getting consent from a patient to treatment. So the  
4 College doesn't have to get consent from members, do  
5 they, to Standards of Practice or things like the  
6 Pandemic Directive?

7 A I would disagree with that because my position would be  
8 the wearing of a mask is a medical procedure or a  
9 treatment, and, as such, it requires informed consent.

10 Q Aren't all of the College's requirements though, like  
11 infection control, those kinds of things, wouldn't it  
12 be a little unusual to say members have to consent to  
13 all those types of things?

14 A I'd have to say that mandating a mask poses an imminent  
15 risk to mental or physical harm, whereas infectious  
16 measures perhaps don't carry that imminent risk to  
17 harm, and so I would disagree with that.

18 Q Well, we'll agree to disagree on whether consent really  
19 applies here then.

20 One thing to be clear though, the College in the  
21 Pandemic Directive never said there must be masking for  
22 patients, correct?

23 A That is correct.

24 Q You had a discussion about what happened when you  
25 stopped masking and how patients reacted, and I think  
26 you said most never said a thing, 99 percent were

1       unconcerned, but, Dr. Wall, isn't it fair to say that  
2       patients don't vote on what standards apply to their  
3       health care provider?

4       MR. KITCHEN:                   I take an issue with that,  
5       because that's not a proper quote from what Dr. Wall  
6       said, he didn't say anything about 99 percent. So  
7       perhaps we need to go back to the record, but,  
8       Mr. Maxston, I only object to that question because  
9       you're putting words in Dr. Wall's mouth that aren't  
10      his.

11      MR. MAXSTON:                 You know, I think he did say  
12      99 percent, but that's really not the point of my  
13      question, (INDISCERNIBLE) just forgetting than that  
14      (INDISCERNIBLE) --

15    Q   MR. MAXSTON:               But I think you had a -- made  
16      a comment that most of your patients never said a  
17      thing, but, again, my question is then patients don't  
18      vote on what you should or shouldn't apply as part of  
19      your practice when it comes to your college; they don't  
20      tell you what to do; is that not correct?

21    A   That's correct.

22    Q   You, in response to a question about why so many  
23      patients were understanding, you mentioned that there  
24      was patient trust and character, and you said that  
25      there was no risk of harm to your patients. And I'm  
26      going to suggest to you that that's, frankly, kind of

1 an astonishing statement to make. Are you absolutely  
2 confident that not masking poses absolutely no risk to  
3 your patients?

4 A Yes.

5 Q I want to turn to some of the questions you had with  
6 Mr. Kitchen about the phone discussion you had with  
7 Mr. Lawrence, and I think you mentioned that the  
8 College was in a difficult place, but their role is  
9 protecting the public. You've talked about literature  
10 not supporting masking and kind of talked about what I  
11 think you felt were Mr. Lawrence's -- the tone of his  
12 comments. But I just want to be clear, Mr. Lawrence,  
13 at that stage, is the Complaints Director; he's not  
14 making any findings of unprofessional conduct, is he?

15 A That's --

16 Q I don't mean to trick you, that's the Hearing Tribunal,  
17 isn't it?

18 A I would agree, yes.

19 Q So you talked to Mr. Kitchen about the commencement of  
20 an investigation, and that's a discretion that a  
21 Complaints Director has, correct?

22 A Yes.

23 Q And, again, this isn't a gotcha question, but Section  
24 65 of the HPA allows a Complaints Director to seek a  
25 suspension; is that not accurate?

26 A Yes.

1 Q And I think you said in response to, again, one of the  
2 questions about Mr. Lawrence's interaction with you,  
3 you said that Mr. Lawrence advised you that he was  
4 fulfilling his public protection duty; is that  
5 accurate?

6 A Yes.

7 Q Mr. Kitchen asked you a question about what happened  
8 after your discussion with Mr. Lawrence. I think there  
9 was a question about whether Mr. Lawrence asked you  
10 anything about your private life, and you said no, and  
11 the question was something along the lines --

12 MR. MAXSTON: -- Mr. Kitchen, you can jump  
13 in --

14 Q MR. MAXSTON: -- did you then feel free to  
15 decide to wear or not wear a mask, and your answer was,  
16 no, you felt the strong arm of the College was about to  
17 step in and stop your practice. But it really wasn't  
18 the College that stepped in to stop your practice, it  
19 was AHS, wasn't it?

20 A Well, it was AHS that closed my practice in December,  
21 but it was the College that was ensuing the  
22 investigation further and looking into the suspension  
23 of my licence.

24 Q Again, what I think I was really getting at is your  
25 wording was that you were afraid the College was going  
26 to step in and stop you from practicing, but the

1 College never did that ultimately. Dr. Linford didn't  
2 do that, and it was AHS that did that?

3 A Yes, but this is still an ongoing investigation, and  
4 the College still has the possibility of shutting my  
5 practice down if they deem so at the end of the  
6 hearing.

7 Q And I guess I disagree with you a bit. I would say it  
8 would be a Hearing Tribunal not the College, because  
9 the Hearing Tribunal issues orders.

10 You talked about your son practicing at the  
11 clinic, and you indicated that he wasn't masking. Did  
12 he have a medical exemption note?

13 A No, he did not.

14 Q He didn't have a doctor's note then is what I'm getting  
15 at?

16 A That's correct.

17 Q You talked with Mr. Kitchen about the standard  
18 treatment you provide to patients, and you engaged in  
19 an interesting discussion about hand and practice and  
20 chiropractic, filling us all in on the nature of that,  
21 but I really want to stress, I think this is consistent  
22 with Dr. Halowski's testimony yesterday, you would  
23 agree there are other elements of practice, like  
24 educating patients?

25 A Absolutely.

26 Q And consulting them?

1 A Absolutely.

2 Q Yeah, and you can do that with social distancing?

3 A Absolutely.

4 Q Mr. Kitchen asked you questions about the principles  
5 that you employ in your practice, which ones are  
6 important to you, and I think you said the first one is  
7 do no harm to patients. Have you ever considered what  
8 the impact would be if you were wrong about masking?

9 A I'm confident in my understanding of masking to such an  
10 extent that I know it's not harmful.

11 Q Mr. Kitchen asked you a question, do you permit  
12 patients to not mask, and I believe you said yes, and  
13 he said why, and you said about freedom to make their  
14 own choices, something along those lines. I wonder if  
15 you can go back to Exhibit D-2, which is the AHS  
16 rescind order, which re-opened your clinic. And I'll  
17 just give you and the Tribunal Members a couple of  
18 minutes to go to that. Are you there, Dr. Wall?

19 A Yes, I am.

20 Q Okay. Order Number 4 says: (as read)

21 Dr. Curtis Wall must ensure that all patients  
22 he treats continuously wear a mask that  
23 covers their mouth and nose for the duration  
24 of their time in the clinic, unless they are  
25 able to provide evidence that they have been  
26 granted a mask exemption.



1 I'm going to suggest to you that you're in breach of  
2 that order, aren't you, because you don't require a  
3 mask exemption order or letter?

4 MR. KITCHEN: Mr. Maxston, forgive me, I'm  
5 going to object to your question only on the basis that  
6 you just called this an order; it's not an order. If  
7 you call it what it is, then I have no issue with your  
8 question.

9 MR. MAXSTON: Well, you know what, it says  
10 "following conditions".

11 Q MR. MAXSTON: So you're not in compliance  
12 with Condition Number 4 then?

13 A That would be correct.

14 Q Yeah, and to be clear, the first line says: (as read)  
15 Notice is to inform you, on January 5, 2021,  
16 the undersigned Executive Officer of Alberta  
17 Health Services rescinded an order.

18 So they're rescinding an order, and they're placing new  
19 conditions on your practice; that's correct?

20 A Correct.

21 Q And, again, Order Number 4 -- sorry, Provision Number 4  
22 is something you're not complying with? Correct?

23 A Correct.

24 Q You had a discussion --

25 MR. MAXSTON: I'm just mindful of time here;  
26 I think I can wrap this up in just another maybe 5

1 minutes.

2 Q MR. MAXSTON: You had a discussion about  
3 AHS, and you said that there was really no wiggle room  
4 from the College as a result of AHS's I guess  
5 pronouncements, but for seven months, you never  
6 inquired about whether there was any wiggle room, did  
7 you?

8 A No, I did not.

9 Q You had a discussion about requiring patients to mask  
10 and causing them harm and discussed your concerns about  
11 oxygen and carbon dioxide, and you said even -- I think  
12 you said even if it's imperceptible, that is, imminent  
13 physical harm and danger; isn't COVID also an imminent  
14 physical harm and danger?

15 A If you look at the statistics of people who are dying  
16 from COVID and the recovery rate, 99.97 percent of  
17 people recover, and this is no different than an  
18 average seasonal flu. And so if an average seasonal  
19 flu is also an imminent risk or harm, then, yes, we  
20 could say they're on the same level.

21 Q I think along the same lines a little later on, you  
22 made a comment that COVID-19 isn't an emergency; is  
23 that your recollection?

24 A Yes, it is.

25 MR. MAXSTON: This isn't in evidence, so,  
26 Mr. Kitchen, you can object if you want.

1 Q MR. MAXSTON: But we hear on TV about the  
2 fourth wave, you heard last year about the first,  
3 second, third wave, and high ICU numbers and  
4 hospitalizations. If COVID isn't an emergency, what  
5 is?

6 MR. KITCHEN: I'm going to have to object.  
7 It's a hypothetical, plus you're bringing in evidence  
8 that's just not --

9 MR. MAXSTON: Sure, I'll rephrase it.

10 Q MR. MAXSTON: Why isn't COVID an emergency?

11 MR. KITCHEN: Okay, hold on. Again, you're  
12 asking an opinion that's completely out of the scope to  
13 give.

14 MR. MAXSTON: Well, Mr. Kitchen, your client  
15 described COVID as not being an emergency, so he's  
16 offered that view. I'm certainly allowed to question  
17 him about that.

18 MR. KITCHEN: All right --

19 Q MR. MAXSTON: And I'll just base the  
20 question: Why isn't it an emergency?

21 A I'm basing that on the research that I have heard. I'm  
22 basing that on many people that are well beyond my  
23 knowledge level with respect to emergency --  
24 emergencies and emergency preparedness, and so that is,  
25 again, an opinion based on other expert evidence, not  
26 my own.

1 MR. MAXSTON: Mr. Chair, can you give me 5  
2 minutes. I think I can finish up a little bit into the  
3 lunch hour. Is that fair?

4 THE CHAIR: Yeah, that's fine.

5 MR. MAXSTON: Okay, I'll try to be quick.

6 Q MR. MAXSTON: You had an exchange with  
7 Mr. Kitchen about whether there was any comment from  
8 the College about which is more important, prescreening  
9 or masking, and I think you said no, but you'll recall  
10 when I took Dr. Halowski through Exhibits C-21 to C-22,  
11 don't those contain numerous statements where the  
12 College is inviting you to contact the College?

13 A Can you rephrase that question, please?

14 Q Yeah, you said that there was no comment from the  
15 College about which is more important, prescreening or  
16 masking. And I'm going to suggest to you that that  
17 really isn't the issue; that you could have reached out  
18 to the College and asked them what was more important.

19 A Yes.

20 Q You made some comments in response to a question that  
21 you believed that the College consulted with AHS and  
22 that it believes the information is accurate and that  
23 it's relying on that, so would it be fair to say that,  
24 in your view, the College is acting in good faith when  
25 it's carrying out these pandemic steps?

26 A According to their idea of good faith, yes.

1 Q There were a number of questions Mr. Kitchen asked you  
2 about were you surprised by the College doing this, or  
3 the College created this step, did these things, and I  
4 think my concern with that was isn't it fair that the  
5 College is made up of chiropractors?

6 A Yes, a majority of chiropractors, and I believe there  
7 are some public members.

8 Q Yeah, I think, in fairness, you're quite right on  
9 council and on Hearing Tribunals, there are public  
10 members, but I think my concern was that the way those  
11 questions were phrased and the way your answers were  
12 phrased, it made it sound like the College was sort of  
13 a third-party entity out there, kind of hovering  
14 around. The College is made up of chiropractors, and  
15 don't chiropractors vote on these, as councillors, vote  
16 on pandemic directives and standards of practice?

17 A I don't know if every individual chiropractor actually  
18 voted on the Pandemic Directive.

19 Q I should have been more precise, you're right,  
20 chiropractors on council.

21 A Yes.

22 Q So these are decisions, at least in part, where public  
23 members made by chiropractors to apply to the  
24 chiropractor profession?

25 A That's correct.

26 Q You talked about the Pandemic Directive being

1           unreasonable because there are no provisions for  
2           exemptions. Do you recall Dr. Halowski's testimony  
3           that, in his knowledge, no other college has exemptions  
4           for masking?

5     A     Yes, I do.

6     Q     I'm almost there. Mr. Kitchen asked you a question to  
7           the effect of is the College very concerned with  
8           pleasing the CMOH, and you said -- I think you said  
9           yes, and there's collaboration between CMOH and AHS and  
10          the College. That's really your opinion though; you  
11          don't -- haven't tendered any evidence to support that,  
12          have you?

13    A     No evidence tendered, but it stands to reason that  
14          there has to be collaboration between the College and  
15          Alberta Health Services.

16    Q     One of Mr. Kitchen's final comments, and this is my --  
17          I think my final question was do you believe you've  
18          breached any CMOH orders, and you said no. But isn't  
19          it fair that when we look at the AHS closure order,  
20          they referred to CMOH orders being breached, and that's  
21          why they closed the clinic?

22                 MR. KITCHEN:                         Mr. Maxston, I don't know that  
23                 you're -- I think you're misleading here, because you  
24                 are saying --

25                 MR. MAXSTON:                         (INDISCERNIBLE)

26                 MR. KITCHEN:                         -- well, you're saying in your

1 question that there's a breach of a CMOH order. Well,  
2 that's kind of an ultimate issue. If there was no  
3 doctor's note from Dr. Wall verifying that he fell into  
4 an exemption, I'd agree with you, but --

5 MR. MAXSTON: You know what I'm going to do,  
6 I'm going to -- it's a fair comment, Mr. Kitchen.

7 Q MR. MAXSTON: Just very briefly, Dr. Wall,  
8 can you go to the closure notice, which is Exhibit D-1.  
9 I'll get everybody to do that, and, I'm sorry, this is  
10 my last question.

11 And, Dr. Wall, let me know when you're there, and  
12 I'll start my question then.

13 A Yeah, go ahead.

14 Q So what I was really getting at is (a) and (b) are kind  
15 of mirror images, this is on page 1, but it says --  
16 I'll just read item (a), and then there's a question:  
17 (as read)

18 Practitioner does not wear a face mask while  
19 providing care within 2 metres distance from  
20 patients. This activity could contribute to  
21 the spread of COVID-19. This is a breach of  
22 Section 2(1) of the nuisance and general  
23 sanitation regulation, which states that [I  
24 won't read that out] and of Section 26 of the  
25 CMOH-38-2020, which states that ...

26 So on the face of it, this order says you're breaching

1 a CMOH order.

2 A Yes, on the face of it.

3 MR. MAXSTON: Okay, those are all my  
4 questions, Mr. Chair. Thank you for your indulgence in  
5 going a little bit into the lunch hour.

6 I welcome Mr. Kitchen's comments, we could  
7 reconvene at 1:00, we could reconvene at 1:15, whatever  
8 your decision is.

9 THE CHAIR: Before we decide that, can we  
10 get an idea of what the afternoon will look like?

11 MR. MAXSTON: I expect I will be a couple of  
12 hours in questioning Dr. Wall. I don't know how long  
13 of course Mr. Kitchen's cross-examination -- or, pardon  
14 me, redirect will be, and then, of course, there's your  
15 time for questions.

16 I'm hopeful we can get through Dr. Wall today  
17 but --

18 Q MR. MAXSTON: And, Dr. Wall, you've given me  
19 some very short answers at times, which is helpful for  
20 moving ahead, but at other times, I'm sure you're going  
21 to want to elaborate on some of my questions.

22 MR. MAXSTON: And, in fairness, I do have a  
23 lot of questions for Dr. Wall.

24 THE CHAIR: Okay, Mr. Kitchen, is that  
25 your vision of this afternoon? I don't see us calling  
26 any other witnesses today, unless we get --



1 MR. KITCHEN: I have --

2 THE CHAIR: -- through more quickly.

3 MR. KITCHEN: Well, I have one witness  
4 standing by, who is one of the four patient witnesses,  
5 so it will be quick. Each one of these four patient  
6 witnesses will be quick. Mr. Maxston and I have talked  
7 about this.

8 So as I see it, we're likely to be done with  
9 Dr. Wall by 3:30, 3:45. I'd like to use the entire day  
10 to get one more witness in, considering how slow we're  
11 moving and that -- you know, yesterday, we finished --  
12 it's my fault, I understand this, but yesterday we  
13 didn't quite use the full time; I'd like to try to use  
14 the full time to get in that one extra witness, because  
15 I cannot see that taking more than an hour total.

16 MR. MAXSTON: I think maybe, Mr. Kitchen,  
17 I'd invite your comments, maybe just see where we're at  
18 by, you know, 3:00, 3:30, and then -- I know it's tough  
19 to have a witness hanging, but I'm going to be very  
20 brief with that witness if we get to him or her today.

21 MR. KITCHEN: Okay, well, I, yeah, that's  
22 important to me that we at least try to preserve that.

23 THE CHAIR: Okay, that's our objective.

24 So we will recess for lunch. It's 10 after 12, so

25 let's reconvene at 1:15, and we'll continue with

26 Mr. Maxston's cross-examination at that time. Thank

1     you.

2     \_\_\_\_\_

3     PROCEEDINGS ADJOURNED UNTIL 1:15 PM

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

4

5 September 8, 2021 Afternoon Session

6

7 HEARING TRIBUNAL

8 J. Lees Tribunal Chair

9 W. Pavlic Internal Legal Counsel

10 Dr. L. Aldcorn ACAC Registered Member

11 Dr. D. Martens ACAC Registered Member

12 D. Dawson Public Member

13 A. Nelson ACAC Hearings Director

14

15 ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

16 B.E. Maxston, QC ACAC Legal Counsel

17

18 FOR DR. CURTIS WALL

19 J.S.M. Kitchen Legal Counsel

20

21 K. Schumann, CSR(A) Official Court Reporter

22

23 (PROCEEDINGS RECOMMENCED AT 1:15 PM)

24 THE CHAIR: Okay, it's 1:15. Mr. Kitchen,  
25 you're okay; your technology is okay?

26 MR. KITCHEN: I'm ready to go.

1 THE CHAIR: Okay.

2 MR. KITCHEN: Can you hear me? Good.

3 THE CHAIR: Yes, we can hear and see you.

4 So, Mr. Maxston, the floor is yours.

5 Discussion

6 MR. MAXSTON: Sure. Mr. Chair, during the  
7 break, I think about 12:15 or so, 12:20, I asked  
8 Ms. Nelson to send Mr. Kitchen a document I intend to  
9 rely on in cross-examination, and it is the email  
10 exchange, the March 4 response from Dr. Halowski and  
11 Dr. Wall's March 3 email to him.

12 I, frankly, don't intend to spend a lot of time  
13 with that, but I, of course, wanted to send it to  
14 Mr. Kitchen. I'm going to get to that probably 5 or 10  
15 minutes into my examination. I wonder if Mr. Kitchen  
16 will consent to Ms. Nelson sending that to the Hearing  
17 Tribunal Members now.

18 MR. KITCHEN: Yeah, that's fine. Just  
19 forward it to Dr. Wall, so he has a copy.

20 MR. MAXSTON: And, again, I don't intend to  
21 spend a lot of time with that. I think it should  
22 probably be marked as an exhibit, and I think we might  
23 be up to H-4 or 5, if we are -- Mr. Chair, and  
24 Ms. Nelson can do that; she can put it into the  
25 Dropbox, and we'll ask the court reporter to mark that  
26 as part of her --

1 MR. KITCHEN: I do have an issue with --  
2 okay, let me just pull up what you sent me here,  
3 because I think I might --

4 MS. NELSON: I also just want to hop on and  
5 let you know, Walter Pavlic is not currently on the  
6 call, so I'm just going to give him a call on his cell  
7 phone and try to get him in the meeting. It looks like  
8 he's dropped off.

9 THE CHAIR: Yeah, and my oversight. Thank  
10 you, Amber.

11 MR. MAXSTON: Mine as well. Maybe,  
12 Mr. Kitchen, we should not discuss this further until  
13 Mr. Pavlic comes online.

14 MR. KITCHEN: That's fine. Yeah, no, but I  
15 do want to discuss a point with you.

16 MR. MAXSTON: Yeah.

17 (ADJOURNMENT)

18 MR. MAXSTON: Mr. Pavlic, just before you  
19 came on, I mentioned to the Chair that, I think about  
20 12:15 or 12:30, I asked Ms. Nelson to send Mr. Kitchen  
21 a document by email that I intend to rely on in  
22 cross-examination, and it is the March 3, 2020 email  
23 from Dr. Wall to Todd Halowski, and Dr. Halowski's  
24 March 4 response. I'm going to briefly refer to that  
25 in my cross-examination. I would like that to be  
26 entered as an exhibit, and I understand Mr. Kitchen

1 might have some questions about that, so I'll turn the  
2 floor over to him.

3 MR. KITCHEN: I received instructions from  
4 my client, and there's no objection to putting that in  
5 as is.

6 THE CHAIR: Okay, thanks, Mr. Kitchen. So  
7 if we could have that document shared to the members of  
8 the Hearing Tribunal and --

9 MS. NELSON: So what I'm going to do, I'm  
10 going to add it to the Dropbox file, you should all  
11 still have access to that file. I'm going to put it in  
12 File H, so you can find it there. Just give me about 2  
13 minutes to add that in, and I'll let you know when it's  
14 there for your review.

15 THE CHAIR: Would it be possible to email  
16 it?

17 MS. NELSON: Sure, yeah, I can email it  
18 instead if that's easier for everyone.

19 THE CHAIR: It's certainly easier for me  
20 than having to go in and getting into the Dropbox  
21 again.

22 MS. NELSON: Okay, so what I'll do I'll  
23 send everyone an email now, all the Tribunal Members,  
24 so you have it, and then while the hearing's in  
25 session, I'll still upload it to Dropbox, so, Karoline,  
26 you'll be able to find it in File H.

1                   EXHIBIT H-7 - Response to Curtis Wall Re -  
2                   Vaccinations

3           THE CHAIR:                   Excellent, thank you, Amber.

4                   Mr. Maxston, are you going to start with this  
5           document?

6           MR. MAXSTON:                No, I think in about 10  
7           minutes I'll get to it, and it will be very brief, so I  
8           wonder if I might just start now, and when I get to  
9           that, I'll get to that document, I'll make sure  
10          everybody's been able to access it.

11          THE CHAIR:                I think that's a wise idea.  
12          Let's use the time.

13          DR. CURTIS WALL, Previously Sworn, Cross-examined by  
14          Mr. Maxston

15   Q   MR. MAXSTON:                So, Dr. Wall, I'm just going  
16          to ask you a couple of questions about your educational  
17          background baed on what Mr. Kitchen said, and I  
18          understand you graduated from Palmer College in  
19          Davenport, Iowa, in 1996. Did you receive any public  
20          health education at Palmer?

21   A   Yes.

22   Q   And was that health education in relation to public  
23          disease management?

24   A   No, it was not. It was a very basic course, going over  
25          basic microbiology and discussing infectious diseases,  
26          but not in management.

1 Q And do you have any advance training or degrees in  
2 public health?

3 A No, I do not.

4 Q When you graduated from Palmer, do you recall taking an  
5 oath that included, in part, an obligation to preserve  
6 the integrity of the profession?

7 A Yes, I do.

8 Q You came a licensed chiropractor in 1996 in Alberta I  
9 understand, and I believe you said this during your  
10 discussion with Mr. Kitchen, but would you agree that  
11 practicing in the profession of chiropractic is a  
12 privilege not a right?

13 A Yes, I would.

14 Q And would you also agree that the chiropractic  
15 profession is a self-regulating profession under the  
16 Health Professions Act in Alberta?

17 A Yes, it is.

18 Q I'm not going to ask you to go to this, but are you  
19 familiar with Section 3 of the Health Professions Act  
20 and the public protection mandate it establishes for  
21 colleges?

22 A I believe I've read through it, yes.

23 Q You're also, I'm assuming, familiar with the fact that  
24 the College, as a regulator, governs the conduct of  
25 chiropractors in their professional capacities?

26 A Yes, I'm aware of that.



1 Q Section 3 of the HPA, and, again I'm not asking you to  
2 go there, talks about the College establishing and  
3 enforcing requirements for the profession, and I just  
4 want to take you through a couple of things quickly  
5 here. You would agree that the College sets initial  
6 registration requirements?

7 A Yes.

8 Q For the profession?

9 A Yes.

10 Q And that's mandatory?

11 A That's correct.

12 Q And happily, you met those requirements a few years  
13 ago?

14 A Yes.

15 Q There are annual practice permit renewal requirements?

16 A Yes, there are.

17 Q And those are mandatory?

18 A Yes.

19 Q The College has a continuing competence program; is  
20 that correct?

21 A Yes, it does.

22 Q And is that mandatory in order to keep practicing?

23 A Yes, it is.

24 Q You're aware that the College creates Standards of  
25 Practice and Codes of Ethics?

26 A Yes, I am.

1 Q You're aware that the College creates practice visits?

2 A Yes.

3 Q For members?

4 A Yes.

5 Q And a participation and practice visit is mandatory,  
6 isn't it?

7 A Can you explain a practice visit?

8 Q If the College sends someone out to do a practice visit  
9 under the Health Professions Act, and they come to your  
10 clinic and assess what's occurring at the clinic,  
11 that's what I'm referring to.

12 A Yeah, I think there are definitely parameters  
13 surrounding that. It's -- I'm not sure that the  
14 College can just randomly come to a practice. I think  
15 there has to be some reason behind it, to my knowledge.

16 Q Yeah, and I think I'm referring to the practice visit  
17 program established under the HPA, and I think you're  
18 quite right, there are some parameters for how practice  
19 visits occur.

20 I'd like to ask you to go to the Standards of  
21 Practice -- I'm just going to digress for a moment --  
22 the Standards of Practice are in Exhibit A-11, and I'm  
23 not going to be long on this, but once you're there on  
24 A-11 and Tribunal Members are there, I'm going to ask  
25 you to go to page 20 and the standard of practice for  
26 recordkeeping. And that's Standard of Practice 5.1.

1 A Yeah, I'm there.

2 MR. MAXSTON: Mr. Chair, I'll assume, unless  
3 someone waves their hand, everybody else is at Standard  
4 5.1.

5 Q MR. MAXSTON: Dr. Wall, my purpose in taking  
6 you to this, number one, to flag that it addresses  
7 recordkeeping requirements, and it says: (as read)  
8 Patient health records must be dated,  
9 accurate, legible, and comprehensive.  
10 You'd agree that's mandatory?

11 A Yes, I would.

12 Q (as read)

13 All services provided by the chiropractor  
14 must be documented by the chiropractor and  
15 entries must be clearly identifiable as  
16 having been made by the chiropractor.

17 Again, a mandatory requirement, correct?

18 A Correct.

19 Q And if you skip down a couple of lines, there's a  
20 paragraph that says: (as read)

21 All patient health records must include the  
22 following information.

23 And there's some bullets, "Personal Information  
24 History", "Physical Exam", "Findings", "Written  
25 Diagnosis". You would agree that that's a mandatory  
26 set of contents for your records?

1 A Correct.

2 Q Is it fair to say that, until you independently decided  
3 that you weren't going to follow the Pandemic  
4 Directive, that you always follow ACAC requirements?

5 A That's correct.

6 Q I think you describe yourself as a fairly compliant  
7 person, and I'm not surprised to hear that. I'm  
8 wondering if I can get you to go to the notice of  
9 hearing, which is Exhibit A-1. It's the first  
10 document. I just want to take you through it.

11 A I'm good to go.

12 Q Okay. So I want to be careful, Mr. Kitchen can jump in  
13 here, but I don't think we ever heard -- we talked  
14 about this at the beginning of the hearing, but I don't  
15 think we ever heard from you whether you are denying or  
16 contesting the charges and are saying they don't  
17 constitute unprofessional conduct. I assume you're  
18 going to agree that that's what you're doing in the  
19 hearing?

20 A Can you repeat that, sorry?

21 Q Yeah, you're contesting the charges; you're arguing  
22 that you did not commit unprofessional conduct?

23 A That is correct.

24 Q Okay. I'm going to take you through each of the  
25 charges, and I want to be very clear, I'm not asking  
26 you to make admissions of unprofessional conduct; I'm

1 more interested in the facts in the charges are the  
2 factual foundation.

3 So Charge 1 says: (as read)

4 Beginning on or about June of 2020 and at the  
5 Wall Chiropractic Clinic: (a), [you] failed  
6 to use PPE, specifically failed to wear a  
7 mask; (b), failed to observe the required 2  
8 metres of social distancing when unmasked;  
9 (c), until on or about December 2020, failed  
10 to have a plexiglass barrier at the clinic  
11 reception and/or did not require patients to  
12 mask; [and then] when he interacted with  
13 patients, members of the public, or both.

14 Do you dispute any of those facts?

15 A No, I do not.

16 Q And if we go to Charge Number 2: (as read)

17 Beginning on or about June of 2020 in the  
18 clinic, one or more staff members of the  
19 clinic, the staff, failed to use PPE,  
20 specifically staff failed to wear masks; (b),  
21 failed to observe the required 2 metres of  
22 social distancing when unmasked and/or, (c),  
23 did not require patients to be masked when  
24 they interacted with patients, members of the  
25 public, or both.

26 Again, I'm not asking you to make an admission of

1 unprofessional conduct, but do you accept those facts?

2 MR. KITCHEN: Mr. Maxston, I don't mind the  
3 question, but, in general, I'm going to ask that you  
4 break it up for each one of these pieces.

5 MR. MAXSTON: Sure, I'm happy to do that.

6 MR. KITCHEN: Okay, thank you.

7 MR. MAXSTON: Yeah.

8 Q MR. MAXSTON: Let's go to 2(a), do you  
9 dispute those facts, Dr. Wall?

10 A No, I do not.

11 Q And similarly for 2(b)?

12 A No, I do not.

13 Q And similarly for 2(c)?

14 A No, I do not.

15 Q Okay, we go to Charge Number 3: (as read)

16 Beginning on or about June 2020, Dr. Wall  
17 treated patients while not wearing a mask  
18 and/or did not require patients to be masked,  
19 and, (a), he did not advise patients of the  
20 increased risk of transmission of COVID-19  
21 due to masks being worn.

22 Do you agree with that factually?

23 A Like "masks not being worn" I believe is --

24 Q Yeah.

25 A -- what you meant?

26 Q Yeah, sorry, yeah.

1 A That's correct.

2 Q And (b): (as read)

3 He advised patients that masks were not  
4 required.

5 Is that factually accurate?

6 A Correct.

7 Q And (c): (as read)

8 He advised patients that wearing masks had no  
9 effect concerning transmission of COVID-19.

10 Is that accurate factually?

11 A Correct.

12 Q So if we go to Charge Number 4: (as read)

13 Beginning on or about June of 2020, Dr. Wall  
14 failed to chart and/or failed to properly  
15 chart communications with his patients about,  
16 (a), him not wearing a mask.

17 Would you agree with that?

18 A Yes, I would.

19 Q (b): (as read)

20 His staff not wearing masks.

21 Would you agree with that?

22 A Yes, I would.

23 Q And (c): (as read)

24 His patients not wearing masks?

25 A Yes, I would.

26 Q And then, finally, Charge Number 5: (as read)

1           Beginning on or about June of 2020, Dr. Wall  
2           and/or the staff, (a), failed to follow CMOH  
3           orders regarding masking and COVID-19.

4           Do you accept that factually?

5    A    Yes.

6    Q    And (b):   (as read)

7           Failed to follow the ACAC Pandemic Practice  
8           Directive.

9           Do you agree with that factually?

10   A    Partially, but, yes, with respect to masking; is that  
11           what that (b) would be?

12   Q    Yeah, I would -- yes, I think, in fairness to you, I'm  
13           thinking of masking, social distancing, and the  
14           plexiglass barrier.

15   A    Correct, yeah.

16   Q    Okay, thank you.  So I think, Dr. Wall, it's fair to  
17           say that you're arguing that you have an exemption to  
18           masking, but you're also calling four experts who will  
19           dispute the science behind masking, they'll argue that  
20           masking causes harm, and argue that masking isn't  
21           necessary.  Is that your position as well; it's not  
22           just that you have a medical exemption?

23   A    That is correct.

24   Q    And aside from any exemption for your anxiety disorder  
25           personally not masking, is it not fair to say you don't  
26           believe in masking generally in terms of COVID for a



1 number of reasons?

2 MR. KITCHEN: You're going to have to get a  
3 little more specific. I don't necessarily object to  
4 the question generally, but you're going to have to be  
5 a little more specific about what you mean about  
6 belief.

7 Q MR. MAXSTON: So I'll ask the question a  
8 little differently. You don't believe in masking  
9 generally in terms of COVID-19 as a preventative  
10 measure?

11 A Correct.

12 Q And just to be clear, you don't believe that  
13 chiropractors should have to mask or social distance or  
14 use plexiglass barriers; is that fair?

15 A Correct.

16 Q I'd like to take you to Exhibit A-11, another standard  
17 of practice, and specifically page 15, which is  
18 Standard of Practice 4.3. And I'm sorry, Dr. Wall,  
19 we're going to skip around a little bit with the  
20 documents this afternoon, but I'll let you and the  
21 Tribunal Members get to that document, and then I'll --  
22 I've got a few questions for you.

23 THE CHAIR: Would you repeat that document  
24 number, again, please.

25 MR. MAXSTON: Yes, Mr. Chair, it's A-11, the  
26 Standards of Practice, and more specifically I'd like

1           you to go to page 15, which is 4.3, "Infection  
2           Prevention and Control".

3           THE CHAIR:                               Thank you.

4    Q   MR. MAXSTON:                       So, Dr. Wall, we heard  
5           Dr. Halowski give some evidence about this standard,  
6           and you'd agree with me that this standard was in place  
7           before COVID?

8    A   Yes, I would.

9    Q   And you would agree that it was binding on you and is  
10          binding on you?

11   A   Yes.

12   Q   You'll see at the end of the first paragraph, just  
13          before the colon, it says "Chiropractors must", and  
14          then it sets out a number of duties that you have -- I  
15          shouldn't say "duties", I should say obligations.  
16          Would you agree with me that those bullets that follow  
17          are all musts, for lack of a better phrase?

18   A   I'm sorry, are you still on 4.3?

19   Q   Yeah, I'm just looking at that series of bullets. The  
20          first one says: (as read)

21                Remain current and generally accepted routine  
22                practices.

23          And I'm just looking at the -- just before that, it  
24          says: (as read)

25                In their clinical practice, chiropractors  
26                must ...

1           And my question was all those bullets are musts, if I  
2           read this correctly; would you agree with that?

3     A     Yes, I would.

4     Q     And is it your evidence that you've complied with this  
5           standard of practice at all times?

6     A     Let me take a minute and just read those bullets,  
7           please. It would appear that the protective barrier,  
8           if that is referring to the plastic barrier, was  
9           something that I did not do. So that one bullet,  
10          there's --

11    Q     You know, Dr. Wall, I'm not trying to sort of trick you  
12          here. I had a question specifically, frankly, about  
13          the second-last bullet. It says: (as read)

14                 Must utilize appropriate personal protective  
15                 equipment in circumstances indicating such  
16                 measures.

17          I think you'd agree you're not complying with that  
18          because you're not complying with the Pandemic  
19          Directive?

20    A     Correct.

21    Q     And, again, on its face, to be fair to you. I'd like  
22          to turn to the emails that were just entered as an  
23          exhibit, and we have your March 3, 2020 email, and as I  
24          asked you during my brief questions before, I asked you  
25          to just refresh your memory, and you would acknowledge  
26          now that Dr. Halowski did respond on March 4 to your

1 email?

2 A Yes, I would.

3 Q I'm looking at your email, and I just have a couple of  
4 quick questions about it. The second paragraph says:  
5 (as read)

6 I fully recognize the position chiropractors  
7 are in with respect to being governed under  
8 the HPA, and I intend to follow any  
9 guidelines and rules put forth to our  
10 profession through Standards of Practice and  
11 bylaws.

12 Can you tell me why you said that?

13 MR. KITCHEN: Mr. Maxston, I understood that  
14 you were putting this document in so that you could  
15 discuss about whether or not there was a response. Now  
16 you're asking a question about the substance of the  
17 email.

18 MR. MAXSTON: I don't think I said I was  
19 confining my questions; I was putting it in to be used  
20 for cross-examination, and I only have a couple  
21 questions.

22 MR. KITCHEN: Well, I don't think the  
23 substance of the email is relevant. You and I have  
24 both seen the email. There's nothing in there about  
25 masking or the ACAC Pandemic Directive or any of that.  
26 The contents of the email aren't relevant. It's not a

1 relevant question.

2 MR. MAXSTON: Well, I would disagree.  
3 There's a comment in the second paragraph I'm taking  
4 your client to about compliance with future  
5 requirements of the College, so I guess we'll ask the  
6 Tribunal to let us know whether I can ask that  
7 question.

8 MR. KITCHEN: Well, I now admit I didn't ask  
9 you this, but you did not indicate when you asked for  
10 my consent to put this email in that you were going to  
11 ask substantive questions on the content of what  
12 Dr. Wall said in the email. I understood you to mean  
13 you were putting it in to show that it was sent and  
14 that Halowski -- Dr. Halowski sent a response, which I  
15 have no issue with.

16 MR. MAXSTON: Well, I --

17 MR. KITCHEN: So I'm going to object to  
18 questions on content, and I guess I'm going to have to  
19 object to you putting the document in for the purposes  
20 of asking substantive questions on the content of the  
21 email that Dr. Wall sent, which is irrelevant to these  
22 proceedings.

23 MR. MAXSTON: Well, I think it is, and when  
24 I mentioned my intention to have this entered, I said I  
25 intend to refer to it briefly during cross-examination.  
26 I didn't put any parameters on it, and I --

1 MR. KITCHEN: Well, I was trying to be --  
2 you know, because I don't want to unduly contest  
3 things, okay? So that's why I didn't contest is  
4 because I didn't understand you to mean, and you didn't  
5 say you were going to ask questions on the contents.

6 MR. MAXSTON: Well, I'm just going to say  
7 that in my experience when you tender a document to be  
8 used in cross-examination, it's not limited. I don't  
9 have to say that I'm going to ask questions on 'X',  
10 'Y', and 'Z'; I simply say I intend to refer to this.

11 So, again, I think it's relevant, my client thinks  
12 it's relevant, it talks about compliance issues, and  
13 it's in March of 2020 just before COVID hits and the  
14 directive comes out. I don't have a lot of questions,  
15 but I'd like to ask them, so I think we'll have to ask  
16 for the Tribunal to let us know what they --

17 MR. KITCHEN: Well, I'm going to object both  
18 to the questions, but I'm going to go back to object to  
19 the document being entered for substantive questions.  
20 This is similar to the issue we faced last week when I  
21 asked to have in the evidence that the studies that I  
22 questioned Dr. Hu about exist, and I was limited to  
23 asking procedural questions about their existence not  
24 on contents. That's what I'm going to ask -- that's  
25 how I ask this to be treated.

26 MR. MAXSTON: And I think the difference

1 from my perspective, Mr. Kitchen, is Dr. Hu is an  
2 expert, and he was being confronted with expert reports  
3 he didn't have any familiarity with, and I think, quite  
4 properly, the Tribunal put some parameters on what  
5 could be asked. This is an email exchange that your  
6 client knows about, and it's relevant to the issues.  
7 I'll let the Hearing Tribunal tell us what --

8 MR. KITCHEN: No, but if I had've known, if  
9 you had've made your intentions about questioning a  
10 little more clear, then I would have been in the  
11 position to object to it being entered for broad  
12 purposes as opposed to specific narrow purposes. I  
13 wasn't given that opportunity.

14 MR. MAXSTON: Yeah, I think I said I was  
15 going to refer to it. And, again, in my experience, in  
16 cross-examination, when you tender a document, you  
17 don't have to say what exactly you're going to ask  
18 about.

19 Anyhow, I've made my submissions on this point.

20 THE CHAIR: Yeah, I think we'll take a  
21 brief recess here so that the Tribunal can discuss this  
22 and consult with our independent legal counsel. So if  
23 we could be moved to a break-out room, please, and  
24 we'll be back with everybody shortly. Thank you.

25 (ADJOURNMENT)

26 THE CHAIR: We've discussed this amongst

1       ourselves and with independent legal counsel. Our  
2       decision is that the questioning can be allowed. We  
3       feel the document is relevant. Cross-examination is  
4       not limited in this regard. We don't feel that the  
5       situation with Dr. Hu and the medical -- or the studies  
6       is directly comparable. And, Mr. Kitchen, you have an  
7       opportunity to address anything raised in redirect  
8       examination of Dr. Wall. So on that basis,  
9       Mr. Maxston, subject to any further objections from  
10      Mr. Kitchen, please carry on.

11      MR. MAXSTON:                   Yeah, I'll be brief,  
12      Mr. Chair.

13    Q   MR. MAXSTON:                Dr. Wall, I've taken you to  
14       the second paragraph that says: (as read)

15           I fully recognize the position chiropractors  
16           are in with respect to being governed under  
17           the HPA, and I intend to follow any  
18           guidelines and rules put forth to our  
19           profession through Standards of Practice and  
20           bylaws.

21       And my question to you was why did you make that  
22       statement?

23    A   I made that statement because I'm a compliant  
24       chiropractor, and I, for the last 25 years, have upheld  
25       the Standards of Practice and bylaws and the Code of  
26       Ethics, but nobody could see what was coming around the



1 corner a month later, and here we are with different  
2 Standards of Practice and bylaws through the Pandemic  
3 Directive that have created the issue that's being  
4 contested right now.

5 Q So you've changed your view I think is what you're  
6 saying?

7 A Only to the point that it affects this particular  
8 hearing.

9 Q And just briefly, this is in March, early March of  
10 2020, before the directive, but you've got  
11 Dr. Halowski's email address at that point, don't you?

12 A Yes, I do.

13 Q Dr. Wall, I'd like to take you to Exhibits D-8 and D-9,  
14 the two CMOH orders, CMOH Order 38-20 and 42-20. I am  
15 not going to take you through those in detail. I've  
16 got some questions for you about them generally, but if  
17 you want to have those in front of you, certainly  
18 that's fine.

19 A Okay.

20 Q So just putting aside the Pandemic Directive for the  
21 moment, was your understanding with CMOH Order 38-20  
22 that you were required to mask when treating patients?

23 A That I was required to mask when treating patients?

24 Q M-hm.

25 A Yes, yes.

26 Q And in fairness to you, you also have taken the

1 position that there's an exemption or exception as well  
2 in this CMOH order; is that correct?

3 A That is correct.

4 Q And when we look at CMOH Order 42-20, and I, again,  
5 don't want you to go through that, I think it's also  
6 fair to say that it essentially mirrors 38-20, and  
7 would you agree there's an requirement for you to mask,  
8 and then there's an exemption as well?

9 A Yes.

10 Q So I think the question I have or the thing I want to  
11 explore with you is really timing. So in June of 2020,  
12 you decided to not mask and not social distance and not  
13 use barriers; that's fair to say?

14 A That's correct.

15 Q When we look at the CMOH orders, 38-20 is dated  
16 November 14, 2020, and 42-20 is dated December 11,  
17 2020. So my question to you is there wasn't a CMOH  
18 order in force in June of 2020 that set out exemptions  
19 for masking; is that correct?

20 A Correct.

21 Q And, again, I'm not going to take you through this in  
22 detail, but Exhibit F-2 is CMOH Order 16-20, and you'll  
23 probably recall that 16-20, again, is from May 3 of  
24 2020, and it's what we discussed previously in the  
25 hearing about requiring either adherence to the CMOH  
26 schedule, which required masking --

1 MR. MAXSTON: -- and there's a question  
2 coming, Mr. Kitchen --

3 Q MR. MAXSTON: -- or opting into a College  
4 directive if they had one; is that your recollection?

5 A Yes, it is.

6 Q And would you agree that, when we look at that Exhibit  
7 F-2, and then there's F-1, the Government of Alberta  
8 safely staged COVID relaunch, that it was a requirement  
9 for the College to establish a Pandemic Directive?

10 A Yes.

11 Q Just bear with me for a moment, Dr. Wall. Don't mean  
12 to belabour this point, but on Exhibit F-1, which is  
13 the government relaunch document, if I can get you to  
14 go to that, it's Exhibit, again, F-1, "Alberta's safely  
15 staged COVID-19 relaunch".

16 A Okay.

17 Q Page 2, the second bullet talks about: (as read)

18 Dental and other health care workers will be  
19 allowed to resume services starting May 4, as  
20 long as they are following approved  
21 guidelines set by their professional  
22 colleges.

23 You understand that that meant it was mandatory for you  
24 to comply with the Pandemic Directive if you wanted to  
25 re-open?

26 A Yes.

1 Q And when we look at CMOH Order 16-20, and, my  
2 apologies, that's F-2 if you want to look at it, I have  
3 a couple of quick questions for you.

4 Again, this is the CMOH order that talks about  
5 colleges creating their own Pandemic Directives. This  
6 CMOH order doesn't reference any exemptions, does it?  
7 And I mean exemptions from masking and social  
8 distancing.

9 A Not that I can see, yeah.

10 Q And you'd agree with me, of course, this is dated May  
11 3, 2020, and it would have been in force in June of  
12 2020 when you decided to not comply?

13 A Correct.

14 Q Dr. Wall, I'd like you to go to the Pandemic Directive  
15 itself, and we've been using I think Exhibit C-22,  
16 which is the, I'll call it, the most recent version,  
17 January 26th, 2021, although the contents of it  
18 relating to masking et cetera haven't changed. So I'll  
19 just ask you to go to that, please.

20 A Okay.

21 Q So I think you may have discussed this with  
22 Mr. Kitchen, but do you recall when you received the  
23 Pandemic Directive?

24 A Are you referring to the very first one or this most  
25 recent --

26 Q Thank you --

1 A -- one?

2 Q -- yes, thank you, the May 3, 2020 version, thank you.

3 A I believe it was in May, early May.

4 Q Yeah. And you would have received that as a regulated  
5 member getting like I guess as part of the normal  
6 communications from your college?

7 A Correct.

8 Q So I'd like you to go to page 1 of the -- pardon me,  
9 page 2 of the Pandemic Directive. Page 1 is kind of an  
10 introductory table of contents. Item number 1 in the  
11 middle of the page, numbered item 1, says "Follow  
12 all" -- I should go back, there's an opening  
13 sentence -- or opening statement: (as read)

14 As regulated health professionals,  
15 chiropractors are required to, 1, follow all  
16 mandates and recommendations from Public  
17 Health and the Government of Alberta  
18 regarding your personal and professional  
19 conduct. As a regulated health professional  
20 you have a fiduciary responsibility to follow  
21 all civil orders that originate from any  
22 level of government.

23 Would you agree with that statement?

24 A Yes, I would.

25 Q And the second one is a little more specific, number 2,  
26 it says, again chiropractors: (as read)

1           Read and adhere to all communications from  
2           the ACAC.

3           Would you agree that that's intended to be a binding  
4           direction from your college?

5    A    Yes, I would.

6    Q    Dr. Wall, I'm going to ask you to go to page 3 of the  
7           Pandemic Directive, and in kind of the middle of that  
8           page, there's a heading that says "Patient Screening",  
9           and there's some comments there about: (as read)

10           Chiropractors must assess and screen patients  
11           for symptoms of COVID-19 as per requirements  
12           of Public Health.

13           Were you doing patient screening?

14   A    Yes, I was.

15   Q    Okay. If you skip head to page 4 of the Pandemic  
16           Directive, and you go to the bottom of the page, there  
17           is a heading "Hand Hygiene", and if we go to the next  
18           page, there's a -- it's the first complete paragraph:  
19           (as read)

20           When hands are visibly soiled, they must be  
21           cleaned with soap and water, as opposed to  
22           using alcohol hand-rub.

23           Again, the word "must" is used. Were you adhering to  
24           the hand hygiene requirements in this Pandemic  
25           Directive?

26   A    Yes, I was.

1 Q If we skip ahead a couple of pages to page 6, at the  
2 top of that page, Dr. Wall, there's a heading of  
3 "Environment Cleaning and Disinfection", and then there  
4 are some comments about proper disinfectant products  
5 and some requirements there. Were you adhering to the  
6 environment cleaning and disinfection part of the  
7 standard?

8 A Yes, I was.

9 Q And if we go to page 7, there's a heading that says  
10 "Required Clinic Environment Adaptions", and it's got  
11 some interesting comments about books, magazines, toys,  
12 et cetera. Were you adhering to that requirement?

13 A Yes, I was.

14 Q The next heading on that page is "Physical Distancing",  
15 and I'm going to ask you a question about the very next  
16 page, page 8, and that first black bullet on the top of  
17 that page says: (as read)

18 Non-clinical employees and the public must be  
19 2 metres from each other.

20 And then: (as read)

21 Reception and payment area -- [and there's a  
22 question coming] -- if 2 metres cannot be  
23 maintained at reception/payment area, either  
24 staff must be continuously masked or the  
25 installation of a plexiglass/plastic barrier  
26 must occur to protect reception staff.

1 I'm assuming that you weren't following this part of  
2 the Pandemic Directive; the only exception being after  
3 December 20, you began using plexiglass; is that fair?

4 A That's correct.

5 Q So if we go to the next section on page 8, the heading  
6 "Personal Protective Equipment", and there's a heading  
7 "Staff and practitioner PPE", and it reads: (as read)

8 On April 23, 2020, AHS announced, effective  
9 immediately, AHS is advising all health care  
10 workers providing direct patient care in both  
11 AHS and community settings to wear  
12 surgical/procedure masks continuously at all  
13 times and in all areas of the workplace if  
14 they are involved in direct patient contact  
15 or cannot maintain adequate physical  
16 distancing from patients and co-workers.

17 I'm assuming you would say you weren't following that?

18 A That's correct.

19 Q And if we go to the next heading, "PPE requirements",  
20 got three bullets: (as read)

21 Surgical or procedure masks are the minimum  
22 acceptable standard; chiropractors and  
23 clinical staff must be masked at all times  
24 while providing patient care; [and then next]  
25 nonclinical staff must be masked when a  
26 physical distance of 2 metres cannot be



1 maintained.

2 I'm assuming you would agree that you weren't following  
3 that aspect of the Pandemic Directive?

4 A That's correct.

5 Q And if we go to the very next page, that's page 9,  
6 there are a series of steps for donning and doffing  
7 masks. I'm assuming you couldn't have been following  
8 those because you weren't masking; is that fair?

9 A That is correct.

10 Q Okay. Dr. Wall, I'd like you to go to the last page of  
11 the Pandemic Directive, page 12, and that's a heading  
12 "Resources". Do you recall whether you went through  
13 and reviewed any of these resources?

14 A Yes, I did. I did click on them. I'm unfamiliar with  
15 them now, but I did recall clicking on those at the  
16 time.

17 Q Yeah, and I wasn't going to take you through them, I  
18 just wondered if you'd accessed them.

19 Do you, in particular, remember whether you  
20 accessed the three AHS ones that are listed under  
21 "Personal Protective Equipment"?

22 A I'm positive that I looked at all of the resources,  
23 but, yeah, so I would have come across it, I'm sure.

24 Q And I take it, Dr. Wall, I'm going to ask you a  
25 question about what happens in a few weeks, but reading  
26 those resources or accessing them didn't change your

1 mind later on about whether to comply?

2 A That is correct.

3 Q And this is a little housekeeping on my part, I think I  
4 asked you this, but the Pandemic Directive does not  
5 contain an exemption for masking; is that correct?

6 A That's correct.

7 Q And there's -- I should have been a little more  
8 expansive -- there's no exemptions for social  
9 distancing or plexiglass barriers?

10 A Correct.

11 Q Okay, I'd like to take you to the AHS closure and  
12 rescind orders, and those are Exhibits D-1 and D-2.  
13 I'm just wait for you to get to those and get the  
14 Hearing Tribunal Members to those as well.

15 A I'm good.

16 Q So there's a couple "Whereas" paragraphs, and I went  
17 through these with you a little bit in my prior  
18 questions for you, but when we look at "Whereas"  
19 paragraph 8, it says: (as read)

20 Practitioner does not wear a face mask while  
21 providing care within 2 metres distance from  
22 patients.

23 You'd agree with that, that's factually correct?

24 A Yes.

25 Q The next statement says: (as read)

26 This activity could contribute to the spread

1                   of COVID-19.

2           Would you agree with that statement?

3    A    No, I would not.

4    Q    And if we go to item (b), "Whereas" Section (b): (as  
5           read)

6           Practitioner does not implement continuous  
7           masking by all staff and patients.

8           That's correct, isn't it?

9    A    Yes, it is.

10   Q    And: (as read)

11           Physical barrier at front desk reception is  
12           also not available.

13           That was correct at that time?

14   A    Correct, yeah.

15   Q    And then we have another statement: (as read)

16           This activity could contribute to the spread  
17           of COVID-19.

18           And again notwithstanding that this is Alberta Health  
19           Services, you wouldn't agree with that, would you?

20   A    No, I would not.

21   Q    If we go to D-2, the rescind order -- oh, and I should  
22           go back, you did close your clinic after receiving D-1?

23   A    Yes, I did.

24   Q    So you chose to comply with the AHS order?

25   A    Yes.

26   Q    I think I know the answer to this question, but did you

1           agree with the closure order?

2     A     No, I did not.

3     Q     And would it be fair to say that you strongly disagreed  
4           with that order?

5     A     Very strongly disagreed.

6     Q     Would it be fair to say that, despite the references I  
7           took you through in (a) and (b), you don't believe  
8           there's a scientific basis for the conclusions in those  
9           "Whereas" paragraphs?

10    A     Correct.

11    Q     And I suppose, a little more broadly, it would be fair  
12           to say that you disagree with the CMOH orders and the  
13           science they're based on?

14           MR. KITCHEN:                    If you specify a section, he  
15           can answer, but --

16           MR. MAXSTON:                    Sure.

17           MR. KITCHEN:                    -- that's too broad.

18           MR. MAXSTON:                    Yeah, that's fair.

19    Q     MR. MAXSTON:                    Do you agree with the CMOH  
20           orders not having a scientific basis for masking and  
21           social distancing and plexiglass barriers?

22           MR. KITCHEN:                    Again, when you went from all  
23           to three, why don't you try them one at a time.

24    Q     MR. MAXSTON:                    Dr. Wall, consistent with  
25           Mr. Kitchen's advice, do you take issue with the  
26           CMOH -- any science the CMOH orders are based on in

1 terms of masking?

2 A Yes, I do.

3 Q And any science in terms of social distancing?

4 A Yes, I do.

5 Q And any science in terms of plexiglass barriers?

6 MR. KITCHEN: You're going to have to point  
7 us to what CMOH order requires plexiglass barriers?

8 MR. MAXSTON: I'll take that back; that may  
9 be the Pandemic Directive alone, Mr. Kitchen, so I'll  
10 leave that one.

11 Q MR. MAXSTON: I want to continue with  
12 looking at the rescind order, and I think you told me  
13 in some of the questions just before lunch you're not  
14 in compliance with Order Number 4; is that correct?

15 A Correct.

16 Q And this is Exhibit D-2.

17 A Yeah.

18 Q There was a discussion yesterday about Orders 1 and 3,  
19 Order 1 saying you must follow the Pandemic Directive,  
20 which would include masking, and Order Number 3 that  
21 says you can get consent to practice unmasked. Would  
22 you agree that there's an inconsistency between those  
23 two orders?

24 A Can you rephrase that or just --

25 Q Yeah, I'll break it down. Order number 1 says you have  
26 to comply with the ACAC's requirements, which is the

1           Pandemic Directive, and that includes masking, doesn't  
2           it?

3     A     Yes, it does.

4     Q     And if we look at Order Number 3, it says you must  
5           inform the patient you will be unmasked while providing  
6           services. And my question to you is there's an  
7           inconsistency between those two orders, isn't there?

8     A     Yes, it -- yes.

9     Q     Okay. When your clinic was shut down, you said you  
10          complied with the order, you didn't launch a court  
11          challenge to it, did you?

12    A     No, I did not.

13    Q     So you were prepared to respect the authority of the  
14          AHS? I'll rephrase it. Were you prepared to comply  
15          with their direction?

16    A     Yes, I was.

17    Q     In terms of the re-opening order and the four orders,  
18          was it your intention to comply with all of them?

19    A     Are you referring to the four points under the rescind  
20          notice?

21    Q     Yeah, that's what I'm looking at, and in fairness to  
22          you, we'll just call them the four points. Was it your  
23          intention to comply with all four of those?

24    A     I can see point number 4 talks about: (as read)

25                 Ensuring all patients he treats continuously  
26                 wear a mask that covers their mouth.

1       At that point, I would say that I believe patients have  
2       the need to exercise their own health freedom when it  
3       comes to that point, in the same way that I would  
4       exercise my own health freedom with respect to masking.

5     Q    So would it be fair to say then that you re-opened, but  
6       you weren't in compliance with that fourth point when  
7       you re-opened?

8     A    Yes.

9     Q    I'd like you to go -- bear with me, Dr. Wall. I'd like  
10       to take you back to the Standards of Practice, which  
11       were Exhibit A-11 and specifically page 11. And,  
12       again, no surprises, I want to talk to you about the  
13       "Informed Consent", Standard 3.1.

14    A    Go ahead.

15    Q    Okay, there's under 3.1, we go to I think the third  
16       paragraph, it says: (as read)

17           As part of the informed consent process,  
18           chiropractors are responsible for disclosing  
19           to each patient --  
20       1 and 2 are diagnosis, purpose, nature of treatment,  
21       but I'm curious about number 3: (as read)

22           The potential risks including those that may  
23           be of a special or unusual nature.

24       First, would you agree that's a requirement for you to  
25       do?

26    A    Yes, I agree.

1 Q And when you talked to patients about masking, did you  
2 tell them about the risks of you not masking?

3 A No, I didn't, because I didn't believe that there was a  
4 risk to me not masking.

5 Q I take it then, when we go to the paragraph right after  
6 that: (as read)

7 Chiropractors must private patients the  
8 opportunity to ask questions concerning risks  
9 [et cetera].

10 You really didn't engage in a Q-and-A then with  
11 patients about masking, your masking?

12 A That is correct. And my understanding of this informed  
13 consent process is that this is referring to  
14 chiropractic care. I'm not sure that this is getting  
15 into mask wearing per se. This looks like it's  
16 regarding the treatment that is being proposed to the  
17 patient. Wearing a mask in this situation seems  
18 extraneous, but I could be wrong.

19 Q I just have one other quick question for you, if we go  
20 to the final part of that page, it says: (as read)

21 Informed consent must -- [and then item 6] --  
22 be present on all existing patient files if  
23 verbal informed consent is noted from  
24 previous treatment.

25 Did you take the position that you had to get consent  
26 from a patient when you weren't masking?



1 A No, I did not.

2 Q And I'm going to skip around here a little bit. Order  
3 Number 3 in the Exhibit D-2, the AHS rescind order,  
4 says: (as read)

5 Prior to booking an appointment, Dr. Curtis  
6 Wall must inform the patient he will be  
7 unmasked while providing services.

8 And I'll just stop there. Were you complying with  
9 that; prior to booking an appointment, were you  
10 informing the patient that you would be unmasked?

11 A Yes, I was.

12 Q And then the second part is prior to booking an -- oh,  
13 sorry, you: (as read)

14 -- must obtain a patient's explicit consent  
15 to proceed with booking and undertaking said  
16 services.

17 I take it you weren't getting the patient's explicit  
18 consent based on what you were telling me before,  
19 because you didn't think you had to do that?

20 A Okay, I understand now. Yes, I was getting there  
21 consent, because I had to have them sign a form stating  
22 that they were okay to be treated by me while I was not  
23 wearing a mask. So perhaps I answered wrongly in the  
24 first place, but, yes, I was following all the  
25 conditions and restrictions on my practice, so that did  
26 require a consent, you're right.

1 Q Okay, so if we were to look at every one of your files  
2 after that rescind order, they'd have that patient  
3 consent form on them?

4 A No, it wouldn't be in a form on every file. I had two  
5 separate pieces of paper, each delineating -- one was  
6 the prescreening questions, that they were all negative  
7 to those questions, and the second form listed the  
8 exemption that I had to wearing a mask and that that  
9 patient was okay to be treated by me, so they would  
10 sign that one too, yeah.

11 Q So that was -- the rescind order was dated January 5,  
12 2021. Did you have those kinds of consents on your  
13 charts before January 5, 2021?

14 A No, I did not.

15 Q And I don't want to put words in your mouth, is it fair  
16 to say, if we looked at your charts then from June  
17 onwards, we wouldn't see patient consent charted on,  
18 patient to masking, you or you being unmasked?

19 A That is correct.

20 MR. KITCHEN: Hold on, just to clarify, you  
21 mean June of 2020?

22 MR. MAXSTON: Did I say a different date?  
23 My apologies.

24 MR. KITCHEN: No, you just said June. If we  
25 had --

26 MR. MAXSTON: June of twenty --

1 MR. KITCHEN: -- (INDISCERNIBLE) to deal  
2 with.

3 Q MR. MAXSTON: So I'll go back. From June of  
4 2020 onward, we would see charting about -- on your  
5 patient charts about you getting patient consent to you  
6 not being masked?

7 MR. KITCHEN: Well, hold on, you're getting  
8 confusing and misleading there, because he just said  
9 that he does do it after he's been asked to do it. So  
10 if you want to ask did he do it from June 2020 to when  
11 he had to start doing it, that's fine.

12 MR. MAXSTON: Yeah, I was really asking  
13 him --

14 MR. KITCHEN: But to try and -- okay.

15 MR. MAXSTON: Yeah, I was really asking that  
16 because you sort of objected, so my point, I think the  
17 answer was from June of 2020 onwards, there isn't  
18 charting about Dr. Wall's masking or not being masked,  
19 and I think Dr. Wall said that was correct.

20 A That is correct.

21 Q MR. MAXSTON: Dr. Wall, did you ever provide  
22 patients with views about masking that were in  
23 opposition to your own?

24 A I left it to the patient. If they were comfortable  
25 with masking and believed in it, that they were very  
26 willing to wear a mask, so we never engaged in strong

1 conversation about that.

2 Q Okay, and would that have applied to your decision to  
3 mask as well; you didn't have a dialogue with them  
4 about opposing views on that front?

5 A Only if a patient was really asking me questions about  
6 it, then perhaps we would dialogue further.

7 Q Okay, so it was up to the patient to raise that; that  
8 was your practice?

9 A Yeah, patients ask questions about all kinds of health  
10 issues, and so, you know, in this situation, that was  
11 no different.

12 Q Okay. I want to move now to your involvement with the  
13 College, or the College's involvement with you is more  
14 accurate, and I'd like you to go to Exhibits A-2 and  
15 A-3, and, frankly, you could probably just go to A-3,  
16 because A-3 includes A-2, which is Ms. Ho's email to  
17 Dr. Halowski. Maybe just ask you to get there, and you  
18 can let me know when you're ready to go.

19 A Okay, I'm on A-3.

20 Q And I'm going to refer to the email to Ms. Ho, even  
21 though it's a separate exhibit, but I'm just going to  
22 take you through it using A-3. I just have a couple of  
23 questions about it.

24 So this was an email from Ms. Ho to you dated  
25 December 1, 2020. Can you tell me if you have any  
26 information about how that email was sent to you?

1 A Yes, I do. The email came to me, initially I thought  
2 the email was spam quite honestly, and so I didn't  
3 answer the email, and then it was followed up by a  
4 telephone call, to which I took it.

5 Q I'm looking at the second paragraph, it says: (as read)

6 As per our phone conversation, you indicated  
7 that you are [quote] mask exempt.

8 Is that a correct statement by Ms. Ho?

9 A Yes, it is.

10 Q And then: (as read)

11 As per CMOH 38-2020, please indicate which  
12 exemption you would fall under; otherwise,  
13 you are required to be masking within 2  
14 metres distance with a patient.

15 Did you ever get back to her about your exemption?

16 A Yes, I did.

17 Q Okay. The next paragraph says: (as read)

18 As per your administrative staff, you  
19 indicated that there is no plexiglass barrier  
20 at reception and that staff are not masking.

21 Is that an accurate statement?

22 A Yes, it is.

23 Q If we go to the sort of tail end of that paragraph, it  
24 says: (as read)

25 Your clinic must have control measures, eg.,  
26 physical barrier, to promote physical

1 distancing at all times.

2 And you didn't have a physical barrier at that point,  
3 did you?

4 A No, I did not.

5 Q And then it says: (as read)

6 Otherwise, the administrative staff must be  
7 masked as per CMOH 38-2020.

8 Again, you'd agree with me that your administrative  
9 staff wasn't masked?

10 A That's correct.

11 Q I'm looking at the letter that Dr. Halowski sent to  
12 Mr. Lawrence, that's Exhibit A-3, and I just have one  
13 question about it. At the very tail end of the email,  
14 the second-last paragraph says: (as read)

15 Further to the email from Public Health, in  
16 conversation with Dr. Wall, he indicated that  
17 he does not mask and has provided for  
18 barriers in his clinic.

19 Is that an accurate statement; that's an accurate  
20 statement by Dr. Halowski of what you said?

21 A Yes.

22 MR. MAXSTON: Mr. Chair, I plan to go about  
23 another 10, 15 minutes and take a break at 2:45, if  
24 that works for everybody. And, Dr. Wall, if you need a  
25 break sooner, you let me know, but we've been chatting  
26 for about an hour and a bit now, so I'll just go about

1 another 10, 15 minutes, if that's okay.

2 THE CHAIR: That's okay, I believe,  
3 Mr. Maxston. Thanks.

4 Q MR. MAXSTON: I'd like you to go to  
5 Exhibit A-5, which is Mr. Lawrence's December 21, 2020  
6 letter to you.

7 A Okay, I'm there.

8 Q And in paragraph 2, Mr. Lawrence is saying: (as read)  
9 You [meaning you, Dr. Wall] would not be  
10 taking steps to become compliant with these  
11 requirements.

12 And that was what you had communicated to him?

13 A In respect of masking, is that what you're referring  
14 to?

15 Q Yeah, I think so in the Pandemic Directive.

16 A Yeah, specifically to do with masking, yes.

17 Q And I guess, in fairness to you, and social distancing  
18 and plexiglass barrier.

19 A Yeah. Is that prior to me installing the plexiglass  
20 barrier or after?

21 Q Yeah, I think the plexiglass barrier is bit of a  
22 variable, because I agree that after December of -- I  
23 think it's December 20th, those came up, but my comment  
24 to you was he accurate in saying you weren't going to  
25 be taking steps then to become compliant?

26 MR. KITCHEN: Well, he's answered the

1 question; he said he's not going to be compliant with  
2 masking, so it's fine if you want to get a little more  
3 specific.

4 MR. MAXSTON: Well, I think I did.

5 Q MR. MAXSTON: Social distancing, you're not  
6 going to be compliant with that?

7 A Correct.

8 Q And the plexiglass barriers referenced in the Pandemic  
9 Directive, you're not going to be compliant with that?

10 MR. KITCHEN: Well, he's already answered --

11 A No, I've already put it --

12 MR. KITCHEN: -- that.

13 A Yeah, I've already put it up.

14 MR. MAXSTON: Okay. I was about to go on to  
15 my next set of questions, but they're actually probably  
16 going to be longer than 15 minutes. Mr. Chair, would  
17 you want to take a 10- or 15-minute break now? I think  
18 it would be --

19 THE CHAIR: Yeah, you know, if it makes  
20 sense in terms of fluidity for your questioning, that's  
21 fine. It's 2:30. Let's recess for 15 minutes and  
22 reconvene at 2:45, and we'll continue with the  
23 objective of meeting Mr. Kitchen's plans to have his  
24 witness around 3:45.

25 MR. MAXSTON: We're going to follow the  
26 accepted practice that, of course, Dr. Wall can't chat



1 about his testimony with Mr. Kitchen.

2 THE CHAIR: Yes, that's --

3 MR. MAXSTON: Thank you.

4 THE CHAIR: -- (INDISCERNIBLE). Okay,  
5 we'll see you at 2:45.

6 (ADJOURNMENT)

7 THE CHAIR: Okay, we're back in session.

8 MR. MAXSTON: Sure.

9 Q MR. MAXSTON: Dr. Wall, I was just taking  
10 you through your interactions with the College, and we  
11 talked about Mr. Lawrence's letter. I'd like you to go  
12 to Exhibit A-6, which is I think an undated, unless I  
13 missed something, letter from you in response to  
14 Mr. Lawrence, and I'd like to take you through that.

15 I think, in fairness, this document was received  
16 by the College I think on January 11, but I'll ask you  
17 to clarify when I start your questions, Dr. Wall, on  
18 this when it was sent. I don't think there's a date on  
19 it. So if you can let me know when you're at that  
20 document. Again, A-6.

21 A Yeah, I'm there, and it does appear January 11th.

22 Q Yeah, okay. So, Dr. Wall, some of this we've covered  
23 in some detail before, but I'm looking at the second  
24 paragraph, and that's a summary, I believe, of your  
25 comments about trying masking and trying a face shield,  
26 and your decision in June of 2020 to not wear either;

1 is that fair to say?

2 A Yes, it is.

3 Q The next paragraph says: (as read)

4 I considered this decision to be reasonable  
5 based on the information available to me and  
6 based on my conclusion that the ACAC pandemic  
7 practice directive could not be reasonably  
8 interpreted to demand the wearing of a mask  
9 if doing so was harmful to the member and  
10 negatively impacted the member's ability to  
11 provide the best possible patient care.

12 That's your interpretation without any consultation  
13 with the College, correct?

14 A That's correct.

15 Q There's another paragraph just below that, beginning:  
16 (as read)

17 The information available to me at the time  
18 was that the benefit of masks vis-à-vis  
19 reducing COVID-19 transmission was tenuous  
20 and that mask wearing was an additional  
21 precautionary measure, which was worth  
22 implementing only if doing so did not result  
23 in negative impacts that outweighed the  
24 potential marginal benefits.

25 And you then say: (as read)

26 This has been borne out over time.

1 I just want to be clear here, this is stating the  
2 obvious, but you're not a virologist or respirologist  
3 or an epidemiologist?

4 A That's correct, yeah.

5 Q So this is your conclusion?

6 A That's correct.

7 Q The next paragraph says: (as read)

8 I did not think at the time that I should or  
9 needed to obtain any sort of exemption to  
10 wearing a mask or face shield from another  
11 health care practitioner such as a medical  
12 doctor.

13 And I'm going to suggest to you, Dr. Wall, that that's  
14 really kind of an astonishing statement that, as a  
15 health care provider, you would think you didn't need  
16 to go see another health care practitioner. Can you  
17 tell me why you would believe that, why you thought you  
18 could self-diagnosis?

19 A Well, my very obvious symptoms of anxiety and  
20 claustrophobia were very apparent to me. I didn't need  
21 somebody to diagnose that. It was extremely obvious,  
22 and so that would be my short answer.

23 Q The next paragraph you talk about a spring of 2020 AHS  
24 report, and you quote from it briefly I think, or you  
25 reference it. Do you recall Dr. Hu's testimony where  
26 he said that masking guidance has changed since the

1 beginning of the pandemic?

2 A Yes, I do.

3 Q And would it be fair to say that when we look at those  
4 three additional AHS documents, they do support  
5 masking?

6 A I'm sorry, which three initial documents?

7 Q We had an application at the beginning of the hearing  
8 where I asked three AHS documents be entered, and I  
9 took Dr. Hu through them. Would you agree with me, and  
10 I can take you through them, but I don't think I need  
11 to, would you agree with me that those three AHS  
12 documents are supportive of masking?

13 A I believe that's what they would believe, yes.

14 Q On the top of the next page, there's a closing  
15 sentence: (as read)

16 Subsequent studies and reports have confirmed  
17 that the benefits of masks is tenuous at  
18 best.

19 Would you agree with me that there are other studies  
20 that are strongly in support of masking?

21 A I think there are probably multiple studies that would  
22 say that they are in strong support of masking. I  
23 question some of the design flaws with respect to that,  
24 but that is not my expertise, and so I'll leave it at  
25 that.

26 Q Okay. The next paragraph talks about, in part, the

1 CMOH orders, and to use your wording: (as read)

2 Broadly worded exceptions and -- [sorry] --

3 broadly worded exceptions exempting

4 individuals from wearing masks if they had

5 mental concerns or limitations.

6 And then you talk about CMOH Order 38 and CMOH Order

7 42-2020, and we canvassed this before, but those orders

8 weren't in force until November and December of 2020;

9 isn't that correct?

10 A I believe so.

11 Q I'd like you to go to the -- I wish these pages were

12 numbered, it might be easier for me, but the top of

13 page 3 starts off with "Include exceptions for mental

14 conditions or limitations". Are you there, Dr. Wall?

15 A Yes, I am.

16 Q Okay. There is a -- the first complete sentence says:

17 (as read)

18 I have legitimate mental concerns and

19 limitations, and I'm, therefore, not bound by

20 any order of the CMOH to wear a mask.

21 You would agree with me that those were, again,

22 self-diagnosed mental concerns?

23 A Yes, I would. Initially.

24 Q If we go a little bit down, there's a paragraph

25 beginning: (as read)

26 As for the allegation I failed to comply with

1 the Pandemic Directive.

2 There's a closing statement, it says: (as read)

3 However, it appears the fact that I have not  
4 been wearing a mask is the content of the  
5 allegation I failed to comply with the ACAC  
6 Pandemic Practice Directive.

7 And that's still your understanding, at least in part?

8 There's other issues, but ...

9 A That's correct.

10 Q You then say: (as read)

11 I acknowledge that, on its face, the Pandemic  
12 Directive states that mask wearing is a  
13 requirement of members. I further  
14 acknowledge the fact that I have been not  
15 wearing a mask, on its face, amounts to  
16 noncompliance with the practice directive.

17 And you maintain those acknowledgments today, I assume?

18 A Yes, I do.

19 Q Final sentence in that paragraph says: (as read)

20 Any policy or directive of the ACAC that  
21 imposes mandatory mask wearing upon members  
22 but does not permit necessary exceptions is  
23 unreasonable.

24 You never asked for an exception, did you?

25 A No, I did not.

26 Q The next paragraph: (as read)

1 I further submit it was reasonable of me to  
2 conclude that a reasonable reading of the  
3 ACAC Pandemic Directives requirement to wear  
4 masks implicitly permitted necessary  
5 exceptions such as for legitimate mental  
6 health conditions, concerns, or limitations.  
7 Again, that's your conclusion and your interpretation  
8 alone?

9 A Correct.

10 Q Thank you, Dr. Wall, I don't have any further -- any  
11 more questions on that document.

12 At this point or maybe it's happening already,  
13 Mr. Lawrence is conducting the investigation into your  
14 conduct under Part 4 of the HPA, and I'd like to take  
15 you to the investigation report, which is Exhibit A-7.

16 A Okay, I'm there.

17 Q Okay. I'm looking at page 1, and the second paragraph  
18 talks about a December 2, 2020 conversation with the  
19 Registrar and December 3, 2020 conversation during  
20 the -- with the Complaints Director. And we then have  
21 some comments about masking, et cetera. I'm skipping  
22 down to about the fourth-last line, there's a comment  
23 which Mr. Lawrence: (as read)

24 He indicated -- ["he" meaning you] --  
25 indicated that he did not believe he was  
26 endangering the public, as the recovery rate

1                   from COVID-19 is so high.

2           Is that your recollection of the statement you made as  
3           well?

4    A    Yes, it is.

5    Q    You'd agree with me though that even if the recovery  
6           rate is high, there are some individuals who have  
7           serious medical complications because of COVID-19?

8    A    Yes, I would.

9    Q    And that it's fatal for some people?

10   A    Correct.

11   Q    Going to ask you to go to page 4 of the investigation  
12           report, and this is a series of what Mr. Lawrence  
13           describes as key points of the interview. Just got a  
14           couple of questions for you about some of these,  
15           because I think you've answered a lot of the questions  
16           I was going to ask you. About the fifth bullet down  
17           deals with your son working at the clinic, and the  
18           second sentence says: (as read)

19               Dr. Wall indicated that he also did not  
20               require his son to be masked and did not  
21               think it necessary to install any barriers.  
22           Is that accurate?

23   A    Yes, it is.

24   Q    And if it wasn't your son, if it was anyone else there,  
25           would you take the same position?

26           MR. KITCHEN:                   That's a hypothetical. I



1 don't see the relevance.

2 Q MR. MAXSTON: Well, I'll ask you this: Did  
3 you have anybody other than your son working at the  
4 clinic during the time relating to the charges, working  
5 as a receptionist?

6 A No, I did not.

7 Q Okay, well, that answers that question. And the next  
8 arrow, there's a comment about Dr. Wall reiterated that  
9 your son is a healthy individual, and he did not want  
10 to wear a mask; that's accurate?

11 A That's correct.

12 Q I'm going to ask you, Dr. Wall, sort of a general  
13 question, but would you agree that a chiropractor is  
14 responsible for his staff members complying with the  
15 requirements of practice for a chiropractic clinic?

16 A With respect to the mask wearing, I would tend to take  
17 the same position that I've taken for myself. So if my  
18 staff member, being my son, had legitimate concerns,  
19 whether they were religious or physical or otherwise,  
20 then we'd have to walk through that.

21 Q Okay, I was trying to be a little more precise there.  
22 I'm thinking of things like the charting standard I  
23 took you through. If you delegate charting to a staff  
24 member, you're ultimately responsible, aren't you --

25 A That's correct.

26 Q -- for the charting?

1 A That's correct.

2 Q And the same would be true for Standards of Practice  
3 and other College requirements; if staff do things,  
4 you're ultimately responsible?

5 A Correct.

6 Q Dr. Wall, there's a bullet or an arrow about four from  
7 the bottom, it says: (as read)

8 When asked if Dr. Wall ever alerted his  
9 patients to the dangers of not being masked,  
10 Dr. Wall replied that people are aware of the  
11 dangers, and he did not explain any of the  
12 dangers to patients of him not masking.

13 Is that sort of what you said to me before, that you  
14 let patients raise things with you?

15 A If the conversation came up, yes.

16 Q And you rely on the patient to raise that discussion?

17 A As it pertained to mask wearing; is that what you're --

18 Q Yeah.

19 A -- referring to? Yes.

20 Q When you had -- I'm sorry, when you had your interview  
21 with Mr. Lawrence, and I think it was a phone  
22 interview, Mr. Kitchen was present, participated,  
23 listened, I guess is maybe the best way, during the  
24 interview; is that correct?

25 A Are you referring to the interview with Dr. Halowski  
26 and Mr. Lawrence?

1 Q Yes, the one that would have occurred in -- oh, my  
2 apologies, Dr. Wall, January 25, 2021.

3 A Yes, that's correct. Mr. Kitchen was present on that  
4 call.

5 Q Okay, thank you. Would it be fair to say that when you  
6 had that discussion during the interview that you  
7 didn't mention the religious beliefs you talked about  
8 today?

9 A I didn't; I don't think I did mention the religious  
10 beliefs, yeah.

11 Q I'd like to turn to the Section 65 interim order  
12 matters, and as you know from Exhibit -- I'm not going  
13 to take you to this exhibit, but Exhibit D-1 was  
14 Mr. Lawrence's December 3, 2020 letter to Mr. Linford.  
15 I'd like to ask you though about the response letters  
16 that Mr. Kitchen sent on your behalf, and those appear  
17 as Exhibits B-3 and B-4. I'll take you to B-3 first,  
18 which is the December 10, 2020 letter from Mr. Kitchen.

19 A Okay, I'm there.

20 Q So this was a letter written by Mr. Kitchen in response  
21 to Mr. Lawrence's request for Section 65 suspension. I  
22 take it you adopt the contents of this letter; you  
23 instructed Mr. Kitchen to send this letter?

24 A Yes, I did.

25 Q Okay. I'm going to page 2, the second complete  
26 paragraph says: (as read)

1           Any risk to Dr. Wall's patients as a result  
2           of him not wearing a face covering is  
3           speculative at best.

4           That's your position as well?

5    A    Yes, it is.

6    Q    And notwithstanding hearing from Dr. Hu, that's your  
7           position still?

8    A    Correct, yes.

9    Q    And the next sentence, and I should go back,  
10           notwithstanding looking at those AHS documents, that's  
11           still your position?

12           MR. KITCHEN:                    You've asked that at least  
13           once if not a couple times already, Mr. Maxston.

14   Q    MR. MAXSTON:                    The next sentence says: (as  
15           read)

16           There's a lack of scientific evidence that  
17           face coverings have any measurable  
18           effectiveness in preventing the transmission  
19           of COVID-19.

20           Is that your position?

21           MR. KITCHEN:                    Again, Mr. Maxston, you've  
22           asked that, and, obviously, his position, you've just  
23           established, that this was sent on behalf of Dr. Wall  
24           at his instructions, which means it is his position;  
25           you've just established that. So now --

26           MR. MAXSTON:                    Well (INDISCERNIBLE) --

1 MR. KITCHEN: -- you're asking does Dr. Wall  
2 agree that the sky is blue, does he agree that all the  
3 sky is blue, you know, you don't get to -- I don't see  
4 how you get to do that.

5 Q MR. MAXSTON: Well, I guess I could be more  
6 global and say do you agree with every statement in  
7 this letter that Mr. Kitchen has made about COVID and  
8 masking and related matters?

9 MR. KITCHEN: You've already asked that --

10 MR. MAXSTON: Well --

11 MR. KITCHEN: -- and he's already given you  
12 his answer.

13 MR. MAXSTON: I asked him whether he adopted  
14 it but --

15 MR. KITCHEN: Yes, you did. And that means  
16 that if he adopted it, he adopted all of it. And it's  
17 his statement, not mine, so once he adopts it, it's  
18 his, it's sent on his behalf by counsel.

19 MR. MAXSTON: I think even though he's  
20 adopted it, I'm allowed to ask questions, but I'll move  
21 on to something else.

22 Q MR. MAXSTON: I'm looking at the bottom of  
23 page 2 of the letter, it says: (as read)

24 As a matter of factual clarity, Dr. Wall  
25 employees [or "employees" I think should be  
26 "employs"] no staff in his clinic that are

1 not members of his family.

2 You've confirmed that with me: (as read)

3 Dr. Wall reiterates that he has appropriately  
4 installed the required plexiglass barriers at  
5 his chiropractic office and will maintain  
6 such barriers as long as they are required.

7 Why did you install the, quote, required plexiglass  
8 barriers, Dr. Wall?

9 A I believe that was part of the re-opening process for  
10 Alberta Health Services, that my plexiglass barriers be  
11 up, so I did that.

12 Q So that was an aspect of the re-opening order that you  
13 did choose to comply with?

14 A That's correct.

15 Q Okay, let's go to Exhibit B-4. That's Mr. Kitchen's  
16 December 16, 2020 letter. I'll just ask you again, you  
17 adopt this as your response?

18 A Yes, I do.

19 Q Okay I was going to ask you about item number 1, but  
20 we've already dealt with why you installed the  
21 plexiglass barriers. I'm curious about item number 2.  
22 It says: (as read)

23 Attached to this letter as Appendix B is a  
24 medical certificate from an M.D. exempting  
25 Dr. Curtis Wall from being required to wear  
26 any sort of face covering on the basis of a

1           mental disability.

2           At the time of this letter, December 16, I think the  
3           only medical note we had was Exhibit A-8, Dr. Salem's  
4           December 12th, 2020 letter.

5           MR. MAXSTON:                   I can ask Mr. Kitchen to help  
6           out here, was that the enclosure you were referring to  
7           in this letter, Mr. Kitchen? I don't think it's  
8           attached as an exhibit. I think we probably didn't put  
9           it in because it was redundant, but I just want to be  
10          sure that --

11          MR. KITCHEN:                   It is (INDISCERNIBLE)  
12          Exhibit A-8.

13          MR. MAXSTON:                   Yeah. When you -- in item 2,  
14          when you --

15          MR. KITCHEN:                   You're asking this because  
16          it's not contained in this letter, I take it, which --

17          MR. MAXSTON:                   Yeah, I just want to be sure,  
18          in fairness to your client, I'm asking the right  
19          question about the right document and --

20          MR. KITCHEN:                   (INDISCERNIBLE)

21    Q    MR. MAXSTON:                   -- and we're digressing a  
22          moment here, Dr. Wall --

23          MR. MAXSTON:                   --Mr. Kitchen, my sense is  
24          that because your letter is dated December 16, 2020,  
25          the only letter we can have from Dr. Salem is the one  
26          from December 12. He didn't do his other letter

1           until --

2           MR. KITCHEN:                   Yeah, I can't object to that  
3           as being factually inaccurate, so I'll let Dr. Wall  
4           answer, but everything's --

5           MR. MAXSTON:                 Yeah.

6           MR. KITCHEN:                 -- everything's in order so  
7           far.

8           MR. MAXSTON:                 Yeah, I think the other letter  
9           from Dr. Salem is January 8, 2021, so I just want to be  
10          clear I'm asking --

11          MR. KITCHEN:                 That's --

12          MR. MAXSTON:                 -- the right question.

13          MR. KITCHEN:                 That's right.

14   Q     MR. MAXSTON:                 Okay, so if we're proceeding  
15          then that the Appendix B that is being referred to in  
16          this letter is Exhibit A-8, I'd just ask you to quickly  
17          go to Exhibit A-8, Dr. Wall.

18   A     Okay, go ahead.

19   Q     I'm going to read this to you, if you want to go back,  
20          but Exhibit B-4, the letter of December 16, 2020, item  
21          2 says: (as read)

22                 Appended to this letter as Appendix B is a  
23                 medical certificate from an M.D. exempting  
24                 Dr. Curtis Wall from being required to wear  
25                 any sort of face covering on the basis of a  
26                 mental disability, which, as you know, is a



1                   protected ground under Section 4 [and they  
2                   have a reference to the Human Rights Act and  
3                   the Charter].

4                   When I go to Exhibit A-8, I don't see any reference to  
5                   mental disability; would you agree with that?

6       A       Yes, it is not included in that letter.

7       Q       And it says "medical reasons" in Exhibit A-8; is that  
8                   correct?

9       A       That is correct.

10      Q       I would like to take you to Exhibit B-5, which is  
11               Dr. Linford's decision on the Section 65 suspension.

12      A       Sorry, can you clarify B dash what?

13      Q       B dash 5, Bob dash 5, and it's the December 8th, 2020  
14               decision letter from Dr. Linford, and specifically I'll  
15               be taking you to page 2 when you get to it, Dr. Wall.

16      A       Yeah, go ahead.

17      Q       You would agree with me, I'm looking at the second  
18               complete paragraph on page 2, Dr. Wall says: (as read)

19               The impact of COVID-19 on the Public Health  
20               care system is undeniable.

21               That's correct?

22      A       Correct.

23      Q       At the end of that paragraph, the final two sentences  
24               say -- and he's talking about full vaccination  
25               occurring: (as read)

26               Until that time arrives, the COVID-19 virus

1           remains a real and imminent public health  
2           threat.

3           You'd agree that's his statement?

4    A    I'm sorry, where is that statement again?

5    Q    Sorry, it's about two-thirds of the way down, it's the  
6           second-last full sentence, beginning "Until that time  
7           arrives", and it's in the same paragraph we were just  
8           chatting about.

9           THE CHAIR:                    I think it's a third of the  
10          way down the page, not two-thirds.

11         MR. MAXSTON:                  Yeah.

12         THE CHAIR:                    It's the third paragraph.

13    Q    MR. MAXSTON:                  I don't know if it helps,  
14          Dr. Wall, but I've taken you to the statement: (as  
15          read)

16                 The impact of COVID-19 on the public health  
17                 care system is undeniable.

18                 I'm about five lines below that in the sentence  
19                 beginning "Until".

20    A    Got it, yeah, I see that now.

21    Q    Yeah, sorry, it's a little hard to follow, because  
22          it's -- there's some incomplete paragraphs.

23                 So I'm just asking you to confirm, Dr. Linford is  
24          stating: (as read)

25                 Until that time [I think he means full  
26          vaccination] arrives, the COVID-19 virus

1           remains a real and imminent public health  
2           threat.

3       Those are his words?

4   A    Yes.

5   Q    I take it you would disagree with that?

6   A    Yes.

7   Q    The next sentence is:  (as read)

8           I find that the Complaints Director has a  
9           legitimate concern of risk to the public by  
10          Dr. Wall's decision to not wear a face mask  
11          or face shield when seeing and treating  
12          patients.

13       That's his statement?

14   A    Yes, it is.

15   Q    And you would disagree with it?

16   A    Yes, I would.

17   Q    We go to the next paragraph, there's a second sentence:  
18       (as read)

19          I have decided that conditions on Dr. Wall's  
20          practice permit will be sufficient to address  
21          the risk to the public by Dr. Wall not  
22          wearing a face mask or face shield when  
23          seeing and treating patients.

24       So those are his words in identifying a risk to the  
25       public?

26   A    Correct.

1 Q And, again, you would disagree with that?

2 A No, he is saying that the conditions were sufficient to  
3 address the risk to the public. That I agree, he  
4 believes that the conditions on my practice would be  
5 sufficient to meet -- to meet the risk to the public.

6 Q Okay, thanks for clarifying that. If we look at the  
7 balance of the letter, there are a series of directions  
8 on that page, and I'm using the word "directions"  
9 because Dr. Linford uses that, he says: (as read)

10 Your practice permit will be subject to the  
11 following practice -- I direct that

12 Dr. Wall's practice permit will be subject to  
13 the following practice conditions pending  
14 completion of this hearing.

15 There are, as I said, four directions from him then.  
16 Would you agree that those are binding on you?

17 A Yes, I would.

18 Q And would you agree that they're still binding on you,  
19 to be more clear?

20 A Yes.

21 Q And have you complied with those conditions or orders,  
22 and are you continuing to comply with them?

23 A Yes, I have.

24 Q So in this case, you've determined that you will follow  
25 a College requirement?

26 A Can you be more specific?

- 1 MR. KITCHEN: This isn't a College  
2 requirement, or maybe it is, then we have to establish  
3 that. It's obviously a requirement of Dr. Linford.
- 4 MR. MAXSTON: I'll rephrase my question.
- 5 Q MR. MAXSTON: This is a -- those are a  
6 series of directions ordered by Dr. Linford under  
7 Section 65 of the HPA; is that correct?
- 8 A Yes.
- 9 Q And Dr. Linford is appointed, pursuant to the HPA, to  
10 make these kinds of decisions; would you agree with  
11 that?
- 12 A Yes.
- 13 Q And my question was are you complying, are you  
14 continuing to comply with the directions, the  
15 conditions on your practice permit?
- 16 A Yes.
- 17 Q And my follow-up question was this is a situation where  
18 you are complying with a direction from a College I'll  
19 call him designate or officer?
- 20 A Correct.
- 21 Q And as you are likely aware, Section 65 of the HPA  
22 contains a right for you to appeal a Section 65  
23 direction to the courts. Did you launch any kind of  
24 court deal concerning the Section 65 direction?
- 25 A No, I have not.
- 26 Q Dr. Wall, I want to switch gears now and talk about

1       your decisions you made, your decisions or independent  
2       decisions in June of 2020 about not masking and not  
3       social distancing, et cetera.

4               When you -- and I think we've covered this, but I  
5       want to be clear -- when you decided in June of 2020  
6       that you weren't going to wear a face mask or use  
7       social distancing, you were aware that those choices  
8       would contravene the Pandemic Directive as written?

9       MR. KITCHEN:                   Mr. Maxston, I'd have to say  
10      that you've asked this and he's answered it, and the  
11      answer's not controversial.

12      MR. MAXSTON:                  Well, I won't re-ask the  
13      question on the basis that you're telling me your  
14      client has already agreed to that.

15   Q   MR. MAXSTON:                  Can you tell me, Dr. Wall,  
16      when you started this review of, you know, the masking  
17      issue for you? And by "review", I mean the inquiries  
18      you made about efficacy of masking.

19   A   Well, when the Pandemic Directive came into place for  
20      chiropractors, I believe that was specific to May with  
21      the Pandemic Directive, and so wearing a mask  
22      immediately had me asking questions because I  
23      experienced the symptoms that I was experiencing, so I  
24      would have to say in early May.

25   Q   Okay. When you did that, did you look for any articles  
26      or studies that supported masking?

1 A I was looking, in general, at various articles, and so  
2 I don't think I was looking for articles in support of  
3 masking.

4 Q Did you consider any articles in support of masking  
5 when you made your decision?

6 A Yeah, I've seen articles floating around supporting  
7 masking, yes.

8 Q So I'm assuming then that you chose to discount those  
9 articles or studies?

10 A That's correct. I have seen articles that support  
11 masking, and then I've seen those particular articles  
12 debunked, and so, yeah.

13 Q Did you contact any other organizations to get their  
14 views on this masking efficacy question?

15 A No, I did not.

16 Q Specifically, did you contact the Canadian Chiropractic  
17 Association?

18 A No, I did not.

19 Q Did you -- I should go back. Are you insured for  
20 malpractice with the CCPA?

21 A Yes, I am.

22 Q Did you contact the CCPA about your decision?

23 A To not mask?

24 Q Yes.

25 A No.

26 Q Did you consult with any medical health care

1 professionals or specialists?

2 A Not until the time where I had to achieve a doctor's  
3 note.

4 Q And I suppose this is an obvious question, but when you  
5 made the decision in June of 2020, you didn't have the  
6 four expert reports that are being tendered in this  
7 hearing by you?

8 A That's correct.

9 Q Is it your position that it was professionally and  
10 ethically acceptable for you to decide when and how the  
11 Pandemic Directive applied to you?

12 A As it applied to masking, yes, and perhaps the social  
13 distancing, like you mentioned.

14 Q Okay. I'm going to ask you to go to Exhibit A-8, we  
15 went through this a little bit before, but I'm going to  
16 ask you a little bit more detailed questions. That's  
17 the letter from Dr. Salem, dated December 12th, 2020.  
18 And I'll just wait till everybody's there. When did  
19 you first contact Dr. Salem about an exemption letter?

20 A I believe I'd have to really look at my journal. It's  
21 probably sometime in early December.

22 Q Was that after you had received an indication from the  
23 College that there was a complaint?

24 A That is correct.

25 Q So it's fair to say that at least part of your  
26 motivation in getting this letter was to be able to



1           respond to the College's complaint?

2     A     To be supportive, and, yes, because I wasn't under the  
3           understanding that there was a requirement to produce  
4           some type of exemption letter, yes.

5     Q     Is Dr. -- was Dr. Salem your regular family doctor at  
6           the time?

7     A     No.

8     Q     So how did you choose him?

9           MR. KITCHEN:                   We're getting into something  
10          that's pretty personal and private, and I'm not sure  
11          that it's relevant.

12          MR. MAXSTON:                   Sure, I'll be a little more  
13          general.

14     Q     MR. MAXSTON:                 If he wasn't your regular  
15          doctor -- I don't need any background -- did you sort  
16          of pick him out of the phone book, so to speak? And I  
17          remember when there were phone books or -- I'm just  
18          wondering how you made your way to Dr. Salem; that's  
19          what I'm really asking.

20          MR. KITCHEN:                   Again, personal, private, not  
21          relevant.

22     Q     MR. MAXSTON:                 When you made an appointment  
23          with Dr. Salem and subsequently got this letter, were  
24          you aware that Dr. Salem had ever issued any other  
25          exemption letters?

26     A     No, I'm not.

1 Q Was your attendance -- I think there were two  
2 attendances with Dr. Salem, the but the first time you  
3 saw Dr. Salem -- well, this is an obvious question, I  
4 guess -- you'd never seen him for anything before,  
5 anything other medical issues?

6 MR. KITCHEN: Again, this is personal, it's  
7 private, it's not relevant.

8 Q MR. MAXSTON: Isn't it fair to say,  
9 Dr. Wall, that you realized that your own  
10 self-diagnosis of an anxiety issue wasn't going to  
11 withstand scrutiny unless you had a doctor's letter?

12 A I would say that that's likely accurate, yes.

13 Q And you could have gone to a doctor like Dr. Salem in  
14 May or June of 2020?

15 A I could have, yes.

16 Q When you were seeing Dr. Salem the first time, which  
17 gave rise to the December 12th, 2020 letter, did he  
18 perform any tests in terms of your anxiety issues?

19 A It was a consultation, and so we discussed at length my  
20 issue.

21 Q Okay. Did he offer a prognosis to you?

22 A No.

23 Q Did he offer a treatment plan?

24 A No, he did not.

25 Q Did he recommend any steps to address the anxiety  
26 disorder: Relaxation, anything like that?

1 A No.

2 Q If we go to the next document, Exhibit A-9, that's the  
3 second letter, January 8, 2021 letter from Dr. Salem.  
4 Just let you get to that, and I've just got a couple of  
5 questions for you about it.

6 A Okay, go ahead.

7 MR. MAXSTON: Mr. Chair, I'm always just  
8 pressing on. If someone hasn't got a document, raise a  
9 hand or someone let me know if you're -- people haven't  
10 quite gotten to where I am, but I'll just continue  
11 here.

12 Q MR. MAXSTON: I'm looking at the first  
13 paragraph, and it's -- this is a letter to David  
14 Lawrence, and it says: (as read)

15 I am in receipt of your request for  
16 information.

17 I think we've covered this, but this letter is coming  
18 about because Mr. Lawrence is asking for something  
19 further; is that correct?

20 A Yes.

21 Q Yeah, so you didn't ask for this letter is what I'm  
22 getting at?

23 A Correct.

24 Q Okay. About a third of the way through, Dr. Salem  
25 says: (as read)

26 There are no other pertinent documents to

1           satisfy your requests for [quote] tests  
2           conducted or [quote] diagnostic information.  
3           These items are not applicable to the nature  
4           of Dr. Wall's medical issue. As you'll note  
5           from my charting, the primary driver for his  
6           inability to wear a mask is anxiety that is  
7           precipitated by wearing a mask.

8           Just, again, to confirm, Dr. Salem doesn't ever mention  
9           a medical disability in this letter, does he?

10    A    Correct.

11    Q    If we look at the following paragraphs, I'm going to  
12           suggest to you that they are a summary of Dr. Salem's  
13           views about the challenges that COVID presents and the  
14           concerns he has about the validity of COVID testing,  
15           and if we go to the next page, you'll see he talks  
16           about AHS saying there's limited research, et cetera.  
17           Would you agree with me that -- on masking -- would you  
18           agree with me that a large chunk of Dr. Salem's letter  
19           is dealing with his views on the efficacy of masking  
20           and the science behind it?

21    A    He does share his views, yes.

22    Q    And it's fair to say that you and he are literally and  
23           figuratively on the same page on those issues?

24           MR. KITCHEN:                   I think you're asking too much  
25           about the mind of Dr. Salem. You're going to have to  
26           get a little more specific here.

1 MR. MAXSTON: Sure, sure.

2 Q MR. MAXSTON: Dr. Wall, you agree with  
3 Dr. Salem's comments in his letter about COVID and  
4 masking, et cetera?

5 MR. KITCHEN: That's quite general. If you  
6 want to get a little more specific, I'm not going to  
7 take an issue.

8 MR. MAXSTON: Well, I don't think it's an  
9 unfair question.

10 MR. KITCHEN: Well, it's only unfair because  
11 it's so broad and vague. If you want to get more  
12 specific, that's fine. What's --

13 Q MR. MAXSTON: Do you -- Dr. Wall, do you  
14 agree with Dr. Salem's comments that mask wearing does  
15 not reduce the transmission of COVID?

16 MR. KITCHEN: Well, hold on. Can you point  
17 us to a specific comment, because --

18 MR. MAXSTON: Yeah.

19 MR. KITCHEN: -- is that supposed to be a  
20 quote, or is that --

21 MR. MAXSTON: Third paragraph, first line:  
22 (as read)

23 There are numerous studies that refute the  
24 benefit of mask wearing in reducing the  
25 transmission of respirator illnesses.

26 Q MR. MAXSTON: What I'm getting at -- I don't

1        want to have a debate about this -- Dr. Wall, again,  
2        Dr. Salem's views, generally speaking, about masking  
3        are consistent with yours?

4        MR. KITCHEN:                    Again, if you're asking if he  
5        agrees with that statement that you just read, fair  
6        question, but you brought it back as a very general,  
7        vague question that I don't think is acceptable.

8        MR. MAXSTON:                   Well, I'm just going to move  
9        on. I tried to establish that your client agrees with  
10       Dr. Salem, but if you're going to object to that ...

11    Q    MR. MAXSTON:                   In the second letter, would  
12        you agree that there are still no mention of a  
13        prognosis?

14    A    I would agree.

15    Q    And there is no mention of treatment options as next  
16        steps?

17    A    Yes, I would agree.

18    Q    So I asked you before, you could have gotten the letter  
19        from a doctor in May or June of 2020; why didn't you do  
20        that?

21    A    Well, at the time, I did not think it was a requirement  
22        to get a doctor's note for a medical exemption. The  
23        CMOH order does not specifically state that, and so  
24        that's why I didn't get one.

25    Q    I think that we've established though that those CMOH  
26        orders don't come out until November or December, later

1 in the year.

2 MR. KITCHEN: Yes, you asked that, and  
3 you've gotten the answer to it from before, nothing  
4 controversial there.

5 MR. MAXSTON: Mr. Kitchen, I'm going to ask  
6 a question, and unless you're going to object, I don't  
7 think you can help your client with his answers, so I'm  
8 moving along to a question.

9 MR. KITCHEN: I'm not trying to help; I'm  
10 just objecting to questions that have already been  
11 asked.

12 Q MR. MAXSTON: Wouldn't you agree, Dr. Wall,  
13 that something as serious as an exemption to masking  
14 would have required, from the very outset, some type of  
15 medical verification?

16 A Perhaps our opinion about the seriousness of a mask  
17 exemption is different. So, again, I, at the outset, I  
18 thought my health information was a private matter and  
19 that it was very specific to myself, and I didn't  
20 believe that I needed to disclose that information at  
21 the outset, so ...

22 Q So you don't have any training in anxiety disorders, do  
23 you?

24 A No, I don't.

25 Q And, nonetheless, you reached a diagnosis that you had  
26 an anxiety disorder sufficient to qualify you for some

1 type of exemption?

2 A Correct.

3 Q Do you believe it's appropriate for health care  
4 providers to self-diagnose medical issues?

5 A Potentially.

6 Q Like an anxiety disorder?

7 A Potentially.

8 Q Dr. Wall, we've been chatting now I think for about an  
9 hour and 15 minutes. I still have a fair number of  
10 questions, do you need a quick break, and or do you  
11 want to press on and just let me know when you need a  
12 break?

13 A We can press on.

14 MR. MAXSTON: Okay, Mr. Chair, you can feel  
15 free to jump in at any time if you need to direct a  
16 break.

17 Q MR. MAXSTON: Dr. Wall, I want to switch  
18 gears, and I want to go to the ACAC notices to you and  
19 the profession that are set out at Exhibits C-1 to  
20 C-22.

21 In my questioning of Dr. Halowski, I mentioned to  
22 him that Exhibit C1, C-10, and C-13 relate to the  
23 Telehealth option and the College council's ultimate  
24 approval of that. I think your evidence with  
25 Mr. Kitchen was you didn't feel that you could pursue  
26 Telehealth; is that correct?



1     A     That is correct. I actually did look at it, but it did  
2           not fit my practice style. I'm a hands-on  
3           chiropractor, and that was not the way I chose to go as  
4           far as practicing.

5     Q     I'm going to let your counsel decide if there is an  
6           objection here, but I can take you through Exhibits C-2  
7           onward and ask you specific questions about the College  
8           saying you can contact them and asking for input, but  
9           my question to you, to be more general and more  
10          efficient, is would you agree that, throughout Exhibits  
11          C-1 to C-22, there are numerous references to the  
12          College asking for input and inviting members to  
13          contact the College about the Pandemic Directive?

14    A     Yes, I would agree with that.

15    Q     So is it fair to say that you would have received all  
16          of these documents?

17    A     Yes, I did.

18    Q     And you'd already had an email exchange with  
19          Dr. Halowski, and you could have emailed him?

20    A     Regarding what?

21    Q     Regarding masking and the social distancing and I guess  
22          your issues about the Pandemic Directive.

23    A     Correct.

24    Q     And just to be clear, you didn't participate in any of  
25          the platform discussions on the Pandemic Directive?

26    A     How many platform discussions were there?

1 Q You know, I can't recall. I think there's reference to  
2 at least two in those exhibits. I'm just asking you if  
3 you can recall whether you participated in any of those  
4 exchanges.

5 A Yes, I believe I may have participated in the first  
6 one, because I do recall -- and I may be corrected  
7 here -- but I do recall the first draft included  
8 vaguely perhaps specific terms about vaccine issues,  
9 and that was a concern to me, and I think that's what  
10 potentially precipitated the letter to Dr. Halowski,  
11 but I may have participated in that first  
12 ThoughtExchange that was regarding the first draft.

13 Q Okay. But other than that, no communication or contact  
14 with the College?

15 A And then I also participated in a recent draft,  
16 several -- perhaps a month-and-a-half to several months  
17 ago.

18 Q Okay, I'm really concerned with the June to December  
19 2020 time period. So just to be clear, other than your  
20 participation on that one platform or ThoughtExchange,  
21 you didn't have any communication with the College?

22 A That's correct.

23 Q Okay. I'm kind of switching gears a little bit here,  
24 I've sort of got some general questions.

25 There's been comments about your human rights  
26 being violated and Human Rights Act issues. You

1       haven't filed a complaint with the Alberta Human Rights  
2       Commission though, have you?

3     A    No, I have not.

4     Q    I want to ask you some questions about your decision to  
5       not comply with the Pandemic Directive, which I think  
6       it's fair to say you've been very candid in indicating  
7       that you haven't complied with certain parts of it. In  
8       fairness, you said you have complied with others, I  
9       don't want to be unfair. Is it your position that a  
10      health care professional such as you, a chiropractor,  
11      can decide when and if he'll follow a college's  
12      requirements?

13    MR. KITCHEN:                   That's been asked and  
14       answered.

15    MR. MAXSTON:                   Well, no, I don't think it  
16       has. I've asked him about compliance with certain  
17       specific things; that's a more general question, and  
18       it's an important one.

19    MR. KITCHEN:                   Well, I understand you think  
20       it's important, and I have no issue with you asking it  
21       once, but you already asked him, and it's already been  
22       answered. We've done a lot of that over the last few  
23       hours.

24    MR. MAXSTON:                   I disagree.

25    Q    MR. MAXSTON:               My question for you,  
26       Dr. Wall --

1 MR. MAXSTON: -- and I'll wait,

2 Mr. Kitchen --

3 Q MR. MAXSTON: -- is it your position that a  
4 health care professional can decide when and if the  
5 requirements of a profession apply to him?

6 MR. KITCHEN: That's fine. I won't object  
7 to that, but we're going to have problems if you keep  
8 going down this road because you've already been down  
9 this road, but I won't object to this one.

10 MR. MAXSTON: Well, I --

11 MR. KITCHEN: (INDISCERNIBLE) ask it again.

12 MR. MAXSTON: I wonder if we can have the  
13 court reporter repeat that question so I don't mangle  
14 it and get an objection from you, Mr. Kitchen.

15 MR. KITCHEN: That's a good idea.

16 THE COURT REPORTER: (by reading)

17 Q Is it your position that a health care  
18 professional such as you, a chiropractor,  
19 can decide when and if he'll follow a  
20 college's requirements?

21 A I believe if those requirements cause harm to the  
22 member, then I do believe that the member has the right  
23 to make those decisions. We are doctors of  
24 chiropractic. We have spent a multitude of years  
25 learning and applying science, logic, and reason. And  
26 I believe that, in this situation regarding masks, if

1       there is harm being caused, yes, I do believe that a  
2       member should be able to make a decision.

3       Q   MR. MAXSTON:                So if you personally decide  
4       that a requirement of a college causes harm, your view  
5       is you don't have to follow it?

6       A   That is correct.

7       Q   And that's if you personally make that decision?

8       A   Yes, and I'm basing that on multiple studies, not my  
9       own information only. It's based on other scientific  
10      studies that corroborate what I believe, so ...

11      Q   I'm going to suggest to you, Dr. Wall -- and I'm not  
12      attacking your bona fides here, your sincerity -- but  
13      if this happens, we don't have a governable profession  
14      anymore, do we?

15      MR. KITCHEN:                I think that's a hypothetical  
16      that he can't answer.

17      Q   MR. MAXSTON:               Well, how do you think your --  
18      if a chiropractor like you makes an independent  
19      decision, how does that affect the College's role?

20      MR. KITCHEN:                Well, I think that question's  
21      fine, but you need to be a little more specific.

22      Q   MR. MAXSTON:               Dr. Wall, what I'm getting at  
23      is would you agree or disagree with the statement that  
24      health care providers making their own decisions about  
25      requirements makes it challenging for a college to  
26      govern its members?

1 A Yes, it may make it challenging.

2 Q We've gone through a number of situations where you  
3 have chosen to follow and not follow certain  
4 requirements from various authorities, so -- and  
5 there's a question coming, but you've told me you  
6 comply with some aspects of the Pandemic Directive but  
7 not others; you've told me that you are complying with  
8 some aspects of the re-opening order but not others; do  
9 you think that's appropriate for a professional?

10 A To me, it always falls back to harm being done, the --  
11 of course, the principle, first, do no harm applies  
12 primarily to patients but, in this situation, wearing a  
13 mask does harm. And in that situation, how can I  
14 follow the College directive if it's causing harm? So  
15 it makes it difficult for the College, but it doesn't  
16 make it right.

17 Q And just to be clear, you've also chosen to not follow  
18 the orders of -- the re-opening orders from AHS,  
19 certain of them?

20 A Are you referring to the masking of patients?

21 Q Yes.

22 A Yeah, well, that would fall under the same category as  
23 my understanding that wearing a mask causes harm.

24 Q You're going to be calling Dr. Gauthier as a lay  
25 witness; is that correct?

26 A That is correct.

1 Q Your counsel, Mr. Kitchen, sent me something called a  
2 will-say statement about what he anticipates  
3 Dr. Gauthier will testify to. Because of the order of  
4 witnesses that Mr. Kitchen has set out, we haven't  
5 heard from Dr. Gauthier, but is it your understanding  
6 that he has strong personal beliefs against masking?

7 MR. KITCHEN: Speaking to his mind and you  
8 said "personal beliefs", if we go to the will-say  
9 statement, you're going to see that Dr. Gauthier  
10 disagrees with the Pandemic Directive, follows it,  
11 disagrees with it. So if you want to question down  
12 those lines, I think that makes sense.

13 MR. MAXSTON: Sure, I'll --

14 MR. KITCHEN: (INDISCERNIBLE)

15 MR. MAXSTON: -- rephrase that question.

16 MR. KITCHEN: Okay.

17 Q MR. MAXSTON: Do you understand that  
18 Dr. Gauthier has concerns about complying with the  
19 masking and social distancing requirements of the  
20 Pandemic Directive?

21 A Yes, I believe so.

22 Q Is it your understanding that, nonetheless, he complied  
23 with the Pandemic Directive?

24 A I can't speak to that.

25 Q Okay, we'll ask Dr. Gauthier about that then.

26 When we talked about you researching your decision

1       in June of 2020 to not comply with certain aspects of  
2       the Pandemic Directive, wasn't it your obligation as a  
3       professional to notify the College of your concerns and  
4       your intention to breach parts of the Pandemic  
5       Directive?

6     A    I didn't see that anywhere in the Pandemic Directive  
7       that stated I was supposed to consult the College  
8       regarding my exemptions, and so ...

9     Q    I guess what I'm saying to you is I mean we have, for  
10       example, we have a standard of practice, and if you're  
11       not going to follow the standard of practice, there  
12       isn't anything in the standard of practice saying you  
13       should call the College, but I'm asking you wasn't it  
14       incumbent on you as a professional, a health care  
15       provider, to reach out to your college in June of 2020  
16       and tell them what you were intending to do?

17    MR. KITCHEN:                   Unless I'm wrong, I don't  
18       think that is an allegation, and I may be wrong --

19    MR. MAXSTON:                   It's not an allegation; it's a  
20       question --

21    MR. KITCHEN:                   But it's not -- no, no, no,  
22       but it's not an allegation in the notice of hearing.

23    MR. MAXSTON:                   Mr. Kitchen --

24    MR. KITCHEN:                   So --

25    MR. MAXSTON:                   -- not every question I ask  
26       has to be framed in the context of the exact charges,



1       and you've been objecting a fair bit to my questions,  
2       and I'm going to ask for a ruling on this, because it's  
3       another important question. I'm entitled to ask  
4       Dr. Wall, as part of his views of his status as a  
5       professional, what he views his obligations were in  
6       that scenario.

7       MR. KITCHEN:                   But that's a question of the  
8       ultimate issue, right? Is it unprofessional conduct to  
9       not reach out. That's like an ultimate. You're asking  
10      him a question about the ultimate issue, and an  
11      ultimate issue that's not in the notice of hearing, so  
12      I question the relevance of it. That's why I've  
13      objected. I've objected because you've asked questions  
14      that are worth objecting to.

15      MR. MAXSTON:                  Well, Mr. Chair, my question  
16      is --

17    Q   MR. MAXSTON:                  And, Dr. Wall, please don't  
18       answer this question. You won't hear me say that very  
19       often, but please don't answer this at this time,  
20       wasn't it your obligation as a professional to notify  
21       the College about your concerns with the Pandemic  
22       Directive and that you were going to not follow it in  
23       some respects?

24      MR. MAXSTON:                  So, Mr. Chair, I --  
25       respectfully, the ultimate issue is whether not  
26       following the -- certain things is unprofessional

1     conduct, but I think this is a fair question to ask,  
2     because it goes to Dr. Wall's perception of what it  
3     means to be a professional. So I've made some comments  
4     about that question, and I'm going to ask for a ruling  
5     on that.

6     THE CHAIR:                     And, Mr. Maxston, is that not  
7     two questions? First question being the obligation to  
8     notify the College, and then the second question, the  
9     last part of your -- the last part of your statement,  
10    is that a second question?

11    MR. MAXSTON:                  I can break it down into two:  
12    wasn't it your obligation as a professional to notify  
13    the College of your concerns about the Pandemic  
14    Directive, and wasn't it your obligation as a  
15    professional to notify the College of your intention to  
16    ignore parts of it or not comply with parts of it.

17    MR. KITCHEN:                  So I'll just say two things:  
18    One, Dr. Wall did answer by saying, I didn't see an  
19    obligation in the Pandemic Directive, so he's provided  
20    that answer. Nothing controversial there.

21             Secondly, we do have a relevance issue because  
22    that's not about -- there is no allegation. And we've  
23    talked a lot, which is kind of odd, and I haven't  
24    objected much until this point, we've talked a lot  
25    about whether or not Dr. Wall reached out. And that's  
26    not really -- I don't know if that's a key issue until

1 now in this case, but that's not actually an  
2 allegation. There is no allegation in the notice of  
3 hearing that Dr. Wall engaged in professional  
4 misconduct by not reaching out to the College.

5 So there is, for me, I think there's a lack of  
6 relevance when we're making such a big deal out of this  
7 issue when there's actually no allegation. If the  
8 allegation was in there, that would make sense.  
9 There's no allegation of that. So why are we going  
10 down this road?

11 THE CHAIR: Okay, we will take a brief  
12 recess while the Hearing Tribunal discusses this with  
13 counsel, and we'll just ask you to give us a few  
14 minutes, and if we could be moved to a break-out room,  
15 thank you.

16 (ADJOURNMENT)

17 THE CHAIR: Thank you for your indulgence.  
18 We've discussed the question or questions amongst  
19 ourselves and with independent legal counsel. Our view  
20 is that the question as posed as an obligation  
21 pertaining to a health professional, so in a general  
22 sense, and that this goes to what it means to be a  
23 professional, what his obligations were.

24 We do feel that it's within the scope of  
25 relevance, so we do agree with asking Dr. Wall to  
26 respond to the question.

1 Q MR. MAXSTON: Well, I will try to be careful  
2 in my wording here to capture exactly what I said  
3 before, and it will be two questions, and those are my  
4 last two questions, Dr. Wall. Wasn't it your  
5 obligation as a professional to notify the College of  
6 your concerns about the Pandemic Directive?

7 A I wish I could answer that simply. I will say yes.

8 Q The second question, wasn't it your obligation as a  
9 professional to notify the College of your intention to  
10 not comply with the Pandemic Directive?

11 A It's --

12 Q Pardon me --

13 A I'm sorry, go ahead.

14 Q Yeah, I'm sorry, I want to be fair to you, wasn't it  
15 your obligation as a professional to notify the College  
16 of your intention to partly not comply with the  
17 Pandemic Directive, and I'm thinking of masking and  
18 social distancing?

19 A Yeah, I -- with respect to masking, again, this was an  
20 issue that was affecting my health, I believe it was  
21 harmful to me, and so I didn't think that it was  
22 necessary to respond to the College at the time.

23 MR. MAXSTON: Okay, those are my questions,  
24 Mr. Chair.

25 Discussion

26 MR. MAXSTON: In terms of the remainder of

1 the day, my client and I certainly are prepared to stay  
2 a little longer if we need time for Mr. Kitchen to do  
3 his redirect and answer your questions. I think  
4 probably about 4:30 or 5 is the latest we'd want to go,  
5 and I know that may mean we're not finished with  
6 Dr. Wall today, but my client's view and my view,  
7 frankly, is that going any longer than 4:30 or 5 is a  
8 little bit much for a Tribunal, even though we've got a  
9 healthy, robust Tribunal here.

10 MR. KITCHEN: I have some thoughts on that.  
11 One, my witness has arrived. He's Dr. Wall's witness.  
12 He's left for now, because we're obviously not quite  
13 there yet. I'm going to ask, because of the enormously  
14 slow pace, and that's to no one's fault, but the  
15 enormously slow pace at which we've moved that we press  
16 ahead today and get in this witness after we're done  
17 with Dr. Wall. I do have redirect, but I don't expect  
18 to be long. So if we could get going at 4:30 with this  
19 witness, I can't see that witness taking more than 45  
20 minutes at most, which I understand that puts us past  
21 5, but we've ended early quite a few days. We're  
22 making pretty slow progress on evidence.

23 This particular witness, like I said, the reason I  
24 wanted him here today is because he's the only witness  
25 I have who cannot do virtual testimony, so I would ask  
26 that the Tribunal to be gracious with Dr. Wall and I

1 and permit that witness today.

2 THE CHAIR: I think we'll make our best  
3 efforts to achieve that. I don't personally have any  
4 commitments that would prevent me from going to 5:15 if  
5 we needed to. I'm not sure if anybody else -- perhaps  
6 there are? One of the Tribunal Members --

7 DR. ALDCORN: Well, sorry, this is Leslie.  
8 I'm actually seeing patients after we're done here. If  
9 I knew we were done at 5:15, I could ask people to come  
10 at 5:15 instead of 5:00. I would just need to know.

11 THE CHAIR: I think in the best interests  
12 of not having to do this twice, let's decide that we  
13 will go until 5:15 so that Dr. Aldcorn can make her  
14 plans accordingly.

15 And I think it's a long time to go without a  
16 break, I suggest we take maybe 10 minutes now and come  
17 back at 5 after -- let's make it 10 after 4, and then  
18 we'll plow through with Mr. Kitchen's redirect and then  
19 any residual questions and then deal with Mr. Kitchen's  
20 witness. Okay?

21 MR. MAXSTON: Mr. Chair, I just want to make  
22 one comment, I'm very sensitive to Mr. Kitchen and his  
23 witness's availability, but I do want to be clear that  
24 I think -- in terms of chasing the clock, the Hearing  
25 Tribunal shouldn't feel constrained about asking  
26 questions of Dr. Wall and finishing quickly, and so I

1 really want to be -- I see Mr. Kitchen nodding, and I'm  
2 glad, because I'm very sensitive to his witness, but  
3 we've heard a lot from Dr. Wall today, and once he  
4 stops testifying, Mr. Chair, you know this, your  
5 colleagues know this, you can't ask him any other  
6 questions, and there was some pretty important stuff  
7 today. So I agree, let's press on and see where we're  
8 at, but I think completing Dr. Wall today is the  
9 priority, if we can.

10 THE CHAIR: Fair point, Mr. Maxston, and I  
11 will share with both you and Mr. Kitchen that, during  
12 our earlier breaks, we have discussed amongst ourselves  
13 some questions with respect to Dr. Wall, and we are  
14 holding back to determine which, if any, or all of them  
15 are covered either through direct or cross-examine or  
16 redirect. So, yes, the Hearing Tribunal may very well  
17 have some questions for Dr. Wall, but we will cross  
18 that bridge after we've dealt with the redirect.

19 So let's break now and come back at 10 after 4,  
20 and we'll do our best, Mr. Kitchen.

21 MR. KITCHEN: Thank you.

22 (ADJOURNMENT)

23 THE CHAIR: Okay, I believe we are all  
24 here, so the session is that we are reconvened, and,  
25 Mr. Kitchen, you have the floor.

26 MR. KITCHEN: Thank you.

1 Mr. Kitchen Re-examines the Witness

2 Q MR. KITCHEN: Dr. Wall, that email that you  
3 sent to Dr. Halowski, we talked about this, you said  
4 earlier that Dr. Halowski sent you a response. Did you  
5 ever get a response from council to your email?

6 A No, I did not.

7 Q Did you ever get a further response from Dr. Halowski?

8 A No, I did not.

9 Q And what was -- the one response you got from  
10 Dr. Halowski, what did he say?

11 A I believe he was going to refer the matter to council,  
12 and that was about the extent of it.

13 Q Do you think that was a substantive response?

14 A Not substantive. I'm fine if he wanted to have council  
15 respond to it, but not a substantive response.

16 Q We've talked a lot about a risk from masking. I just  
17 want to make sure everybody knows your position. Do  
18 you think there is an increased risk beyond what  
19 anybody already encounters in their daily life from you  
20 not wearing a mask?

21 A No, I do not.

22 Q Did AHS close your office?

23 A Yes, they did.

24 Q Did AHS close -- did AHS take away your practice  
25 permit?

26 A No, they did not.



1 Q The closure order, I'm going to take you there, that's  
2 D-1, and Mr. Maxston can object to this if he wants to,  
3 but I'm going to ask you to pick up -- do you see the  
4 word "nuisance" in the middle of paragraph (a) there?

5 A Yes, I do.

6 Q Could you just read for me the rest of that sentence?

7 A I'll start: (as read)

8 This is a breach of Section 2(1) of the  
9 Nuisance and General Sanitation Regulation,  
10 which states that no person shall create,  
11 commit, or maintain a nuisance, and of  
12 Section 26 of the CMOH 38-2020, which states  
13 that, subject to Section 27 of this order, a  
14 person must wear a face mask at all times  
15 while attending an indoor public place. For  
16 greater certainty, an indoor public place  
17 includes any indoor location where a business  
18 entity is operating.

19 Q Do you think that you fall under Section 27? I can  
20 take you to the Order 38 if you need me to. Do you  
21 want me to do that?

22 A Yes, please, let's review that.

23 MR. MAXSTON: Mr. Kitchen, I'm not sure I'm  
24 going to object to this question, but, with respect,  
25 isn't it irrelevant; doesn't AHS decide who's subject  
26 to it? It's not really your client.

1 MR. KITCHEN: Well, again, I don't know if  
2 there's any controversy here. I think there probably  
3 is going to be some controversy, because there's no  
4 mention of CMOH 38 in the re-opening.

5 Q MR. KITCHEN: So, Dr. Wall, let me just ask  
6 you this: We discussed that there's an exemption  
7 clause in CMOH Order 38-2020 -- well, okay, is there a  
8 general requirement to wear a mask in CMOH Order  
9 38-2020?

10 A Yes, there is.

11 Q And there's an exemption, correct?

12 A That's correct.

13 Q Do you think you fell under the exemption?

14 A Yes, I do.

15 Q So do you think you breached the general requirement to  
16 wear a mask?

17 A No, I don't.

18 Q Now, while I'm on this point, this is important  
19 because -- so you just said now and you said earlier  
20 that the -- you never breached any of the CMOH orders,  
21 but when my learned friend asked you if you agreed  
22 factually to the statement at 5(a) of the hearing  
23 notice, that you failed to follow the Chief Medical  
24 Officer of Health orders regarding masking and  
25 COVID-19, you said, yes, that you agreed to that, so  
26 let me ask you: Do you think that you failed to follow

1 any Chief Medical Officer of Health orders?

2 A No, I don't.

3 Q Dr. Wall, was there a CMOH order in place requiring  
4 masking in June of 2020?

5 A I don't know the exact date of the CMOH order.

6 MR. MAXSTON: Mr. Kitchen, we have the  
7 re-opening order. Are you referring to that, the CMOH  
8 order that directed re-opening if guidelines were  
9 followed from AHS or from CMOH or from the College? Is  
10 that what you're referring to? I'm just asking because  
11 I don't think we have any other exhibits to that  
12 effect, and, clearly, the re-opening order would have  
13 been in force.

14 MR. KITCHEN: Not --

15 MR. MAXSTON: 16-2020 is the re-opening  
16 order.

17 MR. KITCHEN: Yes, right.

18 Q MR. KITCHEN: Well, Dr. Wall, you said to --  
19 Mr. Maxston asked you, well, was there a CMOH order to  
20 require masking and specifying exemptions before  
21 November, and you said, no, there wasn't. We already  
22 know that. So merely just asking, was there a CMOH  
23 order in June of 2020 that generally required masking?

24 A No.

25 Q Do you think things like cleaning your office and  
26 washing your hands are harmful?

1 A No, I don't.

2 Q Do you think preventing people from being within 2  
3 metres of each other violates their personal liberty of  
4 bodily autonomy?

5 A No, I don't.

6 Q So if you're told -- if your patients are told -- if  
7 your patients are told that they have to stay 2 metres  
8 away from you, do you think that violates their  
9 personal liberty to come within 2 metres of you?

10 A They can choose to come within 2 metres of me, so I'm  
11 not sure exactly of the -- maybe rephrase the question.

12 Q Well, let me ask you this -- and I'll leave it here, I  
13 don't want to belabour the point -- but do you think  
14 people's physical movements are restricted when they're  
15 told that they cannot come within 2 metres of other  
16 people?

17 A Yes, I do.

18 Q When -- and this goes back to a question Mr. Maxston  
19 asked you about Dr. Linford's statements on risk, do  
20 you agree with Dr. Linford that there is a risk to the  
21 public from you not wearing a mask?

22 A No, I don't agree.

23 Q Now, you answered a question of Mr. Maxston about the  
24 diagnosis or lack thereof in the December 12th note  
25 from Dr. Salem, and of course, ultimately, there was  
26 this note from January 11th. What was the ultimate

1 diagnosis in the January 11th letter?

2 MR. KITCHEN: While I'm here, I'll find it  
3 for everybody's benefit.

4 MR. MAXSTON: Is it A-9, Mr. Kitchen?

5 MR. KITCHEN: It is A-9. I was just about  
6 to say that.

7 Q MR. KITCHEN: So, yes, so this is the letter  
8 that -- Mr. Maxston was questioning you on this letter.  
9 This is the letter that Dr. Salem responds to  
10 Mr. Lawrence. Does Dr. Salem discuss in this letter  
11 the ultimate reason for why you couldn't wear a mask?

12 A Yes, he did.

13 Q And what was that reason?

14 A It was because of anxiety and dealing with  
15 claustrophobia.

16 Q And is that consistent with what you thought about  
17 yourself in June of 2020?

18 A Yes, it is.

19 Q Are the CMOH orders being challenged in court?

20 A I believe they are, yes.

21 Q Do you think a mandate from -- well, I'll ask you this:  
22 Do you think a mandate that mandates somebody wear a  
23 mask, do you think that violates that person's rights?

24 A Yes, I do.

25 Q Do you think if a mandate violates somebody's rights  
26 that it's unlawful?

1 A Yes, I do.

2 Q Okay, almost done here. In the rescind notice from the  
3 AHS, this is Exhibit D-2, we've talked about point 4,  
4 Mr. Maxston asked you about that, do you regard point 4  
5 as violating the rights of the patients?

6 A Yes, I do.

7 Q And do you regard point 4 as unlawful?

8 A Yes, I do.

9 Q Do you think it is professional to not comply with  
10 requirements that are unlawful?

11 A Could you restate that, please, for me?

12 Q Sure. Do you think it is professional to not comply  
13 with requirements that are not lawful?

14 A That was a lot of nots, I'm sorry.

15 Q No, no, it's okay, it's okay. It's no problem.

16 A Sorry, it is getting late in the day --

17 Q Do you think it's professionally acceptable to disobey  
18 a requirement that is unlawful?

19 A Yes, I think that it is professionally (INDISCERNIBLE)  
20 to (INDISCERNIBLE) a law that is --

21 THE COURT REPORTER: Dr. Wall, you're going to have  
22 to speak up; you're not on speaker or something like  
23 that. I'm finding you very quiet. So, sorry, could  
24 you please restate your answer?

25 MR. KITCHEN: Madam Clerk, can you hear my  
26 just fine?

1 THE COURT REPORTER: I can hear you fine, yeah.

2 MR. KITCHEN: I think what happened is he

3 turned the button, because he has to click it every

4 time so we don't get the feedback.

5 A I'm sorry.

6 THE COURT REPORTER: That's okay. Do you want me

7 to --

8 Q MR. KITCHEN: Do you want me to ask it

9 again, or are you ready to go?

10 A Go ahead and ask.

11 Q Okay. Do you think it is professionally acceptable to

12 disobey requirements that are unlawful?

13 A I think it is professionally (INDISCERNIBLE) --

14 THE CHAIR: We can't hear you, Dr. Wall.

15 Can't hear you at all.

16 A Sorry about that, yeah, I don't know what happened

17 there.

18 Q MR. KITCHEN: Well, I don't want to ask it a

19 third time, but I'm going to ask it a third time, and

20 I'm going to try to ask it exactly the same so that

21 there's nothing unfair here.

22 Do you think it is professionally acceptable to

23 disobey requirements that are unlawful?

24 A Yes, I do.

25 Q Do you think the masking mandate is unlawful?

26 A Yes, I do.

1 Q Last question, is it your understanding that Dr. Salem  
2 recommended, as a means of dealing with your anxiety,  
3 to not wear the mask?

4 A Yes, that's correct.

5 Q And I'm sorry, I have one more question. Do you think  
6 not wearing a mask around your patients is a form of  
7 treatment?

8 A No, it is not.

9 MR. KITCHEN: Okay, thank you, those are all  
10 my redirect.

11 MR. MAXSTON: Mr. Chair, I'm going to ask my  
12 friend's indulgence and yours, I do have one quick  
13 follow-up question, and it relates to the second or  
14 third-last question my friend asked because it was -- I  
15 think it was something a little bit new. And maybe  
16 I'll ask the question, if you're comfortable, Mr. Chair  
17 and Mr. Kitchen, you'll let me know if you've got any  
18 concerns.

19 MR. KITCHEN: Sure.

20 THE CHAIR: Okay.

21 MR. MAXSTON: And thank you for this  
22 indulgence.

23 Mr. Maxston Re-cross-examines the Witness

24 Q MR. MAXSTON: Dr. Wall, this goes back to  
25 the question that was repeated three times, so you're  
26 probably pretty familiar with it, and I believe the



1        wording from my friend was do you believe it's  
2        professionally acceptable to disobey requirements that  
3        are unlawful, and I just want to be clear, who  
4        determines whether they're unlawful?

5        A    Well, I believe that -- sorry, I believe that there has  
6        to be a higher standard. For example, I believe that  
7        the Constitution, Charter of Rights and Freedoms, and  
8        Alberta Human Rights are specifically aspects of the  
9        law that would supersede, for example, a professional  
10       regulatory body's requirements.

11      Q    Sorry, just quickly, just to be clear, it's not the  
12      professional who decides that though; it's the courts,  
13      if it's the Charter or human rights?

14      A    Yeah, well, a person has to go through those measures  
15      for sure, and that's why I've obtained counsel, so,  
16      yeah.

17      Q    Yeah, I just wanted to be clear, when you talked about  
18      "unlawful", I thought it was something I needed to kind  
19      of clarify.

20      MR. MAXSTON:                      Thank you for that indulgence,  
21      Mr. Chair and Mr. Kitchen.

22      MR. KITCHEN:                      You're welcome.

23      Mr. Kitchen Re-examines the Witness

24      Q    MR. KITCHEN:                      I just want to ask one quick  
25      re-cross [sic], which is, Dr. Wall, do you think you'd  
26      ever be able to legally challenge these mandates if you

1           just went along with them and ignored them?

2    A    No, I wouldn't be able to challenge them if I went  
3           along with them and ignored them.

4           MR. KITCHEN:                   Okay, well, I guess it's back  
5           to the Tribunal now.

6           THE CHAIR:                    Okay --

7           MR. KITCHEN:                   I just want to make a note, my  
8           witness is in the room, so I want to give anybody an  
9           opportunity to object if they -- I don't even know if  
10          he can hear anything because we all have headsets on,  
11          but I just -- I want to make a note of that if anybody  
12          has any objections to him being in the room while we're  
13          still doing this.

14          MR. MAXSTON:                  I don't, Mr. Kitchen, provided  
15          he's not going to be asked questions about what  
16          Dr. Wall is just testifying to.

17          MR. KITCHEN:                  I can't imagine. I have no  
18          intention.

19          MR. MAXSTON:                  Okay, yeah, thank you.

20          THE CHAIR:                    Well, at this point, we're  
21          going to take a brief recess so that we can discuss  
22          whether Members of the Tribunal have any further  
23          questions for Dr. Wall. So bear with us, we'll be back  
24          to you as quickly as possible, and if we could go to a  
25          break-out, please. Thank you.

26          (ADJOURNMENT)

1 THE CHAIR: We're back in session. Thank  
2 you for your indulgence. Members of the Hearing  
3 Tribunal do have a couple of questions they would like  
4 to ask Dr. Wall. So I would first ask Dr. Aldcorn to  
5 raise her questions.

6 The Tribunal Questions the Witness

7 Q DR. ALDCORN: Thank you. So, Dr. Wall, I'm  
8 just wondering in the time frame between June and  
9 December, if you had seen any new patients in your  
10 office or patients who had yet to have been to your  
11 office before?

12 A Yes, I have.

13 Q And my second question would be, because I don't know  
14 how your clinic is set up, but when you indicated that  
15 you saw one patient at a time, would that imply that  
16 there was only one patient in your clinic at a time, or  
17 could there be more than one patient in the clinic at  
18 the time, or are you seeing only one patient at a time?

19 A Yeah, so I only saw one person at a time, and so, yeah,  
20 no other people in the clinic.

21 DR. ALDCORN: Thank you.

22 THE CHAIR: Okay. Dr. Dawson --  
23 Mr. Dawson, sorry.

24 Q MR. DAWSON: Dr. Wall, thank you. My  
25 question is in two parts. The first part is has a  
26 patient ever asked you to put on a mask, and if not,

1       how would you respond if a patient asked you to put on  
2       a mask?

3     A   Yes, I have had a patient ask me to put on a mask, and  
4       at the time, I granted that request. They were a very  
5       nervous person, and so I did put on a mask. I told her  
6       that I did have an exemption and that I was --  
7       experienced these symptoms that I've been discussing,  
8       but for that one person and one person only, I did it.

9     Q   THE CHAIR:                   Just a quick follow-up,  
10       Dr. Wall. About what time period would that have  
11       happened?

12    A   That would have been likely between June and -- I'd  
13       have to look back on my record, but, yeah, sometime  
14       between June and October, I would think.

15       THE CHAIR:                   Thank you. Those were the  
16       questions of the Hearing Tribunal for Dr. Wall.

17       If there's no other matters, Dr. Wall, we'll  
18       dismiss you as a witness, and thank you very much for  
19       your time and your testimony.

20       (WITNESS STANDS DOWN)

21       THE CHAIR:                   And, Mr. Kitchen, I believe  
22       we're at the point where you could call in your  
23       witness.

24       MR. KITCHEN:                 Thank you, which I'll do, and  
25       if we only get to the end of my direct, and we can't do  
26       the cross, obviously I don't want to rush Mr. Maxston's

1 cross, then so be it, we'll have to figure that out,  
2 but I think we should at least try to get through the  
3 direct and maybe even the whole thing.

4 THE CHAIR: It's quarter to 5. We've got  
5 30 minutes. Mr. Maxston, are you okay with proceeding  
6 in the eventuality that you don't get an opportunity to  
7 cross-examine today?

8 MR. MAXSTON: Yeah. In fact, I think we've  
9 got a 5:15 hard stop, and for obvious reasons, I'm not  
10 going to want to rush through any cross-examination,  
11 and then, of course, there's redirect and then Hearing  
12 Tribunal questions. I think, regrettably, we're  
13 probably not going to finish with this witness today,  
14 but certainly if we go till 5:15 and see how far we  
15 get, I think that's a good idea.

16 THE CHAIR: Okay --

17 MR. KITCHEN: I think that's reasonable, so  
18 let's proceed on this basis. All right, so -- this is  
19 just a procedural note, he's -- Mr. Kosowan is going to  
20 be appearing on Dr. Curtis Wall's screen, so it has  
21 Dr. Curtis Wall's name, but, obviously, we all know  
22 it's not Dr. Wall; it's the witness I'm calling. So  
23 I'm just going to ask him to have a seat.

24 Madam Clerk, did you want to go ahead and swear  
25 him in.

26 JARVIS KOSOWAN, Affirmed, Examined by Mr. Kitchen

- 1 Q MR. KITCHEN: Mr. Kosowan, do you prefer I  
2 call you Jarvis or Mr. Kosowan?
- 3 A Jarvis.
- 4 Q All right, thank you, Jarvis. What do you do for a  
5 living?
- 6 A I own a (INDISCERNIBLE) agency for Alberta sales  
7 organization.
- 8 Q And just to confirm, are you a patient of Dr. Wall's?
- 9 A Yes, I have been for about 20 years.
- 10 Q Could you just briefly describe for us why you've stuck  
11 with Dr. Wall for your chiropractor for so long?
- 12 A I like the method that he uses. It's not the crunching  
13 and everything else. It's in the technique that I  
14 appreciate and enjoy, and Dr. Wall has become kind of a  
15 friend also over the years, so ...
- 16 Q Do you respect Dr. Wall?
- 17 A Absolutely.
- 18 Q Do you wear a mask when you see Dr. Wall for treatment?
- 19 A Sometimes. Sometimes not. It all depends when the  
20 mask mandate was invoked, I would bring it into the  
21 clinic, but then after that, inside, because it was  
22 only one on one, I had the respect to Dr. Wall to be  
23 able to take my mask off.
- 24 Q Are you grateful that Dr. Wall gives you a choice on  
25 whether or not to wear a mask, depending on whether or  
26 not you want to?

1 A Absolutely. I totally appreciate that.

2 Q Does Dr. Wall wear a mask when you come in for  
3 treatment?

4 A No, he does not.

5 Q Are you aware of the reasons for why Dr. Wall doesn't  
6 wear a mask?

7 A We had a conversation. He had alluded to the fact that  
8 he had a medical exemption for wearing a mask, and I  
9 respect that.

10 Q Now, do you feel comfortable with Dr. Wall not wearing  
11 a mask while he treats you?

12 A Absolutely, no qualms whatsoever.

13 Q Do you believe Dr. Wall puts you at any increased risk  
14 or in any way threatens your health by treating you  
15 without wearing a mask?

16 A No, I do not.

17 Q Are you at all concerned about catching COVID-19 from  
18 Dr. Wall because he treats you without wearing a mask?

19 A No, I'm not.

20 Q Do you think Dr. Wall could provide you with the  
21 treatment you want if all he could ever do is call you  
22 on the phone and talk with you?

23 A Absolutely not. That's not possible physically, I  
24 don't believe anyway, at least I haven't heard of a  
25 procedure, so I prefer the in-office procedure that he  
26 does.

1 Q So do you think Dr. Wall could provide you with the  
2 treatment you want if he could never come within 2  
3 metres of you?

4 A It would be physically impossible.

5 Q Do you have an interest in seeing Dr. Wall continue to  
6 practice as a chiropractor?

7 A Absolutely. I believe he provides a worthwhile  
8 community function to a lot of people that are -- have  
9 the same issues I do.

10 Q Do you think it will harm your interests as a person if  
11 Dr. Wall is ordered to stop practicing or ordered to  
12 only practice over the phone?

13 A Definitely. I don't even know how he'd be able to  
14 operate over the phone, quite honestly, that -- it just  
15 escapes my imagination, quite honestly.

16 Q Do you want to keep Dr. Wall as your chiropractor?

17 A Absolutely.

18 Q Do you think your interests should be considered as  
19 part of any decision to restrict or not restrict  
20 Dr. Wall's ability to practice as a chiropractor?

21 A Absolutely. He's providing a service to me that makes  
22 me feel better physically and also that comes mentally  
23 also, and he provides a service that, without being  
24 able to touch me, he wouldn't be able to provide it at  
25 2 metres of social distancing or over the phone, so I  
26 can't see how it would be possible.



1 Q If Dr. Wall is ordered to stop practicing or stop  
2 treating you except by calling you on the phone, do you  
3 think that would be the Chiropractic College's fault?

4 A Sorry, I didn't understand the question.

5 Q That's okay. I'll ask it again. If Dr. Wall is  
6 ordered to stop practicing or he's ordered to stop  
7 treating you except by calling you on the phone, whose  
8 fault do you think that will be?

9 A I imagine the College did prevent him from practicing  
10 as a chiropractor, because he provides an immense  
11 service to me.

12 Q Do you think Dr. Wall has done the right thing by  
13 letting you not wear a mask while he treats you?

14 A Yes, I do, absolutely. It gives me just -- it gives me  
15 more comfort, knowing that we're not -- I'm not  
16 concerned about getting COVID within the chiropractic  
17 office with Dr. Wall, so, therefore, it gives me the  
18 comfort of take the mask off, I feel better, and I'm  
19 comfortable with that.

20 Q Thank you.

21 Discussion

22 MR. KITCHEN: Now, those are all my  
23 questions, so I leave it to Mr. Maxston if he thinks he  
24 can do a cross as fast as I've done my direct, but I  
25 leave that up to him. I would suggest that that's the  
26 better way to go just because it's more convenient for

1     Jarvis, but -- that's 20 minutes.

2     MR. MAXSTON:                     Yeah, Mr. Kitchen, I think  
3     I'm, and this is no one's fault, but I think I'm put in  
4     a bit of a difficult position because I've got to think  
5     about my questions and then reconvene, and we've got  
6     the 5:15 hard stop. I don't know how long I'm going to  
7     be. I may be very short with this witness, but I don't  
8     know, and I, frankly, would prefer to, and I know this  
9     is an inconvenience, but I, frankly, would prefer to  
10    come back another day and not be racing against the  
11    clock.

12    MR. KITCHEN:                    You honestly think you're  
13    going to be -- you know, it's likely you're going to be  
14    more than 20 minutes?

15    MR. MAXSTON:                    I don't know. I'm just  
16    chatting with -- Mr. Lawrence and I were chatting just  
17    beforehand, and I don't know how long I'm going to be.  
18    I suppose I could ask some questions, and then we could  
19    see where we're at, but I might not be finished, but I  
20    do think I'm going to be pretty short.

21    THE CHAIR:                       May I just interject and say  
22    that don't discount the possibility that Members of the  
23    Tribunal may have questions for the witness.

24    MR. KITCHEN:                    Well, I'm in the Tribunal's  
25    hands. I prefer that we go ahead, so that's certainly  
26    what I want, but, you know, the Tribunal ultimately

1 directs its own proceeding, so I really have to leave  
2 it up to the Tribunal.

3 THE CHAIR: Okay, we do have 20 minutes.  
4 I think Mr. Maxston has expressed his desire to not  
5 have to interrupt his cross-examination, and I do  
6 believe that there may be questions from the Hearing  
7 Tribunal, so I'm -- I want to respect the hard deadline  
8 of 5:15, because, quite frankly, there have been  
9 patients booked based on that timeline.

10 So I think, unfortunately, for the witness, we  
11 will -- and it's up to Mr. Maxston, if he wants to  
12 start. If he wishes to defer until the next date that  
13 we can find to accommodate everybody, then I'm -- I  
14 would agree with that.

15 MR. MAXSTON: With a measure of reluctance,  
16 because I'm sympathetic to Mr. Kitchen and his witness.  
17 I would prefer to wait until we resume.

18 THE CHAIR: Okay. And, please, no  
19 disrespect, sir, if I call you Jarvis, I would just  
20 like to thank you for your testimony today and to  
21 advise you that, at a future date to be determined,  
22 there will be an opportunity for the College counsel to  
23 cross-examine you on your testimony, and I would ask  
24 your cooperation in that regard. We will be in touch  
25 and the College will be in touch with you regarding  
26 future dates. And I think on that basis, we can

1 dismiss you for today, and with our thanks once again,  
2 we appreciate your testimony.

3 A Thank you.

4 MR. KITCHEN: Thanks.

5 THE CHAIR: Okay. With that, I think it  
6 will be up to the College to solicit availability to  
7 determine when we can reconvene to continue on with  
8 this witness and the other witnesses that Mr. Kitchen  
9 has before we get to closing arguments. So I guess  
10 we're not going to go right till 5:15, which is, I'm  
11 sure, good for Dr. Aldcorn.

12 I would like to say thank you to everybody, and,  
13 Mr. Kitchen, I appreciate your comments and  
14 Mr. Maxston's. There has been a lot of testimony, a  
15 lot of documentation, a lot of information over the  
16 last four days, and we appreciate -- on behalf of the  
17 Tribunal, we appreciate everybody's, you know,  
18 cooperation and participation in this. So we'll -- we  
19 will --

20 MR. MAXSTON: Mr. Chair, I'm sorry, one  
21 quick question, I think in terms of next steps,  
22 Mr. Kitchen, I think it was earlier or later last week,  
23 was good enough a list of his witnesses, the order he's  
24 going to be calling them in, and I wonder if he's  
25 comfortable sending that list again to Ms. Nelson but  
26 with some estimated times for each witness, and that

1 would, I think, give us a sense of whether we need to  
2 reschedule two days, three days. It might be we can  
3 schedule two days and one day or something like that,  
4 but I think my cross-examinations of the lay witnesses  
5 will be brief. I'll be a little longer with the  
6 experts. But I guess if we have a sense from  
7 Mr. Kitchen about his timelines, I can jump in, and  
8 then we can get back to the Tribunal saying we need 'X'  
9 or 'Y' days, and then Ms. Nelson can canvass dates.

10 THE CHAIR: Okay. Is that okay with you,  
11 Mr. Kitchen?

12 MR. KITCHEN: Yeah, I think that's a great  
13 idea.

14 THE CHAIR: Okay, great. Okay, well, we  
15 will wait for that to unfold and look forward to  
16 hearing from the College about reconvening. So thank  
17 you once again, we'll call the hearing closed for  
18 today.

19 \_\_\_\_\_

20 PROCEEDINGS ADJOURNED

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1 CERTIFICATE OF TRANSCRIPT:

2

3 I, Karoline Schumann, certify that the foregoing  
4 pages are a complete and accurate transcript of the  
5 proceedings, taken down by me in shorthand and  
6 transcribed from my shorthand notes to the best of my  
7 skill and ability.

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

10

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Karoline Schumann

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Karoline Schumann, CSR(A)

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Official Court Reporter

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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

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DISCIPLINARY HEARING

VOLUME 5

VIA VIDEOCONFERENCE

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Edmonton, Alberta

November 16, 2021

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

4

5 November 16, 2021 Morning Session

6

7 HEARING TRIBUNAL

8 J. Lees Tribunal Chair

9 W. Pavlic Internal Legal Counsel

10 Dr. L. Aldcorn ACAC Registered Member

11 Dr. D. Martens ACAC Registered Member

12 D. Dawson Public Member

13 A. Nelson ACAC Hearings Director

14

15 ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

16 B.E. Maxston, QC ACAC Legal Counsel

17

18 FOR DR. CURTIS WALL

19 J.S.M. Kitchen Legal Counsel

20

21 K. Schumann, CSR(A) Official Court Reporter

22

23 (PROCEEDINGS COMMENCED AT 9:06 AM)

24 THE CHAIR: This Hearing Tribunal is

25 reconvened. We are in session.

26 Mr. Kitchen?

1 Discussion

2 MR. KITCHEN: So the witness who was  
3 supposed to go first thing this morning to be  
4 cross-examined is Jarvis Kosowan, is who we ended with  
5 last time. He's feeling quite under the weather; he  
6 didn't sleep well. He's asked to go this afternoon.

7 I've just spoken with Mr. Maxston, because,  
8 obviously, the greatest concern there is any prejudice  
9 raised by the other side or -- by the College I should  
10 say.

11 So the plan at this point is to have him go this  
12 afternoon because he's unavailable this morning. So I  
13 guess what I'm doing is asking if the Tribunal will  
14 permit that.

15 THE CHAIR: Mr. Maxston, did you want to  
16 speak to that?

17 MR. MAXSTON: Yeah, thank you very much.  
18 Mr. Kitchen was really candid with me, and I really  
19 have no concern here. We can call the witnesses in  
20 whatever order will work for him.

21 THE CHAIR: Okay. Mr. Kitchen, with us  
22 not having Mr. Kosowan this morning, how did you plan  
23 to proceed from this point?

24 MR. KITCHEN: The first two witnesses after  
25 that I had scheduled are Charles Russell and Dave  
26 Hilsabeck, in that order, and then I want to go on to



1 Dr. Justin Gauthier after that. I had another witness  
2 planned for today, but he is unavailable due to urgent  
3 work requirements, and his name was Elvin Music. So at  
4 this point, I have three witnesses I want to do, and  
5 then circle back to Jarvis Kosowan for  
6 cross-examination this afternoon.

7 Now, unfortunately, Dr. Gauthier, because, of  
8 course, he's a practicing chiropractor, he has patients  
9 all this morning. He's blocked off the entire  
10 afternoon, so he can go immediately after lunch, even  
11 if we take an early lunch, but he cannot go this  
12 morning because he's with patients.

13 I had originally planned for the morning to be  
14 quite full with the four other witnesses I had. Now, I  
15 only have two. So that's where I'm at, which makes a  
16 little bit of a rocky day, I understand, but at least I  
17 don't think we'll be running out of time. If anything,  
18 it will be the opposite.

19 THE CHAIR: So you would start with either  
20 Russell, Hilsabeck, or Music?

21 MR. KITCHEN: I'll be starting with Charles  
22 Russell and then moving on to Hilsabeck. And at that  
23 point, I have no witnesses available until first thing  
24 in the afternoon, and that will be either Jarvis  
25 Kosowan, if he's available, or Dr. Justin Gauthier. He  
26 will be available right after lunch.

1 THE CHAIR: Okay, Mr. Maxston, any comment  
2 or thoughts?

3 MR. MAXSTON: No, I'm fine with that  
4 approach. Mr. Kitchen's been very candid, and I know  
5 we all have problems, from time to time, getting our  
6 witnesses to attend, so that's just fine.

7 THE CHAIR: Okay, thank you, Mr. Kitchen,  
8 Mr. Maxston, then we will proceed based on  
9 Mr. Kitchen's comments, and you can call your first  
10 witness this morning, Mr. Kitchen.

11 MR. KITCHEN: Okay, well, I see that, as far  
12 as I can see, Charles -- oh, there he is. Mr. Russell,  
13 can you hear us?

14 THE WITNESS: I can.

15 MR. KITCHEN: Excellent. Now, Madam Court  
16 Reporter is Karoline, her name is Karoline, she's going  
17 to swear you in --

18 THE WITNESS: Okay.

19 MR. KITCHEN: And then we'll get started.

20 CHARLES RUSSELL, Sworn, Examined by Mr. Kitchen

21 Q MR. KITCHEN: Well, good morning,  
22 Mr. Russell. I'm going to, unless you object, I'm  
23 going to call you by your first name, Charles?

24 A Fair enough.

25 Q For the record. Charles, can you tell us what you do  
26 for a living?

- 1 A I'm a commercial real estate agent.
- 2 Q And are you a patient of Dr. Wall?
- 3 A I am.
- 4 Q How long have you been a patient of Dr. Wall?
- 5 A At least 20 years, by my recollection.
- 6 Q And why have you stuck with Dr. Wall as your
- 7 chiropractor for so long?
- 8 A Because he's effective. He does -- he fixes me when I
- 9 need to be fixed.
- 10 Q How do you find that Dr. Wall's treatments help you?
- 11 A I come in in pain, and I leave without pain.
- 12 Q Thank you. Now, let me ask you, do you respect
- 13 Dr. Wall?
- 14 A Absolutely.
- 15 Q Do you wear a mask when you come in to see Dr. Wall for
- 16 treatment?
- 17 A I don't wear a mask for anything.
- 18 Q And so just to confirm, that includes when you're in
- 19 Dr. Wall's office?
- 20 A Absolutely.
- 21 Q Are you grateful that Dr. Wall does not require you to
- 22 wear a mask when you come in for treatment?
- 23 A Absolutely. I probably wouldn't come otherwise.
- 24 Q Does Dr. Wall wear a mask when you come in for
- 25 treatment?
- 26 A No.

1 Q Are you aware of the reasons why Dr. Wall doesn't wear  
2 a mask?

3 A Yes.

4 Q Do you feel comfortable with Dr. Wall not wearing a  
5 mask while he treats you?

6 A Absolutely.

7 Q Now, let me ask you this: Do you prefer that Dr. Wall  
8 not wear a mask while he treats you?

9 A I wouldn't come if he wore -- if I had to wear a mask,  
10 if he was wearing a mask. I might sit still for him  
11 wearing a mask, but I sure won't wear one.

12 Q But if you had the choice, if you could choose, would  
13 you prefer to see Dr. Wall not wearing a mask or with  
14 wearing a mask?

15 A I'd prefer to see Dr. Wall not wearing a mask or  
16 anybody else.

17 Q Why is that?

18 A Because I believe they're ineffective, I believe  
19 they're dangerous, I believe they create more bad  
20 health than they do good health, and it's -- I just  
21 don't believe in that. I've studied it enough to know  
22 it's the wrong thing to do.

23 Q Do you believe Dr. Wall puts you at any increased risk  
24 or in any way threatens your health by treating you  
25 without a mask?

26 A Absolutely not.

1 Q Do you think Dr. Wall has done the right thing by  
2 letting you not wear a mask when you come in for  
3 treatment?

4 A Yes.

5 Q I'm going to shift gears a little bit. Let me ask you  
6 this: Do you think Dr. Wall could provide you --

7 MR. KITCHEN: -- oh, my apologies -- I had  
8 turned it off, and then I called Mr. Maxston, and I  
9 forgot to turn it off again. I apologize. I'll start  
10 again.

11 Q MR. KITCHEN: Do you think Dr. Wall could  
12 provide you with treatment that you want if he could  
13 not come within 2 metres of your body?

14 A I think it would be pretty much virtually impossible.

15 Q And do you think Dr. Wall could provide you with the  
16 treatment you want if all he could ever do is call you  
17 on the phone and talk with you?

18 A I don't think that would work.

19 Q And I know it might be a bit obvious, but could you  
20 tell me why?

21 A He needs to have the hands on.

22 Q And, again, I know it might be a bit obvious, but what  
23 is the treatment that Dr. Wall gives you when you come  
24 into the office?

25 A He adjusts my spine and my neck and whatever else might  
26 be out of line and checks to make sure I'm --

1 everything's lined up.

2 Q And what does he use to do that?

3 A His hands.

4 Q Do you want to keep Dr. Wall as your chiropractor?

5 A Absolutely.

6 Q Do you think it would be against your interests if

7 Dr. Wall is ordered to stop practicing or to only

8 practice over the telephone?

9 A Absolutely, I would be upset.

10 Q Do you think your interests should be considered as

11 part of any decision to restrict or not restrict

12 Dr. Wall's ability to practice?

13 A I would hope it would have some bearing.

14 Q If Dr. Wall is ordered to stop practicing or to stop

15 treating you except by calling you on the phone, would

16 you be upset with that order or that decision and the

17 person or body that made it?

18 A Absolutely.

19 Q Could you explain why?

20 A It's not fair. It's not reasonable. It goes against

21 the Hippocratic Oath. It goes against a lot of things.

22 Q Do you think the chiropractic profession has important

23 core principles?

24 A Absolutely.

25 Q And what do you think some of those are?

26 A Promote natural health, to give people an alternative

1 to the pharmaceutical/medical establishment; to mainly  
2 promote natural health, just natural treatments.

3 Q Do you think those treatments are currently being  
4 adhered to -- sorry, let me say that again, I said it  
5 wrong. Do you think those principles are currently  
6 being adhered to?

7 A Well, I think they are by most of the practitioners.  
8 I'm not sure about the administrative side of it.

9 Q And why do you say that?

10 A Because we're having this hearing right now. I think  
11 it's a travesty that we're even having this hearing.

12 Q And as far as your knowledge, what is it that Dr. Wall  
13 has done wrong that brings us here today?

14 A I don't think he's done anything wrong, but I think one  
15 person out of hundreds was living in fear and thought  
16 they should do something about it.

17 Q How do you think the chiropractic profession should be  
18 acting in response to the Government COVID  
19 restrictions?

20 A I think they should be pushing back. I think they've  
21 got plenty of evidence that the Government's mandates  
22 are unreasonable and not in the interest of good  
23 health.

24 Q Forgive me for asking, Charles, but how old are you?

25 A I don't tell people how old I am. I'm 55 in my mind.

26 Q Do you regard yourself as being in the at-risk category

1           for COVID?

2     A     No.

3     Q     And why is that?

4     A     Because I'm healthy, and I practice good health  
5           practices, and I do the things that make a difference,  
6           and I stay away from chemical drugs.

7     Q     And just one more question, I just want to go back to  
8           what you said earlier, you talked a lot about natural  
9           health. So you -- would you say that chiropractic  
10          treatments, hands-on chiropractic treatments, that's a  
11          part of natural health?

12    A     Absolutely.

13           MR. KITCHEN:                   Well, those are all my  
14          questions. Thank you, Charles.

15    A     You're welcome.

16           THE CHAIR:                    Mr. Maxston?

17           MR. MAXSTON:                 Thank you, Mr. Chair.

18          Mr. Maxston Cross-examines the Witness

19    Q     MR. MAXSTON:                 Mr. Russell, my name is Blair  
20          Maxston. I'm the lawyer for the College's Complaints  
21          Director, and I've just got a few questions for you,  
22          and I will not be asking you how old you are, so you  
23          cannot worry about that. I just have --

24    A     I plead the fifth on it.

25    Q     -- a few questions for you. Sorry?

26    A     I plead the fifth on that one.



1 Q Yeah, well, I probably would too, so good for you.

2 Would you agree with me, Mr. Russell, that  
3 practicing as a chiropractor is a privilege not a  
4 right?

5 MR. KITCHEN: Hold on, that's a legal  
6 opinion question.

7 MR. MAXSTON: Well, I'll rephrase it.

8 Q MR. MAXSTON: Would you agree with me that  
9 not everyone can be a chiropractor; you have to earn  
10 it?

11 A I think you should be qualified.

12 Q And you're aware that the Alberta College and  
13 Association of Chiropractors is the professional  
14 regulator for chiropractors in Alberta, correct?

15 A That's what I understand, yes.

16 Q Are you aware that that college has mandatory  
17 requirements for registration before someone can be a  
18 chiropractor, like going to a certain school, that type  
19 of thing?

20 A That would seem reasonable to me.

21 Q And are you also aware that the College has ongoing  
22 requirements for chiropractors so they can stay in good  
23 standing with the College, like continuing education  
24 and those kinds of things?

25 A Makes sense.

26 Q Would you agree that those requirements are important

1 in order to ensure that chiropractors are competent and  
2 can practice safely?

3 A I would say so.

4 Q Now, Mr. Kitchen sort of touched on this with you, but  
5 you're aware that, at times, the College, the College  
6 of Chiropractors, has had a directive requiring that  
7 its members, people like Dr. Wall, wear masks when they  
8 treat patients; is that your understanding?

9 A It's my understanding, yeah.

10 Q You've made comments today in support of Dr. Wall not  
11 following the requirement for masking; is that correct?

12 A Yes.

13 Q Would you agree with me, Mr. Russell, that you can only  
14 speak for yourself on those matters?

15 A Yes.

16 Q And would you agree with me that there might be other  
17 patients of Dr. Wall who don't share your views?

18 A Could be.

19 Q And would you agree that there could be other patients  
20 who might want Dr. Wall to comply with the College's  
21 pandemic masking directive?

22 A Could be.

23 MR. MAXSTON: Those are all my questions for  
24 you, Mr. Russell.

25 THE CHAIR: Thank you, Mr. Russell.

26 Mr. Kitchen, anything on redirect?

1 MR. KITCHEN: No, I do not have any  
2 redirect.

3 THE CHAIR: Okay, perhaps we can take a  
4 quick break just to see if -- or maybe I'll ask the  
5 Panel now, do any of the Panel Members have any  
6 questions that they would like to discuss in caucus  
7 before we dismiss Mr. Russell? Apparently not,  
8 Mr. Kitchen.

9 So thank you, Mr. Russell. I believe your  
10 testimony today is concluded.

11 A Okay.

12 MR. KITCHEN: Thank you, Charles. You're  
13 free to go in other words.

14 A Okay.

15 MR. KITCHEN: Take care.

16 (WITNESS STANDS DOWN)

17 Discussion

18 MR. KITCHEN: Chair, I guess I'm going to  
19 have to ask that we take a break, and I'm going to try  
20 to get my second witness here as fast as I can, and  
21 I'll also start putting in calls to the other witnesses  
22 I have, because we're moving at opposite of the speed  
23 we were last time.

24 THE CHAIR: It's 9:30 -- just about 9:30,  
25 Mr. Kitchen. How long would you like, and how long do  
26 you think you need?

1 MR. KITCHEN: Well --

2 THE CHAIR: If we check back in 15  
3 minutes?

4 MR. KITCHEN: Yeah, we could check back. I  
5 don't know if I'll have my witness available. He  
6 was -- he preferred to come to the office because  
7 he didn't want to do the technology, so I'm going to  
8 have to call him and see how quickly he can get here.  
9 So --

10 THE CHAIR: Okay.

11 MR. KITCHEN: -- I can't say that he'll be  
12 ready in 15 minutes, but we can check in. Is that all  
13 right?

14 THE CHAIR: Okay. Yeah. I wonder if  
15 there's another way of doing this. Ms. Nelson, can  
16 Mr. Kitchen contact you when his witness is ready, and  
17 you can let us know. We'll shift to our break-out  
18 room.

19 MS. NELSON: Yeah, that works.  
20 Mr. Kitchen, you have my cell number, correct?

21 MR. KITCHEN: No, but I'd like it.

22 MS. NELSON: Okay, so 780-938-1666 is my  
23 cell number.

24 MR. KITCHEN: Okay, thank you.

25 MS. NELSON: What I'll do is I'll just open  
26 up all the break-out rooms, everyone can go into their

1 break-out room, and then, Mr. Kitchen, when you kind of  
2 have an idea of scheduling, just send me a text, and  
3 then I'll communicate to everybody through the rooms.

4 MR. KITCHEN: Excellent, thank you.

5 MS. NELSON: Okay, thank you.

6 THE CHAIR: Okay, we'll take a break.

7 We'll head to our break-out rooms and reconvene at such  
8 time as we have another witness. Thank you.

9 (ADJOURNMENT)

10 THE CHAIR: Mr. Kitchen, could I ask, were  
11 you able to contact your witness or witnesses?

12 MR. KITCHEN: So Mr. Kosowan is available at  
13 10:45 to be cross-examined, and he'll be appearing  
14 virtually, and what I mean by that is he won't be here  
15 in the office with me like he was the last time.

16 THE CHAIR: Okay.

17 MR. KITCHEN: Dr. Gauthier, the earliest he  
18 can be available is 12:45. He expects to be done with  
19 his last patient at 12:30. So wherever we're at with  
20 that means we have this witness now, we have  
21 Mr. Kosowan at 10:45. Then I would propose we have a  
22 lunch break, and then we come back, and we have  
23 Dr. Gauthier.

24 THE CHAIR: I'm sorry, when you say "we  
25 have this witness now", who is that?

26 MR. KITCHEN: That is Dave Hilsabeck. Now,

1 we had this issue last time, of course, because he's in  
2 the office with Dr. Wall and I, so he's appearing on  
3 Dr. Wall's screen, that's why it says "Dr. Curtis  
4 Wall", so just note that it's not Dr. Curtis Wall, it  
5 is, in fact, the witness, Dave Hilsabeck.

6 THE CHAIR: Okay, so I'm sorry, I should  
7 have asked this, are we prepared to resume then?

8 MR. KITCHEN: I am.

9 THE CHAIR: Okay, and Mr. Maxston?

10 MR. LAWRENCE: I don't think Mr. Pavlic is  
11 back, Mr. Chair.

12 MR. MAXSTON: Yeah, I was just going to say,  
13 on my screen, I'm not sure, but I don't think  
14 Mr. Pavlic is here.

15 THE CHAIR: Okay.

16 MR. PAVLIC: Can you hear me?

17 THE CHAIR: Yeah, can't see you; your  
18 camera's off.

19 MR. PAVLIC: Okay, I can put my camera on.  
20 Here we go. There I am. Yeah, sorry, my apologies, I  
21 didn't put my camera on, forgive me.

22 THE CHAIR: We will forgive you.

23 Okay, I think we're all here now. Mr. Maxston,  
24 you're okay to resume?

25 MR. MAXSTON: Yes, thank you for checking.

26 THE CHAIR: Okay. All right, Mr. Kitchen.

1 And just for the record, we are back in session, thank  
2 you.

3 MR. KITCHEN: All right, Madam Court  
4 Reporter, we're ready when you are.

5 DAVID WARREN HILSABECK, Sworn, Examined by Mr. Kitchen

6 Q MR. KITCHEN: All right, Dave, could you  
7 please just say your full name for the record?

8 A My name is David Warren Hilsabeck.

9 Q Thank you. Dave, could you tell me what you do for a  
10 living?

11 A At present, I'm a corporate pilot for an energy company  
12 here in Calgary, based out of Calgary.

13 Q Are you a patient of Dr. Wall's?

14 A Yes, I've been a patient for him for at least 15 years.

15 Q Okay, why have you stuck with Dr. Wall as your  
16 chiropractor for so long?

17 A I appreciate how he manages business with my body,  
18 let's put it that way, how he conducts business with  
19 me, his communication with me, and his responses to me  
20 and my needs, and that's why I've always come back to  
21 him. His gentle nature. I've been to other  
22 chiropractors before, and sometimes are definitely  
23 rougher, but I appreciate how his gentle nature looks  
24 after me.

25 Q Thank you. Now, I'm going to ask you a couple  
26 questions that might seem pretty obvious, so bear with

1           me. Can you describe for me in detail the treatment  
2           that Dr. Wall does on you when you come in to see him?

3    A    The treatment in detail, so a lot of times what we'll  
4           do is discuss where -- the back issues that I'm having,  
5           for example, or hip issues or whatever the case may be.  
6           He will then examine me and to find out where the -- my  
7           problems lie and then will start to treat me  
8           step-by-step, let's say up and down my spine and into  
9           my hips or whatever that my problems are at the moment.  
10          Is that enough detail for what you need?

11   Q    Yes, but let me ask you a question, what does he use to  
12          treat you?

13   A    What does he use. Well, he uses his hands, we're using  
14          his workbench, uses different tools as far as vibrating  
15          massage therapy or the pressure point actuator, and we  
16          use a couple of different benches that he has here to  
17          figure out where my faults are and to help correct  
18          that.

19   Q    Thank you. Dave, do you respect Dr. Wall?

20   A    Greatly, yes, very much so. I appreciate what he has  
21          to say, and how he suggests going forward, what to do  
22          with my body, stretching exercises, strengthening  
23          exercises, those kind of things to get me back into  
24          shape and where I need to be.

25   Q    Do you think Dr. Wall could provide you with the  
26          treatment you want if he could not come within 2 metres



1 of you?

2 A Oh, definitely not, no. Chiropractic is a hands on,  
3 and I mean hands on to my body to be able to adjust me  
4 correctly. If he was 2 feet away, there would be no  
5 sense in even coming here. Like I could not -- he  
6 could not do the adjustments that need to be done at a  
7 2 foot mark -- or a 2 metre mark, so, no, he couldn't  
8 do that.

9 Q If he wasn't able to do that, what do you think you  
10 would do?

11 A I'd be in a world of hurt. First of all, to find other  
12 chiropractor that I trust and respect and have used for  
13 so many years; I've gone to a few other ones, you know,  
14 over the last 40 years, let's say, some with some  
15 success, some without success, and so I would be in a  
16 world of hurt. I wouldn't be able to keep going as  
17 often and, you know, do the things that I do without a  
18 proper chiropractor that can help me out.

19 And chiropractic I find is -- it's different for  
20 everybody -- sorry, it's different for every  
21 chiropractor, they do it in so many different ways. So  
22 one adjustment from one chiropractor doesn't  
23 necessarily mean that it's going to work for me.  
24 Dr. Wall has figured out my body, what I need and where  
25 my weak points are and has been able to fix me up with  
26 that.

1           So going to another one, I'd be in a -- I'd be in  
2           trouble, I think, in very short order, because I'd  
3           probably have to go to a number of them to even figure  
4           out if that style of chiropractic would work for me or  
5           not.

6       Q    Thank you, and I know this may be obvious, do you think  
7           Dr. Wall could provide you with the treatment you want  
8           if all he could ever do was call you on the phone and  
9           talk with you?

10      A    Oh, no way. It's physically impossible. Physically,  
11           because I have to be here, he has to be able to adjust  
12           my back, my spine, my hips, whatever the case may be,  
13           so definitely not.

14      Q    We've already touched on this, but just to confirm, do  
15           you think it would be against your interests if  
16           Dr. Wall was ordered to stop practicing or to only  
17           practice over the phone?

18      A    Yes, of course, it would be against my interests. If  
19           he wasn't available to do this, like I said, I'm in a  
20           world of hurt, and it would take me a long time, a lot  
21           of money just to find another chiropractor. Every time  
22           you go into a new chiropractor, you've got to start all  
23           over; you've got to do the whole process of an initial  
24           consultation and whatnot. So it would take a long time  
25           and a lot of money.

26           So, yes, it's -- your question was is it in my

1       best interest that he is here, most definitely, both  
2       physically and monetarily.

3       Q   Do you think, as a member of the public, that your  
4       interests should be considered as part of any decision  
5       to restrict or not restrict Dr. Wall's ability to  
6       practice?

7       A   Yes. And as a member of the public, I understand what  
8       he's doing, I appreciate what he's doing, and his  
9       thoughtful manner in how he manages me and my family,  
10      and so as a member of the public, yes, it affects me  
11      greatly, and it would -- I guess all I can say is yes.

12             Can you say the question again for me, please?

13      Q   I will, but I just want to confirm something, so your  
14      family comes to see Dr. Wall as well?

15      A   Yes, over the last, you know, 15 years, both my wife  
16      and my kids have come numerous times, and so, yes, it  
17      would affect us greatly to have all of us be affected  
18      this way.

19      Q   Now, let me ask you this: If Dr. Wall is ordered to  
20      stop practicing or to stop treating you except by  
21      calling you on the phone, would you and your family be  
22      upset with that order or decision and the person or  
23      body who made it?

24      A   Most definitely. That affects us greatly. So we would  
25      not be able to -- Dr. Wall could not do what he does  
26      over the phone for us. You know, you can say, Oh, do

1       this exercise or that exercise; but if you need your  
2       spine, your hips, whatever, knees, actually  
3       manipulated, he can't do that over the phone. So, yes,  
4       it would affect us greatly. It would be a huge  
5       hindrance, a big disappointment that somebody would  
6       actually take away his ability to do that.

7       Q   Thank you. Now, I'm going to take us to the -- to some  
8       of the deeper issues. Do you wear a mask when you come  
9       to see Dr. Wall for treatment?

10      A   No, I don't, I don't wear a mask in the office here.

11      Q   Are you grateful that Dr. Wall does not require you to  
12      wear a mask when you come in for treatment?

13      A   Yes, most definitely. I am -- it's frustrating wearing  
14      masks. I find that so often people that are wearing a  
15      mask, if he was wearing a mask, and we're trying to  
16      converse and trying to figure out what's going on with  
17      me, if I can't read the lips sometimes or just see  
18      what's going on, facial expressions, I lose a lot of  
19      communication that way.

20                I find it a huge inconvenience to have to wear a  
21      mask. It doesn't matter where I go. You go into as  
22      simple as a -- into a restaurant, and you're trying to  
23      order, and you're trying to figure out what the  
24      specials are for the day, but you can't hear what  
25      they're saying; you go through a drive-through, for  
26      example, to get some food, and you go -- they're

1       mumbling, it's very, very, frustrating. You go to a  
2       hardwood store, and you're trying to figure out what  
3       you need for parts and pieces, and this guy is sitting  
4       there mumbling, and you can't see what he's talking  
5       about, or you can barely hear what he's talking about,  
6       so with my hearing diminished a little bit, it's very  
7       frustrating. I just don't appreciate it at all having  
8       to wear a mask everywhere.

9       Q   Thank you. Does Dr. Wall wear a mask when you come in  
10       for treatment?

11      A   No, he doesn't, and then, again, you know, in his  
12       office here, he's had the shields up and whatnot, so if  
13       the -- he is protected, but, you know, when he is  
14       working on me and my body, no, he's not wearing a mask.  
15       My -- you know, I want be able to hear him, I want to  
16       be able to see what he's got to say, so I appreciate  
17       that he doesn't wear a mask and that we're able to  
18       communicate properly without me asking, What did you  
19       say, what did you say, what did you say all the time.  
20       It's just so much better for me personally.

21      Q   Do you believe Dr. Wall puts you at any increased risk  
22       in any way or threatens your health in any way when he  
23       treats you without wearing a mask?

24      A   No, not at all. I feel very comfortable with him.  
25       I've known him and his family, a lot of his kids have  
26       been the receptionists and things like that, so over

1       the years, we've got to know each other, and I wouldn't  
2       say on a -- necessarily a personal level, but you  
3       understand where they're coming from. They are not the  
4       partying type of people that are out carousing all the  
5       time. You know, he's not exposing himself to any risk  
6       that I can see or have ever heard of even when he's not  
7       at work here.

8               So for him to -- I do not feel threatened at all  
9       coming in here, it's just a safe environment, and I  
10      haven't got a problem with it at all. It's like our  
11      work environment, you know, we know the people that we  
12      work with, and have we had any COVID problems at work?  
13      No, we haven't. But you know the people, you know what  
14      they're trying to do. So his threat level I think is  
15      next to zero.

16             And even with COVID, you know, we know that you  
17      look at the statistics, and for people that get COVID,  
18      we're sitting at 99.8 percent of the people that get it  
19      survive it. You know, that's huge. Even people, you  
20      know, that get the flu don't even have that kind of  
21      access -- or don't have that kind of, not access, but  
22      record of survival, so I don't feel threatened at all  
23      with what he does here.

24    Q       You are, of course, aware that the Alberta College of  
25       Chiropractic has required, mandated that Dr. Wall wear  
26       a mask when he's treating you; would you agree with

1           that?

2       A    That's what I've heard, that they are mandating it, but  
3           I find that that mandate -- how do I put it? I find  
4           that that mandate isn't necessarily based on strong  
5           data. I feel that a lot of this mandate is more on a  
6           political side of things, and that, you know, you look  
7           at the mask mandates around the world, and I fly around  
8           the world, I see all sorts of different things.

9                 So you look at some place like Japan, for example,  
10           and Japan was masked-up, they were sitting in the high  
11           98, 99 percent of people were masked-up, they still had  
12           huge outbreaks, so masks didn't necessarily fix the  
13           problem.

14                And I feel that the political side of things, you  
15           know, we're being forced to do this, but the data  
16           doesn't necessarily support it as far as I'm concerned.

17       Q    You say you go around the world, and you see other  
18           places; are there any places where you don't encounter  
19           any mask mandates?

20       A    Oh, sure. Like last week, I was down in Dallas, Texas,  
21           for the week. I went down there training, and  
22           everybody has a different way of doing things. So you  
23           get to the airport, for example, and you have to be  
24           masked-up because it's federally regulated in the  
25           airports. They sit there, and they say you've got to  
26           stand 6 feet apart when you're in the waiting area for

1 the airport. So everybody's 6 feet apart. Then all of  
2 a sudden, it's all okay because we can all go through a  
3 tunnel, hop on an airplane, sit side by side, and  
4 that's perfectly fine, and I'm rubbing shoulders with  
5 the person next to me, and that's perfectly fine.

6 So you look at the different ways of doing  
7 business, and you kind of go, well, okay, that makes  
8 sense, that doesn't make sense, that's just plain  
9 stupid. I get down to Texas, I get out of the airport,  
10 we take our mask off, and I didn't put a mask on for a  
11 week. I went to -- into the class, I went to the  
12 simulator, I went to restaurants, we went to hardware  
13 stores, nobody was wearing masks down there. And  
14 people say, Well, you know, that's because they've had  
15 a huge outbreak.

16 Actually it's not. If you look at the statistics,  
17 percentage-wise, we are at a higher percentage of  
18 infection than they do down there, and they don't  
19 have -- they're just not wearing masks. You do see  
20 masks in some of the restaurants, and some of the  
21 servers and whatnot were wearing masks, but none of the  
22 clientele.

23 So I hear, I haven't been to Arizona for a couple  
24 months now, and Florida have been for a while, but I  
25 hear that both those states are the same way: They  
26 have gone away from their masks, and it has not



1       affected them whatsoever.

2       Q    I think I just have one more question for you. Do you  
3            think Dr. Wall has done the right thing by letting you  
4            not wear a mask when you don't want to?

5       A    Yes, I do. I think he's done the right thing. First  
6            of all, he knows what I do and the risk. You know,  
7            I've had to take so many tests and whatnot traveling  
8            across the border, back and forth all the time, and so  
9            I know where I'm at, and I think he knows where I'm at.

10           So when I come in and he's not requiring a mask,  
11           it's -- there's a mutual agreement there that, yeah, we  
12           are both on the safe side of things. We're both very  
13           conscious that COVID is out there, both responsible  
14           with what we're doing and how we're acting and -- with  
15           our lives, but we both appreciate where we're at.

16           And so to come in here and not wear a mask, I  
17           appreciate that we do not have to, he's not requiring  
18           it. If he said I had to wear a mask to be treated, I  
19           wouldn't be happy about it, but would I do it? Yes,  
20           because I need the treatment. So if he's forced into  
21           it, it's not because of his doings, but because of  
22           somebody else is, you know, forcing him to go down this  
23           path.

24       Q    Forgive me, one last question for you, do you think  
25            Dr. Wall prioritises your interests above his  
26            interests?

1     A     That's a good question. I will say yes, because he's  
2           my doctor, my chiropractor, worrying about me. And so  
3           where I'm at, I believe that he's looking after me and  
4           not necessarily him. I don't know what else I can say  
5           about that, but I would agree with that, that he's  
6           looking after me and my best interests.

7     Q     Do you think, by having this hearing, the Complaints  
8           Director for the College is acting in your best  
9           interests?

10    MR. MAXSTON:                   I'm going to object to that,  
11    Mr. Chair. There's no way this individual can comment  
12    on the motivations or intentions of the Complaints  
13    Director.

14    MR. KITCHEN:                   Well, I didn't ask about  
15    motivations of the Complaints Director. I asked if he  
16    thinks it's in his interest, and that's in his  
17    knowledge.

18    MR. MAXSTON:                   Well, I think this line of  
19    questioning is entirely subjective. I suppose I won't  
20    object further to it, but I don't see any value in this  
21    witness expressing personal opinions about the actions  
22    of the College.

23    THE CHAIR:                    Could you repeat the question,  
24    please, Mr. Kitchen?

25    MR. KITCHEN:                   The question I asked is if  
26    Mr. Hilsabeck thought that having this hearing was in

1 his best interests as a patient.

2 THE CHAIR: I'm going to sustain that  
3 objection.

4 A Okay, so I can answer it?

5 Q MR. KITCHEN: No. That means you can't.  
6 Those are all my questions.

7 THE CHAIR: Thank you.

8 Mr. Maxston?

9 Mr. Maxston Cross-examines the Witness

10 Q MR. MAXSTON: Good morning, Mr. Hilsabeck, I  
11 just have a couple of quick questions I want to ask you  
12 based on some exchanges you had with Mr. Kitchen, and  
13 then I've got a few other questions I do want to ask  
14 you.

15 You made some comments earlier about survival rate  
16 and threat and those types of things, and I just to be  
17 clear, you're not a physician or an immunologist or a  
18 virologist; those are your personal views?

19 A That is correct; that would be my personal views on my  
20 research of those subjects.

21 Q You also talked about your belief that the College's  
22 pandemic masking and I should say required masking  
23 mandate wasn't based on strong data, but you, of  
24 course, don't have any knowledge of the process the  
25 College undertook to create that mandate, do you?

26 A No, that's correct, I do not know what the College has

1 done.

2 Q So I'll just ask you some questions then from a broader  
3 perspective. Would you agree with me that a person has  
4 to earn the right to practice as a chiropractor in  
5 Alberta?

6 A Earn the right? He has to take the training. So the  
7 right, I'm not sure what you're going with as far as  
8 the right is concerned.

9 Q I think --

10 A My knowledge --

11 Q Go ahead, sorry.

12 A Okay, my knowledge is for like a chiropractor, a  
13 doctor, they take the training, and then I'm assuming  
14 there is an application for that province or whatnot to  
15 be able to accept -- or to be able to license -- to get  
16 licensed in that province.

17 Q And that kind of ties into my next question, which is  
18 you're aware that the Alberta College and Association  
19 of Chiropractors is the professional regulator or  
20 licensing body for chiropractors in Alberta?

21 A Yes, I understand that, yes.

22 Q And based on your comments just now, I think you'd also  
23 agree with me that there are mandatory requirements to  
24 become registered with the College to be a  
25 chiropractor, like education?

26 A That's correct, yes.

1 Q And would you also agree with me that there are  
2 requirements the College has to keep a licence for a  
3 chiropractor, things like continuing education or  
4 payment of fees?

5 A Oh, sure, yes, I understand that completely. I'm a  
6 pilot; that's all we do.

7 Q I kind of thought you would, yeah. You probably get a  
8 lot of con ed from your regulators as well, so  
9 mandatory con ed.

10 Would you agree that those requirements to keep  
11 registration for a chiropractor are intended to ensure  
12 safe and competent practice?

13 A Would you say that again, please?

14 Q Yeah, those mandatory requirements to keep your  
15 licence, the mandatory requirements the College issues,  
16 would you agree that those are in place in order to  
17 ensure safe and competent practice?

18 A I would, yes.

19 Q Mr. Kitchen spoke with you about the College's  
20 directive, Pandemic Directive, requiring the wearing of  
21 masks when a chiropractor is treating, and I just want  
22 to be clear that, to this day, you're not wearing a  
23 mask, and Dr. Wall isn't wearing a mask when he  
24 performs treatment on you?

25 A That is correct.

26 Q I think it's fair to say you've made comments today in

1 support of Dr. Wall not masking when he treats you.  
2 Would you agree that you can only speak for yourself  
3 when you make those comments?

4 A I can speak for myself and for my family, yes.

5 Q Fair enough. Would you agree that there could be other  
6 patients of Dr. Wall who don't share your views?

7 A Oh, definitely.

8 Q And do you --

9 A Yes.

10 Q -- agree -- I'm sorry.

11 A No, go ahead.

12 Q Would you agree that there may be other patients of  
13 Dr. Wall who, in fact, want him to comply with the  
14 College's masking requirement?

15 A There is that possibility, sure.

16 MR. MAXSTON: Those are all my questions.  
17 Thank you, Mr. Hilsabeck.

18 A Thank you.

19 THE CHAIR: Mr. Kitchen, anything on  
20 redirect?

21 MR. KITCHEN: Just one question.

22 Mr. Kitchen Re-examines the Witness

23 Q MR. KITCHEN: Dave, my friend, my learned  
24 friend, Mr. Maxston, he asked you do you think the  
25 College's mandates are for the purposes of keeping the  
26 public safe. I don't know if those were his exact

1 words, but he can object if he thinks that's not  
2 reflective of the substance of what he said, do you  
3 have any actual knowledge yourself of what motivates  
4 the College when they have mandates for chiropractors?

5 A Do I have any knowledge? No, I don't have any  
6 knowledge of how they do their -- how they do that.  
7 What do I say there? A lot of this stuff, a lot of the  
8 mask wearing, a lot of our regulations, it seems like  
9 it's politically based.

10 Case in point, Calgary, we got a new mayor here in  
11 the last month, and her first response was basically  
12 whatever the Alberta Government says, we're going to  
13 add 28 days to it. Now, how does she become more  
14 knowledgeable than our head of our medical people,  
15 Dr. Hinshaw and her group of people with the AHS? How  
16 do they make those kind of claims after being elected  
17 and within 24 hours make a claim like that? This is  
18 why a lot of this stuff is so political and not  
19 necessarily scientific in my mind.

20 And it's not the same the world over. So I see,  
21 as I'm flying around different places in the world, or  
22 I see different countries and their requirements and  
23 whatnot, I see such a variety of mandates and  
24 requirements, and it's not on science, it's on personal  
25 belief or a political belief or whatever the case may  
26 be, but not necessarily science.

1           So why the difference between Alberta and Texas,  
2           for example? Why such a wide variety of understanding  
3           of what COVID is, what the requirements are, and you  
4           look at the percentage of COVID cases, there's really  
5           no difference. If you look at John Hopkins, and you  
6           look at what Texas has, and you look at Alberta, and  
7           you look at percentages, they are just about identical.

8    Q    Why do you think the College is acting political?

9           MR. MAXSTON:                   Mr. Chair, I might ask my  
10          friend to rephrase that question. I think there's a  
11          premise in that question that the College is acting  
12          politically, and I don't know if this witness has any  
13          information in that regard, and, again, I think we're  
14          going very far from the core issues here.

15          MR. KITCHEN:                   Well, it wasn't a presumption  
16          because that's what he said, so I just asked him why he  
17          thought that. That's all. This is in the same line of  
18          questioning you asked him, Do you think the College is  
19          doing this for safety. Now, he has no knowledge of  
20          that, he said so, but you asked him anyways. I'm  
21          asking the same type of question, asking him why he  
22          thinks the College is acting in a political manner.

23          THE CHAIR:                    I'll allow that.

24    A    I don't see -- you look from Alberta Health Care, for  
25          example, a lot of their decisions keep flip-flopping,  
26          and it doesn't seem to be on science, it seems to be



1 political. You look at each level of government, it  
2 seems to be political, not scientific.

3 Now, you say, Well, where are you getting your  
4 information from. Well, I get it from a lot of  
5 different sources. I read a lot of different -- and  
6 I'm not just talking the main media; I go to different  
7 places and do some analysis myself, and you start  
8 looking at, typical is, John Hopkins, which you would  
9 think would be a fairly reliable source with the data  
10 that they present, and you look at percentages.

11 So why does Alberta have one set of rules, Calgary  
12 have another set of rules, and you think that it's  
13 political. So I'm going down the road there, yes, I  
14 believe that everybody is doing it on a political side  
15 of things and not necessarily a scientific.

16 So do I think that the -- your Association is  
17 doing that? I feel that in a way, yes. I do not know  
18 that you are doing it purely scientific.

19 MR. KITCHEN: Thank you. That's it for my  
20 redirect.

21 THE CHAIR: Okay, I'll just quickly poll  
22 the Panel, are there any questions that the Panel wish  
23 to discuss before we release the witness?

24 Nothing further, okay. Okay, thank you very much.  
25 You are excused, sir, and we appreciate your coming in,  
26 and you can leave if you wish.

1     A     Oh, good, thanks very much.

2           (WITNESS STANDS DOWN)

3     THE CHAIR:                         So, Mr. Kitchen, we have 15

4     minutes before your next witness; is that correct?

5     MR. KITCHEN:                        Yes, that's correct.

6     THE CHAIR:                         Okay, perhaps Ms. Nelson can

7     put us in break-out rooms until 10:45, and then we'll

8     reconvene. We'll adjourn for now and reconvene at

9     10:45 for the cross-examination of -- I'm sorry, I've

10    forgotten his name -- Kosowan; is that right?

11    MR. KITCHEN:                        That's right.

12    THE CHAIR:                         Yeah, okay. Mr. Maxston,

13    you're okay?

14    MR. MAXSTON:                        Yes, that's fine. Thank you

15    for asking.

16           (ADJOURNMENT)

17    THE CHAIR:                         We'll reconvene, and

18    Mr. Maxston will start his cross-examination of

19    Mr. Kosowan.

20    JARVIS KOSOWAN, Previously affirmed, Cross-examined by

21    Mr. Maxston

22    Q     MR. MAXSTON:                        Good morning, Mr. Kosowan.

23           Can you hear me?

24    A     Yes, I can.

25    Q     Thank you. Can you just confirm for me that you're

26           still under oath when you're giving your testimony

1           today?

2     A     Yes, I am.

3     Q     I just have a few questions for you. The first  
4           question I have is are you aware that the Alberta  
5           College and Association of Chiropractors is the  
6           professional regulator and licensing body for  
7           chiropractors in Alberta?

8     A     Yes, I am.

9     Q     And are you also aware that the College has mandatory  
10          requirements such as education before someone can  
11          become licensed as a chiropractor?

12    A     Not totally, no.

13    Q     You'd agree with me though that, generally, that would  
14          be the case to become a member of a profession?

15    A     I would believe that would be correct, yes.

16    Q     Are you also aware, or if you're not, would you agree  
17          with me that the College of Chiropractors has ongoing  
18          requirements to keep registration as a chiropractor,  
19          things like continuing education or paying a yearly  
20          fee?

21    A     Yes, I'm aware of that.

22    Q     And would you agree that the College, having those  
23          requirements, is important to ensure chiropractors are  
24          competent and can practice safely?

25    A     I agree with that.

26    Q     You spoke with Mr. Kitchen, my friend Mr. Kitchen, a

1        little while ago, and you talked about the College's  
2        Pandemic Directive which required masking by  
3        chiropractors when they treated patients; do you recall  
4        that?

5     A    Yes, I do.

6     Q    And do you also recall that when you first testified,  
7        you made comments in support of Dr. Wall not following  
8        that requirement and not masking when he treated you?

9     A    That is correct.

10    Q    Would you agree that when you made those comments, you  
11        could only speak for yourself?

12    A    That is correct.

13    Q    And would you agree with me that there could be other  
14        patients of Dr. Wall who don't share your views?

15    A    That's possible.

16    Q    And would you agree with me that there could be other  
17        patients of Dr. Wall who want him to comply with the  
18        requirement to mask when he's treating patients?

19    A    Obviously. I believe that's the way this whole thing  
20        got initiated, by one of the clients complaining about  
21        the mask not being worn, so I agree with that  
22        statement.

23        MR. MAXSTON:                    Those are all my questions for  
24        you, Mr. Kosowan. Thank you for making yourself  
25        available today.

26    A    Thank you. Am I done or --

1 THE CHAIR: Mr. Kitchen, did you have  
2 anything on redirect?

3 MR. KITCHEN: No, I don't.

4 THE CHAIR: Well, Mr. Kosowan, thank you  
5 very much, once again, for finishing with your  
6 testimony. You are free to leave. We do appreciate  
7 your assistance in this.

8 A All right, thank you very much.

9 THE CHAIR: Thank you.

10 MR. KITCHEN: Thank you.

11 (WITNESS STANDS DOWN)

12 THE CHAIR: So I guess we are on an  
13 extended break, Mr. Kitchen, until 12:45; is that  
14 correct?

15 MR. KITCHEN: Yes, that's correct, my  
16 apologies, that's the earliest my next witness can be  
17 available.

18 THE CHAIR: Okay, we will have an early  
19 and extended lunch break I guess. Perhaps we can --  
20 we'll reconvene at 12:45, and hopefully we'll -- and  
21 that will be the last witness of the day for today; is  
22 that correct?

23 MR. KITCHEN: Very likely. There is an  
24 unlikely chance that the witness, who I was hoping to  
25 call this morning but who's busy with work, may be able  
26 to make it this afternoon after Dr. Gauthier. It's

1 unlikely, but possible; I'm just going to check with  
2 him at lunch.

3 THE CHAIR: Okay, very good. Then we will  
4 recess for now and reconvene at 12:45. Did the Panel  
5 Members wish to caucus? I don't see a need to. Okay,  
6 we'll see everybody back at 12:45. Thank you.

7 MR. KITCHEN: Thank you.

8

9 PROCEEDINGS ADJOURNED UNTIL 12:45 PM

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

4

5 November 16, 2021 Afternoon Session

6

7 HEARING TRIBUNAL

8 J. Lees Tribunal Chair

9 W. Pavlic Internal Legal Counsel

10 Dr. L. Aldcorn ACAC Registered Member

11 Dr. D. Martens ACAC Registered Member

12 D. Dawson Public Member

13 A. Nelson ACAC Hearings Director

14

15 ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

16 B.E. Maxston, QC ACAC Legal Counsel

17

18 FOR DR. CURTIS WALL

19 J.S.M. Kitchen Legal Counsel

20

21 K. Schumann, CSR(A) Official Court Reporter

22

23 (PROCEEDINGS RECOMMENCED AT 12:47 PM)

24 THE CHAIR: The Hearing Tribunal is back  
25 in session at 12:45, and Mr. Kitchen will be examining  
26 on direct Dr. Gauthier.

1 MR. KITCHEN: All right. Well, Mr. Maxston,  
2 you're ready to proceed?

3 MR. MAXSTON: Yes, I am, thank you.

4 MR. KITCHEN: All right, Madam Clerk, could  
5 you please proceed to swear in Dr. Gauthier.

6 DR. JUSTIN ROBERT GEZA GAUTHER, Sworn, Examined by  
7 Mr. Kitchen

8 Q MR. KITCHEN: Good afternoon, Dr. Gauthier.  
9 Could you just please tell us your full name so we have  
10 it for the record?

11 A Sure, Justin Robert Geza Gauthier.

12 Q Thank you. And, Dr. Gauthier, do you practice in  
13 Alberta?

14 A Yes, I practice in Medicine Hat, Alberta.

15 Q And how long have you been practicing?

16 A About two-and-a-half years. I started in practice in  
17 Medicine Hat in March of 2019.

18 Q Thank you. And where did you go to school?

19 A Palmer College of Chiropractic down in Davenport, Iowa.

20 Q And can you tell us anything that sticks out to you  
21 that you were taught at Palmer College?

22 A Can you repeat that?

23 Q Is there anything you learned at Palmer College that  
24 was particularly important to you?

25 A They had a good balance of teaching chiropractic,  
26 integrating it within the medical system. I thought it



1        was a good balance of learning both sides of health.  
2        So talked about the importance of keeping a body in a  
3        frame, a structure, a spine that is balanced and in  
4        line, while understanding there's other issues that  
5        chiropractic does not deal with, and that's where we  
6        kind of work as a team with the medical system, so I  
7        thought it was a good balance of learning the health  
8        system.

9        Q    When you graduated and joined the profession here in  
10        Alberta, were there any principles that you thought  
11        were at the core of chiropractic?

12       A    I think first and foremost our job is to take care of  
13       the spine. That is the core of most chiropractors, and  
14       manipulation or adjusting of the spine is I was taught  
15       quite vital to the profession. There's many other  
16       things that chiropractors will do in addition, but  
17       adjusting and the spine was always the core primary  
18       treatment that chiropractors would give.

19       Q    And how do chiropractors administer that treatment?

20       A    In their office, you've got to assess that person's  
21       spine based on what you see, based on what you feel,  
22       based on the feedback from the patient. Most  
23       chiropractors adjust with their hands, some use an  
24       instrument or a tool, but it's essentially always,  
25       always with contact I guess.

26       Q    And what's the primary treatment that you provide your

1 patients?

2 A I practice an upper cervical technique, so I focus on  
3 correcting the neck as much as possible, so with my  
4 technique there won't be more cracking. If a patient  
5 needs that, I will have them go to another  
6 chiropractor, and so I adjust with the upper neck  
7 primarily, and it's a very low force technique without  
8 twisting or cracking.

9 Q Okay, and what do you use to do that?

10 A But -- it's all by hand, yeah, it's all using --  
11 adjusting by hand.

12 Q Now, forgive me if some of these questions are a bit  
13 obvious, but can you provide that treatment from a  
14 distance?

15 A I might lose my licence if I tried. I don't think it's  
16 possible to do it without actually contacting the  
17 patient. You can't -- I would not be able to properly  
18 assess them. I wouldn't be able to properly adjust  
19 them. I wouldn't reasonably be able to walk anybody  
20 through treating themselves that way or having another  
21 person treating them in that way, so, no, it wouldn't  
22 be possible with what I do.

23 Q And forgive the redundancy, but you wouldn't be able to  
24 provide that type of treatment over the phone?

25 A No. I've had a couple phone calls with patients as  
26 follow-ups a few days later if they're from out of

1 town, and they can't -- just to ensure after their  
2 first appointment that things are going well, and  
3 they're not experiencing any issues, a checkup over the  
4 phone, very, very seldom, less than since I've started  
5 practicing, but the primary treatment is always in  
6 person.

7 Q So do you think Telehealth could be effective for you  
8 to help your patients?

9 A No, no, not with what I do and not with how the  
10 chiropractic that I learned, you know, adjusting by  
11 hand as your primary treatment, I would argue it's not,  
12 it's not possible to do.

13 Q Do you think your patients would find it effective?

14 A No, I don't think I'd have any patients if I tried  
15 doing that.

16 Q Do you believe you would be properly caring for your  
17 patients if you could only provide Telehealth over the  
18 phone?

19 A No, not at all. I wouldn't be able to properly assess  
20 them. I wouldn't be able to feel or see what's going  
21 on, and there's many intangibles that you get from  
22 patients after you've seen them several times that,  
23 over the phone, you simply don't get that you'll see  
24 and hear when the patient is with you. So, no, I don't  
25 think there's any way I would be able to take care of  
26 patients to the same level that I am now, not even

1 close. I don't know what it would look like.

2 Q And if you could only provide Telehealth, you said  
3 earlier that you don't think you'd have very many  
4 patients, so what do you think your patients would do  
5 if you could only provide Telehealth?

6 A I think they would go to another chiropractor, either  
7 somebody in town that does maybe a different style, or  
8 they would travel a couple hours to find someone that  
9 does. I mean, that's what we have. I have a lot of  
10 patients that come from Saskatchewan, Swift Current,  
11 Moose Jaw, Regina from up to three, four, five hours  
12 away, and they specifically come here because they  
13 can't get what they want in those places, so they would  
14 find somewhere else to go. I'd lose probably over 95  
15 percent of my patients if I tried it. Maybe a hundred,  
16 I don't know. I would lose a very exceptionally high  
17 number of patients.

18 Q And forgive me if this question is a bit obvious, but  
19 if you did that, if you only did Telehealth, would you  
20 be able to earn enough income to keep practicing?

21 A I don't think so, not as I've learned to practice, not  
22 as I've learned to practice chiropractic, or as I've  
23 been practicing for the last two-and-a-half years. I  
24 mean if I lost 95 percent of my patients, I wouldn't  
25 have much income at all, so no.

26 Q I'm going take you in a slightly different direction

1           now.

2     A     Sure.

3     Q     Dr. Gauthier, are there different types of health care  
4           workers?

5     A     Yeah. Yes.

6     Q     Do you think there's a difference between yourself as a  
7           health care worker and so-called frontline health care  
8           workers like nurses and doctors at a hospital?

9     A     Yeah, I think we have very different roles and fulfil  
10          different needs, yeah.

11    Q     Do you regard your chiropractic office as a health care  
12          setting?

13    A     Yeah, it's a health care setting.

14    Q     Are there different types of health care settings?

15    A     Yeah, absolutely.

16    Q     Is there a difference between your office as a health  
17          care setting and a hospital as a health care setting?

18    A     Having been a patient in a hospital and a chiropractor  
19          in an office, it's my experience, yeah, they're very  
20          different.

21    Q     How so?

22    A     Mainly just the types of patients and the types of  
23          complaints that we get are very different, but I think  
24          (INDISCERNIBLE) ER specific, it's very acute care or  
25          injuries or accidents, whereas I've never  
26          (INDISCERNIBLE) driven to my office in an ambulance,

1 right? That's not the role of my office is to take  
2 care of people with their acute injuries that are more  
3 serious, and that's in regards to, say, physical  
4 injuries or bleeding, that type of issue.

5 In my couple of years practicing, I've never had a  
6 patient come with a primary (INDISCERNIBLE) of a heart  
7 attack --

8 THE COURT REPORTER: Primary what? Primary what?

9 A -- or come to me saying, Do I have a heart attack, or I  
10 feel like I am, can you examine me? I've never had a  
11 patient come, wondering if they're in the middle of a  
12 stroke. I've never had a complaint of stroke or heart  
13 attack. You know, I've had patients that I've sent to  
14 be assessed for stroke, but that's never been the  
15 primary complaint.

16 Same thing with pneumonia, bronchitis, or anything  
17 like that, I've never had a patient come to me, saying,  
18 Hey, I think I have pneumonia, can you help? I've  
19 never had that type of complaint, whereas in the ER,  
20 from what I've seen, that's a -- those are some of the  
21 more common complaints that ERs get.

22 Q Thank you.

23 (DISCUSSION OFF THE RECORD)

24 Q MR. KITCHEN: So, Dr. Gauthier, let me ask  
25 you this: Do you care about more than just the spine  
26 of your patients?

1     A     Yeah, of course.

2     Q     Give me an example; what are some of the things that  
3            you tend to care about when it comes to your patients?

4     A     So just one example, recently I had a patient who has a  
5            lot of pain and spine, like musculoskeletal issues, so  
6            we went through (INDISCERNIBLE). She's also been a  
7            smoker for 40 years and drinks, you know, five or six  
8            or seven drinks of alcohol per night. And so at our  
9            initial appointment, I said, Hey, like I can help you a  
10           certain amount I believe, but the reality is that if  
11           you continue, you know, smoking and drinking to this  
12           level, you're going to have a difficult time getting to  
13           your full potential, right; like there's a good chance  
14           you're always going to have some issues if you continue  
15           doing those things. It's not -- and I told her, it's  
16           not up to me to make you stop, it's not up to me to  
17           counsel you on how to stop, but to let you know it is  
18           going to prevent, you know, your energy levels, your  
19           fatigue, your immune system, your pain levels, all  
20           those things, and I said I'm happy to find, if you  
21           want, a counsellor to help with that, could be as  
22           simple as a health coach or something. But that was  
23           just somebody last week where I had to have that  
24           discussion with her; it was, you know, beyond what I  
25           could do, but I felt like if I didn't at least  
26           acknowledge those limitations for her, I wasn't doing

1 her justice by just saying, I'm going to help you with  
2 your spine and neck. So we had a discussion on that,  
3 and she was open to looking at other things, so that  
4 was one more recent example.

5 Q Do you care about the overall health of your patients  
6 then?

7 A Yeah. Yeah. Totally, because I mean -- I mean, you  
8 can see it in people when they're in physical pain, you  
9 can tell when people are in a stressful state. Another  
10 patient just last week was -- could tell was very -- in  
11 a lot of mental distress, and, you know, for a couple  
12 minutes, as I was treating her, she starts confessing  
13 to me about stress within her marriage and other issues  
14 that her concussion resulted in. You know, so I  
15 listened and said, Hey, like that's again more than  
16 what I do, and it's not my -- I'm not a marriage  
17 counsellor, but I'm happy to help you find somebody  
18 with that.

19 So, yeah, the emotional, the physical, the  
20 nutritional. Those are all important aspects of it  
21 that don't come up with every patient, but they do come  
22 up.

23 Q When it comes to treating your patients, are there any  
24 principles or ideals that guide you?

25 A Can you explain that a little bit or ...

26 Q Well, I can't too much or else Mr. Maxston will rightly



1 say that I'm leading you, so I'm just wondering if  
2 there's -- do you have any core ideas about the  
3 practice or core ideas about your approach to health or  
4 core principles when it comes to interacting with your  
5 patients that are really important to you as a  
6 practitioner?

7 A Sure, so I mean my primary view of patients is to view  
8 them as people, right, and to want to take care of them  
9 the best that I can, right, and that's not telling them  
10 what to do, not telling them what their treatment is,  
11 and allowing them to make that decision for themselves,  
12 and if they make a choice that I think is bad, that's  
13 their choice, but it doesn't mean I don't take care of  
14 them to the best of my ability, to treat those patients  
15 with respect regardless of whether I think what they're  
16 doing is good or not, they're still deserving that  
17 respect and love that I think we're supposed to have as  
18 health care providers.

19 So to me, that's kind of my core principle that  
20 guides me is to take care of people to the best of my  
21 ability without causing them harm and allowing them to  
22 make choices whether I think it's good or not.

23 Q So that allowing them to make choices then, is that,  
24 for you, is that the same idea as consent?

25 A Yeah, yeah, like they -- I can't force them to do  
26 something that has an impact on their health or

1 otherwise, and I can't do something to them that they  
2 don't want to. So if that day they came in, and they  
3 don't want me to adjust them for whatever reason, even  
4 if everything inside of me, everything that I'm seeing  
5 about them says they need to be adjusted, I don't  
6 adjust them, right, because that's their choice.

7 And if I think they shouldn't get a massage for  
8 the next day for whatever reason, but they choose to,  
9 that's their choice, and it's not going to affect how I  
10 take care of them. They've got to decide for  
11 themselves what they allow me to do and do at other  
12 times as well.

13 Q You mentioned something in your last answer to me about  
14 harm. Is it important to you to make sure you don't  
15 cause any harm to your patients?

16 A Oh, yeah, yeah, I mean if I'm causing more harm than  
17 good, (a), they're not going to come to me for very  
18 long, and (b), I'm not -- even if they did continue  
19 coming to me, I'm not doing my job as a health care  
20 provider to create an overall improvement in their  
21 health, right? So causing harm is a big part of that.

22 Q That's a good idea. All right, Dr. Gauthier, are you  
23 aware that the Alberta College of Chiropractors has  
24 mandated that all chiropractors must wear a mask when  
25 they're treating patients?

26 A Yes.

1 Q And have you worn a mask while treating patients when  
2 required to do so by the College?

3 A Yes.

4 Q Have you done so willingly?

5 A No, it's not been comfortable, but I still have done  
6 it.

7 Q And why do you do it even though you didn't want to?

8 A I mean, it was in our practice directive, right, so the  
9 way I understood it if I didn't, I wouldn't be able to  
10 take care of patients, so it was kind of a -- didn't  
11 really have a choice, a choice in that matter.

12 Q If you didn't have a choice for you, is that the same  
13 as saying you were coerced into doing it?

14 A Well, yeah, I mean if there's not (INDISCERNIBLE)  
15 choice for not doing something I'm supposed to do,  
16 then, yes, it's not a choice. It feels like that to a  
17 certain degree. Sorry, can you repeat that?

18 Q I think I said, to get it exactly right, for you -- is  
19 for you not having a choice in doing something, is that  
20 the same as coercion? And I believe your answer was  
21 yes, with some explanation, but you did break up so  
22 feel free to repeat it, if you can still hear me.

23 A I apologize James, I had a bad internet connection for  
24 a bit. Can you repeat that?

25 Q Yes.

26 THE COURT REPORTER: Did you want me to read it

1 back?

2 MR. KITCHEN: Madam Clerk, yes, because that  
3 way, I'm not slightly varying my question.

4 THE COURT REPORTER: (by reading)

5 Q If you didn't have a choice for you, is  
6 that the same as saying you were coerced  
7 into doing it?

8 A Sorry, can you repeat that, please?

9 THE COURT REPORTER: I'll give you more context if  
10 that helps. Is that okay, Mr. Kitchen?

11 MR. KITCHEN: That's fine, yeah.

12 THE COURT REPORTER: Okay, a series of questions  
13 and answers for you, Dr. Gauthier: (by reading)

14 Q And have you worn a mask while treating  
15 patients when required to do so by the  
16 College?

17 A Yes.

18 Q Have you done so willingly?

19 A Sorry, can we pause so I can try to (INDISCERNIBLE)  
20 different location?

21 MR. MAXSTON: Mr. Kitchen, this isn't my  
22 preference but -- because I'd like to see your witness  
23 when he testifies, but sometimes turning off the video  
24 can make it easier.

25 MR. KITCHEN: Yes, I was going to raise  
26 that, because I understand your position on that.

1 Q MR. KITCHEN: Dr. Gauthier, if you could  
2 turn off your video to see if that improves it, and  
3 then we can decide from there how we want to proceed,  
4 but we should just try it to see if it actually helps.  
5 Is that all right with you?

6 A Sure, so I've got my video off here. Is this sounding  
7 okay or not?

8 Q Sounding better so far. You let us know if you can  
9 hear us better.

10 MR. KITCHEN: Madam Court Reporter, do you  
11 mind reading my -- the first time I asked the question,  
12 if you could read it to Dr. Gauthier again and see if  
13 he's able to fully hear it and respond?

14 THE COURT REPORTER: (by reading)

15 Q If you didn't have a choice for you, is  
16 that the same as saying you were coerced  
17 into doing it?

18 A To me, it is, yeah, without a choice, it feels a  
19 certain amount like coercion, whether the consequences  
20 are severe or not. Yeah, when there isn't a choice, it  
21 feels like that, a certain amount, yeah.

22 MR. KITCHEN: Well, Mr. Maxston, it does  
23 seem to be a little better with his video off, but I'm  
24 sensitive to the fact that you want to be able to see the  
25 witness. Do we want to go back to having his video on,  
26 and then as needed, we'll (INDISCERNIBLE) the question?

1 MR. MAXSTON: Well, I'll ask Mr. Lawrence if  
2 he has any concerns, but I'm prepared, frankly, to go  
3 ahead without the video.

4 MR. LAWRENCE: I have no concerns.

5 THE CHAIR: I think, Mr. Kitchen, we could  
6 try having his audio through a cell phone, but let's  
7 continue with this option to see if this solves it,  
8 because I know there's synchronization problems when  
9 you have different audio and video links.

10 MR. KITCHEN: Okay, thank you.

11 Q MR. KITCHEN: All right, Dr. Gauthier, we're  
12 going to try it with the video off, see if that  
13 improves the audio. It does typically, so we'll go on  
14 that basis for now.

15 A Okay.

16 Q So thank you for your answer to my last question.

17 So let me ask you this because you said you don't  
18 wear the mask willingly, can you tell me what's  
19 difficult about wearing the mask for you or why don't  
20 you willingly wear it?

21 A Sure. So, yeah, I've got asthma, and it's --  
22 typically, it's pretty well controlled, I haven't  
23 really had issues with it over the years. I noticed  
24 shortly after needing to wear the mask, whenever it was  
25 in 2020, March or April, when we were supposed to wear  
26 them, not just at work, but, you know, in the hours and

1        days after working, I just noticed a lot more  
2        difficulty breathing. I just noticed, in general, my  
3        asthma flaring up considerably. It was hard to know  
4        first if it was the mask or whether -- there was a lot  
5        of variables, but that's kind of been the one constant  
6        was that.

7                And it definitely has been for me, the last  
8        year-and-a-half or so has been the worst -- the most  
9        difficulty I've had breathing in relation to, you know,  
10       asthmatic symptoms that I've had in, I don't know, at  
11       least ten years. I've gone through more inhalers than  
12       I had for a long time.

13               I notice especially at the initial appointment  
14       where there's more talking, because I spend a lot of  
15       time with patients, I was just getting short of breath  
16       much quicker. So I just had a lot of difficulty  
17       breathing, and I recognize not everybody feels that  
18       way, but, you know, with the way that my asthma has  
19       been, it's been difficult, yeah.

20    Q        Speaking now just for yourself --

21    A        Yeah.

22    Q        -- do you regard your asthma as a medical -- as a form  
23        of a medical disability?

24    A        Yeah, like I didn't really think of it like that, you  
25        know, until the last year or so when I recognized how  
26        limiting it's been, but, yeah, it's definitely caused

1 me some distress or dysfunction.

2 Q Are you aware that, due to human rights legislation in  
3 the Province, that there are sometimes obligations on  
4 parties to accommodate medical disabilities?

5 A Yes.

6 Q Have you ever asked the ACAC if they would accommodate  
7 you and your asthma medical disability?

8 A No, I haven't.

9 Q When the ACAC mandatory mask directive was issued to  
10 the Practice Pandemic Directive in the spring of 2020,  
11 did the College give you any reason to think that it  
12 would permit you to treat patients without wearing a  
13 mask if you told them about your medical disability and  
14 asked for accommodation?

15 A I honestly can't say I remember what I thought when I  
16 went through that first directive. For me, the reason  
17 I didn't ask I guess, from what I'm remembering, was  
18 that I got the impression that I just -- I wouldn't be  
19 able to treat patients whether I had an exemption or  
20 not, but, again, I can't -- I don't have that practice  
21 directive from that time memorized or remember it  
22 perfectly.

23 Q But what gave you the impression that the College  
24 wouldn't accommodate you?

25 A Well, in the directive, again from what I remember, it  
26 was very clear that wearing a mask was required no



1 matter what, so it didn't seem worth it to even try to  
2 get an exemption or ask about an exemption or, you  
3 know, go to a medical doctor over that.

4 Q Now, you've touched on this, but just to clarify --

5 A Yeah.

6 Q -- however small or however large, do you think wearing  
7 a mask the last year-and-a-half while treating patients  
8 has caused you any degree of harm?

9 A Yeah, I mean I think so. I've definitely noticed like  
10 just more restriction in general, having to wear the  
11 mask, you know, at work, because we're, you know, here  
12 lots of the time. Yeah, I find myself out of breath  
13 just talking to patients, which is not a normal  
14 experience for me. So I mean that combined with the  
15 fact that I've gone through more inhalers, you know,  
16 which I would much prefer not to do, yeah, it's  
17 definitely made -- just restricted my lung function.

18 Q Do you think informed consent should be obtained before  
19 someone requires somebody else to wear a mask?

20 A I do, because I think it has an impact on health. It  
21 doesn't necessarily impact everybody in health, but  
22 some people it does. I know many patients will say  
23 they hate wearing it because it restricts them; other  
24 patients say they don't care.

25 But I've seen that same principle at work in  
26 certain types of shoes, some people put on a pair of

1 shoes that cause them lots of foot and hip and knee  
2 pain, and other people put the same pair of shoes on,  
3 and it doesn't bother them whatsoever. So I've just --  
4 I've kind of come to realize that because something  
5 does not cause one person harm or discomfort doesn't  
6 mean it doesn't do that to another.

7 So because it impacts health, I mean I've noticed  
8 impact to my energy levels and fatigue and breathing,  
9 if it's going to be mandated or examined or pushed, I  
10 think it should be -- it is -- the idea of informed  
11 consent should be applicable to it as well, yeah.

12 Q Was informed consent obtained from you by the College?

13 A No, there was no questions or answers or anything about  
14 it. It was just part of the practice directive that we  
15 had to wear it if we wanted to keep treating patients.

16 Q You mentioned your patients commenting on masks, so  
17 have you noticed that, in some of your patients,  
18 wearing a mask has negatively impacted their health?

19 A Yeah, I've had a lot of patients mention it, and it's  
20 hard to know because there's -- again, there's so many  
21 variables, but many, many patients have mentioned just  
22 their general like energy levels or if it's fatigue,  
23 some of them have noticed headaches when they're  
24 wearing it. Some of them it's very acutely, they have  
25 symptoms within minutes of wearing a mask. When you  
26 see it so many times, and it's so strongly correlated

1 with certain patients, it's hard to deny it. Yeah,  
2 it's definitely come up.

3 And like I said, some patients don't notice a  
4 change at all, whereas some patients really do, and  
5 I -- I mean, I've had some patients develop skin rashes  
6 and, you know, acne-type issues. I myself, about three  
7 months into wearing a mask, ended up with quite a  
8 significant boil on my nose that I never had before.  
9 Again, is it attributable to the mask? Maybe, maybe  
10 not but it was definitely a very noticeable change  
11 shortly after starting to wear them.

12 Q I'm going to ask you some different questions now. Do  
13 you think it's possible, Dr. Gauthier, to actually know  
14 the scientific truth about things like viruses?

15 MR. MAXSTON: I'm going to have to object to  
16 that, Mr. Kitchen. This is a lay witness not being  
17 called for expert opinion evidence, and I think I've  
18 been pretty generous in the types of questions you've  
19 asked. You've got four experts coming. I am going to  
20 object to this, because I think this goes far afield of  
21 what this witness can testify to as a lay witness.

22 MR. KITCHEN: Okay, I understand what you're  
23 saying, and I agree with you. I haven't in any way  
24 asked for an opinion, but I think maybe if you'll let  
25 me go, you'll see I'm not going to ask his opinion on  
26 COVID or the effectiveness of lockdowns; he isn't

1       qualified to give that. I'm asking him if he thinks  
2       it's possible to know the scientific truth, not what  
3       that truth is, but if he thinks it's possible to know  
4       that truth, and that's not an opinion question; that's  
5       a question that could be asked to anyone.

6       MR. MAXSTON:                   I suppose, frankly -- well, I  
7       guess you can ask your question. I'm not sure what the  
8       value of it is, because you're right, I guess it's a  
9       possibility for everyone to know the truth, but I'll  
10      let you know if I'm concerned you're kind of heading  
11      off in the wrong direction.

12      MR. KITCHEN:                   Okay, thank you.

13   Q   MR. KITCHEN:                   So, Dr. Gauthier, let me ask  
14       you that again.

15   A   Sure.

16   Q   Is it possible -- speaking for yourself, right?

17   A   M-hm.

18   Q   From your perspective, is it possible to actually know  
19       the scientific truth about things like viruses?

20   A   Given time and observation and enough people and study,  
21       I think it's possible, yeah.

22   Q   Speaking for yourself, from your perspective, is there  
23       enough scientific information now available to you for  
24       you to determine if restrictions like masking and 2  
25       metres distancing are effective or not effective in  
26       preventing the transmission of COVID?

1 A Can you repeat that?

2 Q Sure. Is there enough scientific information now  
3 available to you for you to be able to make an  
4 assessment if restrictions like masking and distancing  
5 are actually effective or not at preventing the  
6 transmission of COVID?

7 A Well, I think there's quite a bit of evidence about  
8 those things that have come out in the last  
9 year-and-a-half. I mean, I have opinions on it, but,  
10 yeah, I do think there's a lot of information that's  
11 available to tell us how likely it is that they're  
12 helping or not.

13 Q And as far as you're concerned -- and, again, I don't  
14 want you to give me your opinion -- but for you --

15 A M-hm.

16 Q -- is there enough scientific information available for  
17 you to be able to make an assessment whether masking is  
18 working and should be supported or is not working and  
19 should be opposed?

20 A I think, yeah, there is a decent amount of evidence --  
21 there's a decent amount of evidence demonstrating --  
22 I've seen a decent amount of evidence demonstrating  
23 that they may not be working as well as we want them  
24 to. To say with a hundred percent certainty, I can't  
25 do that, but I think the evidence is there.

26 Q Do you think the mask mandate of the College is 100

1           percent based on science?

2     A     No.

3     Q     And if it's not 100 percent based on science, what do  
4           you think of the other things that it's also based on?

5     A     Do you mean what other -- what other ideas is it based  
6           on, or are you talking about like masking or -- like  
7           are you talking specifically of masking in that --

8     Q     If mandating masking is not 100 percent based on  
9           science --

10    A     M-hm.

11    Q     -- then what else do you think it's based on?

12    A     What is it based on, okay. So from my experience, a  
13           lot of the decision -- the decision especially with,  
14           say, patients and masks, they're not mandated to wear  
15           any particular kind, right? We know some masks are not  
16           very effective, some masks are a little more effective.  
17           So the masks that we're mandated to wear, the surgical  
18           or N95 have a little bit better use, still not great,  
19           but a little bit better.

20                 Whereas patients, they don't have to wear the  
21           masks properly. There could be gaps in it. They could  
22           be wearing a mask that filters out an extremely  
23           miniscule amount of, you know, viral particles. We  
24           know that the virus is, in many ways, say largely  
25           airborne in addition to other modes of transmission.  
26           And so when patients are coming in with all these

1 different kinds of masks that don't work, I know that  
2 it is not doing the job that it is supposed to, that we  
3 want it to, but we do it a certain amount out of fear  
4 or to say we're doing something; it's better to do  
5 something than nothing. So I'm not entirely sure  
6 what -- you know, what's driving that.

7 But when I look at, you know, what I see in the  
8 clinic specifically, if I stick to the workplace, what  
9 patients wear and what they're allowed to wear as per  
10 the mandate, it's doing very little to prevent -- if  
11 they did have COVID, right, if they were symptomatic  
12 for COVID -- or not symptomatic but had COVID. So  
13 there's the science part of it, but there's also maybe  
14 the optics part of it. We don't want to be afraid of  
15 doing something that is wrong, so we err on the side of  
16 caution, but, again, that's not necessarily a  
17 scientific debate, that's a, you know, say, ethical or  
18 moral thing.

19 So I know that's a long-winded answer, but, yeah,  
20 it's hard to know what it's based on when it's not a  
21 hundred percent on science.

22 Q Thank you. You mentioned fear, what do you think the  
23 fear is of?

24 MR. MAXSTON: Mr. Kitchen, I do have to  
25 object here formally. There's been a lot of  
26 information from this witness, and I know he's

1     responding to your questions, we're talking about what  
2     is or isn't effective in masking, what does or doesn't  
3     prevent COVID. Again, I think we're now going far  
4     afield. He can't speculate on fear; I don't know how  
5     he can comment on that. He's not a psychologist; he's  
6     not a public health provider. I'm going to have to  
7     object to this line of questioning. I just don't think  
8     it's appropriate for a lay witness. And I'll ask the  
9     Chair to, in concert with the Tribunal Members if  
10    necessary, make a ruling on that.

11   MR. KITCHEN:                   Well, Chair, I'd like him to  
12   be able to answer the question, so I guess I'll put it  
13   to you to make a ruling on that.

14   THE CHAIR:                    Would you repeat the question,  
15   please, Ms. Schumann.

16   THE COURT REPORTER: (by reading)

17         Q     You mentioned fear, what do you think the  
18               fear is of?

19   THE CHAIR:                    That's the question you wish a  
20   ruling on?

21   MR. KITCHEN:                   Yes, please.

22   THE CHAIR:                    Okay. We'll take a break for  
23   5 or 10 minutes and caucus and come back with an answer  
24   for you.

25   MR. KITCHEN:                   Thank you.

26   (ADJOURNMENT)



1 THE CHAIR: Okay, we're back in session.

2 The Hearing Tribunal has discussed the objection  
3 to the question, and we are going to sustain the  
4 objection. We feel this would be pure speculation on  
5 the part of this witness on what others fear, and we  
6 don't believe that's appropriate. We're also of the  
7 feeling that it's nonprobative, and it's not going to  
8 be helpful in terms of finding a ruling on this issue,  
9 so the objection is upheld.

10 MR. KITCHEN: Thank you.

11 Q MR. KITCHEN: Dr. Gauthier, just a couple  
12 more questions. Does the phrase "First, do no harm"  
13 mean anything to you?

14 A Yeah, that's our primary directive. It doesn't matter  
15 how much good we're doing, if we're, at the same time,  
16 harming in a small way or maybe outweighing the  
17 benefits, so, yeah, it's, to me, one of the most  
18 important aspects of health care.

19 Q When you say, "we", you said something about that's our  
20 primary directive; when you say "we", who are you  
21 referring to?

22 A I mean, I'm referring to chiropractors primarily, but I  
23 would apply it to all health care providers.

24 Q Do you think it should apply to health care regulatory  
25 bodies like the College of Chiropractors or College of  
26 Physicians?

1 A If something that's being mandated affects something in  
2 regards to health, then yes.

3 Q Do you think mandating masks aligns with the principle  
4 of "First, do no harm"?

5 A No, no, I don't, because, as I said before, it may not  
6 affect Person A negatively, but it may affect Person B  
7 negatively, and until each individual person is  
8 assessed, it's really difficult to know how it's going  
9 to affect those people. So, you know, it may be not  
10 doing harm to someone, but it might be doing harm to  
11 another, and the mandate is kind of a blanket  
12 treatment, so to speak, so I'm not sure it was  
13 considered or should be.

14 MR. KITCHEN: Those are all my questions.

15 THE CHAIR: Thank you, Mr. Kitchen.

16 Mr. Maxston, did you want a short break before you  
17 start?

18 MR. MAXSTON: You know, I don't think I need  
19 a break, but I just want to double-check with  
20 Mr. Lawrence. Can we maybe have 10 minutes?

21 THE CHAIR: Yes. It's -- let's reconvene,  
22 we might as well take a break now, and then we'll push  
23 through for the afternoon, so let's come back at 2:00.  
24 We'll close the hearing for now and be back at 2.

25 (ADJOURNMENT)

26 THE CHAIR: I think we're back in session,

1           and the floor is Mr. Maxston's for his  
2           cross-examination of Dr. Gauthier.

3           Mr. Maxston Cross-examines the Witness

4    Q   MR. MAXSTON:                    Good afternoon, Dr. Gauthier.  
5           I can't see you, but I'm assuming you can hear me and  
6           see me?

7    A   Yeah, as long as you're okay without the video for now,  
8           I am here.

9    Q   Yeah, that's just fine.   So I want to start --

10   A   Okay.

11   Q   -- off, Dr. Gauthier, with just some basic questions.  
12           I'm sure you'd agree with me that the College is the  
13           licensing and regulatory body for chiropractic in  
14           Alberta?

15   A   Yeah, that's correct.

16   Q   And you'd also agree with me that for you to become a  
17           regulated member of the College, you had to go to an  
18           approved educational institution like Palmer; there was  
19           a requirement for you to become a chiropractor; is that  
20           correct?

21   A   Correct.

22   Q   And would you also agree with me that in order to keep  
23           your licence as a chiropractor, you have to meet  
24           ongoing requirements that the College issues, like  
25           continuing competence, for example?

26   A   Yeah, those are all things that were laid out

1       beforehand, and, yeah, those were expectations I  
2       understood.

3       Q     So I want to ask you some questions in that context  
4       about your comments with my friend about the fact that  
5       the Pandemic Directive was coercion and that you  
6       were -- you had no choice but to comply with it, and  
7       I'm going to suggest to you, Dr. Gauthier, that  
8       something like mandatory continuing competence, you  
9       don't have any choice in that, do you?

10      A     Correct.

11      Q     But that isn't coercion, is it?

12      A     I think because it was something I knew, going into it,  
13       I do see it as a little different, but there is a  
14       difference between expectations and coercion; yeah,  
15       there is an expectation.

16      Q     I guess you knew what it was when you were going into  
17       it, but continuing competence changes over time,  
18       doesn't it, or can change over time?

19      A     Yeah, I can't comment on that. I imagine it can change  
20       a certain amount, but there is a limit to that change.  
21       I don't know what that would be.

22      Q     So if the College sends you a bill each year for \$250  
23       for your yearly practice permit, you don't have any  
24       choice about paying that, do you?

25      A     Correct.

26      Q     And having said that though, that isn't coercion, is

1       it; it's just something you have to do to be a member  
2       of the profession?

3     A    Yeah, that's correct.

4     Q    So when it comes to something like the Code of Ethics  
5       or the Standards of Practice that the College issues,  
6       you don't have a choice about whether to comply with  
7       them, do you?

8     A    No, there's -- no, there's not a choice in whether you  
9       comply with that, no.

10    Q    And I would, again, suggest to you that complying with  
11       the Code of Ethics or the Standards of Practice isn't  
12       coercion, it's just part of the responsibility of being  
13       a professional; would you agree with that?

14    A    Yes, yeah.

15    Q    You talked about -- with my friend, Mr. Kitchen, about  
16       the College not getting informed consent with you. I'm  
17       going to suggest to you that the concept of informed  
18       consent applies to a caregiver and a patient; isn't  
19       that correct?

20    A    I think it's correct with some caveats, I think. When  
21       there's -- when someone is doing something to you that  
22       has a direct impact on your health, I think they are,  
23       de facto, a care provider in that particular instance,  
24       so, yes, but I think there is a caveat in there.

25    Q    Well, let me ask you this: You're aware of the Chief  
26       Medical Officer of Health orders that have come out

1 from time to time in the pandemic requiring masking,  
2 for example, not just chiropractors but the public?

3 A Yeah, correct.

4 Q When the Chief Medical Officer of Health issues those  
5 orders, there is no requirement to get consent from  
6 anyone, is there?

7 A I don't know if there is or isn't by law. I think  
8 there largely hasn't been, but I don't know if there  
9 is, or I don't know what the legality is on that.

10 Q Would you agree with me that the primary purpose of the  
11 College, if you look at the Health Professions Act or  
12 otherwise, the primary purpose of the College of  
13 Chiropractors, like other colleges, medical colleges,  
14 healthcare colleges, is public protection?

15 A The primary goal?

16 Q Yeah.

17 A Again, I don't have that memorized, but I was kind of  
18 under the impression that the primary goal is  
19 protection of individual patients not necessarily the  
20 public, and I think there is a distinction there.

21 But --

22 Q Yeah, sorry, were you finished?

23 A Yes, yeah. I apologize.

24 Q Okay. You talked about, with my friend, Mr. Kitchen,  
25 you talked about the Do No Harm principle, and I think  
26 you said, when talking about masking, that it may not

1       affect Person A negatively, but it could affect  
2       Person B negatively, and it's difficult to know that.  
3       Would you agree with me, Dr. Gauthier, that regulators  
4       like the College can't assess individuals; they have to  
5       put in place general requirements for the profession?

6     A    I guess from a -- from like a fundamental standpoint,  
7       it would be very difficult to assess each individual  
8       person, but I think that would be the correct way to  
9       go. Whether they could or not, I can't speak to that.

10    Q    I'll just give you an example. You know, when we talk  
11       about the College's Standards of Practice for informed  
12       consent or charting, the College doesn't, of course,  
13       have to go out and poll patients and poll individual  
14       chiropractors when they create those kinds of  
15       directions, do they?

16    A    I'm not sure I understood what your question was there.

17    Q    Well, maybe I'll turn to a different aspect here. I  
18       take it your position is that where a college  
19       requirement, in your view, harms a patient, you can  
20       decide not to follow it; is that correct?

21    A    No, that's a pretty broad statement, so, no, I can't  
22       say I would agree to that.

23    Q    So is it fair to say then you think members of a  
24       profession can't selectively decide what requirements  
25       of their profession to follow and then not follow?

26    A    So if I'm looking at letter of the law, like to --

1        yeah, to try to explain it as well as I can, if our  
2        Alberta Human Rights Act says one thing and the College  
3        mandates another, I'm kind of put at a crossroads, and  
4        I'm put in kind of a lose/lose situation as a  
5        practitioner. And what I would do in each individual  
6        circumstance, I can't say. I mean, that's theoretical  
7        and projecting and subjective based on that time.

8                If the Human Rights Act says one thing and the law  
9        says one thing and the College says another, yeah, it  
10       puts it in a very difficult position, and then you do  
11       have to choose whether you are going to do what the law  
12       says or do what the College says, and I don't like that  
13       that happens -- or if -- I don't like that that could  
14       happen, but it, you know, logically could occur.

15    Q    Well, I guess, we'll leave the human rights legislation  
16       argument to a different day, but I think what I was  
17       driving at -- sorry, are you okay, can I continue?

18    A    Sure.

19    Q    What I was driving at is, in your discussions with  
20       Mr. Kitchen, you said that you don't believe the  
21       College's Pandemic Directive is valid; is that fair to  
22       say, and I should say masking?

23    A    No, I didn't say valid. I didn't -- I said I didn't --  
24       I wasn't convinced that it was based 100 percent on  
25       science. And I say that because science doesn't tell  
26       us what we should do; science tells us what will happen



1 or what most likely will happen with a given situation,  
2 but ethics and morals and politics look at what we  
3 should do in a given situation.

4 So to say it's a hundred percent based on science  
5 is not accurate, because science doesn't tell us what  
6 should happen; it tells us what might. I didn't say it  
7 wasn't valid; I said I didn't think it was a hundred  
8 percent based on science.

9 Q So is it fair to say that you do think it's valid?

10 MR. KITCHEN: Well, hold on, hold on. I  
11 mean, we can look at the record, but you didn't use  
12 that word or even a synonym for that word, so -- and,  
13 you know, he's already told you that -- he's already  
14 explained what he said, and it's totally different from  
15 his question, so I have an issue with that.

16 MR. MAXSTON: I guess, Mr. Kitchen, in his  
17 response, he said to me, I didn't say it was invalid,  
18 so I'd like to ask him whether he thinks it's valid. I  
19 think that's a reasonable question.

20 MR. KITCHEN: Well, okay, I guess my problem  
21 is is that's vague. That was relative to what? Valid  
22 legally, valid scientifically, valid (INDISCERNIBLE).  
23 If you could just qualify it, I think it would be okay.

24 MR. MAXSTON: Yeah, well, you know, fair  
25 enough, I guess it's his word, Mr. Kitchen, but, you  
26 know, I'll ask Dr. Gauthier.

1 Q MR. MAXSTON: Do you think the College's  
2 Pandemic Directive was valid in terms of you as a  
3 professional?

4 A Like valid like for what, what goals? Like do I think  
5 it was valid in terms was it like reasonable  
6 expectations for me, valid in terms of did it do the  
7 job of preventing infection? In what way do you mean?

8 Q Well, I'm going to take a different sort of approach on  
9 this, but I just want to go back and say, just to be  
10 clear, you didn't agree with the masking requirement  
11 the College issued; is that fair to say?

12 A For my particular situation, yeah, I found it pretty  
13 restricting, and I wish it was not a requirement for  
14 me, yeah.

15 Q And I think it went a little bit more than sort of, you  
16 know, you personally and your asthma condition, I think  
17 you said that you were concerned that there wasn't  
18 science that would support it; is that fair?

19 A Yeah, I think that's fair. I'm not -- I wasn't  
20 convinced that there was complete agreement as far as  
21 saying, Wear a mask, that the benefits were very  
22 obviously outweighing the risks for our particular  
23 setting. I'm not convinced that for our setting when  
24 there's other options like, you know -- not other  
25 options, but when there are other settings that can be  
26 more, say, an issue with this particular Coronavirus,

1       when I look at the type of patients, the screening that  
2       we do, I wasn't convinced that it was the best  
3       decision, yeah.

4     Q   Yeah, and that's kind of what I was getting at when I  
5       was going back to my questions that Mr. Kitchen --

6     A   Okay.

7     Q   -- objected to. I just wanted to kind of establish  
8       here that you had a personal/medical/scientific  
9       objection, I guess, to the application of the  
10      directive. What I think is important here though is  
11      despite your concerns about the science or your medical  
12      condition, your personal views, you still chose to  
13      follow the masking directive; that's correct?

14    A   Yeah, because for my situation, I didn't see any other  
15      option.

16    Q   And you're aware that Dr. Wall did not follow the  
17      Pandemic Directive in terms of masking?

18    A   I don't -- yeah, I don't know on the details, I don't  
19      know if he had an exemption or not, but -- or if that  
20      matters, but, yeah, it sounds like he wasn't doing it,  
21      and that was kind of how he chose to go about it, I  
22      guess.

23      THE CHAIR:                   Dr. Gauthier, are you moving  
24      away from your microphone, because your voice is fading  
25      and then coming back in.

26    A   Okay, I apologize. No, I wasn't moving, but I'll try

1 to sit maybe closer, more still.

2 MR. MAXSTON: Mr. Kitchen, I hope you'll  
3 just allow me a little bit of latitude here, I'll just  
4 go back.

5 Q MR. MAXSTON: And my question to you,  
6 Dr. Gauthier, was you were aware that, unlike yourself,  
7 Dr. Wall did not comply with the masking Pandemic  
8 Directive requirements from the College; is that  
9 correct?

10 A I was aware he had -- he was not wearing the mask while  
11 treating patients, yes.

12 Q And I think it's fair to say, would you agree, that you  
13 ultimately concluded you could not disregard your  
14 regulatory bodies or your College's direction; is that  
15 correct?

16 A Yeah, because when I looked at the risk and the  
17 benefits, I was still able to function, albeit at a  
18 lower level; say, you know, as far as headaches and  
19 fatigue and breathing and energy, I was able to  
20 function. So my circumstance, it was not worth it to  
21 not comply even though I didn't want to. But, again,  
22 everybody has to weigh that themselves, and that was  
23 the conclusion that I ultimately came to for me.

24 Q I think this will be my final question. When you say  
25 so each person or everyone has to weigh that for  
26 themselves, do you think, again, a member of a

1       profession can decide what requirements of his or her  
2       college they have to follow and what ones they don't?

3       MR. KITCHEN:                   Hold on. My only issue with  
4       that is just it requires a qualification. I mean, are  
5       you asking legally, or are you asking practically,  
6       ethically?

7       MR. MAXSTON:                  I'll just say ethically, and  
8       I'll repeat the question.

9       Q   MR. MAXSTON:              But as a professional, do you  
10       think that members of a profession can decide what they  
11       will and won't follow from their college?

12       A   So, I mean, since you qualified it as "ethically", I  
13       mean I would say no. If the College mandated that I  
14       could only -- and, again, this is very theoretical,  
15       because when you're dealing with ethics and morals, it  
16       is largely theoretical -- if the College mandated I was  
17       only allowed to care for males or only care for females  
18       or only care for a certain person, I would have to look  
19       at that ethically and say that's wrong. And I do  
20       believe it's up to the individuals to say, ethically,  
21       what is correct and incorrect, and if there's something  
22       they believe is wrong, then they should not be forced  
23       to go through with doing something they believe is  
24       incorrect.

25       Q   If you think you have a concern or a problem with  
26       following one of your College's requirements, do you

1 think you have to talk to the College about that?

2 A Yeah, I mean especially depending -- in most  
3 circumstances, probably, yeah.

4 Q I'm going to go back to your example, but if you  
5 decided that, boy, my asthma is so bad or my objections  
6 to the directive are -- you know, my science-based  
7 objections are so significant, would it --

8 A M-hm.

9 Q -- be fair to say before you disregard the or not  
10 comply with the directive, you should reach out to your  
11 college and try and explore options?

12 A I think, again, that depends like on how -- like I'd  
13 have to go back to the mandate and look at it and  
14 compare that to what we are supposed to do or what is  
15 allowable, and from a human rights perspective, if my  
16 understanding -- like if I was in that situation and my  
17 understanding was that if there was an exemption,  
18 whether it had to be official or if my understanding  
19 was that an exemption was just a health condition, and  
20 I didn't require any sort of note, if I was under  
21 the -- under the -- if I was with the understanding  
22 that I had a legal exemption to following the mandate,  
23 I don't know that I would first think to ask the  
24 College about that if the mandate said to me exemptions  
25 are allowed or if the mandate said to me you have to  
26 wear a mask but then the law says you don't have to

1 with an exemption, it probably wouldn't be my first  
2 instinct to ask the College if it's seems clear that  
3 there are exceptions to that rule, so --

4 Q I just want to -- oh, sorry.

5 A No, no, that's okay, go ahead.

6 Q So I just want to understand that if you think you've  
7 got a legal exemption to a College requirement, you  
8 don't have to let the College know that you're not  
9 going to follow it?

10 A No, I don't know that. I'm saying so in this  
11 situation, if the mandate said that we have to wear --  
12 again, I'd have to go back and look at that mandate  
13 from April 2020 or whatever it was, then if that  
14 mandate said that we had to wear masks, but then I also  
15 look at the law and the legality within the Human  
16 Rights Commission, as one example, and if the Alberta  
17 Human Rights Commission says you do not have to wear a  
18 mask with an exemption, then I would look at that and  
19 say that makes sense to me that I would not have to.

20 And if it was clear enough to me that I didn't  
21 have to, I don't know that it would be my first  
22 instinct to ask the College if the law seems very  
23 clear. I can't speak to every circumstance, and I  
24 can't speak to every issue, but on that particular  
25 issue, if my interpretation was the law, it was that --  
26 was in that way, I don't know that I would ask for

1 permission --

2 Q So last year when the directive came out, and --

3 A M-hm.

4 Q -- I'm going to assume for the moment, you didn't have  
5 a Human Rights Commission ruling --

6 A M-hm.

7 Q -- you know, about your condition, you decided --

8 A M-hm.

9 Q -- to follow the Pandemic Directive with reluctance?

10 A Yeah, because in my case, again, it was -- you know, it  
11 takes effort if I want to go that route. Say, if I  
12 thought I needed an exemption, you hear through doctors  
13 and patients that doctors are not really writing  
14 exemptions, maybe I have to go see a specialist,  
15 fitting that into my schedule; there's just a lot of  
16 barriers to doing that, time being one of them.

17 And at that time, with the amount of negative I  
18 experienced with a mask, it wasn't worth it for me at  
19 that time. If it was worse, say I noticed significant  
20 headaches, or if I noticed I was having significant  
21 issues breathing, then it would have been worth it for  
22 me to go and get an exemption and deal with that in  
23 that way, but in my situation, it wasn't.

24 Q I just have one final question for you, Mr. Kitchen and  
25 you engaged in a discussion about how the Pandemic  
26 Directive was created and your concerns I think about



1           whether there were other elements that went into the  
2           creation of it other than perhaps science; you don't  
3           have any direct knowledge of how the Pandemic Directive  
4           was created or on what basis it was created, do you?

5     A     No.

6           MR. MAXSTON:                   Those are all my questions.

7           Thank you, Dr. Gauthier.

8     A     Thank you.

9           THE CHAIR:                   Can I just remind everybody,  
10          we're picking up a lot of paper shuffling from the  
11          microphones, so if you're not involved in an exchange  
12          or a discussion, please mute. It's getting  
13          distracting.

14          Thank you, Mr. Maxston. Mr. Kitchen, anything on  
15          redirect?

16          MR. KITCHEN:                   No.

17          THE CHAIR:                   Okay, any of the Panel Members  
18          have a question? I would actually like to caucus with  
19          the Hearing Tribunal for a moment. There may be a  
20          question, so if you could bear with us. We would like  
21          to go into our break-out room, please, Ms. Nelson.

22          (ADJOURNMENT)

23          The Chair Questions the Witness

24     Q     THE CHAIR:                   There's one question that came  
25           up, Dr. Gauthier, Mr. Maxston referred to getting an  
26           exemption, but the Hearing Tribunal wanted to ask you

1       if you did go to the trouble and time and effort to get  
2       an exemption, what would you do with it?

3     A    What would I do with the exemption?

4     Q    Yes.

5     A    Well, I mean if my health was being compromised enough  
6       that I felt like it was wronging me and I couldn't  
7       practice, I would have that exemption, and I suppose I  
8       would use it as much as possible, as much as I felt was  
9       needed. Anything with health is -- I guess I'm not  
10      sure what you mean.

11    Q    Would you feel the need to provide that exemption to  
12       anybody? How would people know if you had an  
13       exemption?

14    A    I don't know that -- I mean -- by law, I don't know if  
15       they're required to know. I don't know that I would  
16       take it that far, because I'm not necessarily that kind  
17       of person that, you know, says, Oh, it's my freedom and  
18       my right, and this is the law, so I'm going to go by  
19       letter of the law. I think if patients ask, I would  
20       have no problem providing that exemption even if  
21       they're not -- even if I'm not obligated to do so.

22       THE CHAIR:                    Okay, that's fine. Thank you,  
23       Dr. Gauthier.

24    A    Okay.

25       THE CHAIR:                    I believe that that's the end  
26       of your testimony with us this afternoon. Thank you

1           for coming in, and you are free to leave, sir.

2    A    Thank you very much.   Have a good afternoon.

3           THE CHAIR:                    You too.

4           (WITNESS STANDS DOWN)

5           Discussion

6           THE CHAIR:                    Mr. Kitchen, do we have  
7           another witness coming today or is --

8           MR. KITCHEN:                  I don't believe so.   Like I  
9           said, I wanted to have -- yeah, no, Mr. Elvin Music has  
10          told me he's still stuck at work, so either we won't be  
11          calling that witness or we will try to fit him in  
12          during one of the days scheduled for the scientific  
13          experts.

14          THE CHAIR:                    Okay, with that in mind,  
15          perhaps I could ask you and Mr. Maxston what the agenda  
16          for Saturday will look like.

17          MR. KITCHEN:                  So I'm calling two witnesses,  
18          Chris Schaefer is first, Dr. Bao Dang is second.   Based  
19          on history, I thought it was ambitious to even try to  
20          get those two in during that day.   What I'm hoping is  
21          that we can get through Chris Schaefer in the morning.  
22          His report's pretty small.   Obviously, that depends on  
23          how much he talks and Mr. Maxston crosses, but,  
24          ideally, we would get through that in the morning; that  
25          would leave the entire afternoon for Dr. Dang, and  
26          again, ideally, we would, you know, in

1 three-and-a-half, four hours, we would get through  
2 Dr. Dang. I think that's realistic, but based on  
3 history, we might not finish, but that's what I have  
4 set up is to have those two called that day with the  
5 idea that we actually fill the day but don't overflow.

6 THE CHAIR: Any comment, Mr. Maxston?

7 MR. MAXSTON: No, I think that's a fair  
8 assessment. I don't -- my sense is that I will not be  
9 as long with Dr. Dang or Mr. Schaefer as I was in my  
10 direct with Dr. Hu, so I think we'll just make as much  
11 progress as we can that day, and as Mr. Kitchen said,  
12 hopefully we can finish both of those witnesses on  
13 Saturday.

14 THE CHAIR: And that will be the closing  
15 of your case then; we can move on to arguments in  
16 January; is that correct?

17 MR. KITCHEN: No, so January 28th and 29th  
18 are reserved for Dr. Thomas Warren and Dr. Byram  
19 Bridle.

20 THE CHAIR: Okay.

21 MR. KITCHEN: Both of those reports are  
22 quite extensive. I do expect to be quite a long time  
23 with both of them. I know from experience that  
24 Dr. Bridle is a talker like Dr. Hu, so Dr. Hu took a  
25 whole day, spread out over two, but took a whole day,  
26 so what I've done is I've asked for those two days on

1 the basis that I doubt it would take less than a day to  
2 do either of those witnesses, so that's why I've  
3 scheduled those two days with those two witnesses. So  
4 after the 29th of January, then Dr. Wall's case is in,  
5 we're done with the evidence, and we would move on to  
6 closing statements.

7 THE CHAIR: Okay, so we will need to book  
8 some more time after the 28th and 29th?

9 MR. KITCHEN: Yes.

10 THE CHAIR: Perhaps we can give that some  
11 thought and maybe talk about that on Saturday if we  
12 have a few minutes. It's just getting so hard to  
13 accommodate people's schedules; if we can do it with a  
14 little notice, it would be helpful.

15 MR. KITCHEN: Well, closing statements are  
16 easy because it's only Mr. Maxston and I and probably  
17 Mr. Lawrence, so that should be -- I mean, I'm  
18 certainly very flexible. I actually don't have any  
19 commitments yet in February and March, so if we can do  
20 closing, you know, within three or four weeks of  
21 January 29th so that we have the transcripts, that  
22 seems to me to be a good way to move this forward.

23 THE CHAIR: Okay, well, we can talk more  
24 about that, the scheduling, on Saturday, but I guess,  
25 on that basis, that will conclude things for today,  
26 unless there's anything anybody else would like to

1 bring up at this time. Mr. Maxston, do you have  
2 anything?

3 MR. MAXSTON: No, I don't, thank you.

4 THE CHAIR: Okay. All right, then we will  
5 adjourn the hearing for today. We will reconvene at --  
6 what time is your witness coming on Saturday,  
7 Mr. Kitchen?

8 MR. KITCHEN: 9 AM.

9 THE CHAIR: 9 AM, okay. We will reconvene  
10 on Saturday, November 20th, at 9 AM and plan to have a  
11 full day, I think.

12 MR. KITCHEN: Yes.

13 MR. MAXSTON: Mr. Chair, just before we  
14 break, I wonder if I can ask Amber to put Mr. Lawrence  
15 and I in a break-out room. I don't know if we have  
16 anything to chat about, but I wouldn't mind just a  
17 brief chance just to chat with him.

18 MS. NELSON: Yeah, I can do that for you.

19 THE CHAIR: And, Ms. Nelson, if you could  
20 do the same with the Hearing Tribunal and Mr. Pavlic,  
21 we would like to caucus for a few minutes.

22 Thank you everybody. We will see you on Saturday.

23 MR. KITCHEN: Thank you.

24

25 PROCEEDINGS ADJOURNED UNTIL 9:00 AM, NOVEMBER 20, 2021

26

1 CERTIFICATE OF TRANSCRIPT:

2

3 I, Karoline Schumann, certify that the foregoing  
4 pages are a complete and accurate transcript of the  
5 proceedings, taken down by me in shorthand and  
6 transcribed from my shorthand notes to the best of my  
7 skill and ability.

8 Dated at the City of Calgary, Province of Alberta,  
9 this 1st day of December, 2021.

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Karoline Schumann, CSR(A)

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Official Court Reporter

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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

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DISCIPLINARY HEARING

VOLUME 6

VIA VIDEOCONFERENCE

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Edmonton, Alberta

November 20, 2021

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## EXHIBITS

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

4

5 November 20, 2021 Morning Session

6

7 HEARING TRIBUNAL

8 J. Lees Tribunal Chair

9 W. Pavlic Internal Legal Counsel

10 Dr. L. Aldcorn ACAC Registered Member

11 Dr. D. Martens ACAC Registered Member

12 D. Dawson Public Member

13 A. Nelson ACAC Hearings Director

14

15 ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

16 B.E. Maxston, QC ACAC Legal Counsel

17

18 FOR DR. CURTIS WALL

19 J.S.M. Kitchen Legal Counsel

20

21 K. Schumann, CSR(A) Official Court Reporter

22

23 (PROCEEDINGS COMMENCED AT 9:16 AM)

24 THE CHAIR: This is continuation of the

25 Hearing Tribunal for Dr. Wall is back in session.

26 And Ms. Nelson does have your witness in the

1        waiting room and is prepared to bring him into the  
2        meeting, Mr. Kitchen, so I'll turn the floor over to  
3        you.

4        MR. KITCHEN:                    Good morning, Mr. Schaefer,  
5        can you hear us?

6        THE WITNESS:                    Yes, good morning.

7        MR. KITCHEN:                    Excellent. Are you able at  
8        all to tip your camera down about -- yeah, perfect,  
9        there you go, excellent.

10       All right, so, Mr. Schaefer, the first thing we're  
11       going to do is we're going to swear you in, and  
12       Karoline, our court reporter, is going to do that, and  
13       once she does that, then we'll get into the  
14       questioning.

15       THE WITNESS:                    Sounds good.

16       CHRIS SCHAEFER, Sworn, Examined by Mr. Kitchen  
17       (Qualification)

18       MR. KITCHEN:                    So, Mr. Chair, I'm going to  
19       start with some qualification questions. As you'll  
20       know from my end the other day, there was consent  
21       between the parties on the qualification of the next  
22       witness but not on this one, so I'm going to run  
23       through some questions and then propose a qualification  
24       to you, and then, of course, Mr. Maxston will have some  
25       opportunity to make some comments.

26       Q       MR. KITCHEN:                    Mr. Schaefer, the first thing

1 I'll start with is what's your current occupation?

2 A My current occupation is as an Occupational Health and  
3 Safety consultant. I have been doing that now for  
4 quite a number of years. Since 2004, I've had my own  
5 company, but I've been working in Occupational Health  
6 and Safety as a consultant since 1994.

7 Q Okay, thank you. Now, you said "consulting", what are  
8 the types of things you consult on?

9 A Well, I consult on all aspects of Occupational Health  
10 and Safety training. Primarily what I do is one of my  
11 specialties is respirator fit testing and training. So  
12 respirator fit testing and training that I would  
13 consult on would be for any atmospheric hazard from  
14 anything that would require the most basic level of  
15 respiratory protection all the way up to and including  
16 respiratory protection for emergency responders like a  
17 self-contained breathing apparatus, both closed- and  
18 open-circuit systems.

19 Q And do you teach any courses on respirators or how they  
20 fit?

21 A Yes, I do. I do teach a course, a course on respirator  
22 fit testing and training, and I have been teaching that  
23 course as an advisor to the University of Alberta  
24 Faculties of Medicine and Dentistry for several years,  
25 as well as private clients.

26 Q I just want to -- on your résumé, you've got a long

1 list of certifications, I don't want to bring you  
2 through all of them, but I'll just ask you about a  
3 couple of them. One is a CSA respirator training and  
4 fit testing instructor. Can you tell me about that  
5 certification?

6 A Sure. CSA, if you're not already aware, is equipment  
7 certification, and they do have their own standards for  
8 equipment certification. So CSA stands for the  
9 Canadian Standards Association, and if you have ever  
10 worked in an industrial environment, from a very basic  
11 perspective, you would know that CSA does the approvals  
12 for basic safety equipment like steel-toed boots, hard  
13 hats, and safety glasses, among many others, but those  
14 would be probably basic ones that you would be aware  
15 of, and CSA is the certification body for the standards  
16 set for the safety of that equipment and others as  
17 well.

18 So as the course for CSA goes, it's a course that  
19 is within the standards of the use of that equipment  
20 through the Canadian Standards Association.

21 Q Thank you. I see also hazmat instructor. Now, I think  
22 I know what hazmat is, but could you please tell me  
23 what that's all about?

24 A Hazmat is hazards materials and training. So for  
25 people that go into high-risk situations like  
26 biohazardous environments, they need specialized

1 training and specialized equipment, because there is a  
2 lot of chemicals, vapours, and gases and even  
3 particulates that are very small, and those can  
4 penetrate through basically any part of your body.

5 So with hazmat training, it's all about, the  
6 basics are, is you've got to have full containment,  
7 you've got to have full encapsulation of workers or  
8 responders, and they have to be provided for any  
9 potential exposure through either inhalation or skin  
10 absorption of contaminants that could negatively affect  
11 their health.

12 Q Thank you. And just one more, right under that, you  
13 have "H2S alive instructor". Can you tell me what the  
14 H2S alive thing is?

15 A Yes, absolutely. H2S is the chemical formula for  
16 hydrogen sulphide gas. Hydrogen sulphide gas is a  
17 common detriment to oil and gas workers for --  
18 primarily in Western Canada. We see our highest levels  
19 of hydrogen sulphide gas in Western Canada oil fields,  
20 so that is a course that is required for anybody that  
21 works in oil and gas situations that they have that  
22 course so that they know how to protect themselves and  
23 also respond to help others in the event of unintended  
24 or accidental hydrogen sulphide release or exposure.

25 Q All right, thank you. So if I understand this, I don't  
26 think I do, the 'S' stands for sulphide. I'm curious,

1 in your line of work, have you dealt with issues around  
2 carbon dioxide?

3 A Yes, absolutely.

4 Q Have you dealt with issues around oxygen in the air?

5 A Always, always. Yeah, you know, having a safe amount  
6 of oxygen in air is pretty essential to personal  
7 safety, so that's definitely a big part of my whole  
8 career.

9 Q And are you familiar with the Occupational Health and  
10 Safety legislation?

11 A M-hm, yes, I am.

12 Q Thank you. Is that something you commonly work with?

13 A You know, it depends on the course that I'm offering  
14 and the training that I'm offering, but, yeah,  
15 absolutely. Atmospheric hazards are a big, huge  
16 component of Occupational Health and Safety.

17 Q Have you done any testing on the cloth or nonmedical  
18 masks that have been commonly used to try and prevent  
19 the spread of COVID?

20 A Yes, I have.

21 Q Have you done any testing on the medical or procedural  
22 or surgical masks that have been commonly used to try  
23 and prevent the spread of COVID?

24 A Yes, I have.

25 Q Thank you.

26 MR. KITCHEN: Well, Mr. Chair, I'm going to

1 read out for you -- those are all my questions on  
2 qualification -- I'm going to read out what I'd like to  
3 have Mr. Schaefer qualified as. I'd like to have  
4 Mr. Schaefer qualified as an expert in the area of  
5 Occupational Health and Safety, in particular, all  
6 types of respirator masks, including the medical and  
7 nonmedical masks used to attempt to prevent the  
8 transmission of COVID-19. And, of course, I --

9 THE CHAIR: Can you just read that one  
10 more time, please?

11 MR. KITCHEN: Sure. I'd like to have  
12 Mr. Chris Schaefer qualified as an expert in the area  
13 of Occupational Health and Safety, in particular, all  
14 types of respirator masks, including the medical and  
15 nonmedical masks used to attempt to prevent the  
16 transmission of COVID-19.

17 THE CHAIR: Mr. Maxston, did you wish to  
18 comment before we --

19 MR. MAXSTON: I have I think two brief  
20 questions for Mr. Schaefer, and then my friend is aware  
21 of this, I've got a few comments about the  
22 qualification that's being tendered, so I'll just ask  
23 my questions briefly.

24 Mr. Maxston Cross-examines the Witness (Qualification)

25 Q MR. MAXSTON: Good morning, Mr. Schaefer.

26 A Good morning.



1 Q My two questions for you are this: I'm looking at the  
2 bottom of page 2 of your cv, and it talks about, you  
3 say, "Associations: Member of Alberta College of  
4 Paramedics"; are you still a regulated member of the  
5 Alberta College of Paramedics?

6 A No, I am not, but that is a -- that is a course that I  
7 had -- that is a -- sorry, that is a membership that I  
8 had a couple years ago. I had completed the Alberta  
9 College of Paramedic program as far as the emergency  
10 medical responder is concerned, and I did have that  
11 membership, yes.

12 Q Forgive me for not quite understanding this then, were  
13 you a regulated member of the Alberta College of  
14 Paramedics, so you could practice as a paramedic, or  
15 had --

16 A Yes --

17 Q -- just taken the --

18 A -- yes, I was --

19 Q -- courses --

20 A -- yes, I was. I was an actual member of the Alberta  
21 College of Paramedics, registered through the course  
22 that I had taken, so I had specific registration by  
23 completing exams with the Alberta College of Paramedics  
24 to practice as a medic within Alberta.

25 Q Sure, and I --

26 A So I was definitely registered.

1 Q And how long were you a regulated member of the Alberta  
2 College of Paramedics?

3 A One year.

4 Q And do you recall your designation, or were you an  
5 advanced care paramedic, primary care paramedic, EMT,  
6 EM -- you know, do you recall the designation that you  
7 were in?

8 A Of course. EMR, emergency medical responder.

9 Q And you can correct me if I'm wrong, but I think "EMR"  
10 is -- I think there's three designations; the first is  
11 advanced care paramedic, then there's primary care  
12 paramedic, and then there's the designation you were  
13 in, which is EMR; is that correct, to your  
14 understanding?

15 A That's absolutely correct, yes.

16 Q And, I'm sorry, you said you were an EMR for one year  
17 with the College?

18 A Yes.

19 Q Okay.

20 MR. MAXSTON: Those are all my questions,  
21 Mr. Chair, for the witness. I wonder if I might  
22 provide some responses to the qualification that  
23 Mr. Kitchen has tendered.

24 THE CHAIR: Okay.

25 Discussion

26 MR. MAXSTON: My friend will rightly point

1 out to you that I could make these same comments during  
2 my closing statement, and I made them during the  
3 opening statement, but I just want to reiterate the  
4 Complaints Director's position this is not a question  
5 of the efficacy of masking in this hearing, it's about  
6 compliance with regulatory responsibilities. We'll  
7 review that in greater detail. You can, of course,  
8 accept evidence in whatever manner you see fit. The  
9 Complaints Director maintains his position that this  
10 type of evidence should be given little weight in terms  
11 of the charges that are in front of you.

12 I do want to mention that the College anticipated  
13 that Mr. Schaefer's testimony would be confined or  
14 largely confined to the question of surgical or  
15 procedure masks that are set out in the Pandemic  
16 Directive, and, of course, the College does not have  
17 any ability to regulate or control the types of masks  
18 that members of the public wear. So I think the  
19 qualification that's been tendered is perhaps a little  
20 bit broad in terms of it referring to all types of  
21 respirator masks, so I have a little concern in that  
22 regard -- have a concern in that regard.

23 And I'll just, for reference sake, I just want to  
24 remind the Tribunal of some comments that were made by  
25 Mr. Kitchen during the qualification -- pardon me, the  
26 preliminary application that occurred in terms of

1     whether Mr. Schaefer could be called at all as an  
2     expert witness, and you'll recall we objected to that,  
3     and you made a ruling that you would allow  
4     Mr. Schaefer.

5             And just very briefly, this is on page 55 of the  
6     transcripts, this is my friend commenting on what  
7     Mr. Schaefer will be called to testify about: (as  
8     read)

9             It should be quite obvious that this report  
10            [meaning Mr. Schaefer's] deals with a  
11            different subject than Dr. Wall's other three  
12            experts. The other three experts are various  
13            scientists and medical doctors ... They are  
14            all dealing with COVID-19; they're dealing  
15            with the SARS-CoV-2 virus. They're not  
16            dealing with whether or not masks are  
17            harmful. Certainly not in a specific sense  
18            that Chris Schaefer is doing, that being  
19            oxygen levels and carbon dioxide ...

20            The effectiveness of masks is a different  
21            subject from the harms of masks.

22            And a few pages later, you made a ruling that  
23            Mr. Schaefer can testify. So my client's clear  
24            expectation is that Mr. Schaefer's testimony will be  
25            confined to, again, the harms of masks, not the science  
26            related to COVID or transmissibility or anything along

1     those lines.

2             So Mr. Kitchen has been scribbling, and I'm sure  
3     may want to made some response comments to what I said,  
4     but again I think it's important to remember the basis  
5     on which this witness was offered initially when we had  
6     our preliminary application on that, and I think it's  
7     very important for Mr. Schaefer's comments to be  
8     confined to the question of the harm of masks and  
9     nothing more. Thank you, Mr. Chair.

10    MR. KITCHEN:                   Mr. Chair, if I could, just a  
11    couple comments in response.

12    THE CHAIR:                    Yeah.

13    MR. KITCHEN:                   First, the reason I say all  
14    types of respirator masks is because, well, that's just  
15    the reality; that's what Mr. Schaefer has dealt with in  
16    his line of work. And I'm a little surprised to hear  
17    that the Complaints Director didn't anticipate evidence  
18    about nonmedical masks in addition to medical, as, of  
19    course, you'll see in the first paragraph of  
20    Mr. Schaefer's report, it talks about the different  
21    kinds of masks, and so it's a little surprising.

22             But the reason that I've asked inclusion of cloth  
23    masks is -- or nonmedical masks is because that's a  
24    reality of what we're dealing with, and that's what  
25    Mr. Schaefer has dealt with, and those aren't  
26    dramatically different, they're very similar, and so I

1 don't think that scope is too broad, I don't think it's  
2 inappropriately broad, I don't think it's irrelevantly  
3 broad. So I would ask that he not be limited to talk  
4 about medical masks but also be permitted to talk about  
5 nonmedical or cloth masks.

6 And, of course, I have no issue with my friend's  
7 comments about being limited to talk about the harms of  
8 masks and not the efficacy. We won't have any  
9 questions about that, so it's just the harms of masks,  
10 but when I say "masks", I mean medical and nonmedical.  
11 Those are all my submissions in response.

12 THE CHAIR: Thank you. I think we'll take  
13 a short break while the Hearing Tribunal caucuses to  
14 give you an answer to your request, Mr. Kitchen. So if  
15 we could be moved to a break-out room. Hopefully this  
16 won't take very long. Thank you.

17 MR. KITCHEN: Thank you.

18 (ADJOURNMENT)

19 THE CHAIR: Okay, we're back in session,  
20 and the Hearing Tribunal discussed your request,  
21 Mr. Kitchen, and we have one question for Mr. Maxston,  
22 and we wanted a clarification on why Mr. Schaefer  
23 should be limited to medical masks.

24 MR. MAXSTON: I think, Mr. Chair --

25 THE CHAIR: Is it because of what's in the  
26 transcript? Is it because of what's in the CMOH

1 orders?

2 MR. MAXSTON: I think it's because primarily  
3 of what is in the Pandemic Directive that the College  
4 has, which refers to the requirement for chiropractors  
5 to wear surgical or procedure masks as being the  
6 minimum acceptable standard.

7 I think I said in my comments about this question,  
8 and I'll invite Mr. Lawrence to comment if he wants to,  
9 but we anticipated that the primary focus of  
10 Mr. Schaefer's testimony would be on those matters,  
11 because the College cannot -- I see Mr. Lawrence  
12 nodding his head -- the College cannot regulate what  
13 members of the public do, it can only regulate what  
14 chiropractors do. I'm not sure if that answers your  
15 question, but that was the concern. We didn't want  
16 this net to be cast too broadly.

17 THE CHAIR: Okay, I think we're just going  
18 to take that under advisement, Mr. Maxston. We'll go  
19 back into our cubbyhole, and we should have an answer  
20 here shortly, thank you. Just please bear with us, and  
21 we'll go to our break-out room.

22 (ADJOURNMENT)

23 Ruling (Qualification)

24 THE CHAIR: The hearing is back in  
25 session. The Hearing Tribunal has discussed the issues  
26 raised. We just want to clarify that the testimony

1 will be regarding the harm and not the efficacy  
2 associated with these masks, and we've also ruled that  
3 the testimony will relate to the medical masks not the  
4 nonmedical masks.

5 Having said that, we're aware that there are some  
6 issues here, and if Mr. Maxston feels that the line of  
7 questioning goes beyond the scope that we've discussed,  
8 then he certainly has the option to raise objections.

9 MR. KITCHEN: I wonder, and I invite  
10 comments on this, and I can be corrected if I'm off the  
11 mark on this, is it possible for me to receive written  
12 reasons for that decision, because that will likely be  
13 something that will end up being appealed, so -- and  
14 maybe that comes at the very, very end when we get  
15 written decisions -- written reasons on the whole  
16 decision, but that's something I would -- I'd ask for  
17 written reasons on it.

18 THE CHAIR: At the risk of taking us back  
19 to a break-out room, my thought would be that we can  
20 address it in the decision, once the decision is made,  
21 make a note to that effect. I don't think we want to  
22 interrupt this hearing to be doing that. I don't want  
23 to start writing parts of decisions, so --

24 MR. KITCHEN: No, no, I'm not asking you for  
25 it right now, I apologize. No, what I meant is I'm  
26 just asking whether it's, you know, tomorrow or a week



1 from now or a month from now or at the very end,  
2 that's -- I'm not asking for it right now. I'm just,  
3 in general, I'm making it known that, you know, likely  
4 that will be a source of appeal, so I think it best  
5 that there be reasons for that.

6 THE CHAIR: Duly noted, Mr. Kitchen.

7 MR. KITCHEN: Thank you.

8 CHRIS SCHAEFER, Previously sworn, Examined by  
9 Mr. Kitchen

10 Q MR. KITCHEN: All right, well, with that,  
11 Mr. Schaefer, you can hear me?

12 A Yes, I can.

13 Q Excellent, we'll jump right in. And I think you've  
14 already answered this, but just to clarify, you live  
15 and work in Alberta; is that correct?

16 A That is correct, yes.

17 Q Can you tell me what was the, generally speaking, what  
18 was the type of work you did prior to the onset of  
19 COVID?

20 A I had been doing safety training for my own company,  
21 but I had been doing safety training for a lot longer  
22 than that, but -- so safety courses in a variety of  
23 disciplines, as well as fit testing and training.  
24 So -- but fit testing and training has definitely been  
25 a significant portion of the work that I've done in  
26 clients that range from the military, to health care,

1 to educational institutions and private industry.

2 Q Has that work changed any since the onset of COVID?

3 A Absolutely, it's changed a lot. It's changed a lot  
4 primarily because there's so much -- there's no real --  
5 there's no real requirement for many of the masks that  
6 are mandated for COVID, that they would be fit tested,  
7 there's no requirement to that.

8 So before the COVID thing, everything -- any type  
9 of mask whatsoever had to be fit tested on the wearer.  
10 They had to have approval fit test for safety. But  
11 since COVID, since this virus, there has been no  
12 requirement for the majority types of these devices to  
13 require a fit test to the user, which is really, really  
14 odd.

15 Q And why is that odd?

16 A It's odd, because in order to determine whether or not  
17 the wearer is suitable for wearing a mask, there are  
18 some screening processes that have be completed first.

19 So, for instance, if you have difficulty breathing  
20 without a mask, wearing a mask is going to make it much  
21 harder for you to breathe. It will increase breathing  
22 resistance for everybody. So if you're healthy, you  
23 breathe effortlessly right now, you will experience  
24 increased breathing effort by covering your mouth and  
25 nose, and so there's a screening process. Not  
26 everybody is capable of wearing a mask. Nobody -- like

1     there's a screening process that has to be completed.

2             So for people that have pre-existing medical  
3     conditions or identify pre-existing medical conditions  
4     within screening to wear a mask, they have to go to  
5     their doctor and get further testing done to determine  
6     their suitability or ability to be able to wear a mask  
7     and stay healthy. So that's one thing. The screening  
8     process, there's no screening to determine the  
9     suitability of masking for the general population and  
10    employment in general, right? So any workers, there's  
11    no screening anymore; it's just wear one or else, and  
12    that's never happened before.

13            The other thing is is that in order for any type  
14    of mask to protect the wearer, that mask has to make an  
15    airtight seal around the face. Without an airtight  
16    seal, there's no way that it can provide any  
17    respiratory protection. So a fit test determines that  
18    it is making an air-tight seal to your face so that it  
19    can verify that the contaminant is being filtered; it  
20    is having to flow through the filter into the wearer's  
21    mouth and then lungs.

22            But if you don't have an airtight seal, then the  
23    air that you inhale is -- a lot of it's going to follow  
24    the path of least resistance, which is through the  
25    openings, any openings, available openings, because  
26    it's harder to pull air through a filter than it is

1       just to breathe surrounding air. So if there's leaks,  
2       that's where you're going to be pulling the contaminant  
3       in from.

4     Q   And so you talked about air coming in, and it coming in  
5       through what I'm going to call the path of least  
6       resistance, is that also true for air going out?

7     A   Well, you know, there is some air coming in, but when  
8       you look at the volumes of breathing of inhalation and  
9       exhalation, it's going to cause an insufficient air  
10      supply. You're going to get a buildup of your own  
11      exhaled carbon dioxide in the cover, and if you're  
12      going to get -- see, in an actual respirator --

13           Let me explain in an actual respirator, actual  
14      respirators have an exhalation valve built into them,  
15      so that every time you exhale, your carbon dioxide gets  
16      pushed out the exhalation valve so you don't rebreathe  
17      it. If you just put a closed cover on your face, then  
18      it will capture some part of dioxide, and as you  
19      inhale, it will force you to rebreathe some air but  
20      also carbon dioxide that can be significant amounts  
21      above and beyond what is considered safe according to  
22      Occupational Health and Safety air quality standards.

23    Q   Thank you. All right, well, you've already answered  
24      some questions, but just to go back to sort of a  
25      preliminary issue, let me ask you a couple different  
26      questions. Mr. Schaefer, do you know Dr. Curtis Wall

1           personally?

2     A     I've never met him. I don't know what he looks like,  
3           and I really don't know much about him at all.

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

6     A     Absolutely not. I've just been hired to give my expert  
7           opinion, and that's what I'm here for.

8     Q     You don't have any financial interest or stake in the  
9           outcome of this case then?

10    A     No, because I'm getting paid by the hour, and so it  
11          doesn't matter to me what the outcome is.

12    Q     And just to confirm, do you understand your duty to  
13          provide this Tribunal with your expert knowledge and  
14          opinions in an objective and neutral manner?

15    A     Absolutely.

16    Q     Thank you. Now, just to give a bit of a road map,  
17          we've already got into the meat of it a little bit, but  
18          I'm going to be asking you about, you know, what masks  
19          really actually are, and then I'm going to ask you  
20          about carbon dioxide, about oxygen, a little bit about  
21          testing, and then, lastly, I'll ask you, from an  
22          Occupational Health and Safety perspective, a little  
23          bit about the harms or hazards involved.

24                 So to start off, now -- and my friend may want to  
25          object to this, because we've got issues with different  
26          types of masks, but in the very first paragraph of your

1 report, you say -- we're talking about the masks that  
2 are being mandated to attempt to prevent the stop of  
3 COVID, you say: (as read)

4 These masks are the medical, nonmedical, and  
5 procedural masks.

6 Now, can you please explain for us what those terms and  
7 what those types of masks mean to you?

8 A Sure, absolutely. So a medical mask in a health care  
9 setting is referred to an N95. It's something that  
10 is -- what health care uses is a closed cover  
11 primarily, it is N95, which means that it's a filter, a  
12 filtration that's not resistant to oil, that's what the  
13 'N' is. 95 refers to the best-case scenario protection  
14 that you could get with that device if it's properly  
15 fitted and used and disposed of and replaced as  
16 specified, as required, as the manufacturer requires.  
17 And that's what the medical is.

18 The nonmedical is any device that is really you  
19 put it on your mouth and nose. So you could take a  
20 plastic bag put it over your head; I mean, that's not a  
21 nonmedical mask, but, you know what, a nonmedical mask  
22 is anything that covers your mouth and nose. So if you  
23 want to put a bandana on your mouth and nose, you want  
24 to -- you want to -- anything literally that covers  
25 mouth and nose is classified as a nonmedical mask.

26 And a procedural mask is something that is -- is

1 something that they will typically use, and I won't say  
2 what they use it for because it's kind of -- you know,  
3 they use it for different things in health care  
4 settings, but it's a looser fitting -- it's a slightly  
5 looser fitting style, but it's still -- it's still  
6 enclosed enough that it typically -- it's like the blue  
7 mask, right? So a procedural mask is kind of -- it's a  
8 looser fitting than the N95, N95 is a tighter fitting  
9 and, depending on nonmedical, it can be anything from  
10 cloth to virtually anything anybody wants to do to  
11 cover their mouth and nose, because there's really  
12 no -- there's no rules on nonmedical masks; it's really  
13 just anything you put on your mouth and nose could be  
14 considered a nonmedical mask that covers your face.

15 And procedural mask, like I said, it's really just  
16 a -- it's a device. These are all -- they're all like  
17 the -- N95 and procedural would be considered temporary  
18 use only, to be replaced regularly, as needed when  
19 there's moisture buildup inside, and disposed of  
20 immediately. So the procedural and the medical in  
21 health care settings, both have to be used -- they're  
22 really only designed for short duration use and then to  
23 be immediately disposed of. They were never designed  
24 for hour upon hour use. It was never designed that  
25 way, and it's still not designed that way. So it's  
26 been used that way, but it's not designed that way.

1           So there are some dangers to that, but as far as  
2       procedural masks go, just -- it's a looser fitting mask  
3       that they use in the health care settings and  
4       disposable, just like N95. N95s are tighter fitting;  
5       procedurals are looser fitting.

6       Q   Thank you, that's helpful. Would you say that when we  
7       use the word "surgical mask", in your experience, is  
8       that typically a reference to that category of  
9       procedural or blue masks?

10      A   Yeah, you know, surgical masks, you know, in surgery,  
11      physicians and other health care practitioners, they  
12      may use N95, or they may use procedural. It's -- it  
13      depends on -- depends on what's going on, but both may  
14      be used.

15      Q   So you're aware that what the Alberta College of  
16      Chiropractors has mandated that chiropractors must  
17      wear -- this mandate is found in the COVID-19 Pandemic  
18      Practice Directive, you're aware that the masks -- the  
19      type of masks that the Alberta College of Chiropractors  
20      is requiring chiropractors to wear are those procedural  
21      or blue masks?

22      A   Yes, I am aware.

23      Q   Okay. And you're aware that the CMOH orders that  
24      mandate masking for the general public mandates the  
25      nonmedical masks?

26      A   Yes, I am aware.



1 Q All right, in the second paragraph of your report, you  
2 state that: (as read)

3 Masks are required to have engineered  
4 breathing openings.

5 Can you explain what "engineered breathing openings"  
6 are, and why masks are required to have them?

7 A Okay, so if you are going to cover your mouth and nose  
8 with any device, it's important that you do not  
9 restrict your oxygen coming in, the air coming in, and  
10 your carbon dioxide and expelled toxic air leaving, and  
11 that is why we exhale outside of our bodies in the  
12 first place.

13 If we take a look at a mask, a mask has to have  
14 engineered openings. So, for instance, if you take a  
15 look at, say, here is a common Halloween-style mask,  
16 it's got engineered openings for nostrils for  
17 breathing, as well as mouth for breathing. It's  
18 important to be able to have easy, free breathing.  
19 When you restrict your breathing, then you get that  
20 accumulations of exhaled carbon dioxide that are then  
21 rebreathed because there's no exhalation valve to purge  
22 it, so you rebreathe your own exhaled waste toxic  
23 carbon dioxide, which is not going to be good for  
24 anybody, and for people over a longer period of time  
25 and if there's any pre-existing medical conditions  
26 could be a very serious situation.

1           Now, if you look at an actual respirator, like  
2           this, you can see that it is covered, there are two  
3           filters attached in the design. In the middle, there's  
4           an exhalation valve. That's to purge exhaled heat,  
5           moisture, and carbon dioxide, okay, for a reason,  
6           because we don't want to rebreathe it. So air comes in  
7           here, air can only enter through inhalation, air can  
8           only leave through exhalation.

9           And when I say "engineered openings" -- I say  
10          engineered opening and exhalation, but also engineered  
11          opening and inhalation. So if I unscrew the filter,  
12          you can see, if I just turn it like this, you can see  
13          it's a big hole, there's a big hole there. The reason  
14          the hole is there is so that air can flow in very  
15          easily and freely so that, you know, it can enter your  
16          lungs as unobstructed as possible, because anything  
17          that you put on your mouth or nose, it makes it harder  
18          to breathe. Depending upon the person, the length of  
19          exposure, the type of work or activity they're engaged  
20          in, and any pre-existing medical conditions could all  
21          change their ability to be able to wear that device at  
22          all.

23    Q    I notice you used the word "device", just to clarify,  
24          you would say that these procedural or blue masks we're  
25          talking about, you would call that a device?

26    A    Well, let me explain something, it's very difficult for

1 me to refer to any of the mandated masks for COVID as  
2 actual masks. It's really difficult. I struggle with  
3 it. It's hard, because they don't meet the actual  
4 definition of a mask from anything as simple as a  
5 Halloween mask, to a goalie mask, to a scuba mask, any  
6 kind of actual mask that's engineered, it's engineered  
7 for easy breathing.

8 If you look in a goalie mask, it looks full faced,  
9 it looks pretty encapsulated, but it does have  
10 breathing vents, so the air can flow in and out easily.  
11 Every type of mask, it's important that air flows in  
12 easily and air flows out easily.

13 Now, a goalie mask isn't going to offer anybody  
14 respiratory protection or a scuba mask, but they are  
15 devices that are engineered for breathing, but if you  
16 just close your -- take a piece of material or a paper  
17 and cover your mouth and nose with it, it will restrict  
18 breathing, it will restrict your ability to inhale, and  
19 it will restrict your ability to exhale.

20 Q So I know in your report, you use the term "breathing  
21 barriers" to describe these types of so-called masks  
22 that are mandated for COVID. Can you just explain to  
23 me why you use that term?

24 A Well, I coined that term actually, and the reason I use  
25 it is because I think it most accurately describes the  
26 situation -- what actually happens when you wear one of

1     these.  If you've ever worn one, and, for most people,  
2     they probably have, they probably notice immediately  
3     that it does become increasingly difficult to breathe  
4     with one on.  There's a reason that you're blocking  
5     your breathing.  So when I call them breathing  
6     barriers, it's based upon the practicality that they  
7     block breathing, they block the normal flow of  
8     breathing.

9           Now, all respirators, even proper respirators,  
10    like the one I showed you, with the two filters and  
11    exhalation valve in the middle will increase breathing  
12    difficulty a little bit because you are going to pull  
13    air through the filter, so it's going to be a slight  
14    increase in inhalation effort but very minimal, and  
15    because it's designed for breathing, it's very minimal.

16          Let me remind you what I said earlier, anybody  
17    that wears any respirator before COVID needed -- or  
18    mask, for that matter -- needed any type of filtering  
19    mask needed to be fit tested.  And before they could be  
20    fit tested, they had to be screened for their ability  
21    to wear it safely.

22          And without that screening, it's like Russian  
23    roulette, who's going to have to wear one and shouldn't  
24    be wearing one.  Somebody with COPD, somebody with  
25    heart conditions, lung conditions of any type, high  
26    blood pressure, these are all people that need to be,

1 before COVID, needed to be examined by a physician to  
2 determine their ability to safely wear a respirator  
3 that's actually engineered for breathing, much less a  
4 closed cover over your mouth and nose that caps -- that  
5 makes it exponentially harder to breathe and captures  
6 carbon dioxide in significant amounts.

7 So that's why I call it a breathing barrier.

8 Q Thank you. Do you find it strange that we seem to be  
9 doing -- based on what you've said, we seem to be doing  
10 things very differently post-COVID than pre-COVID when  
11 it comes to things like fit testing? Do you find that  
12 strange?

13 A I think it's incredibly strange that there would be  
14 mandates for closed-cover barriers that aren't  
15 engineered -- aren't engineered for easy breathing, and  
16 I find it very strange that there is no requirement for  
17 a fit test for a filtering mask or respirator. That  
18 should be paramount; that should be primary.

19 Q Now, I know you've touched on this, but just to  
20 clarify, you say in the fourth paragraph in your report  
21 that wearing these what we're going to call breathing  
22 barriers are hazardous to the wearer.

23 A M-hm.

24 Q Why exactly are they hazardous?

25 A Well, think about it like this, if you take something,  
26 like if you take a piece of cloth or a piece of paper

1 towel or whatever it is, hold it closely to your mouth  
2 and nose, it becomes more difficult to breathe, right?

3 So we know that it's harder to breathe, which  
4 increases respiration effort. For people with  
5 pre-existing conditions, it's not going to be good.  
6 But even for people without pre-existing conditions,  
7 increased breathing effort, you increase the capture of  
8 carbon dioxide, and then you are re-inhaling that  
9 carbon dioxide, it's going to cause a variety of  
10 negative health effects, even if the person has no  
11 pre-existing medical conditions.

12 So common symptoms of blocking your flow of  
13 breathing and inhaling excess carbon dioxide can be  
14 things like experiencing a headache, nausea, dizziness,  
15 lack of coordination, maybe impaired hearing,  
16 impaired -- sometimes impaired vision. It can be a --  
17 it can be feeling faint, overheating. And it can be  
18 worse than that, it could be people that have a very  
19 difficult time breathing, feel like they can't catch  
20 their breath, and it can go down from there. So  
21 anybody that inhales more than what the -- anybody that  
22 inhales above what the indoor Occupational Health and  
23 Safety standard is for carbon dioxide is at risk.

24 So if you were to look at my report, you would see  
25 the standards for carbon dioxide according to the  
26 Alberta standards for safety and see that the maximum

1 exposure for indoor carbon dioxide is a thousand parts  
2 per million. That's not very high. That's not very  
3 high. That's over a 24 period -- 24-hour period, but  
4 it's not very high. Because the normal oxygen that we  
5 have currently in our atmosphere is around 3 to 400  
6 parts per million. So it doesn't have to go very high  
7 to get to a thousand.

8 And the testing that I've done inside these  
9 breathing barriers is very high levels of carbon  
10 dioxide. Even if somebody like -- here's the thing, if  
11 you wear a breathing barrier, and you are just sitting  
12 at a desk, looking at a computer, you're going to have  
13 hazardous levels of low oxygen just from having it on,  
14 any one of those three devices on it.

15 And if you are doing an activity like lots of  
16 speaking, those levels will drop dramatically, because  
17 your oxygen demand will increase dramatically.

18 And as well as, if you look at physical activity  
19 like, say, going for a run or something, and your  
20 oxygen demands go up significantly, then putting a  
21 closed cover on your face and blocking that ability to  
22 breathe can have a very severe negative impact of your  
23 ability to properly absorb oxygen or as much oxygen as  
24 your body needs and dispel -- disperse and dispel  
25 carbon dioxide away from you so you don't re-inhale it.

26 Q Thank you. I know you said that a thousand parts per

1 million is the sort of the safe limit for carbon  
2 dioxide. How long is too long to be exposed to that  
3 much carbon dioxide or more?

4 A Well, according to the -- the highest level that you  
5 can legally be exposed to in Alberta, according to  
6 Alberta standards -- and they revised their standards  
7 in the spring of this year, they actually -- it was  
8 actually higher, but they lowered it, instead it's  
9 lower, so -- is a thousand parts per million. That's  
10 based on a 24-hour exposure.

11 But I'll tell you based upon the testing that I've  
12 done and other research publications that I have as  
13 references, medical reports and research that I  
14 could -- I'm more than happy to submit a long list of  
15 certified medical scientific reports to show that  
16 levels of carbon dioxide in one of these devices exceed  
17 5, 10,000 parts per million within a minute, anybody  
18 wearing any one of those three.

19 And oxygen levels -- here's -- carbon dioxide is  
20 only one part of the equation. The other immediately  
21 life-threatening condition is low oxygen. Hypoxemia is  
22 low oxygen in the blood; hypoxia is low oxygen in  
23 tissues. So what happens is is if you are not inhaling  
24 oxygen concentration, enough of an oxygen concentration  
25 in air, you're going to suffer -- you're going to  
26 suffer oxygen deficiency in your blood and in your



1 tissues.

2 And so the normal oxygen level in air is 19.5 --  
3 20.9 percent, 20.9 percent. Where it becomes dangerous  
4 to health becomes immediately dangerous, life and  
5 health, according to our regulations is 19.5 percent or  
6 lower.

7 So using instrumentation, you could see that the  
8 oxygen drop between the breathing barrier in the  
9 person's mouth or nose is significantly below 19.5  
10 percent. Immediately, within the first 20 seconds,  
11 you'll see oxygen drop below 19.5 percent, which is  
12 safe levels. And if they're -- if they've got a  
13 tight-fitting cover, if their cover is very  
14 tight-fitting, especially like the N95 style or some of  
15 these cloth covers that are especially tight fitting,  
16 but even with a procedural-based mask, you're going to  
17 see unsafe levels of carbon dioxide and unsafe levels  
18 of oxygen. And even with the procedural-based what  
19 they call mask, which I call breathing barrier, is  
20 levels far in excess of a thousand parts per million,  
21 multiples higher, 10,000, 20,000 parts per million.

22 And I have done -- I've done testing. I've done  
23 video to show it. I am competent to operate testing  
24 equipment, and my testing equipment has been, you know,  
25 properly calibrated and properly tested to ensure that  
26 it's working properly as well, so I could verify it.

1       The readings that I take would hold up in a court of  
2       law.

3       Q   What's the device that you use; what's the name of it?

4       A   Well, there's -- I -- there's a number of devices that  
5       I could use.  It's not -- it's not restricted to one  
6       type of device, because any device that has those  
7       appropriate sensors with those arrangers -- with those  
8       ranges of gas detection, as well as, you know, proper  
9       use and maintenance of the device would be suitable,  
10      but the one that I used was a MultiRAE Lite most  
11      recently.

12      Q   And is that -- is that testing device, is it designed  
13      to test levels of carbon dioxide and oxygen in the  
14      atmosphere?

15      A   Yes, it is.

16      Q   Okay.

17      A   So with these devices, you can get to a (INDISCERNIBLE)  
18      quick with any number of sensor configurations, because  
19      they're designed to test multiple types of gases, but  
20      carbon dioxide and oxygen is a very common  
21      configuration, and the sensors can be -- they can be in  
22      the monitor and installed in the monitor for that  
23      purpose, yes.

24      Q   So we know the limit for carbon dioxide is a thousand  
25      parts per million, and I heard you say that you took  
26      readings inside these masks while they're being worn,

1       and some of those readings were 5 or 10,000 parts per  
2       million, but could you give me an idea of what an  
3       average would be inside the mask after it's been on for  
4       a bit?

5       A    Okay, so let's say a couple minutes of wearing either a  
6       nonmedical, a medical, or a procedural based, you're  
7       looking at, a couple minutes of wearing, 20,000 parts  
8       per million carbon dioxide, oxygen levels as low as 18  
9       percent, 18 to 18-and-a-half percent. The lowest  
10      oxygen can go legally is 19.5 before it becomes  
11      immediately dangerous to life and health.

12                So in Occupational Health and Safety standards,  
13      when we talk about IDLH, which stands for immediately  
14      dangerous to life and health, we're looking at  
15      device -- we're looking at levels that might not  
16      necessarily cause you to drop dead once they're  
17      reached, but certainly they're considered levels that  
18      now become -- those exposures become harmful without  
19      protection from those exposures.

20      Q    And so now I've heard you use the number 20,000. So  
21      are these -- well, let me ask you this: The parts per  
22      million of carbon dioxide inside the mask while it's  
23      being worn, does it fluctuate, or is it steady?

24      A    Well, it depends on a number of things. It depends  
25      upon what's the activity level of the person that's  
26      wearing it. The hard -- the more exertion, the higher

1       the carbon dioxide's going to go. It also depends upon  
2       what is the -- how tight-fitting is it around mouth and  
3       nose. If it's very tight-fitting, obviously it's going  
4       to trap more carbon dioxide than if it's a looser  
5       fitting.

6               So there's various factors. So, yes, it can  
7       fluctuate, or it can remain steady, depending upon the  
8       fit of it and depending upon the activity level of the  
9       person that's wearing it.

10    Q    But in your experience with the loose-fitting ones,  
11       even though there are these leaky areas where air gets  
12       in and out, the parts per million of carbon dioxide  
13       stays above a thousand inside --

14    A    Absolutely. It's still harmful to wear. It's still  
15       hazardous to wear for sure, because when you're exposed  
16       to levels that are levels that are far in excess, even  
17       with the looser -- even if it's not loose-fitting, it's  
18       a looser, slightly looser fitting, you're still going  
19       to find levels of oxygen that are lower than what is  
20       legislatively allowed and levels of carbon dioxide that  
21       are higher than what is legislatively allowed.

22    Q    Now, you talked about some of the effects of this  
23       overexposure to carbon dioxide. Have you, in your line  
24       of work, have you ever encountered individuals  
25       suffering from these effects?

26    A    You know, I am not a physician; I am an Occupational

1 Health and Safety specialist, so I primary measure the  
2 hazard. So I test people and equipment for their  
3 occupations to ensure that they are protected from  
4 respiratory hazards, but I do not evaluate the health  
5 conditions of people that may be affected by low carbon  
6 dioxide or high levels.

7 Q Okay.

8 MR. LAWRENCE: I'm sorry, to interrupt,  
9 Mr. Chair, I don't see Dr. Aldcorn on the screen. I'm  
10 just wondering, did we lose somebody? Excuse me,  
11 sorry, Mr. Kitchen.

12 MR. KITCHEN: That's okay. I don't see him  
13 either. He's --

14 MR. LAWRENCE: She.

15 MR. KITCHEN: I'm sorry, yes, she. Yeah,  
16 that's a concern.

17 MR. LAWRENCE: Oh, there she is, okay.

18 DR. ALDCORN: Sorry.

19 MR. LAWRENCE: So I'm not sure if we want to  
20 just read the last couple of minutes back for  
21 Dr. Aldcorn's benefit.

22 MR. MAXSTON: Maybe we can ask Dr. Aldcorn  
23 when she went offline --

24 DR. ALDCORN: Yeah.

25 MR. MAXSTON -- intentionally or not or  
26 when she came back.

1 DR. ALDCORN: Completely unintentionally.

2 The last we were discussing was the fact that the  
3 numbers of the CO2 and O2 levels would depend on the  
4 nature of the tight-fittingness of the mask and the  
5 exercise level of the individual. And I apologize.

6 MR. KITCHEN: So that means you did miss one  
7 question --

8 DR. ALDCORN: I'm so sorry.

9 MR. KITCHEN: -- well, there's two ways we  
10 can handle this: One, there's going to be a  
11 transcript, of course, you'll get to read it; two, we  
12 could just give Miss -- Miss Karoline to read it. It  
13 doesn't matter to me, so I leave it to the Tribunal.

14 THE CHAIR: Let's have the court reporter  
15 read it back. That way, she'll get the same thing we  
16 all got.

17 THE COURT REPORTER: (by reading)

18 Q Now, you talked about some of the effects  
19 of this overexposure to carbon dioxide.  
20 Have you, in your line of work, have you  
21 ever encountered individuals suffering  
22 from these effects?

23 A You know, I am not a physician. I am an  
24 Occupational Health and Safety specialist, so  
25 I primarily measure the hazard. So I test  
26 people and equipment for their occupations to

1                   ensure that they are protected from  
2                   respiratory hazards, but I do not evaluate the  
3                   health conditions of people that may be  
4                   affected by low carbon dioxide or high levels.

5     Q     MR. KITCHEN:                   Mr. Schaefer -- I take it --  
6           yes, everybody's here, good -- Mr. Schaefer, are you  
7           confident that if somebody else did the same tests that  
8           you've done on these masks or breathing barriers, are  
9           you confident they would come up with the same results  
10          that you have?

11    A     If they're properly --

12          MR. MAXSTON:                   I'm a little concerned, that's  
13          a little speculative. I don't know if you want to  
14          consider rephrasing that, because I mean that -- what  
15          studies, who is conducting them? I think that's just a  
16          little bit broad, because there may well be studies  
17          which disagree with Mr. Schaefer. I'm just a little  
18          concerned about that type of question.

19          MR. KITCHEN:                   Well, I didn't use the word  
20          "studies", but let me try this.

21    Q     MR. KITCHEN:                   Are you confident,  
22           Mr. Schaefer, that if somebody did the same testing  
23           you've done with the same device that you used that  
24           they would produce the same data regarding carbon  
25           dioxide and oxygen?

26    A     Well, if they're following the proper procedure, as I

1       have, and they had done everything the same that I did  
2       as far as making sure that the equipment is -- has been  
3       properly calibrated, properly bump-tested, and making  
4       sure that everything is working as it should, then I  
5       would anticipate that the difference being them holding  
6       it versus you holding it should have no effect on the  
7       readings whatsoever.

8       Q   And just to be clear, you used the same device to test  
9       the levels of oxygen and the levels of carbon dioxide?

10      A   Yes, because the device was equipped with two sensors,  
11      one with oxygen and one with carbon dioxide, to measure  
12      these simultaneously, so I measured them both at the  
13      same time actually.

14                So there's a display on the monitor, there's a  
15      display for the readings of oxygen, and there's a  
16      separate display for the readings of carbon dioxide, so  
17      you can see both in realtime.

18      Q   I see. Now, I notice you used the word "asphyxiation"  
19      at one point in your report; can you just, for those of  
20      us who do not know what that means, can you explain to  
21      me what asphyxiation is?

22      A   Well, asphyxiation is when your body is suffering from  
23      insufficient oxygen, so whether it's, you know,  
24      accidental, intentional, whatever it may be, your  
25      body's not getting enough oxygen, that's asphyxiation.

26                And so there's various levels of it, but



1 asphyxiation may be fatal. It may cause injury. So  
2 these are the kinds of things that this is what -- and  
3 it's all due -- asphyxiation's due exclusively in  
4 this -- in this -- I guess how I should say -- view to  
5 insufficient oxygen.

6 Q Now, you say carbon dioxide is an asphyxiant, and it  
7 displaces oxygen.

8 A M-hm.

9 Q Can you explain why or how that happens?

10 A Well, carbon dioxide is used to -- carbon dioxide can  
11 displace oxygen, because it is considered an inert gas,  
12 so pure carbon dioxide is able to displace oxygen.

13 So, for instance, let me give you an example,  
14 carbon dioxide is often used in industrial situations  
15 to purge out hazardous atmospheres of, say, things like  
16 confined spaces and such to remove oxygen from those  
17 spaces. So we know carbon dioxide can cause  
18 displacement of oxygen. And it can do that in any  
19 closed container, it doesn't have to be a confined  
20 space like industrial, but any closed container where  
21 you've got accumulations of carbon dioxide, and it can  
22 affect how you can absorb and how you can be exposed to  
23 oxygen, how you can absorb oxygen basically.

24 Q Now, I know you've mentioned the 19.5 figure, but I'm  
25 just curious, what is the number that the Occupational  
26 Health and Safety code in Alberta describes as being

1       the point at which, if you go below it, it becomes  
2       hazardous?

3     A   19.5 percent. That's immediately dangerous to life and  
4       health. So you can't go below 19.5 percent for any  
5       reason.

6               And if you are exposed to air in Alberta, if you  
7       are exposed in air -- breathing air that has an oxygen  
8       concentration below 19.5 percent, you have to be  
9       equipped with a separate air source, like  
10      self-contained breathing apparatus, a supplied-air  
11      system, that will give you the correct oxygen  
12      requirement that you need.

13    Q   That number of 19.5, is that fairly universal  
14       throughout jurisdictions?

15    A   Yes, it is.

16    Q   Okay. I know in your report, you mention the  
17       Occupational Health and Safety Administration [sic];  
18       could you tell us what that is?

19    A   Occupation Health and Safety Administration? What  
20       exactly is your question?

21    Q   I'm just wondering what is the Occupational Health and  
22       Safety Administration, because that's not Occupational  
23       Health and Safety Alberta. I just want to know what  
24       that is.

25    A   Okay, so Occupational Health and Safety  
26       Administration [sic] is the US standard of safety

1 requirements. So it's funny, because when you say  
2 it -- you said it full out; I'm more familiar with it  
3 in its abbreviated form, which is OSHA.

4 Q OSHA.

5 A If you would have said "OSHA", I'm like absolutely, but  
6 because I never hear it as Occupational Safety and  
7 Health Administration, that's why I kind of just  
8 hesitated for a second.

9 So anyhow, OSHA is the governing body for safety  
10 standards and exposures in the United States.

11 Q Okay, and is that -- are they similar to OHS here in  
12 Alberta?

13 A Yeah, many of the OSHA standards are accepted in  
14 various jurisdictions in Canada as well.

15 Q So in your report, you refer to a 2007 letter from  
16 OSHA. Can I just get you to turn to the first page of  
17 this letter, that's page 085 or 85 from your report,  
18 and for those who are following along, that's near the  
19 end of the report, and then the top left-hand corner is  
20 the page number, 085. Now, this letter, can I just ask  
21 you to read out the first sentence of the third  
22 paragraph there at the bottom of that page.

23 A (as read)

24 This letter constitutes OSHA's interpretation  
25 of the requirements discussed.

26 Q We must be on different pages. So I'm looking at the

1 first page of the letter --

2 A Okay, I'm looking at -- I'm on page 085.

3 Q Maybe you've got a different page 085. Well, can I get  
4 you to go to just the first page of this letter, where  
5 it says "April 2nd, 2007, Mr. William Costello"; do you  
6 see that?

7 A Oh, okay, okay, yes, I see that now, yeah.

8 Q Okay. And if we go down, the first paragraph starts  
9 with "Thank you", second paragraph --

10 A Yeah.

11 Q -- starts "Within your letter", if you could just read  
12 the first sentence of the third paragraph there.

13 A Okay, so the third sentence of the second paragraph --  
14 third paragraph, okay, okay, I got you, okay. So it  
15 is -- is it the one "to ensure that employees", is that  
16 the second one?

17 Q No, it's starts with the word "Paragraph".

18 A Oh, "Paragraph", okay: (as read)

19 Of paragraph (d)(2)(iii) of the respiratory  
20 protection standard considers any atmosphere  
21 with an oxygen level below 19.5 percent to be  
22 oxygen deficient and immediately dangerous to  
23 life or health.

24 Did you want me to continue?

25 Q No. That sounds a little dramatic to me. Can you help  
26 me understand, you know, from the perspective of an

1 Occupational Health and Safety expert, what does  
2 "immediately dangerous to life or health" actually  
3 mean?

4 A Well, I thought I actually explained that a little  
5 earlier, but I'll tell you what, I'll go over it again.

6 So "immediately dangerous to life and health"  
7 means that if you are exposed at that level or below  
8 that level especially, then you are going to be putting  
9 your health in harm's way. So that can have  
10 significantly dangerous impacts on your health. And  
11 the lower it goes, the lower it goes, like the more it  
12 differentiates, like if it's -- the lower it -- for  
13 oxygen, oxygen requirements here, the lower it goes  
14 below the minimum oxygen requirement, the 19.5 percent,  
15 the more dramatic and the more negative those effects  
16 are going to be. So it's bad.

17 You never are allowed to exceed -- you're never,  
18 ever allowed to breathe air less than 19.5 percent  
19 under any circumstance in Occupational Health and  
20 Safety settings. There's no -- there's no exceptions.  
21 This is the deadline. You can't go below 19.5.

22 If you do, if somebody is tested and they are  
23 exposed to levels of oxygen below 19.5 percent, the  
24 operation, the working operation, would have to be  
25 immediately shut down, and they would have to be  
26 evacuated from that space; even if it was 19.4, they'd

1       have to be immediately evacuated. There's nothing  
2       below 19.5 that's acceptable.

3               If somebody had to work in an atmosphere of 19.5  
4       percent or lower, they would have to be equipped with a  
5       separate source of clean air with -- delivered via air  
6       line, supplied air-breathing apparatus. For those of  
7       you listening that might not necessarily be aware what  
8       that is, that is the same type of breathing apparatus  
9       that fire fighters wear when they go into smoking  
10      buildings, so they have a separate source of air. Why?  
11      Because they need it, because they go into  
12      oxygen-deficient atmospheres. And that's the type of  
13      equipment you need to be exposed to any oxygen  
14      concentration below 19.5 percent.

15    Q    So when people are working with a procedural mask on,  
16          are they working in an environment that's immediately  
17          dangerous to life or health?

18    A    The barrier, the breathing barriers create this  
19          environment. So if you are in your office or home or  
20          wherever it may be, and you are exposed to good  
21          breathing air without a breathing barrier, wearing a  
22          breathing barrier will create this hazardous  
23          environment for your body.

24    Q    Could I get you to turn the page over on this letter,  
25          and you'll see there a box containing two paragraphs of  
26          text; do you see that?

1 A Yes, I do.

2 Q Can I just get you to read the first three sentences of  
3 text inside that box?

4 A (as read)

5 Human beings must breathe oxygen to survive  
6 and begin to suffer adverse health effects  
7 when the oxygen level of their breathing air  
8 drops below 19.5 percent oxygen.

9 So for the person doing the documentation on this, I  
10 should probably say that -- I'll read it over again,  
11 just so that they can do their recording properly on it  
12 by hand. So: (as read)

13 Human beings must breathe oxygen ... to  
14 survive, and begin to suffer adverse health  
15 effects when the oxygen level of their  
16 breathing air drops below (19.5 percent  
17 oxygen). Below 19.5 percent oxygen ...,  
18 air is considered oxygen deficient. At  
19 considerations of 16 to 19.5 percent, workers  
20 engaged in any form of exertion can rapidly  
21 become symptomatic as their tissues fail to  
22 obtain the oxygen necessary to function  
23 properly.

24 And do you want me to read what's in the brackets as  
25 well there as reference?

26 Q No, that's good, thank you. Now, this concentration of

1       16 to 19.5, that range, is that what you've discovered  
2       when you've tested the levels of oxygen between these  
3       breathing barriers and the faces of those wearing them?

4     A   Absolutely. Every oxygen concentration, whether it's  
5       procedural they're wearing, and even at resting rate  
6       without any form of exertion, just resting rate,  
7       resting rate, we're seeing an oxygen drop of below 19.5  
8       percent within 2 minutes of wearing it on either  
9       procedural, nonmedical, or medical masks. Within 2  
10      minutes, and that's without, that's without speaking a  
11      lot or any other type of obvious exertion.

12     THE CHAIR:                   Mr. Kitchen --

13     MR. KITCHEN:                 Yes.

14     THE CHAIR:                   -- I'm just wondering, it's  
15      quarter to 11, we started at 9, and I don't want to  
16      interrupt the flow, but I'm wondering if people would  
17      like to take a 5- or 10-minute break just to stretch  
18      and whatever.

19     MR. KITCHEN:                 I'm fine with that. Can I  
20      just -- because I'm almost done with this area of  
21      questioning; can I just -- can I ask one question to  
22      tie that up?

23     THE CHAIR:                   Certainly, certainly.

24     Q   MR. KITCHEN:             Mr. Schaefer, I'll just get  
25       you to turn the next page over, can you just tell me  
26       who is it that wrote this letter, and what's his title?



1     A     The person who wrote this letter is Richard E. Fairfax,  
2           F-A-I-R-F-A-X, Director, and his title is Directorate  
3           of Enforcement Programs. So he would be in charge  
4           of -- just for the record, this is somebody that's in  
5           charge of enforcement programs for all of OSHA, which  
6           is -- encompasses all of the United States, and in  
7           Canada, we have the same even, within our own  
8           individual provinces, we have the same standards for  
9           oxygen that nothing under 19.5 percent. Everything  
10          below 19.5 percent is immediately dangerous to life and  
11          health. It's universal throughout North America -- or  
12          I should say through the US and Canada.

13     Q     One last question before we break, do you find it  
14           strange that the public has been mandated to wear, by  
15           various government bodies, devices that cause their  
16           oxygen to be below a level that's safe?

17     A     Well, I don't know if "strange" is the right word,  
18           James. I'm not sure if "strange" is the right word. I  
19           think it's much more serious than "strange", because I  
20           know how serious it is, I know how serious the rules  
21           are regarding oxygen concentrations below 19.5 percent.  
22           In every one I've tested, every one, I've tested  
23           adults, I've tested children, everyone, within 2  
24           minutes of wearing either a procedural, nonmedical, or  
25           the medical N95, even that's (INDISCERNIBLE) approved,  
26           within 2 minutes is having oxygen drops below 19.5

1       percent.

2       Q     Thank you.

3       MR. KITCHEN:                   And that's it for me for now  
4       until we come back after our break.

5       THE CHAIR:                    Okay, well, let's reconvene at  
6       11:00 then, and we'll continue on with Mr. Kitchen and  
7       Mr. Schaefer. Thank you.

8       MR. KITCHEN:                   Thank you.

9       (ADJOURNMENT)

10      THE CHAIR:                    We are back in session, and  
11      we'll have Mr. Kitchen continue with his direct exam of  
12      Mr. Schaefer.

13      MR. KITCHEN:                   All right, thank you.

14      Q     MR. KITCHEN:            Now, Mr. Schaefer, I think you  
15      touched on this, but just to clarify, in your  
16      experience, do some people tolerate wearing these  
17      breathing barriers better than others?

18      A     Oh, absolutely, because some people have pre-existing  
19      medical conditions that make it difficult to breathe  
20      without any restriction. If you added a restriction on  
21      top of that, it could be life threatening for those  
22      people, and every bit of, you know -- depending upon --  
23      there's levels, right? So if it's -- it depends on the  
24      level of pre-existing medical condition they have and  
25      the severity of it, but it could be life threatening,  
26      it could cause somebody a life-threatening medical

1 emergency to wear a breathing barrier, even a properly  
2 certified respirator, if they haven't -- if they don't  
3 have the health and they haven't been properly screened  
4 beforehand, before wearing it. It's important. It's  
5 important that we check out and people are  
6 health-assessed before we restrict our breathing. It's  
7 important.

8 Q Do you do screening and fit testing at workplaces for  
9 employees?

10 A Absolutely. Screening is a prerequisite for fit  
11 testing. I can't fit test anybody that hasn't  
12 completed screening protocol.

13 Q Can you tell me what are some of the things you look  
14 for when you're screening?

15 A Well, the screening is a document that the patient -- I  
16 shouldn't say "patient", but the client, the customer  
17 or client is going to complete in their own -- with  
18 their own privacy, so they're going to complete it  
19 completely themselves, and then I just look at the  
20 results.

21 The results that I'm looking for, there's a list  
22 of pre-existing medical conditions, and if they  
23 identify that they currently have any of those  
24 pre-existing medical conditions, then my obligation, as  
25 an Occupational Health and Safety fit testing  
26 professional, is that I have to refer them to their

1 physician for further testing and analysis to determine  
2 whether or not they have the physical fitness to be  
3 able to handle a restriction in their breathing.

4 Q Is asthma one of those conditions?

5 A Yes. Do you want me to mention some of the conditions?

6 Q Well, you can only do that if I ask you to do that.  
7 Well, let me ask you, just off the top of your head,  
8 you don't need to go through the whole list, but just  
9 give me some examples of some of these conditions just  
10 so we have an idea. We know one of them is asthma, but  
11 give us an idea.

12 A Allergies, high blood pressure, cardiac conditions,  
13 lung illnesses. I'm not reading; I'm just going off  
14 memory right now. Let's just see here, I can look up  
15 that form quickly here if you would like me to read  
16 them all, but, you know, those are included in that, so  
17 allergies, asthma, heart disease, high blood pressure.

18 Okay, I'm just going to open it up right now.

19 Q Well --

20 MR. MAXSTON: Mr. Kitchen, I'm not going to  
21 contest your client's view on different conditions.  
22 I'm not sure if we have to go down this road, to be  
23 honest with you. I don't --

24 MR. KITCHEN: Yeah --

25 MR. MAXSTON -- want to have to get him to  
26 read from something, if that's what you need him to do.

1 MR. KITCHEN: No, I don't.

2 Q MR. KITCHEN: And, you know, since what  
3 you're reading from, Mr. Schaefer, is not actually in  
4 the record. I think that's fine, that answers my  
5 question anyways.

6 Now, we've talked about this immediate danger,  
7 that life and health, but does it surprise you then  
8 that most people, when they wear these breathing  
9 barriers, even for hours on end, that they don't pass  
10 out from wearing them?

11 A Well, it doesn't surprise me, but just because they're  
12 not physically passing out does not mean that harm is  
13 not being done.

14 So here's the facts that I've been able to  
15 establish from my testing: People that wear breathing  
16 barriers are subjecting themselves to an oxygen  
17 deficient IDL -- IDLH inhalation atmosphere. And in  
18 many cases, they subject themselves to an IDLH level  
19 carbon dioxide as well.

20 If you subject yourself to IDLH levels of low  
21 oxygen, it will negatively impact your health whether  
22 you're aware of it or not, and that's why all the  
23 governing bodies that govern the rules of health and  
24 safety legislate what the minimum oxygen concentration  
25 in air that you can be exposed to, because you might  
26 not necessarily feel harm right away, you might not

1 necessarily have a headache right away or dizziness,  
2 you might not necessarily feel nausea right away, any  
3 of these other minor -- more minor types of symptoms of  
4 low oxygen.

5 But we know that if you are exposed to a hazard in  
6 a low enough concentration or a high enough  
7 concentration, depending on what the hazard is, harm  
8 will occur, and it might be something -- it might not  
9 necessarily be something that the wearer or user is  
10 aware of, at least not immediately.

11 Q In your experience, has Alberta Health Services or the  
12 Alberta Public Health authorities generally, have they  
13 acknowledged the risks and harms associated with these  
14 breathing barriers that you've been talking about?

15 A I've reached out to Dr. Hinshaw back in June of last  
16 year with a very detailed letter on pointing out -- at  
17 that time, it was -- nothing was mandated, it was just  
18 a recommendation that people wear, in Alberta, N95,  
19 nonmedical, or procedural what they call, you know,  
20 surgical mask for protection from COVID, and I had to  
21 point out a lot of the errors that she had stated.

22 I have read -- the only reply that I have received  
23 from Dr. Hinshaw's office to date is a read receipt.  
24 Actually it was CC'd to 23 other doctors in charge of  
25 public health in Alberta. So I have a lot of read  
26 receipts, no official response.

1           To also clarify, besides not having an official  
2       response, I have never -- there's been numerous  
3       attempts to contact Dr. Hinshaw's office for a  
4       response, and it has not been granted, it's been  
5       denied.

6       Q   Do you have any thoughts on why Alberta Health Services  
7       or the Chief Medical Officer of Health hasn't been  
8       willing to discuss these risks and harms?

9       A   I have thought --

10       MR. MAXSTON:                   I don't want to be difficult  
11       here, but I think that question really is asking your  
12       witness to talk about what's in the minds of the other  
13       people. I think if you rephrase it and ask him a  
14       different question, I might not object, but I don't  
15       think he can speak to why they're not doing or doing  
16       anything.

17       MR. KITCHEN:                   Right, I was asking him his  
18       thoughts, so I'll just ask it again with those words in  
19       there.

20       Q   MR. KITCHEN:                   Mr. Schaefer, and, you know,  
21       maybe you just have no idea, and that's okay, but do  
22       you, from your perspective, can you think of any  
23       reason -- or what do you think the reason is that there  
24       hasn't been any discussion on this?

25       A   I don't know. In all honesty, Mr. Kitchen, I have no  
26       clue, but I will tell you this, is that normally,

1 normally, before any types of mask mandates are --  
2 would be even recommended in Occupational Health and  
3 Safety settings, professionals like myself would be  
4 consulted long in advance of any potential mandates  
5 that would occur, and that has not happened this time,  
6 in this instance.

7 Q Now, as an Occupational Health and Safety expert, as an  
8 Occupational Health and Safety consultant, do you work  
9 at all with Occupational Health and Safety Alberta?

10 A I'm always -- I don't work specifically for  
11 Occupational Health and Safety Alberta; they have their  
12 employees, their own government employees, but do I  
13 work in union with them, like in cooperation?  
14 Absolutely. Everything that is Occupational Health and  
15 Safety-related in Alberta works in cooperation with  
16 Occupational Health and Safety representatives in  
17 Alberta.

18 Q And in your experience, has Occupational Health and  
19 Safety, OHS, have they acknowledged any of these risks  
20 or harms associated with these breathing barriers?

21 A There hasn't been any -- there hasn't been any real  
22 willingness to discuss that on behalf of OH&S, and  
23 they're more than happy to back Provincial mandates  
24 without discussion and without discussion or any other  
25 opinion that's contrary to the AHS mandate.

26 Q Why do you think that is?



1     A     I don't know. I don't know, Mr. Kitchen, but it is  
2           very strange, because in a normal time, before COVID,  
3           there was so much discussion about any new policy that  
4           could be implemented long in advance before it would  
5           become a mandate. There's planning, there's  
6           discussion, there's determination.

7           But I think what I find that's very interesting is  
8           that this is not just an Alberta situation; this is a  
9           worldwide thing. How strange is it that something like  
10          this type of breathing barrier could be mandated,  
11          rolled out so fast without any consulting of, you know,  
12          no one, no one trusted respirator professionals, by  
13          medical staff, who aren't experts in respiratory  
14          protection, they aren't qualified to -- medical doctors  
15          alone are not qualified to comment or give advice on  
16          various aspects of respiratory protection because  
17          they're not asked -- they don't deal in respirators  
18          professionally, they have very limited knowledge about  
19          respirators and masks and their protection levels and  
20          what they can do and what they can't do. And I find it  
21          strange that this has been implemented on a worldwide  
22          basis with virtually no contest, without official  
23          contesting of it, it's very strange.

24        Q     In fact, earlier you said, it was more than strange,  
25                you said it was serious?

26        A     Well, strange that it hasn't been documented, but when

1 I said serious, I said serious in relation to oxygen --  
2 I said serious in response to your question for me on  
3 the effects on people being exposed to less than 19.5  
4 percent oxygen. Yes, that is beyond strange. That is  
5 alarming. That is alarming that these devices could be  
6 mandated when they clearly -- when the testing that I  
7 am trained to perform clearly shows oxygen levels  
8 dropping below 19.5 percent with all three of these  
9 versions of mandated breathing barriers, whether it's  
10 an adult or a child even at resting rate, and we know  
11 that the drop is going to be even more significant for  
12 people that are engaged in any kind of activity.

13 Q And do you understand that we're here today because  
14 Dr. Wall has contested these breathing barriers and  
15 that, for doing so, he is facing professional  
16 discipline?

17 A Yes, I'm aware.

18 Q On page 8 of his report, Dr. Hu, I think his first name  
19 is Jia, but Dr. Hu says -- and just to clarify, he is  
20 the expert tendered by the Alberta College of  
21 Chiropractors -- on page 8 of his report, he says: (as  
22 read)

23 There are no known harms associated with  
24 masking.

25 Now, maybe it's obvious, but do you disagree with his  
26 statement?

1     A     Completely. I completely disagree with Dr. Hu's  
2           statement, because there are numerous scientific  
3           research papers and studies. I've looked through  
4           Dr. Hu's references, and I didn't see one registered  
5           scientific study in any one of his references, but I  
6           have references from registered scientific journals,  
7           medical journals. I have references from the --  
8           published by the National Library of Medicine to show  
9           quite the opposite of what Dr. Hu's references claim.

10                 Plus, in addition, my own -- obviously, my own  
11           testing, of course, but then as far as scientific  
12           references go, there's -- I can send a whole bunch of  
13           actual registered, published, scientific medical  
14           researchers that have shown quite the contrary to what  
15           Dr. Hu has stated.

16     Q     A number of witnesses in this hearing, including  
17           Dr. Hu, have said that the issue of masking as it  
18           relates to COVID is a politicised issue. Do you think  
19           it's a politicised issue?

20           MR. MAXSTON:                     I am going to have to object  
21           to that, Mr. Chair, that runs afoul of commenting on  
22           the harm or lack thereof in terms of masking.

23           MR. KITCHEN:                     I think that's a fair  
24           question.

25           THE CHAIR:                        Can you restate it?

26           MR. KITCHEN:                     And this is part of the reason

1       why I raised the fact that this has been a constant  
2       issue in the hearing, the other expert, Dr. Hu, who  
3       Mr. Schaefer just responded to, said that masking is a  
4       politicised issue, and so have several other witnesses,  
5       so now I'm asking Mr. Schaefer if he thinks masking as  
6       it relates to COVID is a politicised issue.

7       MR. MAXSTON:                   I'll just again state,  
8       Mr. Chair, that I think this witness is being tendered  
9       for a very specific purpose, and that was harms, in his  
10      view, that are caused by masking, and I don't think  
11      this witness is anywhere near the -- is a very  
12      different type of witness from the other experts that  
13      have testified.

14      MR. KITCHEN:                   I don't see what entitles  
15      Dr. Hu to talk about the politicisation of the issue  
16      that doesn't also entitle Mr. Schaefer to talk about  
17      it.

18      THE CHAIR:                   Well, I don't want to go back  
19      and retroactively deal with Dr. Hu, but I do think this  
20      witness was qualified as an expert in a very specific  
21      area, and I do think the question extends beyond that.

22   Q   MR. KITCHEN:                   Well, just one more question  
23       then, Mr. Schaefer, from your perspective, do you think  
24       Occupational Health and Safety is the primary  
25       consideration in forming these mask mandates?

26   A   Well, Mr. Kitchen, Occupational Health and Safety has

1 not been a consideration at all in these mask mandates,  
2 as demonstrated, and I would contest any safety  
3 professional with qualifications equal to mine to prove  
4 otherwise, that oxygen deficiency is created by wearing  
5 a breathing barrier. That is why our parents taught us  
6 to never put a bag over our heads. It is pretty  
7 standard, you cover your mouth and nose with a random  
8 object, it limits your ability to breathe naturally,  
9 and anything that limits your ability to breathe  
10 naturally can potentially be harmful to health. That's  
11 why we have screening, and anybody with pre-existing  
12 medical conditions that has a limit on their breathing  
13 could cause a life threatening medical emergency.

14 MR. KITCHEN: Thank you. Those are all my  
15 questions.

16 MR. MAXSTON: Mr. Chair, if you're  
17 comfortable, I'll just continue on. I don't expect to  
18 be too long.

19 THE CHAIR: Yes, that's fine. Just before  
20 you start, Mr. Maxston, Mr. Schaefer, you're okay to  
21 continue with this cross-examination, or did you want a  
22 break?

23 A I'm fine. Thank you very much, Mr. Lees.

24 THE CHAIR: Okay.

25 Mr. Maxston Cross-examines the Witness

26 Q MR. MAXSTON: Mr. Schaefer, I've got some

1        questions I'm going to take you to in a couple of  
2        minutes that I had thought of in advance of the  
3        hearing, but I want to touch on a few things that are  
4        fresh in my mind now that you've just talked about with  
5        Mr. Kitchen, if you don't mind.

6        A     Sure.

7        Q     So a few minutes ago, you talked about the fact that  
8        some people tolerate masking better than others and  
9        that that was a function of pre-existing medical  
10       conditions and the severity of those medical  
11       conditions; do you remember that exchange you had?

12       A     Yes, I do.

13       Q     And I think you talked about properly screening  
14       individuals as well, and it's important that people are  
15       health-tested in terms of masking and medical  
16       preconditions; do you remember that?

17       A     Well, at least as far as identifying pre-existing  
18       medical conditions that could make them not a good  
19       candidate for wearing any type of mask or respirator.

20       Q     Sure. And you would agree with me that it's important  
21       to go to a doctor to determine whether they have any  
22       pre-existing medical conditions?

23       A     That is correct.

24       Q     I want to touch on a few things that you talked about  
25       with Mr. Kitchen. You talked about, in your view, that  
26       Dr. Hinshaw didn't contact OHS, I think that's the

1 Provincial OHS, but I think you'd agree with me that  
2 you don't have any direct knowledge of that, do you?

3 A I didn't say that Dr. Hinshaw didn't contact OH&S.  
4 What I had said was that Dr. Hinshaw has not been --  
5 air testing on these masks has not been done, so they  
6 haven't -- the safety of people wearing them has not  
7 been properly determined, because there has been  
8 absolutely no air testing on oxygen deficiencies or  
9 carbon dioxide accumulations on these masks by --

10 Q Well, I don't want to belabour -- oh, sorry, so sorry,  
11 were you finished?

12 A Yeah.

13 Q I don't want to belabour this, but I think,  
14 Mr. Schaefer, it's fair to say though you haven't been  
15 involved in the development of the CMOH orders, have  
16 you?

17 A That is fair to say; I have not been involved in the  
18 development of those orders.

19 Q You made a comment I think it was a couple times during  
20 your testimony then, Mr. Kitchen had sort of a wrap-up  
21 question for you, and you were talking about the fact  
22 that it was strange that devices are mandated, that  
23 breathing devices are mandated. Would you agree with  
24 me that it is clear they are mandatory though?

25 A I would agree with you that it is clear that these  
26 breathing barriers are currently mandated, that's

1 correct.

2 Q And you've had a chance to look at the College's  
3 Pandemic Directive, I assume?

4 A I have not memorized it, but I have had exposure to it;  
5 I have looked at it, yes.

6 Q Yeah, and it's not a memory test for you. I'm just --  
7 there's a phrase, and my friend and I talked about this  
8 when you were being qualified, there's a phrase in it  
9 that says "surgical or procedure masks are the minimum  
10 acceptable standard", and it goes on to say that  
11 chiropractors and staff must be masked. You'd agree  
12 with me that that's mandatory for chiropractors?

13 A You know, I can't agree with -- look, just because --  
14 just because it's -- just because one of these or more  
15 of these breathing barriers is mandatory for  
16 chiropractors and other professions, doesn't mean  
17 they're safe.

18 Q Oh, I'm not asking you that. I'm asking you it's  
19 mandatory for chiropractors, question mark, full stop.

20 A Aware a procedural-based is what you're saying?

21 Q Yeah, I'm just saying that the Pandemic Directive, and  
22 I pointed you to the masking situation in particular,  
23 that's mandatory for chiropractors; aside from your  
24 views on the safety or harm, that's mandatory?

25 A That appears to be correct.

26 Q So, Mr. Schaefer, I'm going to turn you to now a couple



1 of, I guess, more generic questions, and I just wanted  
2 to be clear, and you kind of touched on this with  
3 Mr. Kitchen and I think with me a minute or 2 ago, you  
4 haven't been involved in the Government's response to  
5 COVID-19; that's correct?

6 A That is correct.

7 Q And you've been qualified today to provide your opinion  
8 about the harms that masking can cause for the wearer,  
9 and that's correct?

10 A That's correct.

11 Q And you're not here, of course, to provide any evidence  
12 about the benefits that might accrue from masking for  
13 people in the presence of the person being masked; is  
14 that correct?

15 MR. KITCHEN: Hold on, hold on --

16 A Well -- well --

17 MR. KITCHEN: -- that question --

18 THE CHAIR: Just (INDISCERNIBLE),  
19 Mr. Schaefer. Sorry, go ahead, James.

20 MR. KITCHEN: That question is premised on  
21 efficacy of masks, which my friend, my learned friend,  
22 went out of his way to make sure we were not going to  
23 talk about, and now he's trying to talk about it.

24 MR. MAXSTON: I'm trying to just make a  
25 comment that this witness isn't providing that  
26 evidence.

1 MR. KITCHEN: Well, that's been established  
2 time and over again, so I don't understand why we're  
3 just filling the record with repeats of what we've  
4 already established.

5 MR. MAXSTON: Well, I just wanted to be  
6 clear that this witness is not providing evidence about  
7 any potential benefits to persons in the presence of  
8 the wearer of a mask.

9 MR. KITCHEN: Well, I think we're --

10 MR. MAXSTON I'll move on, I'll move one,  
11 yeah. Mr. Kitchen, if you have a problem with this,  
12 you'll let me know.

13 Q MR. MAXSTON: You're not here to provide any  
14 evidence about the transmission of COVID for preventive  
15 measures for COVID?

16 A That's correct.

17 Q Would it be fair to say that your views about mandatory  
18 masking are inconsistent with most government Public  
19 Health agencies, in Canada I should say?

20 A In Canada, as far as the mandates that have come down  
21 provincially and nationally?

22 Q Yeah, that would be correct.

23 A Yeah, I would say that we definitely have a difference  
24 of opinion.

25 Q You talked with my friend, Mr. Kitchen, about the  
26 testing that you've done. None of that testing is

1 attached to your expert report, is it?

2 A That testing that I've done is not -- let me just take  
3 a look here.

4 MR. KITCHEN: Perhaps you could be a little  
5 more specific, Mr. Maxston --

6 MR. MAXSTON Yeah (INDISCERNIBLE) --

7 MR. KITCHEN: -- there's no exhibit that has  
8 a list of the readings. Is that what you're getting --

9 MR. MAXSTON: Yeah, that's kind of what I'm  
10 getting at.

11 Q MR. MAXSTON: And, Mr. Schaefer, this isn't  
12 a gotcha question, but I'm just looking at the second  
13 page of your report, and you talk about using the  
14 MultiRAE Lite, and you observed that upon commencement,  
15 and you have some comments then. I'm just saying  
16 there's no data or test results from those tests you  
17 performed which are part of your expert report,  
18 correct?

19 A I don't have it in the report, specific readings, but I  
20 have -- I've done lots of documentation on it and  
21 reports on it, so --

22 Q Yeah, I'm just -- I wasn't trying to take you down the  
23 road of what you did; I just wanted to be clear they're  
24 not attached.

25 A Yeah, the specific testing, I've done a lot of testing,  
26 so for me to have all of the different test subjects

1       and all of the different readings would be quite  
2       extensive as far as those testing results would be, so  
3       they're not attached, no.

4     Q   Okay. I want to ask you some questions about your  
5       registration with the Alberta College of Paramedics,  
6       and I think you've told me that you were at EMS for one  
7       year, you were a regulated member of that college for  
8       one year. Did you have to meet any entry requirements  
9       to get your EMS registration with the ACP --

10    A   Absolutely.

11    Q   -- College of Paramedics?

12    A   Yes, I did.

13    Q   And that's a mandatory requirement to become an EMS  
14       with the College of paramedics?

15    A   It's a mandatory requirement to be registered with the  
16       Alberta College of Paramedics to work in an  
17       occupational setting as a medic in Alberta.

18    Q   And even though you were only a -- I shouldn't say  
19       "only" -- but it was a one-year period you were a  
20       regulated member, there were mandatory requirements you  
21       had to follow during that year like con ed or paying a  
22       licence fee; would you agree with that?

23    A   Yes, in fact, the only requirements they registered  
24       with Alberta College of Paramedics, because I completed  
25       all of their requirements, the only requirement, moving  
26       forward from year to year, was to pay the fee to stay

1 registered. And that registration is required to work  
2 as a medic in Alberta, and I had no intention of  
3 working as a medic in Alberta as I was already fully  
4 employed as an Occupational Health and Safety  
5 specialist, so that's why I ended it.

6 Q Sure. And just to be clear, is it your understanding  
7 that if you don't follow those requirements, you can't  
8 be a member of the College?

9 A Yeah, you have to follow -- you have to work -- you  
10 have to practice your skills within a protocol as  
11 determined by Alberta College of Paramedics, yes, in an  
12 occupational setting.

13 Q Sure. I'm going to ask you a fairly specific question  
14 here, but would you comply with the paramedic  
15 equivalent of the College's pandemic requirement about  
16 mandatory masking if you were in the field?

17 A I would comply with wearing a mask, but I would not  
18 wear a breathing barrier. I have not worn a breathing  
19 barrier, and I won't. So, remember, there's a big  
20 difference between what's currently been mandated and  
21 what an engineered mask is.

22 A mask is safe to wear. A mask is engineered  
23 inhalation openings. A mask has an engineered  
24 exhalation opening. That's safe. It's established as  
25 safe. It's proven as safe over many decades.

26 So a closed cover is not something that I would

1 wear, no, but I would wear an actual mask.

2 Q So I just want to be clear, again, when we look at the  
3 Pandemic Directive for the College of Chiropractors, it  
4 says that the requirement is a surgical or a procedure  
5 mask; you would comply with that kind of directive from  
6 your regulatory body if that was applicable?

7 A I know that those aren't masks. Those are breathing  
8 barriers. I'm not going to jeopardize my health and  
9 safety through low oxygen and accumulations of carbon  
10 dioxide for any occupation, because that's my health,  
11 and my health is important to me. It's more important  
12 than anything else.

13 Q So you would choose to not comply with it?

14 A I would wear -- I would wear something that far exceeds  
15 the recommended protection, which is an actual  
16 certified respirator that actually is designed for easy  
17 and safe breathing, I would wear that, and it would far  
18 exceed any potential respiratory benefit that a  
19 breathing barrier could provide.

20 Q Those are all my questions --

21 A (INDISCERNIBLE)

22 Q Sorry, did you want to finish? I cut you off.

23 A Oh, sorry, I just wanted to say that -- so what I would  
24 wear would be far and above what has been currently  
25 mandated.

26 MR. MAXSTON: Those are all my questions,

1 Mr. Schaefer, thank you.

2 A Thank you very much, Mr. Maxston.

3 THE CHAIR: Mr. Kitchen, did you have  
4 anything on redirect?

5 MR. KITCHEN: Just a couple.

6 Mr. Kitchen Re-examines the Witness

7 Q MR. KITCHEN: Mr. Schaefer, you attest to  
8 the truth of what you said about the results of the  
9 testing you did?

10 A Well, I am under oath in this courtroom, so I believe  
11 I've already done that.

12 Q You just finished a discussion with my learned friend  
13 about whether or not you would wear a breathing barrier  
14 if your regulatory body told you you had to in order to  
15 practice, and if you didn't have access to the  
16 respirator, if all you had access to was the breathing  
17 barrier that they said you had to wear, would you wear  
18 it to keep your licence?

19 A No, I would not wear it to keep my licence because my  
20 health is more important than my job.

21 MR. KITCHEN: Thank you.

22 Q MR. KITCHEN: Wait, hold on, forgive me.  
23 Mr. Maxston asked you about screening and  
24 pre-conditions. Just to clarify, you would say that  
25 masks -- well, would you say that masks are harmful to  
26 people who have no pre-existing conditions at all?

1     A     Look, a mask is engineered for breathing.  People  
2           without pre-existing conditions should be able to wear  
3           an actual engineered mask with engineered inhalation  
4           and exhalation valves no problem, provided -- you know,  
5           depend -- again, it depends like on previous -- if  
6           there's no pre-existing conditions, they're considered  
7           fit, then an actual mask is safe to wear for that  
8           person.

9                 But if you're talking -- I'm not talking about a  
10            breathing barrier here.  A breathing barrier with no  
11            inhalation valves, no exhalation valve, that's not safe  
12            for anybody.

13           MR. KITCHEN:                    Thank you.  Those are actually  
14            all my redirect questions.

15           THE CHAIR:                      Thank you very much,  
16            Mr. Schaefer.  I believe that concludes your testimony  
17            this morning, and we thank you for your attendance and  
18            for your testimony, and you're free to leave the  
19            hearing.

20     A     Thank you very much, Mr. Lees.

21           THE CHAIR:                      It's 20 to 12, and we could  
22            start at 12:45.  Mr. Maxston?

23           MR. MAXSTON:                    Yes, I wondered, do you have  
24            any questions?  You didn't have any questions, I'm  
25            assuming, of Mr. Schaefer --

26           THE CHAIR:                      Oh, I'm sorry, I jumped the



1 gun there. Did the Members of the Tribunal want to  
2 caucus and discuss that? I think I'll have to take a  
3 lashing for that, probably ten lashes, but yeah.

4 So I suggest then that we break for lunch, and we  
5 reconvene at 12:45 with Mr. Kitchen's witness and go  
6 from there.

7 MR. MAXSTON: Just so I'm clear, Mr. Chair,  
8 my apologies, will you want Mr. Kitchen -- maybe this  
9 is a question Mr. Kitchen is going to ask, do you want  
10 him to have Mr. Schaefer available then at 12:45 if you  
11 have any further questions? And I'm just asking, I  
12 don't know exactly where we're heading at 12:45.

13 THE CHAIR: Okay, I'll touch base with the  
14 Tribunal Members when we break here, and if there are  
15 some follow-up issues from the Hearing Tribunal with  
16 respect to Mr. Schaefer, I'll get in touch with  
17 Mr. Kitchen, and we'll arrange to get him back.

18 MR. KITCHEN: Yeah, if you could just please  
19 let me know within 10, 15 minutes, just that way, I can  
20 release him or I can keep him around.

21 THE CHAIR: Yeah, thank you for bringing  
22 that up. That's my fault, I got ahead of myself. When  
23 we break now, we'll go into a break-out room first, the  
24 Panel Members and our legal counsel, and we'll just  
25 find out if there are any follow-up questions, and then  
26 I will let you know, Mr. Kitchen.

1 MR. KITCHEN: Okay, thank you.

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3 PROCEEDINGS ADJOURNED UNTIL 12:45 PM

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

4

5 November 20, 2021 Afternoon Session

6

7 HEARING TRIBUNAL

8 J. Lees Tribunal Chair

9 W. Pavlic Internal Legal Counsel

10 Dr. L. Aldcorn ACAC Registered Member

11 Dr. D. Martens ACAC Registered Member

12 D. Dawson Public Member

13 A. Nelson ACAC Hearings Director

14

15 ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

16 B.E. Maxston, QC ACAC Legal Counsel

17

18 FOR DR. CURTIS WALL

19 J.S.M. Kitchen Legal Counsel

20

21 K. Schumann, CSR(A) Official Court Reporter

22

23 (PROCEEDINGS RECOMMENCED AT 12:46 PM)

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

26 MR. KITCHEN: All right, Dr. Dang, first

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

4     THE WITNESS:                     Okay.

5     DR. BAO DANG, Sworn, Examined by Mr. Kitchen

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

13            So, Mr. Chair, the -- Dr. Wall tenders Dr. Bao  
14    Dang as an expert in the area of respirology and, in  
15    particular, COVID-19 and the efficacy of masking and  
16    related measures.

17            Now, I'll turn it over to Mr. Maxston, who I think  
18    wants to just make some comments on that.

19    MR. MAXSTON:                     Mr. Chair -- thank you,  
20    Mr. Kitchen -- Mr. Chair, as I've discussed with  
21    Mr. Kitchen, I just want to, again, emphasize the  
22    Complaints Director's view that you can accept evidence  
23    in whatever manner you see fit, but that the Complaints  
24    Director's position is with respect to these expert  
25    witnesses that the focus of this case is regulatory  
26    compliance and not the efficacy of masking, and you

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

3       MR. KITCHEN:                   Thank you.

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

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

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

10      MR. KITCHEN:                   Okay.

11      THE CHAIR:                    -- let's proceed.

12   Q   MR. KITCHEN:                   Okay, all right. Well,  
13       Dr. Dang, let's start with, do you practice here in  
14       Alberta?

15   A   I do.

16   Q   And where?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26    A     That is correct.

1 Q I just want to ask you a few questions about your  
2 impartiality. Dr. Dang, do you know Dr. Curtis Wall  
3 personally?

4 A No, I've never met him.

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

7 A I do not.

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

10 A No, I do not.

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

14 A Yes.

15 Q Thank you. Dr. Dang, are there different types of  
16 health care settings?

17 A Yes.

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

20 A Yes, that is correct.

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

23 A I would say so.

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



1           chiropractic office?

2     A     Yes, I would think so.

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

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

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

10    A     Yes, potentially.

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

14    A     Yes, absolutely.

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

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

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

- 1 Q Thank you. Now, I'm going to move into your report.  
2 In the second paragraph of your report, you state how  
3 ridiculous it would have been to mandate the entire  
4 public wear masks during past outbreaks of respiratory  
5 infections, such as H1N1 and SARS. Now, the first  
6 question I have for you on that is are those infections  
7 viral-based or bacterial-based?
- 8 A Both of them are viral-based.
- 9 Q And you said H1N1 was in 2009 and SARS was in 2003;  
10 that's correct, right?
- 11 A Yes, I actually, of course, took part in the medical  
12 care during those time periods as well.
- 13 Q Well, that was my next question, so you were practicing  
14 medicine during both of those?
- 15 A Well, in 2003, I was in medical school, and then in  
16 2009, I was in my full practice at that time.
- 17 Q Okay.
- 18 A But in both cases, I had clinical exposures, of course,  
19 to them.
- 20 Q Right. Besides those, are there any other historical  
21 viral outbreaks that you've had experience dealing  
22 with?
- 23 A Not major ones that I can think of, to my knowledge,  
24 directly.
- 25 Q Now, forgive my ignorance, I can't help but notice that  
26 SARS must have something to do with what's going on

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

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

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

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

1 Q And in your opinion, was that the correct approach to  
2 take back then?

3 A Yes, I believe so.

4 Q And do you think back then that not mandating masking  
5 was an unsafe thing to do for patients and for health  
6 care workers?

7 A No, I mean -- you're asking is -- because we didn't  
8 mandate masks in our universal setting, was that unsafe  
9 for the --

10 Q Yeah --

11 A -- patients?

12 Q -- that's what I'm asking.

13 A Yeah, yeah. So, no, I don't think -- I think we did  
14 the right -- I think the public health authorities did  
15 the right thing at that time, it just had masking in  
16 very limited settings, which was what was always  
17 applied in the past anyways -- or in the past in terms  
18 of modern medicine.

19 Q Why do you think it is that there was no attempt to  
20 implement or impose mandatory masking back then?

21 A Well, I don't think anyone can say with certainty.  
22 There are multi-factorial reasons. One, I don't think  
23 at that time or as I say even now there was any firm  
24 evidence that that would work. Applications to general  
25 population would be problematic to say the very least,  
26 and it would be, at that time, probably considered a

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

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

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

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

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

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

23 A Correct.

24 Q So not scientific reasons?

25 A Correct.

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

1           then?

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

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

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

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

22       A    Yes, I would disagree with that assessment.

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

1 infections?

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

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

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

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

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

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

24 A Oh, then that's the correct answer.

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

1 A That would be correct, yes.

2 Q Help us understand, us nonmedical people, what is a  
3 micron?

4 A Well, a micron is microscopic so you can't see it  
5 unless it's under a microscope, and even smaller than  
6 that, not even a regular microscope. So I imagine most  
7 of the audience here had to use a regular microscope at  
8 some point in their schooling, high school or  
9 university. You would have to go up to the next order,  
10 which is an electron microscope, to probably see these  
11 viroids. So we're talking about a magnification of  
12 100,000 to a million times to even see a dot, for  
13 example.

14 Q Is electron microscopes what they use to be able to see  
15 things like RNA and DNA?

16 A Yeah, I'm not even sure they can see that, but they  
17 could see bacteria, and they could see some viruses.  
18 They're those kind of microscopes that fill up the  
19 entire room basically in the old days. Maybe they're  
20 smaller now, but I used to work, when I was doing my  
21 training, on an electron microscope, and it filled up  
22 the entire room, and, yeah, it required a lot of power.  
23 It was like one of those super computers you would  
24 think of in the old days.

25 Q So just to try and get an idea of the size of the  
26 SARS-CoV-2 virus, is it similar to a really large



1 molecule?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 metres apart before boarding the plane.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 scientific fact?

2 A I'd say that's a theory that has been debated and  
3 disputed, yes. Not a fact.

4 Q On the second page of your report, you mention a  
5 randomised control trial on the effectiveness of masks  
6 regarding COVID that was conducted in Denmark --

7 A Correct.

8 Q -- for short, it's called the DANMASK-19 study. Can  
9 you just tell me briefly about some of the findings of  
10 this study?

11 A Well, it was a study in a public setting looking at  
12 masks and seeing if it would reduce rates of COVID, and  
13 the findings were negative, meaning it didn't  
14 significantly show a reduction in COVID infection.

15 The significance of this study -- I mean, every  
16 study has problems -- is that it is the only randomised  
17 control trial looking specifically at COVID. Every  
18 other piece of evidence so far is based on either  
19 previous literature pre-COVID or else based on  
20 observational data. So the only randomised control  
21 study, which is considered -- generally considered the  
22 highest form of research, looking specifically at this  
23 issue during the COVID pandemic so far is a negative  
24 study for showing benefits with wearing a mask.

25 Q Now, you've said that randomised control trials are,  
26 you said, the highest -- of the highest value, is that

1       what you said?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 THE CHAIR: That's fine. I was just going  
25 to ask, Mr. Maxston, you're okay?

26 MR. MAXSTON: Yes, I'm fine, thank you.



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

2 MR. KITCHEN: Thank you.

3 (ADJOURNMENT)

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

6 MR. KITCHEN: Thank you.

7 Q MR. KITCHEN: Now, Dr. Dang, before the  
8 break, you were talking a little bit about randomised  
9 control trials versus observational evidence. Now,  
10 observational evidence does have some value; is that  
11 right?

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

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

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

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

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

4 A No, they have not decreased.

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

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

11 Q Now, Dr. Hu has stated that every country that has  
12 imposed masking as a mandate has experienced decreased  
13 transmission of COVID; do you agree with him?

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

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

18 A None that could support it conclusively.

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

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

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

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

6 A For various reasons, I do, yes.

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

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

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

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

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

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

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

1 statement likely to be true?

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

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

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

14 Q Hundreds just in Medicine Hat?

15 A Yeah.

16 Q (INDISCERNIBLE)

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

18 Q Right, but Dr. Hu has said that it's less than 100 for  
19 the whole province.

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

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

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

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

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

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

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

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

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

1 A Yes, correct.

2 Q And how many peaks or waves of the virus have we had so  
3 far?

4 A I believe we're in the fourth one they say in Alberta  
5 anyways.

6 Q And for how many of those waves has mandatory masking  
7 been in place?

8 A In terms of the Alberta rules, I believe it was  
9 instituted December 8 -- or announced on December 8th,  
10 2020, which is I believe during the second wave.

11 Q So is there any data to suggest that the third wave and  
12 fourth wave were decreased because of masking?

13 A No, because their waves were much higher than the very  
14 first wave when there was no mandatory masking at all,  
15 provincially or by city.

16 Q So the cyclical nature of the virus is going on  
17 unabated by universal widespread masking?

18 A Correct, I think it's independent of that. I don't  
19 think it has made any impact on viral transmission.

20 Q So you wouldn't say there's even any correlation, let  
21 alone causation?

22 A Correct.

23 MR. MAXSTON: Just while you gather your  
24 thoughts, I just want to express a bit of a concern  
25 that some of the questions have some preambles to them  
26 and the question at the end; I'm a little concerned

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

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

8   Q   MR. KITCHEN:                    Dr. Dang, do you think enough  
9       evidence has accumulated over the last year-and-a-half  
10      to allow us to reasonably know, one way or the other,  
11      whether the Public Health restrictions have been  
12      effective regarding COVID?

13   A   No, I think it's highly debatable to now.

14   Q   So mindful of my learned friend's comments, it's highly  
15      debatable, so you're saying -- I want to make sure I  
16      understand -- is there enough evidence to say that the  
17      restrictions definitely don't work?

18   A   No, I don't think anyone can say that either with  
19      certainty. I say that is debatable that you can say  
20      that these restrictions have had a meaningful impact.  
21      If you go by case numbers itself, in terms of the  
22      volume of COVID cases, in some jurisdictions, we have  
23      seen the highest rates ever despite vaccinations,  
24      restrictions, et cetera. So if you go by results, you  
25      could argue that they've had no impact because you have  
26      more cases than ever.

1 Q And just to be clear, there is not enough evidence to  
2 definitely say they do work?

3 A Correct, yes, there's -- I would agree with that  
4 statement completely. There is no definite evidence  
5 that they do work as they were intended, and that the  
6 point is really debatable at this point.

7 Q Based on a preponderance of evidence, if you had to  
8 choose between the restrictions are generally working  
9 or the restrictions are generally not working, which  
10 would you say is the case?

11 A Well, I said previously, given the -- many  
12 jurisdictions having the highest cases ever since the  
13 pandemic began, over almost two years now, I would say  
14 that they generally are not working.

15 Q You said the word "debatable"; is there a debate  
16 currently ongoing about the effectiveness of these  
17 measures?

18 A I think, to some extent, there is a debate. I believe  
19 currently the debate has been more leaning to one side  
20 than the other in terms of the ability to debate, but  
21 anything in the scientific realm should be debatable  
22 and argued reasonably.

23 Q Do you think the Alberta Public Health authorities are  
24 open to debate?

25 A Based on what I can see so far of their actions, no, I  
26 do not think they are open to debate.



1 Q Do you find that strange?

2 A I do. Normally, the scientific community should be  
3 open to debate and arguments and to see both sides of  
4 the situation before making profound measures that  
5 impact basically the entire population.

6 Q Do you think the decisions that Alberta Health Services  
7 or the CMOH are making, do you think they're entirely  
8 informed by science?

9 A I do not think they have considered all the evidence in  
10 science that is available or looked at both sides of  
11 the situation, so the short answer to that being, no, I  
12 don't.

13 Q Do you think there's anything nonscientific that's  
14 influencing these decisions?

15 A Well, I think there's always an element of a bit of  
16 fear and the tendency, it appears, from this  
17 organization to err on one side rather than the other.  
18 I think there's also, to some extent, a kind of a  
19 domino effect from what is happening around the world,  
20 so that every jurisdiction has to feel like they're  
21 following everyone else's, and it's reached a point  
22 where it's very hard to go against the grain, as it  
23 were. But there have been some countries that have  
24 successfully done that, and I think I put a point in my  
25 report to that effect as well.

26 Q And would you say that impact, is that a scientific

1 impact?

2 A Sorry, can you clarify that?

3 Q You said there's the domino effect of feeling like you  
4 have to follow what other jurisdictions are doing; is  
5 that effect a scientific effect?

6 A No, I think that's mainly a social political effect.

7 Q Dr. Hu has repeatedly stated that the evidence  
8 supporting the effectiveness of masks is, quote,  
9 overwhelming. Do you think that's a scientifically  
10 accurate statement?

11 A Well, I disagree with that statement is I think the  
12 best I can say. I think that there is not overwhelming  
13 evidence. I think it is still highly debatable at this  
14 point, and there have been studies in the past for and  
15 against his position.

16 Q Dr. Hu has also said that there's heaps and mounds of  
17 evidence supporting the effectiveness of masks.

18 A I would not say --

19 Q Do you -- I was just going to ask you, do think the  
20 statement is an exaggeration?

21 A I disagree with the statement.

22 Q Would you say he's -- you merely disagree with him, or  
23 would you say he's exaggerating?

24 A Well, I don't think what he said is true. I don't  
25 think there are heaps and mounds. Although heaps and  
26 mounds is a very subjective description, so maybe, in

1       his mind, heaps and mounds are -- is different from  
2       what I think of heaps and mounds.

3       Q     Dr. Hu said masks are an effective tool for preventing  
4       the spread of respiratory viruses writ large. In your  
5       opinion, is this a medically sound statement?

6       A     Again, I would disagree with that, based on the studies  
7       in the past, looking specifically at viral  
8       transmission, masks have not been proven to be  
9       beneficial in that sense. And from a structural point  
10      of view, I don't see how they could be, given the sizes  
11      of viruses versus the pores of masks.

12      Q     And forgive me if this seems redundant, but then Dr. Hu  
13      goes on to say in the last page of his report that:  
14      (as read)

15             The efficacy of masking on disease  
16             transmission is beyond doubt.

17      Do you agree with that statement?

18      A     I do not.

19      Q     Let me ask you a different question: Do you think that  
20      statement is even reasonable?

21      A     Well, personally, I don't think it's reasonable. As I  
22      mentioned before, science is open to debate, and so  
23      this is I think still a very debatable point. And  
24      there has been some research looking into this long  
25      before COVID, and the results have been mixed at best.  
26      So to say that this is definitely one way or the other

1 is not right.

2 Q Do you think there are some things about science or  
3 medicine that really aren't debatable because we know  
4 what the answer is?

5 A Yes, but very few things.

6 Q Okay. So does it surprise you then that Dr. Hu is so  
7 confident that he's absolutely right about the efficacy  
8 of masks?

9 A Well, really I can't speak for Dr. Hu or his intention,  
10 I presume they're honourable, but I think, as I say, in  
11 any scientific debate, especially on a question as  
12 this, that potentially it could affect civil society to  
13 such a broad extent, I think it should be open to  
14 debate, and I don't think that there is firm evidence  
15 saying conclusively that masking worked or that they  
16 justify the measures that have been in place.

17 Q Now, of course, to Dr. Hu's credit, he specifically  
18 said masks aren't perfect, nothing's perfect, masks  
19 aren't perfect.

20 A Correct.

21 Q Are you -- would you say that masks don't work at all  
22 ever?

23 A It -- no, I think that it depends on what the purpose  
24 of the mask is and the conditions that they're used.  
25 In some very limited settings, they might be useful to  
26 some extent. Even in the days, as I mentioned, the

1 previous pandemics that I was experiencing, we didn't  
2 have these universal rules in the community of  
3 populations, but we certainly had limited settings in  
4 isolated rooms, in negative pressure rooms, and  
5 different types of masks and different procedures for  
6 wearing the masks.

7 So -- but the original purpose of wearing masks,  
8 supporting my OR research -- or in the studies that  
9 looked at it in the operating room, it's not for viral  
10 transmission protection but really to prevent  
11 transmission of very large things like blood and saliva  
12 and things like that.

13 Q So some masks could work sometimes for some things?

14 A Correct, yes.

15 Q But when it comes to COVID, from your observations, are  
16 the masks working to stop the transmission of COVID?

17 A No, and if we go completely by result-based assessment,  
18 then I think that definitely you can say, no, it has  
19 not been successful in that way.

20 Q Now, I want to go back to this issue of causation and  
21 correlation, because I think this is probably pretty  
22 important.

23 Dr. Hu stated in his testimony that a very, very,  
24 very large number of health care workers in Italy  
25 contracted and died from COVID early on. He concluded  
26 that part of the reason that happened was because the

1 Italian health care workers ran out of masks. Now, in  
2 your opinion, is there a causal link between masking  
3 and what happened to the Italian health care workers,  
4 or is that only correlation?

5 A Well, that would be, at best, correlation. I think  
6 even if you clarified that with Dr. Hu, he would agree  
7 with that if he's a clinician and a researcher because  
8 that's -- that's not a randomised control study, and  
9 that's not -- there are other factors at play, so you  
10 can always say, at best, that there's a -- there may be  
11 a correlation.

12 Q So there's no scientific basis to attribute causation  
13 to that?

14 A Correct.

15 Q Dr. Hu in his testimony described the lockdown  
16 restrictions imposed last December -- which we've  
17 already talked about, that's the first time universal  
18 masking was in place all across the province -- he  
19 stated that cases went up after that November, December  
20 lockdown, but then eventually later, the cases went  
21 down. He then concluded that the lockdown caused the  
22 cases to eventually go down, and that the initial rise  
23 in cases was only correlated with the lockdown. Do you  
24 agree with Dr. Hu's analysis?

25 A No, I don't think you can have one or the other. You  
26 have to say, at best, there may be a correlation. As I

1 mentioned too before, I believe that the virus is  
2 cyclical.

3       And if -- and I remember that first lockdown quite  
4 clearly in my mind, because I kept track of it, and for  
5 personal reasons, I just remember it, but the  
6 Government announced -- well, Medicine Hat was the last  
7 city that announced a mandatory mask, of all the major  
8 cities in Alberta, on December the 4th, and then four  
9 days later, the Premier announced a lockdown on -- a  
10 masking and general restrictions on December the 8th,  
11 but to be effective that weekend, so it would be a few  
12 days to give people some time to prepare for that.

13       Even though he instituted that, at that time, the  
14 cases for that time period had reached the highest it  
15 had seen at that time. It continued to reach -- go up  
16 slightly for the first few days, but then it peaked,  
17 and then after that, it steadily started to go down. I  
18 mean, you can look into the statistics for this; you  
19 yourself can easily prove that.

20       Now, obviously even by their own words, they said  
21 that it would take two -- at least two weeks or more  
22 before any of these measures would take -- would have  
23 any benefit. So the fact that it peaked already and  
24 started to come down two or three days after they  
25 announced the general lockdown shows that those  
26 restrictions had nothing to do with the cases going

1 down, but I believe just due to the cyclical nature and  
2 the natural path -- pathogenicity of the virus, so --  
3 and then we've seen that since with subsequent waves  
4 from what I can see.

5 Q So did Dr. Hu make a mistake when --

6 A Dr. Hu's entitled to his opinion. I don't know, I  
7 can't speak to what he says. I can only tell you what  
8 I believe, and I disagree with his assessment.

9 Q Okay. He was very clear on this, because I asked him  
10 his position.

11 Is conflating causation and correlation, is that a  
12 pretty big mistake?

13 A I believe so --

14 MR. MAXSTON: I'm sorry, I'm going to have  
15 to comment again. I think you can ask your client  
16 where he disagrees and why he disagrees, but that kind  
17 of a question sort of presumes a response.

18 Q MR. KITCHEN: Dr. Dang, when it comes to  
19 medicine and science, is it really important to not  
20 conflate correlation and causation?

21 A Correct, the two do not always end up agreeing.  
22 Correlation may be helpful to stimulate further  
23 research and hypotheses, but the causation may turn out  
24 to be something completely different.

25 Q Do you see any causal link, causal link between the  
26 lockdown measures like mandatory masking and the COVID



1 numbers, be it cases, ICUs, or deaths; do you see any  
2 causation between these lockdown measures like masking  
3 and those COVID number?

4 A No, I don't see any conclusive evidence of that, and I  
5 don't think anyone can say conclusively that the  
6 lockdowns or these restrictions caused lower cases.

7 Q But that's what -- isn't that what Public Health says?

8 A Well, I can't speak for what Public Health says. I can  
9 observe what I see and what the numbers are like in the  
10 world and in our province throughout all this.

11 Q But you said, you know, I can't see how anyone could  
12 say this, and yet isn't just about everybody saying it?

13 A I can only speak to myself and my own conscience and  
14 the evidence that is presented to me that is available  
15 to everyone else. I can't speak for anyone else. I  
16 would say it's universal, but I agree that there are --  
17 I think the majority of people do believe, at least at  
18 this point, that these restrictions have had some  
19 impact, but, again, I believe that is probably due a  
20 lot to social political reasons as well.

21 Q Maybe you can't answer this and you tell me if you  
22 can't, but why do you think it is that we are making  
23 Public Health decisions based on social and political  
24 concerns and not scientific concerns?

25 A Well, I think like everything else in civilization,  
26 we're human beings, so we don't just deal with facts,

1       we deal with emotions too, and we deal with -- right  
2       now we're dealing with fear and panic and paranoia,  
3       et cetera, and I believe that each and every government  
4       is trying to respond in, they think, the best way to  
5       deal with that.

6       Q    To deal with the fear?

7       A    Correct, and to maintain, perhaps in their eyes, a  
8       civil order and control perhaps, but that is my  
9       opinion.

10      Q    Well, and that's what you're here to give us.

11               Do you think the term "anti-mask" is pejorative?

12      A    Correct, I do.

13      Q    Do you think it is fair and accurate to label someone  
14      as an anti-masker if they are opposed to mandatory  
15      masking but not voluntary masking?

16      A    I believe that is pejorative in that case, yes.

17      Q    Do you think people should be free to mask if they want  
18      to?

19      A    Well, yes, in general, that I think was always an  
20      option in the past in -- many jurisdictions did that;  
21      for example, Japan, a lot of people wear masks for  
22      other reasons, but, yes, I believe it should be a free  
23      choice.

24      Q    What does the phrase "informed consent" mean to you?

25      A    Well, it generally means that you tell the patient what  
26      can happen -- the procedure that you plan to do, the

1 risks and benefits of it, the evidence for or against  
2 it, and then they make a decision after being informed  
3 of all relative and important features about the  
4 decision; they make a decision whether to go for it or  
5 against it, and without any coercion or duress.

6 Q Do you think informed consent is obtained if only the  
7 benefits are discussed but not the risks?

8 A Correct -- no, correct, I -- yes, you're -- I do not  
9 think informed consent is obtained in that case. You  
10 have to give the risks and benefits and all the  
11 important salient features about whatever that decision  
12 is before informed consent is obtained.

13 Q When it comes to masks, would you say that there are  
14 both potential benefits and potential risks?

15 A Yes, I would.

16 Q So do you think mandatory masking is consistent with  
17 informed consent?

18 A No, because there is no consent being sought. It is  
19 just a rule being imposed. So by definition, that is  
20 the complete opposite of informed consent.

21 Q What does the phrase, "First, do no harm" mean to you?

22 A That's one of the tenets of any physician, primum non  
23 nocere in Latin, that we are taught, first, do no harm,  
24 and the principle is whatever we suggest, we always  
25 have to keep in mind that whatever we do, not cause  
26 harm to the patient.

1 Q Do you think mandatory masking is consistent with,  
2 first, do no harm?

3 A I do not.

4 MR. KITCHEN: Mr. Maxston, just to give you  
5 an idea. I'm probably only about 20 minutes from being  
6 done; 30 minutes at the very most. Yeah, I'm going to  
7 say probably 20 minutes or less.

8 Q MR. KITCHEN: All right, Dr. Dang, with  
9 that, I'm going to move into asking you some questions  
10 about the harms of masking as you've discussed them in  
11 your report.

12 A Okay.

13 Q You state near the bottom of the second page of your  
14 report that wearing a mask is, quote, not harmless.  
15 You go on to discuss how humans are designed to  
16 breathe. Now, can you tell me, as a respirologist, how  
17 are humans designed to breathe?

18 A Well, I can certainly tell you as a respirologist, but  
19 I think anyone can tell, without respirology training,  
20 that we're meant to breathe as we are, unobstructed,  
21 freely through our mouth and nose, ideally good air of  
22 course, clean air.

23 Q So even if we're breathing unobstructed, if we're  
24 breathing bad air, what happens?

25 A Well, then we have to -- then, as I mention in the  
26 report, in certain circumstances, we have to, of

1 course -- we can use protective measures if the  
2 benefits outweigh the drawbacks of that.

3 So if you're -- obviously, if you were exposed to  
4 mustard gas or something like that in World War I, then  
5 you would have to wear a special gas mask to prevent  
6 that. It would obstruct your breathing, and no one, I  
7 think, would argue with that, but, for that temporary  
8 purpose, that would be beneficial.

9 Q So given the choice between access to -- or decreased  
10 access to oxygen and breathing mustard gas, which is  
11 the better choice?

12 A Well, breathing the lower oxygen as long as it can  
13 still sustain life for the shortest period of time  
14 possible.

15 Q And forgive me, but is that because mustard gas is so  
16 dangerous?

17 A Correct, I believe it is deadly in many cases.

18 Q If you're exposed to mustard gas, is your rate of  
19 survivability less than 99 percent?

20 A I don't have the exact numbers, but I certainly  
21 wouldn't want to be exposed to mustard gas under any  
22 circumstances. Even the survivors have damage in terms  
23 of pneumonitis and other chronic health problems too.

24 Q So we would never do a randomised control trial with  
25 mustard gas?

26 A Not during these days. Maybe during World War I, they

1           might have, but, no, we wouldn't.

2     Q     It's kind of like the parachute example?

3     A     Correct.

4     Q     Now, the types of masks that are mandated for COVID,  
5           how do those types of masks interfere with the normal  
6           breathing process as you've described it?

7     A     Well, it could be something from very mild to very  
8           significant, depending on the type of mask, how it is  
9           worn, how much it has changed, et cetera, and also  
10          their condition of the patient -- or the person who  
11          wears the mask. If they have chronic lung disease,  
12          they may be impacted more severely than others.

13                 I can tell you just from personal -- I mentioned,  
14          I run a pulmonary function lab, and just as kind of a  
15          personal inquiry, I had some healthy testing whereby  
16          just wearing a mask versus not wearing a mask and doing  
17          a pulmonary function test, and these are completely  
18          healthy people. The lung functioning drops about 15 to  
19          20 percent. So it does play an impact, in my opinion.

20                 Obviously, that's just my own anecdotal kind of  
21          evidence, but I believe that any reasonable person  
22          would agree that wearing anything that covers the mouth  
23          and nose would, at least to some degree, obstruct your  
24          airways and breathing. Whether it's clinically  
25          significant or not is debatable though.

26    Q     So this reduction in lung function, that's across the

1 board, the same for everybody?

2 A Well, it's rough -- because everyone's going to be  
3 slightly different, but, yeah, in a healthy individual,  
4 it seems to me, from what I've seen, roughly 15 to 20  
5 percent.

6 Q But help me understand, is that really significant or  
7 not really?

8 A It won't be noticeable if you're sitting still, doing  
9 light stuff, but if you're exerting yourself or  
10 exercising, you could definitely notice a difference,  
11 and if you have some sort of lung health problem --  
12 other health problems, it would probably be much more  
13 noticeable.

14 Q So do you find it surprising that some people seem to  
15 tolerate wearing these masks more than others?

16 A No because everyone has different lungs, shall we say,  
17 and also everyone in the public wears masks differently  
18 and the types of masks, so everyone will have a  
19 different response.

20 Q You mentioned in your report self-contamination due to  
21 moisture retention. Can you just describe, what is  
22 this self-contamination due to moisture retention?

23 A Well, it's just simply when you breathe, of course,  
24 you're breathing moist air, there's water in it,  
25 et cetera, water vapour, and anything that it hits will  
26 condense. I mean, you see that so when you wear

1       scarves or anything to cover your face.

2               So same thing with masks; if you wear a mask long  
3 enough, you're going to collect moisture there, and  
4 then that can, in turn, collect secretions, your own  
5 secretions, or things that are exposed at -- or  
6 contaminants around you, and then in the end, you're  
7 going to be breathing that in again. So that's what I  
8 mean by moisture contamination.

9               In fact, the appropriate way to wear a mask before  
10 all this began, in a health care setting is that we had  
11 to change our masks frequently. So, generally, I would  
12 change it, if I had to -- first of all, I wouldn't wear  
13 it any longer than I had to, but if you had to wear it  
14 for an extended period of time, you should probably  
15 change it every hour, and we're talking about  
16 disposable, you know, surgical-type masks.

17              But that's simply not happening in the public.  
18 You're having people wearing cloth masks or the same  
19 surgical mask over and over again and touching them,  
20 et cetera. So even the application of wearing them  
21 safely is not -- is not done. I would say in 99.9  
22 percent of the population in a community setting.

23   Q       And what would some of these contaminants be?

24   A       Well, it would be whatever is in your saliva basically.  
25       So it could be bacteria, it could be viruses, and then  
26       whatever you breathe around you, could be particulate



1 matter, could be anything from just smoke, dust,  
2 vapours, allergens, could be viruses. I mean, if you  
3 were exposed to someone coughing with COVID or any  
4 other virus, it could go onto there, then you could  
5 have breathing it in theoretically.

6 Q Hold on. So, theoretically, wearing a mask could  
7 actually increase your chance of contracting COVID?

8 A Well, could increase your chance of getting any  
9 infection, if you don't wear -- if you don't change the  
10 masks and don't keep them clean, correct, yes.

11 Q Okay. In your practice or in the literature, either  
12 one, what are some of the harms that you have observed  
13 from continuous or prolonged mask wearing?

14 A Well, there's -- of course, there's psychological  
15 damage that could be done, both to patients,  
16 particularly in younger ones, kids for example. There  
17 are things like severe allergic reactions.

18 I had one patient, a health care worker in the  
19 hospital who couldn't wear a mask, because every time  
20 the patient wore the mask, there would be a very severe  
21 rash, and this is well-documented, she -- the patient  
22 had pictures to prove it, and despite wearing several  
23 types of masks of different material, they all produced  
24 the same results.

25 And then, of course, there's people -- my  
26 practice, of course, consists of mostly people who are

1 short of breath, so if they're extremely short of  
2 breath, of their oxygen, et cetera, they are severely  
3 impacted by wearing a mask.

4 Q Can you describe for me generally what lung disease is?

5 A Well, lung disease just means any disease that affects  
6 the lung, but the most common ones that I see would be  
7 chronic obstructive pulmonary disease, also known as  
8 COPD or emphysema, and asthma --

9 Q Okay.

10 A -- those would probably be the two commonest chronic  
11 lung disease seen in the community.

12 Q Are those people more negatively impacted by wearing a  
13 mask than people who don't have those conditions?

14 A Many of them are because their lung functions are  
15 already impaired to start off with.

16 Q So you have patients with asthma?

17 A I have many patients with asthma.

18 Q In your opinion, is asthma, you know, a valid medical  
19 basis for having an exemption from wearing a mask?

20 A In some circumstances, depending on the severity of the  
21 asthma or any lung disease, something that's very mild  
22 and if the patient can tolerate wearing a mask, then it  
23 may not be a problem that way, but other people are  
24 severely impacted.

25 I believe Dr. Hu mentioned the Canadian Thoracic  
26 Society saying that masks weren't harmful or were safe,

1 but if you look at the actual guidelines, and I have  
2 them in front of me, it's a very short statement by the  
3 way, and they reference old literature, for the most  
4 part, but even within their context, they do leave room  
5 for patients to remove masks if it causes them  
6 shortness of breath. So they recognized -- and in  
7 their own statement, they recognize that -- they say  
8 that wearing a mask will obstruct breathing to some  
9 extent, so ...

10 Q Well, Dr. Hu didn't give us the whole quote, but what  
11 he said twice was that he said that the Thoracic  
12 Society said that prolonged mask wearing does not  
13 exasperate any underlying lung condition. Is that what  
14 the Thoracic Society has said?

15 A Well, I have the argument here. This is quoting what  
16 they say exactly. What they say is quite -- a little  
17 bit different, they say: (as read)

18 There is no evidence that wearing a  
19 mask/facial covering will lead to prolonged  
20 symptoms or a flare-up of an underlying lung  
21 condition.

22 They say there's no evidence; that's as far as they're  
23 willing to go. I personally believe that statement is  
24 still too strong, but that doesn't mean that there  
25 isn't any harm; it just says that from what they can  
26 see, there's no evidence.

1           However, in that same paragraph that I quote that  
2       statement, at the very beginning, they say: (as read)

3           Breathing through a mask takes more effort,  
4           and this may vary depending on whether one is  
5           using a commercially produced mask, a mask  
6           made at home, or a simple cloth covering.

7           For those with underlying lung diseases, the  
8           effort required may cause a feeling of  
9           shortness of breath while wearing the mask.

10          In such situations, we recommend that  
11          individuals remove the face mask, and if  
12          symptoms do not immediately settle, they  
13          should follow the existing strategy for  
14          relief of acute symptoms.

15       MR. KITCHEN:                   Mr. Maxston, how do you feel  
16       about me providing you a copy of this statement and  
17       then asking to have it entered as an exhibit?

18       MR. MAXSTON:                  I don't think I have a problem  
19       with it, Mr. Kitchen, but I think, to the extent your  
20       client is expressing an opinion different than  
21       Dr. Hu's, the Tribunal is aware of that, and they're  
22       going to have to make their determination. So I don't  
23       think a great deal turns on it. Mr. Lawrence might  
24       have some different views on that, but he's shaking his  
25       head no. Frankly, if it will move us ahead, and you  
26       think you don't have to go through the document in

1 detail, I'm happy to have it sent over, but I think  
2 this is just another point the Tribunal is going to  
3 have to dissect and decide on, Mr. Kitchen.

4 MR. KITCHEN: Okay, so here's what I'll do,  
5 when we're done, I'm going to get a copy of this, it  
6 should be easy, because it's the Thoracic Society of  
7 Canada, I'll get a copy of it. I'll submit it to you,  
8 and then you can let me know if you consent on it being  
9 entered as an exhibit, and then we can provide it to  
10 the Tribunal.

11 MR. MAXSTON: I think, Mr. Kitchen, I'd be  
12 very reluctant to object to it being entered as an  
13 exhibit. Your client has read from it. Again, I think  
14 it's just something the Tribunal's going to have to  
15 digest, so I think you can send it to --  
16 Mr. Nelson's [sic] nodding his head -- you can send it  
17 to Ms. Nelson, at some point, and it can be distributed  
18 to the Tribunal.

19 MR. KITCHEN: Thank you.

20 THE CHAIR: And to our reporter too.

21 MR. KITCHEN: I don't know where we're at  
22 for letters and numbers, so we'll figure that out after  
23 the fact.

24 EXHIBIT H-8 - Excerpt from the Canadian  
25 Thoracic Society guidelines (Document not  
26 Provided to be Marked)

1 Q MR. KITCHEN: So, Dr. Hu -- Dr. Dang, I  
2 apologize -- I've got Dr. Hu in front of me here -- the  
3 Thoracic Society statement said there's no evidence for  
4 masking impacting underlying lung conditions. Do you  
5 disagree with that?

6 A Well, yes, I think there has been some evidence that it  
7 does potentially show potential harm, but my point was  
8 their statement was much more limited than what Dr. Hu  
9 was saying. They're saying, in their statement, they  
10 have found no evidence. That doesn't mean it's not  
11 there; it just means that they look -- and if you look  
12 at the reference, which I can certainly send you or you  
13 can find yourself, it's a very short statement. It's  
14 only I think two or three pages, and it has very few  
15 references. So it's not like they did an expansive  
16 literature review to look at this, nor, would I expect  
17 there'd be a lot of research into this. I think  
18 pre-COVID, it just made sense that wearing a mask when  
19 you have severe lung disease, unless you actually have  
20 to, was not something that would be done.

21 Q All right, so in your opinion, as a respirologist, are  
22 there medically valid reasons for exemptions from being  
23 required to wear a mask?

24 A Absolutely.

25 MR. KITCHEN: I think I'm just about there.  
26 Just give me a second.

1     Q     MR. KITCHEN:                     Dr. Dang, I'm just going to  
2             ask you one more question -- and I'll give my learned  
3             friend a chance to object, because he might -- there's  
4             been a particular word used by both you and Dr. Hu and  
5             others, but, particularly, you and Dr. Hu that I have  
6             found very interesting, and that word is the word  
7             "politicised". Dr. Hu has said that the masking issue  
8             is politicised, and you have said the same thing, but  
9             I'm not sure that we've really heard an explanation of  
10            what the heck that means. When you say that the mask  
11            issue is politicised, what do you mean by that?

12    A     I mean, I think that the decisions on masking have not  
13            been made based on the medical literature, medical  
14            debate, or medical judgments mainly, but has been based  
15            on what is happening with human interactions in society  
16            and with the governments currently, and is made based  
17            on a lot of emotional and nonmedical reasons.

18    Q     Do you find that surprising?

19    A     I actually don't. I think that in times when people  
20            are calling for crisis or certainly the pandemic has  
21            probably been the largest crisis we've ever dealt with  
22            in a long time and certainly in terms of magnitude  
23            extending around the globe, there's very little else to  
24            compare within recent history, that when something like  
25            that happens, and we are dealing with raw emotions,  
26            especially when we're dealing with fear, paranoia, and

1 power, so we are dealing with, you know, the very  
2 features of politics.

3 Q You said "power", so do you think power is part of  
4 what's influencing the decisions on mandatory masking?

5 A I believe --

6 MR. MAXSTON: Mr. Kitchen, I think I'll  
7 object to that. I think your last question was  
8 debatable, I didn't object to it, but we're now --  
9 "power", you tell me what that means, I think that  
10 one's just a little too far. I would --  
11 politicisation, correct, Dr. Hu weighed in on that, but  
12 I think it might just be a little too far.

13 Q MR. KITCHEN: Dr. Dang, you're aware that  
14 every health professional regulatory body has imposed  
15 mandatory masking on their members; is that your  
16 understanding?

17 A Well, more or less indirectly. I believe the  
18 Government, that has done that, and then the regulatory  
19 bodies have approved of it or have been either  
20 explicitly or tacitly agreeing to it; they're certainly  
21 not opposed to it.

22 Q Right, and my learned friend can stop me here, but  
23 that's actually I think a fair description of what  
24 happened with the College. We had a lot of evidence  
25 from -- the College said, Well, when we constituted the  
26 mask mandate, we had to because Dr. Deena Hinshaw said



1       that in order for our members to practice, we had to  
2       have a mask mandate. So I think what you've just said  
3       is not controversial.

4               Last question I'll ask you on this, you said you  
5       didn't find it surprising; do you find it strange?

6   A   About the masking pandemic worldwide or restrictions in  
7       general?

8   Q   Do you find it strange that politics is influencing  
9       decisions on whether people wear masks or not?

10  A   I disagree with those things profoundly, but I don't  
11       find it strange that politics has done that, because it  
12       has endeavoured to do that sort of thing throughout  
13       history. I myself have fled from a communist country,  
14       so I know what these things are.

15       MR. KITCHEN:                       Those are all my questions.

16       THE CHAIR:                        Okay, Mr. Maxston, did you  
17       want a moment before you start? It's 2:30, and we've  
18       been going for just about two hours, why don't we take  
19       a 10-minute break.

20       MR. MAXSTON:                    Mr. Chair, I have a question  
21       for Mr. Kitchen before I begin my cross-examination,  
22       and I think it's something that Dr. Dang shouldn't be  
23       present to hear, there's no magic in it, but it's about  
24       my cross-examination. I'd like to ask him a question  
25       on the record. Can we just take 5 minutes, if  
26       Ms. Nelson can put Dr. Dang into a break-out room and

1       then break for -- I think it's good idea to have a  
2       break. I won't be terribly long, but I think if we can  
3       just deal with that one matter now, I'd like to do  
4       that.

5       THE CHAIR:                       Okay, so we will move Dr. Dang  
6       into a break-out room, and then you can put your  
7       question on the record.

8               And so, Dr. Dang, we're going to transfer you to a  
9       break-out room so you won't be participating in the  
10      hearing, and we have a matter that we need to deal with  
11      without your presence, and then we're going to take a  
12      short break, then you can come back and have  
13      Mr. Maxston conduct his cross-examination.

14    A    Okay, that's fine, thank you.

15       THE CHAIR:                       Okay, thank you.  
16       Discussion

17       MR. MAXSTON:                    So, Mr. Chair and Mr. Kitchen,  
18      you know, pre-virtual hearings, when I was going to do  
19      a cross-examination of a witness, and I wanted them to  
20      look at a document, I'd walk across to my friend and  
21      I'd give him the document, and I'd say, Do you want to  
22      take a look at this. The document that I have that I  
23      can potentially give to Mr. Kitchen and to you, but I  
24      don't know if it's necessary, and that's why I raise  
25      it, is the CPSA's COVID re-opening practice document,  
26      and it essentially says -- and I'm happy to send it as

1 a courtesy, in any event, to Mr. Kitchen -- that masks  
2 are required for physicians, and I'm going to ask  
3 Dr. Dang, Are you aware of masking requirements for  
4 your profession last year, are you aware of the AHS  
5 mandate. I don't have to put that document in, unless  
6 my friend's going to object and say, Oh, no, no, I take  
7 issue with whether there were masking requirements for  
8 the CPSA, that kind of thing.

9 So I don't want to sandbag my friend, I don't want  
10 to sandbag the witness, but I don't know if I need to  
11 send this document or not.

12 MR. KITCHEN: I have no issue. I mean, I  
13 don't have it. I mean, Dr. Dang and I essentially  
14 established that fact, so --

15 MR. MAXSTON: That's why I think it may not  
16 be necessary. Some of the tail end of your questions,  
17 Mr. Kitchen, were you're aware of imposing these. So I  
18 think my question will be to Dr. Dang, You're aware of  
19 your profession having one of these and requirements.

20 So if we can go on that basis, then I don't think  
21 I need to provide this document to Mr. Kitchen, but I  
22 didn't want to surprise him, of course.

23 MR. KITCHEN: No, I appreciate that.

24 THE CHAIR: Okay, just before we break,  
25 Mr. Maxston, how long do you anticipate your cross will  
26 be?

1 MR. MAXSTON: I'm hoping 20 minutes.

2 THE CHAIR: Okay, then let's take a  
3 shorter rather than a longer break; let's just break  
4 for 10 minutes and come back at, I don't know, 20 to 3,  
5 and then maybe we can wrap up around 3. So a 10-minute  
6 break for now, and we'll see you in 10.

7 (ADJOURNMENT)

8 THE CHAIR: Okay, it's Mr. Maxston's turn  
9 for cross-examination of Dr. Dang, and just I'll  
10 mention it now so I don't forget, we would like to  
11 caucus with the Hearing Tribunal after Dr. Dang has  
12 finished the cross-examination to see whether or not  
13 the Panel has any questions of him.

14 Mr. Maxston.

15 Mr. Maxston Cross-examines the Witness

16 Q MR. MAXSTON: Good afternoon, Dr. Dang.

17 A Good afternoon, Mr. Maxston.

18 Q I'm going to take you through three or four questions  
19 relating to the things you just talked about with my  
20 friend, Mr. Kitchen.

21 I think you made a comment -- I think there was a  
22 question, rather, from Mr. Kitchen, when it comes to  
23 mandatory masks, are there potential risks and  
24 potential benefits, and I think your answer was one  
25 word "yes". Would you agree with me that Alberta  
26 Health Services and the Chief Medical Officer of Health

1           and Health Canada, and the College of Chiropractors in  
2           terms of its Pandemic Directive, which you've seen,  
3           they're erring on the side of potential benefits?

4    A    Yes, I agree that that is their intent.

5    Q    We talked a little bit -- or you and Mr. Kitchen,  
6           rather, talked a little bit about this concept of  
7           informed consent. Would you agree with me that when  
8           we're talking about that, it's typically, as you  
9           mentioned, in the context of informed consent between a  
10          caregiver and a patient?

11   A    That's classically the case that I'm experienced with  
12          anyways, yes.

13   Q    And it really isn't a concept that applies to let's  
14          say, for example, you and the CPSA; they don't come to  
15          you and get your consent for a fee or something like  
16          that, do they?

17   A    Not in that manner, no, correct.

18   Q    Okay. Towards the tail end of Mr. Kitchen's questions  
19          with you, he asked you is asthma a valid exemption to  
20          masking, and I think you answered to him that it may or  
21          may not be depending on the person and the, I guess,  
22          the nature of the asthma or maybe the severity of the  
23          asthma --

24   A    Correct.

25   Q    -- would you agree with me -- oh, I'm sorry.

26   A    Sorry, I was just agreeing with you; I said "correct",

1       yes.

2       Q    Would you agree with me that it's appropriate to get a  
3           physician to make a proper assessment and diagnosis of  
4           whether asthma is a valid exemption for a particular  
5           patient?

6       A    I think, most of the time, that would be a reasonable  
7           thing depending on access, of course.

8       Q    You talked about with my friend, I think the question  
9           was, as a respirologist, are there medically valid  
10          exemptions from wearing a mask, and I think your answer  
11          was, yes, absolutely. This will be a little redundant,  
12          but, again, is the best course of action to get a  
13          physician to properly assess any medical exemption?

14      A    Generally speaking, that would be the usual route, yes.

15      Q    Okay. I'm going to ask you some general questions.  
16          Mr. Kitchen went through a great deal of your  
17          background in your practice, but I just want to ask  
18          you, you haven't had any experience working with the  
19          Chief Medical Officer of Health on COVID-19 measures?

20      A    No, I have not.

21      Q    Okay. Would it be fair to say that your views in your  
22          expert report are contrary to what AHS or the Chief  
23          Medical Officer of Health or the Public Health Agency  
24          of Canada say about requirements for masking?

25      A    Yes, they are in opposition.

26      Q    One of the reasons we're at this hearing is the Alberta

1 College and Association of Chiropractors Pandemic  
2 Directive, which I assume you've had a chance to  
3 review, and you stop me if I'm wrong, but I think it's  
4 fair to say that, under that document when you get into  
5 about page 9 or 10, that there's a requirement to wear  
6 surgical or procedure masks. You're a member of the  
7 CPSA; are you aware that they also have similar masking  
8 requirements for you?

9 A I actually haven't read yours because I never received  
10 it, but, yes, if you are -- I'll take your word for it,  
11 but, yes, the CPSA also follows the law, I mean that is  
12 a Provincial law, so I -- whether or not the College  
13 has expressly stated it, I think they're obliged to  
14 follow the law, so yes.

15 Q Yeah, the -- now, there is no great surprise here, but  
16 during the break, the question I was asking of  
17 Mr. Kitchen was, you know, I've got a CPSA document,  
18 and it talks about mandatory masking, and you've just  
19 confirmed that I didn't think that was an issue or that  
20 I needed to present it to you, so I'm glad we're on the  
21 same page.

22 This is a fairly direct question, I'm assuming you  
23 comply with the CPSA's masking requirements?

24 A Yes, I have, and I've done whatever I legally can to  
25 mitigate it, but, yes, I've been in full compliance  
26 with the rules.

1 Q And it's sort of the flip-side of the same coin here,  
2 but Alberta Health Services has some mandatory masking  
3 requirements as well, and I'm assuming, when you're in  
4 the Medicine Hat Regional Hospital, you comply with  
5 those as well?

6 A I do certainly, yes. I obey the law. Doesn't mean I  
7 have to agree with them though.

8 Q Yeah, fair enough, fair enough. As part of you obeying  
9 the law -- I'm assuming you would say yes -- I'm  
10 wearing a mask when I have to, and I'm observing social  
11 distancing when I have to in my practice?

12 A Correct.

13 Q This applies to Dr. Wall, but I'll phrase it in the  
14 context of you as a physician: There were requirements  
15 for you to become a regulated member of the CPSA; is  
16 that correct?

17 A Correct.

18 Q That would have been your initial registration, your  
19 education, et cetera, correct?

20 A That's correct.

21 Q And would you also agree that there are ongoing  
22 requirements that the CPSA has for you to maintain your  
23 licence, like con ed or record retention or paying  
24 those fees every year?

25 A Correct.

26 Q Would you agree with me that it's the responsibility of



1 a professional to follow those requirements of their  
2 regulatory college?

3 A For the most part, as long as they do it within their  
4 just limits, correct.

5 Q So is it your view that a member of a profession can  
6 opt out of the requirements of their college or  
7 regulatory body at their choosing?

8 A Again, generally, no, but it depends on what the -- as  
9 long as they act within their just limits. I mean, the  
10 College couldn't say you had to get a golf membership  
11 to be -- remain a member, then I think you could justly  
12 fight that or even oppose that. I'm just giving a  
13 hyperbole example. But within your just limits, yes,  
14 there are -- I bring that up because the CPSA had a  
15 recent issue, which I think they acted -- where they  
16 tried to act beyond their just limits, and they did  
17 back down, so I just want to point that out.

18 Q Sure, well, you know, I'm not trying to be cagey here.  
19 The mandatory masking requirement that the CPSA has,  
20 even if you disagree with it, that's part of their just  
21 limits, isn't it?

22 A Well, that's I say -- that -- the Province imposed  
23 that; they didn't impose that; they just went along  
24 with it. But, yes, so far, you know, I should stay in  
25 practice, I have to agree to it -- or I'm following the  
26 law.

1 Q And you followed your college?

2 A Yes.

3 Q Dr. Wall's testimony was, in part, that he had a  
4 medical exemption that allowed him to not comply with  
5 CMOH orders, and his medical exemption, and Mr. Kitchen  
6 can correct me, but I believe it was two-fold, it was  
7 anxiety and claustrophobia. Consistent with the  
8 discussion I had with you a few minutes ago, I'm  
9 assuming that you would expect someone would approach a  
10 physician to have a clinical diagnosis of anxiety or  
11 claustrophobia when they're seeking a medical exemption  
12 for masking?

13 A That would be the usual case. I mean, there is  
14 certainly individual circumstances, but that is  
15 generally the case.

16 Q Would you want someone to self-diagnose, a nonphysician  
17 to self-diagnose their own exemption for masking, their  
18 medical exemption for masking?

19 A Am I okay to explain this a little bit more or --

20 Q I asked the question, so yeah.

21 A So in general, yes, I would agree with you. However,  
22 as I mentioned before, it depends on access and the  
23 situation. If I fill -- I fill out -- as you know or  
24 you may not know, the Province has its specific mask  
25 exemption form there to fill, and in it, I'm not --  
26 because I've signed some of them -- it lists all the

1 different conditions, amongst them psychiatric, of  
2 course, or anxiety and that sort of thing.

3 And, generally speaking, a patient comes, and I  
4 assess them within my competence, which would be lung  
5 disease, and if I agree with them, then I would fill  
6 out the form, and it's basically just signing the form.

7 The form, because of patient confidentiality, does  
8 not require you to tell anyone -- the patient's telling  
9 anyone else what specific condition they have; they  
10 just have to indicate they have a valid medical  
11 condition from amongst a list of that, and one of them,  
12 of course, is psychological or psychiatric.

13 I will say, however, the -- if a patient comes in  
14 and tells me they are extremely short of breath, and  
15 the mask makes it worse, I mean I can do a whole bunch  
16 of testing, but at the end of the day, you have to  
17 rely, to some degree, on the patient being truthful and  
18 honest, right? Everyone -- we're not here -- we're not  
19 a court of law, we're here to try to help our patient,  
20 we assume they tell us what is true or not. So if a  
21 patient comes in and says, This causes me severe  
22 anxiety or whatever, and I cannot wear the mask and  
23 function; well, what are you going to do, you're going  
24 to agree to that, I think, because --

25 Q I think we're on the same page. Yeah, I think we're on  
26 the same page. My comment to you is shouldn't the

1 person come to you as the physician or respirologist  
2 and review that with you?

3 A Generally speaking, yes. I mean, I don't know the  
4 circumstances of Dr. Wall honestly but -- in terms of  
5 his medical exemption, but, yes, generally, that would  
6 be the case.

7 MR. MAXSTON I'm going to ask Mr. Lawrence  
8 if he thinks we need to caucus, but other than that, I  
9 don't think I have any further questions for you. He's  
10 saying no; he's shaking his head. So those are all my  
11 questions, Dr. Dang. Thank you for your time today.

12 A Sure. Thank you.

13 THE CHAIR: Thank you, Mr. Maxston. The  
14 Hearing Tribunal is going to caucus for just a couple  
15 of minutes to see if we have any questions.

16 Yes, Mr. Kitchen, did you have anything in  
17 redirect?

18 MR. KITCHEN: I've just got one question on  
19 redirect.

20 THE CHAIR: Okay.

21 Mr. Kitchen Re-examines the Witness

22 Q MR. KITCHEN: Dr. Dang, you said -- you were  
23 talking to Mr. Maxston, you said that you do wear a  
24 mask when you legally have to. When you wear a mask  
25 because you have to because of the CPSA or the CMOH  
26 orders, are you doing it against your will?

1 A Well, I'm being coerced I believe, yes. If it were not  
2 for that rule, I would not be wearing it.

3 Q So you're not wearing it willingly?

4 A Correct.

5 MR. KITCHEN: Thank you. That's it.

6 THE CHAIR: Okay, Dr. Dang, if you could  
7 just bear with us for 2 or 3 minutes while we caucus to  
8 see if the Hearing Tribunal has any further questions  
9 of you, and we'll be right back.

10 A Okay.

11 THE CHAIR: Thank you.

12 (ADJOURNMENT)

13 THE CHAIR: We're back in session.

14 Dr. Dang, the Hearing Tribunal does not have any  
15 further questions for you. We'd like to thank you for  
16 taking the time to attend and to provide your  
17 testimony. You are free to leave and with our good  
18 wishes.

19 A All right, thank you, you as well, good night.

20 (WITNESS STANDS DOWN)

21 THE CHAIR: On that note, we will adjourn  
22 the hearing for today. We've got dates set for I think  
23 the end of January, if I remember. So unless either  
24 party has something they wish to raise at this time.

25 MR. MAXSTON: I think, Mr. Chair,

26 Mr. Kitchen and I are to stay on to help out the court

1 reporter with a couple of questions, so I'd just ask  
2 Amber to leave us in the room, and, otherwise, thank  
3 you to everyone for their time today.

4 THE CHAIR: Okay, although it's still  
5 November. Merry Christmas. We won't see you all;  
6 enjoy the holidays, and we'll see you in January.

7 MR. KITCHEN: Thanks, you too.

8 THE CHAIR: Thanks, bye-bye.

9 \_\_\_\_\_  
10 PROCEEDINGS ADJOURNED

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1 CERTIFICATE OF TRANSCRIPT:

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3 I, Karoline Schumann, certify that the foregoing  
4 pages are a complete and accurate transcript of the  
5 proceedings, taken down by me in shorthand and  
6 transcribed from my shorthand notes to the best of my  
7 skill and ability.

8 Dated at the City of Calgary, Province of Alberta,  
9 this 1st day of December, 2021.

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Karoline Schumann

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Karoline Schumann, CSR(A)

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Official Court Reporter

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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

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DISCIPLINARY HEARING

VOLUME 7

VIA VIDEOCONFERENCE

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Edmonton, Alberta

January 28, 2022

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1 Proceedings taken via Videoconference for The Alberta  
2 College and Association of Chiropractors, Edmonton,  
3 Alberta

4

5 January 28, 2022 Morning Session

6

7 HEARING TRIBUNAL

8 J. Lees Tribunal Chair

9 W. Pavlic Internal Legal Counsel

10 Dr. L. Aldcorn ACAC Registered Member

11 Dr. D. Martens ACAC Registered Member

12 D. Dawson Public Member

13 A. Nelson ACAC Hearings Director

14

15 ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

16 B.E. Maxston, QC ACAC Legal Counsel

17

18 FOR DR. CURTIS WALL

19 J.S.M. Kitchen Legal Counsel

20

21 K. Schumann, CSR(A) Official Court Reporter

22

23

24

25

26

1 (PROCEEDINGS COMMENCED AT 9:18 AM)

2 THE CHAIR: Good morning, everybody. This  
3 is a continuation of the Hearing Tribunal for Dr. Wall,  
4 and we are back in session today, and I believe we left  
5 off on November 20th with witness testimony with  
6 Mr. Kitchen's witnesses. So that's the point at which  
7 we will pick up again.

8 I believe the transcript indicates that there's a  
9 Dr. Bridle that will be testifying today; is that  
10 correct, Mr. Kitchen?

11 MR. KITCHEN: Correct.

12 THE CHAIR: Okay, just a quick  
13 housekeeping item, I'd ask everybody to mute your cell  
14 phones. And good morning, Mr. Maxston, as well.  
15 Perhaps we'll start with you, if you have any comments  
16 you wish to make.

17 Discussion

18 MR. MAXSTON: Yes, thank you, Mr. Chair.  
19 Before we hear Dr. Bridle's evidence, I'd like to make  
20 some comments to you and your colleagues regarding  
21 process and scheduling matters. This isn't a  
22 preliminary application in the true sense, but to the  
23 extent you feel comfortable, my client will be asking  
24 for some advice and direction, for lack of a better  
25 phrase, I've advised him of my intention to raise these  
26 matters before the beginning of the hearing -- or

1 Dr. Bridle's evidence, and I understand he'll have a  
2 response.

3 Specifically the Complaints Director has asked me  
4 to make comments regarding the scheduling of the  
5 closing argument phase of the hearing and next steps,  
6 and this arises from Ms. Nelson's recent emails and  
7 Doodle poll to everyone, attempting to secure April 4  
8 as the date for closing submissions. And the comments  
9 I'm making this morning also arise from the Complaints  
10 Director's ongoing and very serious concerns about the  
11 length of the hearing and the costs that continue to be  
12 incurred, and, as you know, I previously raised this  
13 with the Tribunal when we were objecting to  
14 Mr. Schaefer being called as a fourth expert witness.

15 My client was very, very supportive of proceeding  
16 on April 4 with closing submissions, given the  
17 considerable amount of time that has been spent on this  
18 hearing and I think our understanding that perhaps most  
19 people were available that day.

20 And by way of background, and recognizing the  
21 difficulties that can sometimes occur in terms of  
22 scheduling hearing dates and scheduling witnesses, my  
23 client remains concerned about the significant number  
24 of witnesses that Dr. Wall has called in terms of the  
25 lay witnesses and the expert witnesses. As you know,  
26 we've taken the position that the lay witnesses really

1 can't offer anything in terms of this hearing; it's  
2 about Dr. Wall's conduct and his regulator, and we've  
3 also indicated that we felt four experts was  
4 repetitious and was unnecessary.

5 The Complaints Director's concerns also arise from  
6 the number of days that have been scheduled for the  
7 hearing to receive Dr. Wall's evidence, and, in some  
8 cases, days where we haven't been able to utilize the  
9 full day, and that, in turn, has made the hearing that  
10 much longer.

11 So this leads me to my primary point today, and  
12 that is that the Complaints Director, again, is very  
13 strongly of the view that closing submissions should  
14 only need one day. They are a summary of the parties'  
15 positions and evidence, and scheduling closing  
16 submissions for one day should be more than sufficient,  
17 and, more specifically, April 4 should be sufficient in  
18 terms of the amount of time necessary to prepare.  
19 There's a lot of time coming now -- or that will occur  
20 between now and April 4.

21 So, again, my client is prepared to proceed with  
22 closing arguments on April 4, would like that to occur.  
23 I know Mr. Kitchen disagrees with that, but the -- and  
24 he has some comments he'll make, but the Complaints  
25 Director is asking for, again for lack of a better  
26 phrase, some advice and direction from the Tribunal

1 about how we're going to proceed and whether we can  
2 proceed on April 4, all with a view to maximizing the  
3 efficiency of the hearing.

4 I understand again that Mr. Kitchen has some  
5 comments in response.

6 THE CHAIR: Thank you, Mr. Maxston.

7 Mr. Kitchen?

8 MR. KITCHEN: Thank you. I have several  
9 comments.

10 We've heard a few times about the costs, and  
11 that's not relevant. I'm sure it is for the Complaints  
12 Director obviously but not for this hearing, not for  
13 the Tribunal. Quite frankly, if he doesn't like his  
14 costs, there's a way to remedy that, right? We don't  
15 have to keep going on this. Nobody is set in stone:  
16 Thou shalt, must continue this hearing. So I don't  
17 understand why we keep hearing that.

18 It's expensive to prosecute members of a  
19 regulatory body when those members put up a legitimate  
20 legal defence. Of course it is; that should come as no  
21 surprise.

22 So I say that because that can't be considered as  
23 a relevant component here. I mean, we could go down  
24 the road on how much Dr. Wall has suffered financially  
25 through all of this, you know, how much his family has  
26 suffered. He's had to hire legal counsel, right?



1 Enormous resources have been spent on his side. I  
2 haven't mentioned that because it's not relevant.

3 So a considerable amount of time, yeah, of course,  
4 of course it does, yes. This is a significant,  
5 significant issue, right? This is a scientific issue,  
6 it's a professional conduct issue, it's a matter of  
7 truth, it's a matter of integrity and professional  
8 regulation, and it's going to take some time. We  
9 haven't been at it for 20 days. It's not unusual for  
10 trials in the court to go for 20 or 40 days. My friend  
11 knows that. I think we've been at it for six or seven  
12 days. My friend took three days with his witnesses. I  
13 tried to utilize time as best I could. That's why I  
14 tried to fit in Mr. Jarvis [sic], and then, of course,  
15 we weren't able to continue that. I had witnesses  
16 standing by while we went through all of the Complaints  
17 Director's witnesses. I had no issue with that.

18 So again, it's not -- it's almost as if my  
19 friend's trying to say that Dr. Wall is doing a  
20 filibuster; that's not what's going on, okay? I didn't  
21 call 16 of his patients; he could have, he didn't. You  
22 know, I could call expert witness after expert witness  
23 after expert witness, and I could go, you know, go  
24 through all the more and -- arguments about why each  
25 witness should be allowed in, because there is no rule  
26 of court that applies here that caps the witnesses, but

1 I haven't done that. I've brought in four relevant  
2 witnesses, expert witnesses, and we're getting through  
3 them as fast as we can.

4 There is an enormous amount of evidence though,  
5 nonetheless, as you've seen. That evidence has to be  
6 synthesized, and it has to be discussed in closing  
7 argument. I'm not going to read to you line by line  
8 what Dr. Hu said or what Dr. Bridle says today out of  
9 the transcripts, but I'm going to have to go through  
10 the evidence, because the evidence is what matters.  
11 This case is about following the evidence to where it  
12 leads.

13 So -- and I've reviewed the evidence obviously for  
14 today, and there's a large amount of it, and we're not  
15 done yet, and part of the reason I submit there's a lot  
16 of evidence is because Dr. Wall's right, he's  
17 scientifically right, he's professionally right.  
18 That's why there's so much evidence to show that. I'm  
19 not going to ask this Tribunal, at the end of all this,  
20 to rule in his favour on a scant amount of evidence;  
21 I'm going to ask them to rule on his favour on a large  
22 amount of evidence. So I'm going to have to go through  
23 that evidence, and I'm not going to take four days to  
24 do it, but I'm not going to take 4 minutes to do it  
25 either.

26 And then I have to get into the legal argument,

1    which is complex, it's long, and this Tribunal deserves  
2    and Dr. Wall deserves for the Tribunal to hear a full  
3    explanation of how statutory human rights works, of how  
4    the Canadian Charter of Human Rights works, of how it  
5    applies to the College, of how Section 1 works, of how  
6    it's possible to justify these rights infringements. I  
7    have to go through a long list of rights infringements,  
8    because I have to establish that; it's Dr. Wall's  
9    burden.

10       This is not something that's going to be done in a  
11    couple hours. It's going to legitimately take me  
12    several hours to go through this, and then, of course,  
13    you may have questions, and we may have delays, like we  
14    had this morning, we started 20 minutes late. It's  
15    patently unreasonable to say we're going to get through  
16    it in one day.

17       Now, I understand that, you know, the Complaints  
18    Director is not a lawyer; I get that, I get that. But  
19    I think my friend, because my learned friend, because  
20    he is so reasonable, I think he can agree with me, that  
21    we're not going to get through a closing argument in  
22    five or six hours, which is typically what we have in  
23    one day. I could be the entire day before I get  
24    through mine, and then he deserves an opportunity to  
25    respond, and he might have a lot to respond to. Then  
26    I, of course, have an opportunity to rebut, and then we

1 have questions.

2 So it's not unreasonable, in any sense, to say  
3 there's got to be two days, and it's not unreasonable  
4 to say it's got to be two days in a row. We've broken  
5 up the evidence; that's fine. It's not ideal, but  
6 that's fine. But closing argument needs to be two  
7 days, two consecutive days in a row. And it's not fair  
8 to my friend, to be quite frank, if I go the whole day,  
9 and then he has to wait four weeks before he gets to  
10 respond to it because we've split it up.

11 The last thing I'll say is this: My client and I  
12 were available for days in February and March. It just  
13 so happens that the only day when everybody else was  
14 available is April 4th, and there's no option for April  
15 5th, notwithstanding the fact that I have a trial I  
16 have to travel to for April 6th. I would have been  
17 willing to do April 4th and 5th if it had've been  
18 available. If we had've done those two days in a row,  
19 I would have done that, because we might only need a  
20 day-and-a-half, we might get through on the 5th, and  
21 then I could travel that evening. I don't like that,  
22 but I would have been willing to do that, but that  
23 option wasn't even presented --

24 THE CHAIR: Mr. Kitchen --

25 MR. KITCHEN: -- for whatever reason --

26 THE CHAIR: -- I'm --

1 MR. KITCHEN: Go ahead.

2 THE CHAIR: -- committed to another  
3 hearing with another college on the 5th.

4 MR. KITCHEN: No, and there we go. Now we  
5 know -- yeah, I understand that. So I don't -- but I  
6 don't know why it was always ever presented to Dr. Wall  
7 for only one day. I've made my position clear. I've  
8 explained to Ms. Nelson that the defence requires two  
9 days. So I don't know why it was only presented as one  
10 day; it should have been presented as two days, because  
11 that's our position.

12 So I can see why my friend is asking for direction  
13 here, because right now, as it is, we have a problem,  
14 because the Hearings Director is looking for one day  
15 when the defence has made it very clear there needs to  
16 be two days, which is perfectly reasonable, and he has  
17 a right to full answer in defence.

18 So I'm going to keep my calendar as open as I  
19 possibly can. I'm open all through May, I'm open  
20 almost all of June, I'm open all of July, so is my  
21 client. As soon as -- the soonest that everybody else  
22 can get two consecutive days, I'm going to be there,  
23 unless it happens to fall on the one or two days in May  
24 or June or July that I don't have available. So  
25 Dr. Wall is obviously not trying to delay this, okay?

26 I'll remind you that the initial delay was the

1 College's -- I won't say fault -- it was due to the  
2 College, okay? Dr. Wall filed his expert reports in  
3 April 2021, almost a year ago now, and we were gearing  
4 up, ready to go, and the College had to say, No, we're  
5 not ready.

6 And so here we are, you know, over a year later,  
7 after all this happened. That's not on Dr. Wall. He's  
8 keen to see this go through, he's ready to see it go  
9 through, but he has a right to full answer in the  
10 defence, and he's going to assert that, and he's going  
11 to require two days for closing argument. Those are my  
12 submissions.

13 THE CHAIR: I think before we caucus to  
14 consider a response, I will say that I can't speak for  
15 the two regulated members on the Panel, but I can speak  
16 for myself, and I think I can -- it's probably the same  
17 situation for Doug -- we're under significant demands  
18 these days. I'm booking 10 to 15 days a month for  
19 hearings, so it's difficult to find these periods of  
20 time. I know everybody has demands on their calendar.

21 We all just had a month off at -- some weeks off  
22 at Christmas, but fair enough, Mr. Kitchen, we will --  
23 the Hearing Tribunal will caucus with counsel, and  
24 we'll take a -- and I hate to start doing this, but  
25 we'll take as short a break as possible, we'll be back  
26 in 10 minutes. If not, we'll let Amber know, and she

1 can advise everybody, and then hopefully we can move  
2 forward. So if you could -- thank you, Amber.

3 (ADJOURNMENT)

4 THE CHAIR: Well, the Hearing Tribunal and  
5 our counsel have considered the information we were  
6 presented with. I think our conclusion is that  
7 expecting to conclude final arguments and deliberations  
8 on the same day is probably not realistic. We also  
9 need time, and we also do not want a break following  
10 closing arguments until we're able to meet and  
11 deliberate on this matter. So I think it's realistic  
12 to ask for two days and to find two days that are  
13 consecutive. I'm not going to ask people to look at  
14 calenders now. Perhaps we can do that over lunch or at  
15 the end of the day.

16 I think we should get back on track and get this  
17 witness in, but I will say that the Hearing Tribunal  
18 has confirmed that they would be willing to meet on  
19 April 3rd. We're meeting on Saturday, tomorrow, so if  
20 Sunday, April 3rd, is an option, that could be two days  
21 in a row. Otherwise, Ms. Nelson will be back in the  
22 position of asking people if they could -- perhaps  
23 there's been changes to people's calenders, but,  
24 anyway, try and find two consecutive days.

25 It is a big -- I appreciate Mr. Kitchen's  
26 comments, there is a lot of evidence to cover, there's

1 also some complex legal arguments to be made, and I'm  
2 sure Mr. Maxston will have significant submissions to  
3 make as well, so we will try to find two days. I'm not  
4 going to cancel April 4th at the moment until we've  
5 found an option, but we will ask Amber to focus on  
6 doing that as soon as possible.

7 I understand that there's costs. These hearings  
8 are not cheap. That's the cost of doing justice, and  
9 that will be -- potentially it could be part and parcel  
10 of any final decision on this, but, in any event, we do  
11 not want to be in a position of telling either party,  
12 the College or Dr. Wall, how to present their final  
13 arguments. So we will look for two days. Hopefully  
14 everybody will be able to find something in their  
15 calendar that works without us incurring a further  
16 undue delay.

17 On that note, Mr. Maxston?

18 MR. MAXSTON: Yeah, Mr. Chair, I just had  
19 two comments, and I don't want to belabour this, I,  
20 unfortunately, am out of town for that weekend, so the  
21 3rd would not work for me, and my second thought was I  
22 would suggest that we simply ask Ms. Nelson to send out  
23 a Doodle poll as soon as possible, that we not try not  
24 to compare schedules. I find that sometimes gets a  
25 little cumbersome, as everybody's flipping back and  
26 forth. Perhaps we could ask her to send out a Doodle



1 poll, you know, quite quickly with a two-day block.

2 The other comment I wanted to make was to my  
3 friend, Mr. Kitchen, and it might assist him in terms  
4 of Dr. Bridle, I've spoken with my client, and in terms  
5 of the qualification process and your questions,  
6 Mr. Kitchen, for Dr. Bridle; my client is prepared,  
7 subject to hearing from you in terms of, you know, the  
8 basis on which you're tendering your expert, my client  
9 is prepared to accept him as an expert witness without  
10 you having to go through, in any kind of detail, his  
11 qualifications, making again the same -- or submitting  
12 the same caveats we have before, that these issues are,  
13 you know, compliance issues and not scientific masking  
14 issues.

15 I don't know if that will assist you, Mr. Kitchen,  
16 or if you want to go through, I'll call it, a typical  
17 qualification process, but it might save you some time.  
18 I anticipate your -- the basis on which you're going to  
19 be tendering your expert witness is going to be, you  
20 know, fairly similar to what you've done before, and  
21 I -- if we can save some time that way, we're prepared  
22 to do that. I'll leave that with you.

23 MR. KITCHEN: Well, thank you, I appreciate  
24 that. I think that is probably an approach that I'll  
25 take for Dr. Warren tomorrow, and I will send you a  
26 proposed qualification today so that, you know, you

1 have notice about it tomorrow, and you can let me know  
2 if there's any issues.

3 Today I am going to run through qualification with  
4 Dr. Bridle, even though I don't anticipate a lot of  
5 objections, and it will be similar to what I've asked  
6 with Dr. Dang, but it's slightly different, and so I am  
7 going to establish the record for that.

8 THE CHAIR: Okay, well, thank you both.  
9 It's 8 minutes to 10, let's just take a quick break,  
10 and then we can plow through until lunch. We'll start  
11 at 10:00 with Dr. Bridle, okay?

12 MR. KITCHEN: Ms. Nelson, could you just --  
13 because I haven't been able to communicate with  
14 Dr. Bridle. Could you just let him know that we're  
15 going to start at 10 so he has a heads-up?

16 MS. NELSON: Yes, I can do that for you.

17 MR. KITCHEN: Okay, thank you.

18 THE CHAIR: Thank you. And then, just to  
19 confirm, April 3rd is off the table.

20 (ADJOURNMENT)

21 THE CHAIR: We're back in session. Just  
22 two very quick items before I turn the floor over to  
23 Mr. Kitchen. I wanted to ask, Mr. Kitchen, do you have  
24 any documents that you plan to share with -- today or  
25 table?

26 MR. KITCHEN: No. Dr. Bridle's report and

1 his cv are part of the record, so you should have  
2 access to them.

3 THE CHAIR: Okay.

4 MR. KITCHEN: Please let us know if you  
5 don't, and that's all I intend. So I mean that could  
6 change if my friend brings something in, and then I  
7 need to bring something in in -- I don't anticipate  
8 that, but certainly for my direct, no documents.

9 THE CHAIR: Okay. And I just would like  
10 to tell people that during our first break to discuss  
11 your opening comments, one option we did look at very  
12 briefly and discarded was the option of having written  
13 closing arguments, and we decided that that was not an  
14 attractive option for this case, but we did -- we were  
15 trying to look at all options, and that was one that  
16 was brought up.

17 So with that note, I'll ask Mr. Kitchen to call  
18 your witness, and we can continue.

19 MR. KITCHEN: Sure, Ms. Nelson, if you could  
20 bring him in, and then we'll -- and then, Karoline, if  
21 you can swear him in.

22 (DISCUSSION OFF THE RECORD)

23 DR. BYRAM BRIDLE, Sworn, Examined by Mr. Kitchen  
24 (Qualification)

25 Q MR. KITCHEN: So, Dr. Bridle, just to make  
26 sure that you know where we're going, I'm going to be

1 asking you what we call qualification questions, and  
2 then I'm going to be offering to the Tribunal the  
3 qualification I'm going to qualify you as, they'll make  
4 a ruling on that, my friend will have a chance to give  
5 some comments, and then I'll get into questioning you  
6 on substance, but this shouldn't take too long.

7 So to start with, Dr. Bridle, are you a doctor  
8 because you have a Ph.D.?

9 A Yes, that is correct.

10 Q What's your Ph.D. in?

11 A It's -- okay, so my training is -- well, I guess is  
12 to -- for -- to have a full understanding, I have a --  
13 first, I obtained a Bachelor of Science degree in  
14 biomedical sciences, then a Masters of Science degree  
15 in immunology, and then a Ph.D. in immunology, and then  
16 I did a six-year post-doctoral fellowship to become  
17 certified as a viral immunologist, and I now hold, in a  
18 faculty position, as an associate professor of viral  
19 immunology at the University of Guelph.

20 Q Thank you. Your Ph.D., when did you get that and from  
21 what university?

22 A So it was from the University of Guelph, and I guess I  
23 would refer everybody to my cv, I -- it's been so long,  
24 I can't even recall the exact date.

25 Q That's okay. Are you a professor now currently?

26 A Yes, I'm an associate professor.

1           So just so everybody understands what that  
2 entails, the initial appointment for people for  
3 academics in a university setting is as an assistant  
4 professor. And then if we have progressed  
5 satisfactorily in our development as a faculty member,  
6 we then undergo usually about within, on average, about  
7 six years -- no, sorry, five, five to six years after  
8 being appointed as an assistant professor, we have to  
9 be -- we undergo a very rigorous review process where  
10 our performance is assessed independently by at least  
11 three world-renowned experts in the field.

12           And if our progress is deemed to have been  
13 satisfactory, then typically what happens is we are  
14 awarded tenure and promoted to the position of  
15 assistant professor.

16           And then the final stage would be full  
17 professorship, and that usually is about eight years  
18 later with a similar process involved.

19           So right now I am an associate professor of viral  
20 immunology.

21   Q   Thank you. Have you received any awards or  
22 recognitions within the last two years?

23   A   Yes. So you want to just limit it to the last two  
24 specifically --

25   Q   Yes.

26   A   -- or last --

1 Q Otherwise, we'd be here for a while.

2 A Okay. So, yes, so I've won several teaching awards.  
3 So one of the awards that I received was the equivalent  
4 of teacher-of-the-year within my college. It's the  
5 most -- like it's a prestigious award that's awarded  
6 within -- for, you know, the college that I -- for the  
7 college -- among the colleges that I'm involved in  
8 teaching in.

9 And what that entails is -- entails -- so I'm  
10 involved specifically with training or teaching  
11 veterinary students and -- in the field of immunology,  
12 general immunology. And so what happens is that, just  
13 like an M.D. program, it's a four-year -- it's four  
14 years of classes, four-year program.

15 And so for that award, what happens is all of the  
16 students in the second, third, and fourth year of the  
17 program vote on who they felt the top -- who the top  
18 professor is in that program. So that's one of the  
19 awards that I won recently.

20 Also what happens at the end of every academic  
21 year, the -- these professional students then vote on  
22 who they felt the top professor was for that given  
23 academic year, but I received that recognition, and  
24 that's -- so we get voted in basically as an honorary  
25 class president for that class.

26 I also recently received a research award for

1 outstanding research.

2 And I'm just trying to think, I think those are  
3 probably key highlights, you know, to highlight my --  
4 yeah, the fact that I have been objectively assessed in  
5 terms of my teaching ability and research ability and  
6 have been recognized in those ways as being above  
7 average.

8 Q Thank you. Just give me one second, my phone was off,  
9 but my answering machine is on; I'm just going to turn  
10 it off.

11 THE CHAIR: I'll just mention,  
12 Mr. Kitchen, for everybody, Dr. Bridle's cv and other  
13 related information is in Folder E, and it's package  
14 number 5.

15 MR. KITCHEN: Yes, thank you.

16 Q MR. KITCHEN: Dr. Bridle, have you -- are  
17 you currently performing or overseeing research  
18 projects?

19 A Yes, a large number. So I'm known as what's called a  
20 research-intensive faculty member. So as faculty  
21 members at any university across Canada, our work is  
22 divided into three areas, and we all have -- we  
23 dealt [sic] on to have unique what we call  
24 distributions of effort.

25 So our work is divided among, again, three areas  
26 of focus, one is research, one is teaching, and one is

1 service. And so in my case, my distribution of effort  
2 is divided as such: 65 percent devoted to research, 25  
3 percent devoted to teaching, and 15 percent devoted to  
4 service.

5 And just so there's some perspective with that,  
6 the sort of average dedication to research, like for  
7 the average faculty member across Canada, would be more  
8 in the range of 40 percent. So, therefore, I'm  
9 considered a research-intensive faculty member, and so  
10 that's an emphasis. And as such, I do have a fairly  
11 extensive research program and research team that I  
12 manage.

13 And so right now, active within my lab, there's  
14 sort of three areas of research that I'm focusing on.  
15 I do a lot of basic fundamental viral immunology  
16 research in which we look at the post-immune response  
17 to viruses and, you know, how we protect ourselves from  
18 viruses following infection.

19 And then the -- and then there's two more  
20 translational/applied areas of research. One is -- in  
21 both cases, they're using what we call immunotherapy,  
22 and the most common immunotherapy that I do research on  
23 are vaccines. And -- and for two purposes: So one arm  
24 of this program is focused on trying -- developing  
25 vaccines for the prevention of infectious diseases, and  
26 then the other one is for developing immunotherapies



1       for the treatment of cancers. Similar technologies can  
2       potentially apply to both, certainly scientific, the  
3       principles are fairly -- you know, overlap between the  
4       two. So I have those three areas of research is my  
5       emphasis right now.

6               And I guess I also, for full disclosure, just  
7       because it's probably most relevant to what's being  
8       discussed today, I did receive two grants to support my  
9       research program, infectious diseases, one from the  
10      Ontario Government and one from the Federal Government,  
11      and those are a specifically to conduct pre-clinical  
12      research in the area of SARS-Coronavirus-2 vaccines.

13   Q   Thank you, you've answered some other questions I have.

14               And forgive me if this is not the right way to ask  
15      this, but are you currently a reviewer or an editor of  
16      any academic journals?

17   A   I recently served as the guest editor for a special  
18      issue of a journal for -- and the journal is known as  
19      Vaccines, and that issue is now complete.

20               I do serve -- I'm active as a reviewer for many  
21      scientific journals, so that's a regular part of my  
22      job, and that comes under the service component that I  
23      was talking about. So that service component not only  
24      involves service to my institution, but it involves  
25      service to the -- well, to the public, but especially  
26      service to the larger scientific community.

1           And part of that is I serve as a reviewer on  
2 multiple grant review panels, including grant review  
3 panels for the Federal Government, and our -- that's  
4 our primary source of academic funding in Canada for  
5 medical research. So that organization is known as  
6 C-I-H-R for short or the Canadian Institutes of Health  
7 Research.

8           For that, I have served on multiple committees,  
9 including one that looks at grants that are being  
10 applied for in an area of cancer research, but probably  
11 my most -- definitely my most substantial contributions  
12 to that grant review agency has been serving on their  
13 virology and viral pathogenesis panel. In fact, I am  
14 currently serving a three-year term, invited term, as a  
15 reviewer.

16           And I guess, not that I usually like to tout, you  
17 know, things like accolades and awards, but, again, I  
18 understand that it's important to also -- you're trying  
19 to make considerations in this case about my potential  
20 to serve as an expert witness, so I'd have to point out  
21 that I have received three consecutive citations  
22 from -- and so I guess I forgot to mention this when  
23 you were asking about awards, because this is within  
24 the last two years -- and my service on the  
25 virology/viral pathogenesis panel, in which we  
26 determined which Canadian research -- researchers get

1 funding in that area. I have received three  
2 citations -- consecutive citations from CHR as being  
3 one of their most elite reviewers, which is an award  
4 given after the -- end of review competition, the  
5 chairs of the review panels, and the CHR staff that  
6 attended those panels identify the top 15 percent of  
7 reviewers for that particular review cycle across all  
8 of their panels, and then those top 15 percent receive  
9 these citations and try to set that standard for what  
10 the other reviewers should try and achieve in terms of  
11 the quality of the reviews that they provide.

12 And so as part of my job as well, yes, I routinely  
13 provide reviews, it can be to any scientific journal,  
14 and I do it for a large number of scientific journals.  
15 There's no limitation on that. Any scientific journal,  
16 if they feel that a faculty member anywhere in the  
17 world possesses expertise relevant to what that paper  
18 is about, then they can contact us and ask us if we  
19 would like to review. That's done on a voluntary  
20 basis; we're not required to do it, but it's done on a  
21 voluntary basis. And that is the foundation, the  
22 underpinning of how we establish the most rigorous  
23 scientific data.

24 So the top scientific data in the world of science  
25 is what we refer to as peer-reviewed scientific  
26 publications, and so those are -- that's scientific

1 data that has been compiled into what we call a  
2 manuscript, and that manuscript goes to what we call  
3 peer reviewers, that would be somebody like myself,  
4 who -- and we can have no conflict of interest, no  
5 connection with the authors of that paper. So that's  
6 important to make sure it's fully objective. And  
7 then -- in many phases, it's not even disclosed who  
8 the -- now with a lot of journals, not even disclosed  
9 who the authors are, to ensure that there can be no  
10 biases.

11 And then we give our feedback, either we recommend  
12 that the paper be rejected because the science is not  
13 of a sufficient quality, or we can recommend that it be  
14 accepted with different amounts of revision required to  
15 try and increase the quality of the science. And so,  
16 ultimately, if accepted, that means that -- so what  
17 we're talking about when we're talking about  
18 peer-reviewed scientific literature, that's the process  
19 that's followed. And so, yes, I participate in that  
20 and have done so for a large number of journals, and I  
21 do it on a regular basis and have throughout the  
22 duration of my independent academic career.

23 Q Thank you. When you do your research, you obviously do  
24 a lot of it, do you sometimes work with other  
25 scientists?

26 A Yes. Yes, my research team is highly collaborative.

1    So, again, if anybody would like to refer to my cv,  
2    you'll find that -- so the way authorship works in --  
3    certainly in the area that I work in and so the  
4    academic realm, there is typically -- and it varies  
5    from research area to research area, there's sort of  
6    different conventions in the authorship of what  
7    typically happens. When you're looking at these  
8    papers, you'll often see a large number of names  
9    listed, and so those are all the people who contributed  
10   in some way to the sciences in that manuscript.

11           And the names that are at the beginning -- so this  
12   is the case for sure with all of my citations, the way  
13   it works, all the names at the beginning are typically  
14   the trainees that did most of the hands-on laboratory  
15   work, and then the names that are in the latter half of  
16   the authorship are what we call the senior authors.  
17   They're the ones that got the funding for the research,  
18   that often design the research project, and they  
19   oversee the management of the trainees that are working  
20   on that and provide feedback and troubleshooting,  
21   et cetera.

22           So -- and so when you're looking at sort of the  
23   level of collaborative-ness, you want to know who the  
24   senior authors are. And one of the -- and immediate  
25   ways to identify that is -- I mean, so, obviously, when  
26   I'm publishing something, my trainees are readily

1     identifiable typically because they're going to be from  
2     my institution. Although with that said, I have many  
3     trainees actually who have collaborated with mine from  
4     other institutions.

5             But so when you look at that latter part of the  
6     list, when you see people, especially from other  
7     institutions -- and I mean if there are any other  
8     faculty members as senior scientists, those are  
9     collaborators, official collaborators.

10            And so, yes, I've collaborated extensively.  
11     There's no way I could go through all of them, but I  
12     collaborate with researchers from around the world. I  
13     guess I can give you an example. So, for example, with  
14     a recent publication that we had on SARS-Coronavirus-2  
15     vaccines, for example, that was a strategic  
16     collaboration with the National Microbiology  
17     Laboratory, which is part of the Public Health Agency  
18     of Canada, where they conducted part of our research.  
19     There were three separate research groups at the  
20     University of Guelph where -- that we came together  
21     strategically to do this work. So that's one type of  
22     example. So, yes, so I've collaborated with scientists  
23     in the Government and lots of scientists from other  
24     academic institutions, including others around the  
25     world.

26            So, yeah, my research team is highly

1 collaborative, so every one of my publications  
2 represents some type of formal scientific  
3 collaboration.

4 Q Thank you. Have you published any peer-reviewed  
5 articles or any other type of publications in the last  
6 two years either on your own or collaboratively with  
7 others?

8 A Yes. So I'm actually quite proud of that fact  
9 honestly, and this is why: So just to understand the  
10 setting, what happens is because of the lockdowns  
11 related to COVID-19 policy, a lot of research programs  
12 had to shut down and for substantial periods of time.  
13 And, indeed, my research was declared nonessential, and  
14 so the worst shutdown that we were facing originally  
15 was a -- it turned out to be six months of interruption  
16 to research, really nonessential research.

17 However, again, like I mentioned because I do --  
18 because -- so this problem of COVID-19, specifically  
19 SARS-Coronavirus-2, the virus that causes COVID-19,  
20 because that's in my area of expertise and so many of  
21 the -- so much of the research and research tools that  
22 I work with were applicable, my group pivoted very  
23 rapidly to focus on COVID research, and like I said, we  
24 were successful in getting grants available to pursue  
25 that.

26 So we have continued our cancer research, we've

1 continued our basic virology research throughout this,  
2 but those two aspects have -- you know, we have  
3 experienced substantial interruptions to those  
4 components and -- but we focused our efforts on  
5 infectious diseases on the SARS-Coronavirus-2.

6 And so as a consequence, in fact, the last two  
7 years, remarkably despite that -- those, you know,  
8 impediments to research, the last two years have  
9 actually been my most productive in terms of  
10 publications. I -- again, you'd have to look at my cv  
11 to get the exact number. I -- what I can tell you,  
12 yeah, well -- oh, yeah, so, actually, I do have a  
13 fairly accurately grasp. We actually have so many  
14 papers that are currently under review that have been  
15 submitted that, you know --

16 What I can say for sure is that by the end -- by  
17 Christmas of last year, over the last two years, I had  
18 published 29 paper -- 29 peer-reviewed, scientific  
19 papers in scientific journals that are indexed in all  
20 the common databases and -- so 29 publications. And  
21 since then, I have had two or three more published. I  
22 have had two more accepted, and I have two or three  
23 more that are currently under review.

24 So, yeah, so it's been quite productive, and so  
25 the reality is -- so, for example, my institution,  
26 again, that has garnered attention because the average



1 publication record for faculty, in fact, dropped off  
2 substantially, to the point -- in fact, I should point  
3 out -- we actually normally have a performance review  
4 every two years, and because of this impact, our  
5 actual -- first performance review was supposed to  
6 occur very early on during the declared pandemic but  
7 was cancelled because of this impact at that time. And  
8 then we were supposed to have our last review very  
9 recently because this has been going on for two years  
10 now, and that's been cancelled.

11         So the next time we're going to have a review  
12 actually is going to have been -- at this point, it's  
13 going to have been a six-year gap, and that is to  
14 recognize the fact that it was unfair to evaluate the  
15 performance of faculty members who had had such massive  
16 interruptions to their research programs and their  
17 ability to be productive.

18         So, in fact, you can't expect the review  
19 committees to review six years of progress from every  
20 faculty member, so what's happening -- so, in fact,  
21 it's just been assumed that everybody -- at my  
22 institution, that everybody has performed reasonably  
23 well, because it actually gets linked to pay bonuses at  
24 the end of that two-year period, and so everybody will  
25 get the same pay bonus. And then when we have our next  
26 review, which will have been a six-year gap, it will --

1 we'll be starting from scratch again in terms of a  
2 review.

3 So, yeah, that's where I'm at with the publication  
4 record that I am particularly proud of, that my  
5 research team has been so incredibly productive  
6 throughout all of this, so that's kudos to them.

7 Q Thank you. And just to clarify some of those  
8 publications have been related to SARS-CoV-2 and/or  
9 COVID-19?

10 A Yes, that's true, yes, we have several peer-reviewed  
11 publications dealing with SARS-Coronavirus-2.

12 Q Have you been an expert witness in legal proceedings  
13 before today?

14 A I have. So, yeah, to disclose my involvement with  
15 those, I was in one that was ultimately not heard -- I  
16 was -- I -- so -- and the first one that I was involved  
17 with related to Corona -- SARS-Coronavirus-2. I served  
18 as an expert witness, was involved with various aspects  
19 of that case for many months leading up to it. I was  
20 cross-examined for 5 hours and 15 minutes for that  
21 case, but, ultimately, that case was thrown out. So  
22 I'm not a legal expert, but my understanding,  
23 therefore, is that I was not officially qualified as an  
24 expert in that case because the case ultimately was not  
25 heard, and my understanding is that's a requirement to  
26 be considered qualified, but I served as an expert

1 witness in that case.

2 I have -- I've served in an unofficial capacity  
3 for hearings that were run like court hearings for --  
4 the most recent one was for a physician in Ottawa, an  
5 ear, nose, and throat specialist, who was -- and this  
6 was due to the vaccine mandates and whether or not  
7 they're privileged to serve into hospitals in Ottawa  
8 should be taken away because of not accepting, you  
9 know, the two jabs in that case, but that was not an  
10 official court proceeding, but it was run by lawyers.

11 And then I was also involved in a court case  
12 dealing with vaccine mandates that were -- that was --  
13 this was for hospital workers in Toronto, and now that  
14 one is more complicated honestly. Again, I don't have  
15 the legal expertise, but it was my understanding and  
16 the understanding of the legal team that had recruited  
17 me to provide expert evidence to the people hearing the  
18 case that I had to qualify as an expert.

19 What I can tell you is that the -- one of the two  
20 experts on the -- serving on the other side, they  
21 were -- one was dismissed before the court hearing,  
22 their expert report, and then the other one was  
23 dismissed during the court hearing. Mine was  
24 discussed, and the lawyers accepted my expertise, and  
25 my report, my understanding was, had been admitted into  
26 court. There was a court hearing. My report was

1 discussed.

2 But then in the final report, what confused  
3 everybody is a -- the ruling ultimately was -- left  
4 only my report on the table, because the other two had  
5 been removed, and so, ultimately, the ruling was based  
6 on wording that the lawyers had used to, I guess,  
7 develop their case and not on the expert evidence. So  
8 the expert evidence ultimately was not considered in  
9 the ruling.

10 So, again -- so I was left with I had been told,  
11 on one hand, that I was qualified as an expert in that  
12 case, and then on the other hand, I was told that maybe  
13 not because the expert evidence, ultimately, was not  
14 considered. So that's just for full disclosure.

15 Because one of the things that I've got -- that  
16 I -- that was brought up is anytime I -- I didn't know  
17 from the first case, and I know it has to be disclosed,  
18 and I didn't want to get in trouble, so I disclosed  
19 that I was qualified as an expert witness in that --  
20 the first case, and then I was accused of lying, but I  
21 just didn't know because I'm not a legal expert, and so  
22 that's been clarified.

23 So that's why, for your full disclosure, I want  
24 you to know what's happened. So in that last case,  
25 whether or not I was officially qualified, I'm actually  
26 uncertain of, but certainly my -- in both cases, nobody

1       disputed my -- the ability to serve as an expert. And  
2       in the last one, my expert report was actively  
3       discussed in court. That's for full disclosure.

4       Q   Thank you. Now, Dr. Bridle, do you know Dr. Curtis  
5       Wall personally?

6       A   I don't know him at all, no, and I -- so all I know is  
7       the name, and, in fact, I still know very little about  
8       him.

9       Q   Do you have any financial interest in the outcome of  
10       this case?

11       A   No.

12       Q   Do you understand your duty to provide this Tribunal  
13       with your expert knowledge and opinions in an objective  
14       and neutral manner?

15       A   Yes, yeah, and that's -- as a scientist, that's what I  
16       am expected to practice on a regular basis as I  
17       mentioned, otherwise, the entire peer-review process  
18       will be compromised, and I will endeavour to do that  
19       today as well.

20       Q   Thank you.

21       MR. KITCHEN:                   Well, those are my  
22       qualification questions. Chair, I want to have  
23       Dr. Bridle qualified as the following -- I can read  
24       this a couple times -- but I want him to be qualified  
25       as an expert in the area of viral immunology and, in  
26       particular, SARS-CoV-2, COVID-19, and the efficacy of

1   masking, physical distancing, and other restrictions  
2   intended to prevent the transmission of SARS-CoV-2.

3   THE CHAIR:                               Mr. Maxston?

4   MR. MAXSTON:                            Mr. Kitchen, I'm going to ask  
5   you to read that back, I got part of it or most of it,  
6   but I just need to hear all of it again, if you could  
7   do that.

8   MR. KITCHEN:                            Yeah, no problem. I'd like to  
9   have Dr. Bridle qualified as an expert in the area of  
10   viral immunology and, in particular, SARS-CoV-2,  
11   COVID-19, and the efficacy of masking, physical  
12   distancing, and other restrictions intended to prevent  
13   the transmission of SARS-CoV-2.

14   MR. MAXSTON:                           Thank you, Mr. Kitchen.

15         Mr. Kitchen, I don't want to -- I may have a  
16   question or two for Dr. Bridle at this point, but can  
17   you clarify what other restrictions you're referring  
18   to? I don't want to be too difficult here, but that's  
19   a little bit open-ended; I just wonder if you can  
20   comment on that.

21   MR. KITCHEN:                           Sure. I'm going to ask Dr. --  
22   what I anticipate asking Dr. Bridle specifically about  
23   specific other restrictions, right. I've identified  
24   masking and physical distance as specific restrictions,  
25   right? But the reality is, and I -- you know, I think  
26   we often hear this from the public health people is

1       that, Look, it's a whole, right? You can't talk about  
2       these things very well isolated; they need to be talked  
3       about as a whole. That's one reason I have that in  
4       there is I'm going to have generalized questions, and  
5       Dr. Bridle's going to have generalized answers, I  
6       anticipate, about COVID restrictions globally or  
7       generally. That's one.

8               And two, I'm following along the same lines that  
9       you established with Dr. Hu, which I didn't take issue  
10      with; you know, you had the catch-all other measures.  
11      You know, I figured that was appropriate, so I didn't  
12      object, and so I'm following along in the same vein so  
13      that we don't get into issues of, well, you know, you  
14      can only talk about masking or physical distancing.  
15      That doesn't really make any sense. It wouldn't make  
16      any sense for Dr. Hu, it wouldn't make any sense for  
17      Dr. Dang, it wouldn't make any sense for Dr. Bridle, so  
18      that's why I'm putting that in there; not because I'm  
19      going to go to specific other restrictions, but because  
20      I want to talk about them generally.

21      MR. MAXSTON:                    Okay, thank you for that. I  
22      just have a couple of quick question for Dr. Bridle.

23      Mr. Maxston Cross-examines the Witness (Qualification)

24      Q   MR. MAXSTON:                    Good morning, Dr. Bridle. I  
25      wonder if you can answer a couple of quick things for  
26      me. You had a discussion with Mr. Kitchen about the

1 fact that you have your Ph.D., I think you're a viral  
2 immunologist. Is it correct that you're not a medical  
3 doctor then? I just want to be clear about that.

4 A Yes, that is correct. I do not hold an M.D. degree,  
5 nor a D.V.M. or any type of medical -- professional  
6 medical degree. I'm not a professional --

7 Q And similar to that --

8 A -- (INDISCERNIBLE) --

9 Q -- are you now a member of a regulated profession  
10 under, you know, the Ontario regulated Health  
11 Professions Act or something similar?

12 A No.

13 Q So you're not a member of a regulatory college like the  
14 College of Chiropractors of Alberta, for example, if  
15 you were in Alberta?

16 A That is correct.

17 Q Have you ever been a member of a regulatory college?

18 A No.

19 Q I think you touched on this with Mr. Kitchen, but have  
20 you advised any public health bodies concerning  
21 COVID-19; have you been asked to consult with them?

22 A Yes. So I have -- so, for example, I've had numerous  
23 interactions with the National Advisory Committee on  
24 Immunization, lots of back-and-forth emails, so, yeah,  
25 so that's a great question.

26 So I focus on research. I tend to focus more on



1 the pre-clinical side, feeding into the translational  
2 research arm. I have had some of my research go into  
3 clinical -- human clinical trials, but that gets passed  
4 off to those who work on the clinical research side.

5 So the type of research that I do helps inform  
6 public policy --

7 Q Yeah, I --

8 A -- public health policies but --

9 Q I think I --

10 MR. KITCHEN: Mr. Maxston, you need to let  
11 my witness finish.

12 MR. MAXSTON: Yeah, sorry, sorry.

13 Q MR. MAXSTON: I just wanted to -- I didn't  
14 want you to go down a certain road. I was more  
15 interested in whether you, for example, worked with the  
16 Ontario Chief Medical Officer of Health or anything  
17 along those lines.

18 MR. KITCHEN: And he'll --

19 A No, I haven't worked directly -- sorry.

20 MR. KITCHEN: Obviously, he's going to  
21 answer that question, but, Dr. Bridle, you are  
22 permitted to finish your answer to my friend's two  
23 questions ago.

24 A Okay, sure, yes. Yeah, so when it comes to public  
25 health, the type of research that I do and the science  
26 that I publish is what is used to inform public health

1 policy. So things like, for example, we've heard a lot  
2 about the epidemiological modelling, so what -- so --  
3 and what happens is when these epidemiological models  
4 are made, there's a lot of assumptions that are plugged  
5 into those.

6 And so, for example, the type of research that I  
7 do would be important in terms of what kind of data  
8 gets plugged into these models when it comes to  
9 assumptions like naturally acquired immunity, for  
10 example, or vaccine-related efficacy, right, these  
11 assumptions that dictate how some of the measures right  
12 now are performing, and that then influences the  
13 output, which is when we're trying to predict what  
14 cases and severe outcomes like hospitalizations and  
15 intensive care unit admissions, for example, I get  
16 into, just so that the -- everybody has an  
17 understanding of sort of where I stand on that  
18 spectrum. So my data feeds into that, you know, basic  
19 science aspect that informs then these models and how  
20 they're run.

21 But to directly answer your question, Mr. Maxston,  
22 I have not worked directly with the medical -- with  
23 Ontario's Medical Officer of Health. With that said, I  
24 have provided letters to them, you know, with my input,  
25 but I have not been formally recruited by them to  
26 discuss, you know, scientific matters.

1 MR. MAXSTON: Thank you, Dr. Bridle, those  
2 are all my questions.

3 Mr. Kitchen, I don't have any concerns with the  
4 manner in which you're tendering this witness. I think  
5 you've told me you wanted to have a little flexibility  
6 in terms of the other restrictions phrased, and I'll  
7 object if I need to, but I don't anticipate I would  
8 have to do that.

9 MR. KITCHEN: Thank you. Well, Mr. Chair,  
10 it's over to you then to let us know if you accept that  
11 qualification. I can read it again --

12 THE CHAIR: Yeah, no, that's okay. I  
13 think we all got it. Do we need to caucus, Mr. Pavlic?

14 MR. KITCHEN: You're muted.

15 MR. PAVLIC: My apologies, I had a little  
16 bubble over my mute button. Yeah, maybe we should just  
17 take a very brief minute.

18 THE CHAIR: Okay.

19 MR. PAVLIC: Yeah.

20 THE CHAIR: Thank you.

21 MR. PAVLIC: Thank you.

22 (ADJOURNMENT)

23 Ruling (Qualification)

24 THE CHAIR: We're back in session, and,  
25 Mr. Kitchen, the Hearing Tribunal has no objection to  
26 your qualifying this witness as an expert in his stated

1 field.

2 MR. KITCHEN: Thank you. Well, then I  
3 propose we continue on with questioning, and then if we  
4 need to take a break, then I'm sure somebody will put  
5 their hand up.

6 DR. BYRAM BRIDLE, Previously sworn, examined by  
7 Mr. Kitchen

8 Q MR. KITCHEN: Dr. Bridle, you can hear us,  
9 right?

10 A Yes, I can.

11 Q Excellent, all right, well, I'm going to jump right in.  
12 First, I want to start with a few basic questions,  
13 I know you touched on this in the qualification, but  
14 just to clarify, what is the virus that causes the  
15 disease of COVID-19?

16 A Yeah, so just to be clear, the virus in question here  
17 is known as the Severe Acute Respiratory  
18 Syndrome-Coronavirus-2. It's specifically been given  
19 that designation 2, because about 18, 19 years ago,  
20 there was an outbreak, including in Canada, of the  
21 original Severe Acute Respiratory Coronavirus, which is  
22 now either just called SARS-CoV or sometimes now  
23 referred to as SARS-CoV-1.

24 So this is dealing with the Severe Acute  
25 Respiratory Syndrome-Coronavirus-2, which was first  
26 identified and that information made public in the year

1 2019 now, late in the year 2019, and this is where we  
2 get this term "COVID-19" from. So what COVID-19 is,  
3 that's the Coronavirus disease, and then the 19 part  
4 refers to that was initially identified in 2019.

5 And, again, yeah, to differentiate -- and this is  
6 an important distinction for people to make --  
7 SARS-Coronavirus-2 is the virus. COVID-19  
8 is the disease. Being infected with the virus doesn't  
9 equate with having a disease. To have a disease, one  
10 must have signs for -- and/or symptoms of illness. So  
11 there's a clinical part to that diagnosis. So, again,  
12 one can be infected with the virus but not necessarily  
13 have disease, and, in fact, scientific literature right  
14 now shows that there's a much larger than previously  
15 anticipated and still unknown proportion of the  
16 population that has been or can be infected with  
17 SARS-Coronavirus-2 and not get COVID-19, the disease.

18 And so a way to kind of make sure that everybody  
19 understands that properly, we are all, all of us right  
20 now, I can guarantee, are infected, infected with all  
21 kinds of microorganisms, including lots of viruses. We  
22 think -- we hear a lot about our microbiome, and we  
23 often think about the bacteria that coat the outside  
24 and inside of our linings specifically, like the  
25 mucosal membranes throughout our body or gut, our  
26 respiratory tract, reproductive tracts, et cetera, and

1       then, of, of course, our skin.

2               But part of that microbiome is also what we know  
3       as the virome, so we actually have probably more  
4       viruses in and on our body than we actually do  
5       bacteria, and, interestingly, a lot of those viruses  
6       are actually -- have infected the bacteria that are in  
7       or on our body, and these are known as bacteriophage.

8               So I mean this just highlights that we can be  
9       infected with an agent but not have disease, and so  
10       that's the distinction here. SARS-CoV-2 is the virus  
11       that, in some people, can cause the disease known as  
12       COVID-19.

13    Q    Thank you. Now, when it comes to the virus and the  
14       disease and everything that's been going on in the last  
15       two years, what would you say is the most important  
16       difference or some of the most important differences  
17       between scientists such as yourself and public health  
18       doctors such as Dr. Hu?

19    A    Yeah, so I can't comment specifically on Dr. Hu, but I  
20       can provide some generic feedback, because, again --  
21       so, for example, individuals like myself, again, so we  
22       train -- we train medical professionals. In my  
23       specific case, I've chosen to work with the University  
24       of Guelph. I've been offered a position at the  
25       University of Ottawa where I would have been teaching  
26       students in the M.D. program, but because I felt I

1     could do more sophisticated research at the University  
2     of Guelph, because there's more animal models available  
3     and the type of research I do, I teach students in the  
4     doctor veterinary program.

5             However with that said, I've also had many of my  
6     undergraduate and graduate students that I've trained  
7     and mentored have gone to medical school as well.

8             And so as a consequence because of this teaching,  
9     I'm routinely involved with communicating, for example,  
10    I've chaired for many years our department's seminar  
11    series committee, and so through that, I host other  
12    scientists through my collaborative network. I've been  
13    in contact with all kinds of faculty members who teach  
14    in these types of programs.

15            So what's important to note is when one has an  
16    advanced degree, so, for example, a Master -- so that  
17    would be like a Master's degree and especially a Ph.D.,  
18    a Ph.D. takes it to a far greater extreme. What one is  
19    being educated in in that area is a very deep  
20    understanding of a particular area of expertise. So in  
21    my case, I have spent years studying in incredible  
22    detail the areas of virology and immunology, and  
23    although not relevant to today, but also cancer  
24    biology.

25            And so the key difference, what people have to  
26    understand -- and, again, this -- I mean no offence by

1    this in any way, but it's just to encourage  
2    understanding -- is if somebody holds an M.D., and the  
3    same would be for a D.V.M., any of these professional  
4    medical degrees, what you have to understand is when it  
5    comes to the medical doctorate programs, these are  
6    undergraduate programs -- they're undergraduate  
7    professional programs, right? So people when they get  
8    these degrees, they are declared professionals, but  
9    they are undergraduate degrees. So that is why, for  
10   example, if you see somebody who holds a graduate  
11   degree, the graduate degree will always, even if it's a  
12   Masters degree, it will always be listed after the  
13   undergraduate medical degree, and that's to recognize  
14   the fact that one is training at the undergraduate  
15   level, whereas the other one is more in-depth training  
16   at a graduate level. So literally -- so that's what  
17   you'll typically see. So if I were to list my  
18   credentials, I would be required to list my Bachelors  
19   of Science first, my Masters of Science second, and my  
20   Ph.D. last, and what we usually do is we just simply  
21   list the Ph.D. because it essentially trumps the  
22   others. So that's why you'll typically see -- not  
23   people won't list the Bachelors or Masters, and I don't  
24   like to do that because, you know, it's not about  
25   trying to garner, you know, praise from others, it's  
26   simply to recognize that, you know, ultimately we have



1     achieved -- we have -- we've got a Ph.D.

2             So that's why you see -- so the order in which  
3     degrees are listed actually is important in the  
4     scientific and medical community to recognize these  
5     distinctions, and so at the -- so, in other words,  
6     individuals like myself, who have deep expertise in  
7     immunology and virology, so I would teach in these  
8     programs in those areas that are under my expertise and  
9     try and get as much of that expertise conveyed to the  
10    people who are earning these undergraduate medical  
11    degrees.

12            One of the universal concerns actually -- so when  
13    I start my teaching -- and I mention this because it's  
14    important to understand the full scope of your  
15    question -- I -- so I -- one of the things I take pride  
16    in, as far as I know to date within the D.V.M. program,  
17    doctor veterinary medicine program that I teach, as far  
18    as we know to date, it involves the most extensive  
19    training in immunology in North America. I can't say  
20    for sure, because I don't know what every medical  
21    college in North America, what their programs entail,  
22    but so far, and has been recognized by my  
23    administration, we haven't seen one that's more  
24    intensive.

25            And by that I mean, we teach -- I have 30 lecture  
26    slots with my students to talk about -- you know, to

1 lecture them about immunology. Included with that is  
2 we have what we call independent learning sessions,  
3 where they also do some learning on their own about  
4 immunology. We also have -- I've incorporated what I  
5 call interactive learning sessions where we use a  
6 technology called iClickers, where I can put up  
7 questions and have the students then provide their  
8 feedback so I can gauge how well they are or are not  
9 understanding concepts, plus we have review sessions  
10 where they can openly ask me any questions that they  
11 want.

12 And then the other thing that we have is I run --  
13 the class, because it's large, gets split into two, so  
14 I run two laboratories split across two halves of the  
15 class, so four laboratory sessions in total. So each  
16 student gets six hours of laboratory exposure to  
17 immunology, so hands-on learning.

18 So I just say that to put in perspective, because  
19 in Canada, in the M.D. program, the average M.D.  
20 program in Canada provides in the ballpark of ten  
21 lectures, only lectures and none of these other  
22 aspects, no laboratory, you know, hands-on learning,  
23 ten lectures on average in the first year of the M.D.  
24 program and less than that for virology.

25 So on the extreme end would be McMaster  
26 University. I have had several of my students go to

1   McMaster University and of course to collaborate -- I  
2   mean, I did my post-doctoral fellowship there, so I --  
3   and I collaborate and still collaborate with people  
4   from McMaster, so I know this very well. They're on  
5   the extreme low end in Canada actually with five  
6   lectures in immunology in the first year of the  
7   program.

8           So I say that because when it comes to things like  
9   immunology and virology, therefore, if it's just an  
10   M.D., then somebody who just holds an M.D. and who has  
11   not taken advanced training in these areas would have  
12   only the most superficial understanding of these areas  
13   of science. And at an extreme, it is possible to get  
14   into these programs without completing an undergraduate  
15   program. I'd like to point that out because their  
16   undergraduate immunology training, for example, the  
17   University of Guelph involves about 35 lectures in  
18   immunology, so -- but those tend to be in third and  
19   fourth year. People can get admitted into medical --  
20   and they're not often prerequisites as well. So even  
21   an undergraduate student with a Bachelor of Science  
22   degree who has taken an undergraduate immunology  
23   course, for example, from the University of Guelph  
24   would have a much more comprehensive understanding of  
25   immunology and virology than the average person at the  
26   point of completing their medical doctorate.

1 Q Thank you. Okay, now I've got some questions about  
2 your report. In Section 3 of your report, and just for  
3 those following along, that's page 2 of 18. So in  
4 Section 3, Dr. Bridle, you refer to the SARS-CoV-2  
5 virus --

6 A Sorry, Mr. Kitchen, may I just ask a question; am I  
7 allowed to bring up my report to refer to it?

8 Q Yes, yes, you are.

9 A Okay, I'm going to be looking -- I'm going to bring it  
10 up on my -- I have a second screen here and that is  
11 what I'm looking at. So, sorry, which page?

12 Q So I'm on page 2 and 3 of 18 pages, and this is Section  
13 3, where you say: (as read)

14 SARS-CoV-2 is not a problem of pandemic  
15 proportions.

16 A Okay, just let me get there, page 2. Yes, okay, I'm  
17 there.

18 Q You discuss infection fatality rates in this. Well,  
19 let's start here: Could you just briefly explain for  
20 us, so we know, what is the infection fatality rate?

21 A Okay, yeah, so what -- infection fatality rate, what  
22 that tells you is if you have a population and you can  
23 confirm that an infection has occurred and how that --  
24 and I want to point out how that is determined, what  
25 method is used is important, because if techniques are  
26 used improperly, one might be erroneously identified as

1       being infected. But so what infection fatality rate is  
2       supposed to be is if somebody is genuinely infected, it  
3       gives you an indication of what the chances are that  
4       that is going to be fatal for that individual.

5               So the best way to understand it is, again,  
6       because we're talking about percentages, it's best to  
7       put it, give the example of how having a population of  
8       100 people, so if you know what -- if you have a group  
9       of people that you know for sure are infected with a  
10      pathogen, then the infection fatality rate would tell  
11      us how many, what proportion of those 100 people would  
12      be expected to die as a result of that infection.

13   Q    Could you please describe the relative danger of  
14       SARS-CoV-2? And I say "relative" because, you know,  
15       obviously we're not working in a vacuum here. So if  
16       you could tell us the relative danger of SARS-CoV-2.

17   A    Yes. So what I'd like to point out just before I start  
18       giving the full answer, and I'll come back to this at  
19       the end, there is -- what I want to point out is in my  
20       report -- just, again, to put it in perspective, my  
21       report was submitted I can't remember the exact date,  
22       but it was, you know, well -- it was quite some time  
23       back in 2021. So I'm going to talk about, because this  
24       has been admitted as evidence, I want to talk about  
25       what was available to me at that time, but it's  
26       important to note that things have also changed quite a

1 bit in the context of the Omicron variant, so I'd like  
2 to touch on that at the end.

3 So in terms of what I have in the report, what  
4 you'll see is that ultimately I cite a scientific  
5 paper, again, a peer-reviewed published paper that  
6 estimates -- that estimated at that time that the  
7 infection fatality rate for SARS-Coronavirus-2 was  
8 likely in the ballpark of 0.15 percent. So, again, to  
9 put that in perspective, if a hundred people were  
10 infected with SARS-Coronavirus-2, you'd expect 0.15  
11 percent of them to die.

12 Now, this is important because when the pandemic  
13 was declared, many of us might recall or certainly you  
14 can look up the, you know, the headlines, it was  
15 declared -- there were concerns at the beginning,  
16 because we didn't know a lot about this virus at the  
17 very beginning, so what I'm referring to there is  
18 towards the end of 2019 when this virus was first  
19 identified, we didn't know, you know, what exactly the  
20 outcome of infection would be, and there were serious  
21 concerns that we might be looking at infection fatality  
22 rates as high as 10 percent. So that was stated by  
23 many health professionals including Anthony Fauci and  
24 many others.

25 Then as time progressed, and we started to realize  
26 that it was a relatively limited demographic that was

1 at high risk from this virus, that was rephrased, and  
2 the concerns were then that this might be in the  
3 ballpark of -- infection fatality rate might be in the  
4 ballpark of about 1 percent, and that would be serious  
5 if it was at 1 percent, definitely with 10 percent,  
6 also at 1 percent. I would argue as an expert in this  
7 area, a 1 percent infection fatality rate, that  
8 declaration of a pandemic would likely -- would be  
9 warranted at a 1 percent infection fatality rate.

10 But this is where it's important is what we soon  
11 realized because of the way that the testing was being  
12 done, and there'd certainly be flaws with the testing  
13 as it's been performed in Canada, what I'm referring to  
14 there are the reverse transcript-ase PCR tests or what  
15 we often refer to as just the PCR test. "PCR" meaning  
16 polymerase chain reaction test, which are -- the way  
17 we're using them, they're notorious for identifying a  
18 lot of false positives. So that's why you have to keep  
19 sort of mentioning and when I'm giving these statements  
20 that a lot of -- at its root is when you know  
21 somebody's infected.

22 So what we know is that there have been a lot of  
23 people who have been infected who never got sick, and  
24 so initially our estimates of infection fatality rate  
25 were based on people who actively had COVID. Now,  
26 we -- again -- so, again, we recognize now that

1     there -- that there -- a lot of people can be infected  
2     but for whom this is not even a pathogen. And what I  
3     mean by that is because it does not count as disease in  
4     those individuals.

5             For example, that's very common in children, and  
6     one of the reasons for that is children simply have  
7     physically expressed many fewer of the receptors the  
8     virus uses to grab onto our cells and infect it. So  
9     there's many children who get infected, but the  
10    infection is -- never becomes productive enough to  
11    cause disease.

12            And so as we've appreciated that, the way this is  
13    calculated is, like I said, you have to have -- in  
14    order to calculate infection fatality rate, you have to  
15    know the number of deaths, and you divide that by the  
16    denominator, which is the number of people who are  
17    infected. So early on in this pandemic, we -- the way  
18    this was being calculated, of course, we've always had  
19    quite accurate numbers of deaths, because that's -- I  
20    mean, you know, unfortunately, that is a very easy  
21    outcome to define and identify and document, and  
22    there's really -- there's no controversy about that  
23    outcome, that a death is black or white, either  
24    somebody's died or they have not. So we have very  
25    accurate data about deaths.

26            The problem is we still don't have fully accurate



1 data for the denominator, which is how many people have  
2 been infected. But as we have expanded the testing and  
3 looking for evidence of -- and, again, it's not even  
4 the virus but evidence that the virus is present in  
5 somebody's body by detecting portions of the genetic  
6 material that this virus would have, what we've been  
7 able to appreciate is that the denominator -- the  
8 denominators kept growing, in other words, right? We  
9 have found that more and more people have been  
10 infected.

11 So, for example, there's the great study that was  
12 published, actually a Canadian study, a high -- that  
13 was published in a very high-impact scientific journal,  
14 and it was a clinical trial that was being run out of  
15 British Columbia looking -- actually looking at healthy  
16 people for evidence of immunity acquired against  
17 SARS-Coronavirus-2, so, again, knowing that this was a  
18 novel virus. And what it found is that a majority of  
19 people who were not sick had evidence of having  
20 acquired, especially as time has gone on, so a year  
21 after the declaration of the pandemic, a large number  
22 of people who were unaware that they were sick with  
23 SARS-Coronavirus-2, you know, there was no sickness  
24 that they could identify, had evidence of what we call  
25 seroconversion, so the immune system having responded  
26 to the virus and produced antibodies against it.

1           So what this publication that I cited here did is  
2   it accounted for this ever increasing denominator, and  
3   so it corrected for the early massive overestimations  
4   of the infection fatality rate and came up with one  
5   that they felt at that time was more reasonable. And,  
6   again, I point out that this publication is from  
7   earlier in 2021, much earlier in 2021. And they  
8   estimated that the overall infection fatality rate was  
9   0.15 percent.

10          So to put that into perspective for people, and  
11   this is largely agreed upon, I mean people like  
12   Dr. Fauci, for example, have publicly declared themself  
13   that, you know, the flu is often associate -- the  
14   annual flu is often associated with an infection  
15   fatality rate in the ballpark of 0.1 percent. So an  
16   infection fatality rate of 0.15 percent would be like a  
17   particularly bad flu season.

18          And the other thing to point out is when one looks  
19   at this publication, that's the overall infection  
20   fatality rate for the entire population. And in this  
21   case, we know that this virus is much more dangerous  
22   for a much more restricted subset of individuals,  
23   specifically the frail elderly and those who are  
24   immunosuppressed. And then we've come to identify some  
25   very key predictors of dangerous outcomes of infection:  
26   Obesity at the moment is the number one risk factor

1 associated with fatal outcomes, and alongside that are  
2 multiple comorbidities. So the average person who has  
3 died with SARS-Coronavirus-2 -- with the  
4 SARS-Coronavirus-2 infection has had, on average, more  
5 than three other comorbidities, meaning other  
6 illnesses, other health problems in addition to  
7 infection with the SARS-Coronavirus-2.

8       So why this is important is because if you were to  
9 remove those individuals from this analysis, you end up  
10 with an infection fatality rate for the rest of the  
11 population that is well below 0.1 percent, with the  
12 extreme being when you go into children. So if we go  
13 to the under 18-year-old demographic, the infection  
14 fatality rate would be well, well below 0.1 percent,  
15 and our own public health data show that, that there  
16 have been extremely few deaths. So, yeah, very few in  
17 that young demographic. So -- but this is the thing,  
18 so that's what I have in the report.

19       Now, what's important to note is that was dealing  
20 with data where we were dealing with the original  
21 variant and some of the variants that started to  
22 emerge, so, for example, the Alpha variant. Those  
23 variants we now know, certainly relative to the current  
24 Omicron variant -- and I think this is important  
25 because presumably I mean with this hearing happening  
26 today, I guess we're talking about the relevance of

1 certain COVID-19 policies as it exists today. If we  
2 ask somebody today to implement a certain policy,  
3 what's relevant is what the situation looks like today.

4 So the Omicron variant is far more infectious than  
5 the original variants -- actually I should restate  
6 that. It's more infectious than the original variants.  
7 The Delta variant was particularly infectious, that's  
8 when we first saw a change in the virus towards one  
9 that is more infectious and that can spread, therefore,  
10 easier, and this seems to have continued with the  
11 Omicron variant.

12 And this is very typical of viruses. What I'd  
13 like to highlight is -- and so this leads to what we  
14 call cases, right? Cases -- and, again, what I'd like  
15 to point out is the cases that we are identifying in  
16 our public health data are not actually cases of  
17 COVID-19; they're cases that were called -- although we  
18 often equate them to cases of COVID-19, what they are  
19 in reality is they are positive test results, again,  
20 for the presence of portions of the virus's genetic  
21 material in an individual. So people tested positive  
22 by the PCR test for -- and that provides some evidence  
23 that they may be infected with a potentially infectious  
24 form of SARS-Coronavirus-2. So that's important.

25 And what I'd like to point out is cases in and of  
26 themselves are not dangerous. So if somebody were to

1     acquire any of the respiratory pathogens and develop  
2     mild to moderate signs or symptoms of illness like  
3     other common cold-causing viruses, including other  
4     types of cold-causing Coronaviruses, like Norwalk  
5     virus, like respiratory syncytial virus, and like  
6     influenza viruses as examples, they would be cases of  
7     respiratory illness. So that -- and all those cases,  
8     those viruses are highly transmissible, but in most  
9     cases do not cause -- well, I should -- I'll talk about  
10    the cold-causing viruses, in most cases do not cause  
11    severe disease.

12           So if we think about the common cold, highly  
13    contagious. I mean, we've all seen this, especially  
14    anybody who's been in -- volunteered in a school,  
15    worked in a school, or has children in school, and in  
16    also workplaces, schools especially, I mean, a cold  
17    will spread rampantly throughout the school population  
18    and in all the homes connected with the school. So the  
19    ability to spread rapidly is not in itself a concern if  
20    it's only causing, in most people, mild to moderate  
21    disease. The reason why I focused on cold viruses is  
22    they excluded things like respiratory syncytial virus  
23    and influenza viruses, for example, because they  
24    actually can be particularly dangerous, not only the  
25    same demographics that we're talking about with  
26    SARS-Coronavirus-2 but especially in young children,

1    which are quite -- actually protected because of that  
2    unique physical, you know, lack of expression of the  
3    receptor the virus uses to grab onto our cells that --  
4    and it's not confined to SARS-Coronavirus-2, it's  
5    unique in that our very young are not susceptible in  
6    this case. But all these people are susceptible to  
7    potentially severe and fatal outcomes with influenza  
8    viruses and the young for sure with respiratory  
9    syncytial virus.

10           And so that -- so that's why -- so, yes, so I want  
11    people to understand Omicron is more -- because this  
12    relates to the infection fatality rate, -- it can  
13    spread easier, but it is definitely much less dangerous  
14    than any of the previous variants. That is clear.  
15    We're seeing that everywhere. I want to -- so what's  
16    important to understand this -- is because of the  
17    public health messaging, right, that's been out there,  
18    and personally as an expert -- I have contentions with  
19    this, but I'm just putting out what the public health  
20    messaging is right at the moment -- is that the  
21    vaccines being used for SARS-Coronavirus-2 have been  
22    purported to be -- I mean, originally, they purported  
23    to be very protective and protect people from infection  
24    and disease and very good at preventing transmission.  
25    That certainly has been downgraded, and I would argue  
26    that current data suggests that they are not reducing

1 the spread of the disease at all.

2 In fact, the remarkable phenomenon and of concern  
3 to me is that we're actually seeing cases occurring  
4 predominantly among the fully vaccinated, which might  
5 actually be evidence of vaccine-enhanced disease. But  
6 I raise this because in vaccinated individuals, this is  
7 the messaging, that it's supposed to be, supposed to be  
8 reducing their chances of getting infected and their  
9 chance of transmitting the virus to others. And yet in  
10 all of our school and work environments where it's  
11 almost completely people who are vaccinated, so there  
12 should be reduced transmission and they're masking, the  
13 viruses are still spreading rampantly. So this is the  
14 nature of Omicron.

15 But our data also show that while the cases of  
16 Omicron have skyrocketed across all of Canada,  
17 including Alberta, the most serious outcomes have  
18 steadily declined. So there's been a -- there's been,  
19 over time, a complete uncoupling of cases and the most  
20 severe outcomes. So as we've continued to have  
21 these -- and, remember, the first wave early on in the  
22 pandemic has been dwarfed by multiples -- recent waves,  
23 including the most recent with Omicron, has completely  
24 dwarfed the previous wave if you look on the graphs and  
25 the number of cases that are occurring. Yet, we have  
26 progressively gotten -- gone closer and closer to

1 baseline when it comes to hospitalizations and ICU  
2 admissions and deaths, and so that's clear evidence  
3 that Omicron is less dangerous.

4       Also biologically, I can explain why this is, and  
5 it -- there's two phenomenon that explain why Omicron  
6 now is much less dangerous than the previous variants.  
7 So -- and this goes hand-in-hand actually with the  
8 vaccines. The vaccines, unfortunately, we've delivered  
9 them into the muscle, which is called a parenteral  
10 route. That tricks the body, the immune system into  
11 thinking that there's a systemic infection, not a  
12 mucosal infection. Remember, the natural infection is  
13 through the airways. And so when the body thinks that  
14 there's a systemic infection, what it wants to do is it  
15 protects all of the key entry points into the body to  
16 protect from future systemic infections.

17       So when it comes to respiratory tract, the only  
18 place that these vaccines confer some protection is in  
19 the very lower airways, and that's because if a virus  
20 gets into our lower airways, there's not much  
21 physically to prevent that virus from getting into the  
22 blood, and that's because of gas exchange, right?  
23 We -- so in the alveolar space, we have blood vessels  
24 that come very, very close to the alveolar space to  
25 allow the gas exchange, oxygen to go into the blood and  
26 carbon dioxide to be released. So that also means that



1 if a virus gets there, there's only the ever so tiniest  
2 physical barrier to prevent it from getting into the  
3 blood. So our body produces antibodies in the lower  
4 airways.

5 So this is the thing -- and I say that because  
6 this is important -- the most severe outcomes of  
7 infection with SARS-Coronavirus-2 is when the virus  
8 goes down into the lungs. When it's in the upper  
9 airways, it's not particularly dangerous. When it gets  
10 dangerous is when it gets down into the lungs, and it  
11 causes a severe pneumonia, then you start getting  
12 inflammation in the lower lungs, and that can interfere  
13 with things like gas exchange, and it can cause a lot  
14 of damage to the physical architecture of the lower  
15 airways, which is where all the gas exchange has to  
16 occur.

17 And when it gets into those lower -- in the lower  
18 lungs, that's where the real problems are when the  
19 virus then starts entering the bloodstream, and we get  
20 what's called viraemia, and that means the virus can  
21 distribute all throughout the body using the blood, our  
22 blood, as highways of all the places -- all kinds of  
23 different places in our body. So that's where the  
24 severe outcome occurs.

25 And that's also why the vaccines with earlier  
26 variants were doing, you know, a somewhat decent job at

1 dampening the most severe aspects of the disease. But,  
2 as we've now recognized, they weren't preventing  
3 infection, and they weren't preventing transmission.  
4 And this is why they're having no impact on Omicron,  
5 the spread of Omicron, is because -- this is the other  
6 key biology you have to understand -- so if the virus  
7 doesn't go deep in the lungs, you tend not -- you're  
8 going to tend not to get severe disease. It's the  
9 difference between bronchitis and pneumonia, and many  
10 of us will know that pneumonia is -- has a much more  
11 severe prognosis than bronchitis, which is the upper  
12 airways. Pneumonia being in the lower airways.

13         So the interesting thing is Omicron now has  
14 accumulated a lot of mutations, a lot of mutations, and  
15 it has changed how this virus behaves. In one -- so  
16 one way it changed it is has become more infectious,  
17 but it's also become much less dangerous, because when  
18 we talk about viruses, we refer to something that's  
19 called tropism. Tropism is a scientific term that  
20 means where the virus likes to go in our body. So the  
21 original variants like to infect our upper airways and  
22 then migrate into our lower airways, and that's where  
23 they were dangerous.

24         The Omicron variant also infects through the nasal  
25 passages and the mouth and infects our upper airways,  
26 but it does not migrate down into the -- deeper into

1 the lower respiratory tract. It now has the more  
2 restrictive tropism, meaning it likes to stay in the  
3 upper airways. So this explains why the vaccines are  
4 now largely irrelevant in the context of the Omicron  
5 variant because the protection is in the lower airways  
6 and not in the upper airways. And so somebody -- and  
7 that also explains why the virus -- whether you have  
8 immunity or not is not particularly dangerous because  
9 it's restricted to the upper airways.

10 It also explains why everybody can equally  
11 transmit the virus, because nobody -- well, sorry,  
12 sorry, I -- that's untrue. I'm going with sort of the  
13 public messaging that's out there. So I'll tell you  
14 what the exception is to that. But it's thought right  
15 now that everybody, whether or not they have been  
16 vaccinated or not, can transmit at least the same  
17 quantity of the virus because it's in the upper  
18 respiratory tract.

19 But the reason why I want to point that out is I'm  
20 an immunologist and have found it profoundly  
21 frustrating that it's not recognized that our immune  
22 system actually does its job and functions naturally.  
23 The purpose of a vaccine is to simulate a natural  
24 infection, try and do the best that we can to simulate  
25 an actual infection as accurately as we can to confer  
26 immunity. As I mentioned that these -- we've made a --

1    you know, the vaccines going parenterally actually  
2    trick your immune system into thinking it's a systemic  
3    infection, so we're not getting proper protection of  
4    our airways.

5           Somebody who has been naturally infected will have  
6    mounted an immune response, and their immune response  
7    is going to be far more relevant, especially to the  
8    Omicron variant, because they've been infected the  
9    natural -- by the natural route. Our immune system  
10   when infected by the respiratory tract makes sure that  
11   it provides infector mechanisms that can protect all,  
12   all areas of the respiratory tract, upper and lower.  
13   So I want to point that out.

14           So we don't know a lot about natural immunity  
15   because we haven't been looking for it, but somebody  
16   who has natural immunity, we can't make any assumptions  
17   about their health status without knowing, because if  
18   somebody has natural immunity, they're actually going  
19   to be the most protected in the context of Omicron, and  
20   they're going to be the ones that spread the  
21   SARS-Coronavirus-2 to the least of anybody in Canada  
22   right now.

23           So I know that's a lot, but it's -- it's a lot of  
24   science, again, to understand the importance of the  
25   infection fatality rate, what it means, and why we have  
26   been seeing it declining, and why we can conclude that

1 the danger of SARS-Coronavirus-2 even more recently has  
2 continued to decline.

3 So, again, I'd just like to finish by, again,  
4 saying SARS-Coronavirus-2 with the dominant -- the  
5 variants out there right now, by far the dominant one  
6 is Omicron. It is more transmissible right now and  
7 much less dangerous right now.

8 And just to understand as well from the virology  
9 perspective, that's typical for a virus. Any  
10 pathogen -- so, again, you think about -- so if we  
11 think about viruses as organisms, right, if we just  
12 take that very like objective approach, and we think  
13 about this from the perspective of an organism and an  
14 organism trying to survive; it is never to an advantage  
15 to any microorganism to cause severe harm or kill its  
16 host, because if it does, it's going to render itself  
17 extinct.

18 So what happens over time is, arguably -- so we --  
19 we often forget about this, as I mentioned, our bodies  
20 are loaded with viruses that causes no harm. The vast  
21 majority of viruses that we're exposed to in the world  
22 do not cause disease. That is where viruses want to  
23 get to and for the reason of survival. Because, again,  
24 like I said, if they were to infect the host and kill  
25 that host, they're rendering themselves extinct.

26 So the natural progression for a virus is to

1    become -- so think about it, if you want to maximize  
2    survival, if you want to maximize the number of your  
3    kind, right, you can think about any organism, what you  
4    want to do is maximize your ability to propagate and  
5    minimize your ability to harm your host and especially  
6    not kill them. And so that's why viruses over time  
7    will naturally progress to ones that are more  
8    infectious, because the more hosts they can infect, the  
9    more they propagate, right, and the larger their  
10   numbers become, but they simultaneously become less  
11   dangerous, because if they were to kill all those  
12   hosts, they're going to render themselves extinct.

13        So that's what this virus is doing, has been  
14   doing. We have the evidence of this. This is the --  
15   so this is a natural progression for this type of  
16   virus: It's reaching -- starting to approach a more  
17   ideal way to live with us by, you know, spread readily  
18   among people but not cause substantial harm to people,  
19   and it would probably -- likely continue to progress  
20   this way ideally, and so that's very important to  
21   understand.

22        So, again, just to highlight, being more  
23   infectious does not equal more dangerous. Again, I'd  
24   like to highlight the common cold is highly infectious,  
25   but for most people not dangerous. That seems to be  
26   where the Omicron variant is right now.

1               Sorry, Mr. Kitchen, it looks like you're muted.

2     Q     Sorry, I muted, because I didn't want to cause any  
3           noise to interrupt you.

4           Okay, if I understand you correctly then, we have  
5           an infection fatality rate that has changed over time,  
6           so I want to ask you a couple of questions about that.

7           You've said it's much less dangerous now. Can you  
8           give me a rough number of what the IFR rate is now or  
9           in the last few months? And I understand that might be  
10          several decimal points, but if you could give us some  
11          idea just so we have a number.

12    A     Well, actually I haven't seen a good, reliable  
13          peer-reviewed publication on that actually, and that's  
14          because the Omicron variant, you know, has -- it's  
15          quite recent, and, again, that would be the most  
16          relevant data. So all I can tell you is that, again,  
17          based on what I described for -- relative to the data  
18          that I highlighted -- that was highlighted in my  
19          report, which is dealing with older variants that  
20          unquestionably were more dangerous to the high-risk  
21          demographics, the Omicron is much less dangerous. So  
22          all I can say with certainty is that it would be well  
23          below the previously documented 0.15 percent, but I  
24          don't have a specific number that I could give you  
25          right now upon which I -- for which I could lean on a  
26          legitimate peer-reviewed scientific paper.

1 Q Let me ask you this: Is the survivability rate sort of  
2 the other side of the coin of the infectious fatality  
3 rate?

4 A Yes.

5 Q Okay, so, you know, the 99 percent --

6 A So sorry, could I just clarify that, Mr. Kitchen?

7 Q Go ahead.

8 A So, yeah, so, in other words, just to make sure that  
9 it's clear, yes, absolutely, infection fatality rate, I  
10 mean, so if you take the inverse of that, that's the  
11 survivability rate. So that infection fatality rate  
12 that was updated early in 2021 of 0.15 percent, the  
13 other way to put that is that 99.85 percent of those  
14 deemed to have been infected with the virus would be  
15 expected to survive, and, again, that was with the  
16 older, more dangerous variants.

17 Q Okay, so just to clarify, 99.85 survivability rate,  
18 that would have been the number in 2020?

19 A So, again, this is -- that publication was -- that I  
20 cited was in 2021. It would have taken into account  
21 data up until very early in 2021.

22 Q Okay, okay. So the survivability rate being 99.85 in  
23 2020, that's gone up since 2020?

24 A Absolutely, yes, in the context of the Omicron variant.  
25 So like I said, so in terms of that data, yeah. What  
26 I've looking at, in particular, is the public health



1 data. And so, again, there -- so anybody can go to  
2 public health websites to see this for themselves. But,  
3 for example, I'm in Ontario, but Ontario, I mean,  
4 there's nothing particularly unique about our  
5 demographic relative to most of the other provinces,  
6 especially Alberta, so a lot of our data are very  
7 similar.

8 So, for example, like I mentioned public health  
9 data, so I'm talking about this is not looking at  
10 anybody else's interpretation of the data; this is the  
11 public health data, the raw public health data that's  
12 available to every Canadian. So you could go right now  
13 onto the Public Health Ontario website or Public Health  
14 Alberta website and see these data to confirm.

15 This phenomenon, which I get has caused some of us  
16 to be worried about, that the vaccines in context of  
17 the Omicron variant have actually set up the immune  
18 system to respond suboptimally, meaning that there  
19 might actually be enhanced potential for infection of  
20 those who are vaccinated, right? What we see in terms  
21 of public health data is that the cases right now have  
22 been occurring for the past month. This happened --  
23 this crossover happened at about -- at about -- well,  
24 in Ontario it happened on Christmas Eve. In Alberta,  
25 for example, the crossover happened a little bit later,  
26 up to a week later. But now the -- for the last month,

1 the -- with the Omicron wave, the number of cases have  
2 been occurring disproportionately among  
3 double-vaccinators.

4 So that then -- so that's the public health data  
5 that I'm relying on. So the same public health data,  
6 when you look at it -- and so because I know the -- I  
7 can -- I know the numbers much better off the top of my  
8 head for Ontario, that's what I'll use as my example.  
9 So keeping that in mind, simultaneously, the public  
10 health data has been looking at the most severe  
11 outcomes, and that includes data on hospitalizations.  
12 So the way in Ontario we show it is hospitalizations  
13 but not including admissions to ICU units, and then we  
14 also look at the proportion of people that are in --  
15 have been to the ICU unit, and then we also have data  
16 on deaths. And so when we look at these outcomes, so  
17 as we've seen this huge spike in the -- massive spike  
18 in the cases of, again, I don't want to say COVID-19  
19 but certainly infection, evidence of infection from  
20 SARS-Coronavirus-2, of which a proportion of those  
21 would have COVID-19, we have simultaneously seen,  
22 again, an uncoupling of the most severe outcome. The  
23 number of people admitted into the ICUs and hospitals  
24 has been lower, so despite record cases, it's been  
25 lower than the previous waves. All the more -- most  
26 severe outcomes have been reduced. Again, so I

1 highlight this shows an uncoupling of this idea of  
2 infectivity and the most severe outcomes of the  
3 disease.

4 And this is important as well because -- well,  
5 yeah, I guess I'll leave it at that, yeah. So using  
6 public health data, so, again, I can't use that to give  
7 you a specific infection fatality rate, current update  
8 of one, but all I -- what I can tell you is the same  
9 public health data that existed when this 0.15 percent  
10 infection fatality rate was estimated, right, compared  
11 to the public health data available now, the public  
12 health data is clearly showing this is less dangerous.  
13 So, again, I highlight that it -- the current rate  
14 would be less than .15 percent, but I can't  
15 definitively state what it would be.

16 Q I want to make sure we understand this, because I don't  
17 think any of us are mathematicians, with a 99.85  
18 survivability rate, if 1,000 people were actually  
19 infected, statistically, how many of those would die?

20 A The -- so you're saying 1,000?

21 Q 1,000, yes.

22 A Okay, and this is with the assumption of .15 percent of  
23 infection fatality rate? Is that what you're --

24 Q Yeah, exactly.

25 A -- wanting me to do? So that would be -- so 1.5 [sic],  
26 and based on basic math, if we round up at a decimal

1 point of .52, two people. So I guess the more accurate  
2 number, therefore, would be you would have -- because  
3 rounding up actually has a substantial -- you're  
4 increasing the outcome by -- what is that -- by a  
5 third, so 2,000 people infected. In fact, in early  
6 2021, you would have expected 1 to die.

7 Q Okay so if 10,000 people are known to be infected,  
8 statistically, 15 of those would be expected to die?

9 A Yes -- back in 2021, early 2021. Not --

10 Q Okay --

11 A -- now, not now. It would be -- it would be --

12 Q Right.

13 A -- likely be much lower, but how much lower I can't say  
14 definitively.

15 Q Now, you obviously touched on this, but the next thing  
16 I wanted to ask you is about the issue of endemic,  
17 because you touched on this in your report. Now, I'm  
18 now in Section 6 of your report. I'm not necessarily  
19 going chronologically through your report, but the  
20 issue of endemic, first, can you help us understand --  
21 because I know you used that term -- can you help us  
22 understand what "endemic" actually means comparative  
23 to, let's say, "pandemic" or "epidemic"?

24 A Yeah, obviously with the timing. So an epidemic and a  
25 pandemic, you're dealing with an acute scenario,  
26 meaning short time frame, where an infection is

1 occurring and spreading, and the difference between an  
2 epidemic and a pandemic is the scope, the scope of the  
3 problem.

4       So with an epidemic, the scope is much -- on  
5 a much smaller geographical scale. So, for example,  
6 with the SARS -- the original SARS, Severe Acute  
7 Respiratory Syndrome by Coronavirus that caused the  
8 disease SARS, which we called, you know, at that time,  
9 the Severe Acute Respiratory Syndrome was the disease,  
10 that was -- because it was much more limited scope,  
11 that was declared in Canada to be an epidemic.

12       So a pandemic is all dealing with the scope. So  
13 if it's on a much broader scale, and in this case, you  
14 know, if that -- it's on a global scale, then it gets  
15 declared as a pandemic. If the dangerous, right, the  
16 most dangerous outcome -- because, again, I have to  
17 highlight, so, for example, if you have a common  
18 microbe that's part of the human microbiota, that's  
19 something that can readily be transmitted potentially  
20 around the globe, but if it has no dangers associated  
21 with it, although it has that same scale, it's not  
22 going to be defined as a pandemic.

23       So that's the two things, there has -- there's two  
24 things for -- to declare something a pandemic: There  
25 has -- it has to meet a certain threshold of danger and  
26 a scope, a very large scope of the problem. But, yeah,

1 so that's dealing with things in the acute or  
2 short-term.

3 When we talk about something being endemic, we're  
4 talking about something long-term. So the -- most of  
5 the Coronaviruses that we're used to, the ones that  
6 cause the common cold, like I would argue the Omicron  
7 variant is likely one that -- and the way it's behaving  
8 is starting to fit largely into this category. They're  
9 what we would call endemic; they're always with us,  
10 right? We're always interacting with them. They're  
11 always causing some form of mild disease.

12 So in that context, you know, we would not  
13 declare -- so a cold definitely, even in terms of the  
14 scope of a cold or the flu -- and the flu is a good  
15 example. The reason why the flu sometimes meets this  
16 threshold of an epidemic or pandemic is because the flu  
17 can be very dangerous, right? So we've heard of flu  
18 epidemics, and we -- you know, we -- many of us now  
19 have probably heard, in one form or another, of the  
20 Spanish flu outbreak in the early 1900s, right, which  
21 was declared a pandemic. And we have had a pandemic  
22 flu also declared as swine flu in the 2000s, back  
23 around 2009. So, you know, that's because they can  
24 spread on a large scale. But the flu gets called an  
25 epidemic or a pandemic because it is also associated  
26 with high fatality rates in those cases.

1           Now, when it comes to the common cold, again to  
2     differentiate, the common cold spreads at least as  
3     readily as the flu. So in terms of scope, it would fit  
4     into the definition of an epidemic or a pandemic, but  
5     it's never going to be declared as such because it  
6     never reached the threshold of danger.

7           So these viruses -- so what "endemic" means is if  
8     it is -- essentially in layman's terms, it would mean  
9     these are viruses that we basically have to learn to  
10    live with over the long term. So SARS-Coronavirus-2,  
11    we can see we've tried -- we've tried all kinds of  
12    things to stop it for two years. Not only have we  
13    failed, it's -- I mean, it's spread among people better  
14    than it ever has in the two years in the form of the  
15    Omicron variant, right? And that, we just have to show  
16    the number of cases. So that -- the virus has been  
17    very successful in bypassing all of our attempts to  
18    stop it.

19          The ideal, the ideal outcome, if you're dealing  
20    with something that causes disease and you identify it  
21    at the epidemic or pandemic stage, meaning short-term,  
22    the ideal outcome, right, and the goal that we would  
23    always have would be to eradicate that pathogen so we  
24    never have to deal with any risk of illness from it,  
25    again.

26          But an endemic agent is one in which we have

1 failed to eradicate it, and the virus now is able to  
2 bypass any and all the barriers that we put up to try  
3 and stop it. So there's no question, no question, in  
4 my professional opinion, this virus has all of the  
5 characteristics of an endemic pathogen now, including  
6 the fact that we can already define it as being with --  
7 having been with us for long term, right? It has now  
8 existed, and we don't know how long it existed before  
9 it was identified, but if we go with the starting point  
10 being when it was first identified, it's now been with  
11 us for over two years. That alone suggests it's  
12 endemic.

13 The fact that our most recent wave was just  
14 completely out of control in terms of cases, not in  
15 terms of danger, again, show this is going to be  
16 endemic, and the reason -- there's several biological  
17 reasons. These are viruses that are amenable to  
18 mutation. The Coronaviruses will just constantly  
19 mutate. That's why we keep getting the cold.

20 Corona -- and to explain this, the reason is in  
21 order for a virus to propagate, it has to copy itself.  
22 When these viruses copy themselves, they actually -- so  
23 you think about this as -- literally if somebody is --  
24 if you want to photocopy -- the way I like to explain  
25 this, say you have a report, a very large report of  
26 hundreds of pages that you want to copy, if you put it



1 on a modern state-of-the-art photocopier, almost all  
2 the time, you are going to get a complete, you know,  
3 100 percent accurate replication of that document,  
4 right, the copy that you pull up; you're going to have  
5 all the pages copied. Many of us had familiarity with  
6 some of the, as we were developing this technology, of  
7 not having to put one page at a time on top of the  
8 glass and copy, many of us have had the experience of  
9 the early versions of doing the fully automated  
10 copying, and it would be very frustrating, because you  
11 would end up with, at the end, you would find out, as  
12 you take the document back to your office and you start  
13 going through it, you're missing page 7, and you're  
14 missing page 132, there was a paper jam, you know, that  
15 occurred or something.

16 So that's what these viruses are like, when they  
17 copy their genetic materials, they actually have built  
18 in to -- and this is a survival mechanism -- they have  
19 built in, so that copying process, and it's an  
20 error-prone process, intentionally error-prone. It  
21 incorporates mistakes into the copying the genome, and  
22 that's so you end up with different versions of the  
23 virus that can probe the environment that it's in, and  
24 if that change confers an advantage to the survival of  
25 the virus, that subspecies of the virus will start to  
26 dominate. That's how this happens. And so that's why

1 we're always going to -- we're never going to be able  
2 to stop these viruses from mutating, and that's why  
3 they become endemic.

4       So for the flu, for example, the flu is actually  
5 way better than Coronaviruses, including  
6 SARS-Coronavirus-2, at mutating. It mutates much more  
7 rapidly. That is why our flu vaccines are so  
8 ineffective from year-to-year, because if we were  
9 dealing with the same strains that we were dealing with  
10 the previous year, our vaccines would actually be much  
11 more effective, because they're based on last year's  
12 strains. The problem is we're using last year's strain  
13 to educate our immune system to deal with a much  
14 different-looking current strain.

15       So it's not as extreme as that with the  
16 Coronaviruses, but they do the same, just a -- slower,  
17 slower. And so that means that, almost certainly, we  
18 are going to be, whether vaccinated or not, no matter  
19 what we do, I can pretty much guarantee, and no matter  
20 whether we have been naturally infected or not, I  
21 pretty much guarantee we are all going to be infected,  
22 for the rest of our lifetimes, with the  
23 SARS-Coronavirus-2 repeatedly. It won't be as often as  
24 the flu, because, again, it takes longer to mutate, so  
25 I -- but we will all be infected and reinfected.

26       But, again, based on the course that it's been

1 following, that if it's like these other pathogens,  
2 they will be relatively mild to moderate infections,  
3 just like all of the other endemic respiratory  
4 pathogens.

5 And what we'll have to be diligent about is, like  
6 all these other respiratory pathogens, we will have to  
7 be diligent to look after the very high risk but  
8 limited demographics. So, for example, even the common  
9 cold can potentially be dangerous, for example, in  
10 babies and the frail elderly, right? So that's what we  
11 mean by endemic.

12 And in my professional opinion, this virus is now  
13 endemic, and it's going to be with us likely for the  
14 rest of our lives. I don't see how now we can possibly  
15 render it extinct from the globe.

16 Q So does that mean all of our measures right now to  
17 attempt to prevent the spread of SARS-CoV-2 are  
18 completely futile?

19 A There's one thing -- well, so I can tell you, the most  
20 dominant benefit -- beneficial, you know, strategy that  
21 anybody can use with any respiratory pathogen,  
22 including SARS-Coronavirus-2, is stay home when you're  
23 sick. That applies to any of the respiratory pathogens  
24 that we have, and so we -- well, that's the one thing  
25 that I really, really, really, really hope the global  
26 population will have learned from this declared

1 pandemic is just what I call is basic social hygiene.  
2 This has been the most frustrating thing for somebody  
3 who has expertise in this area.

4 I see it in my workplace, and, I will admit, I'm  
5 guilty as charged at times. As a faculty member, there  
6 are certain deadlines that we absolutely -- I mean, we  
7 can't push them off. So, for example, I have to get  
8 grants in order to pay my research team and run the  
9 research that I do. So if there is a grant deadline, a  
10 submission deadline, and I say, I'm sick, I'm -- so,  
11 therefore, I'm not going to go into work, and I'm not  
12 going to submit this grant; the granting agency is  
13 never going to give me an extension. I lose the  
14 ability to get that funding.

15 So there are times -- and some households, maybe  
16 both parents work, so it's very inconvenient if you  
17 wake up on a given morning and your child is quite  
18 sick. As long as I -- you know, I don't think most  
19 parents aren't going to send their kids in if they  
20 think it's literally going to be detrimental to their  
21 physical wellbeing, they're -- you know, they're going  
22 to collapse or something. But if they wake up sick,  
23 clearly sick with signs or symptoms, it can be very --  
24 very difficult to -- you know, very inconvenient to try  
25 and find childcare or cancel your own work schedule so  
26 that you can stay home.

1           And so many of us have gone into the public with  
2   these -- with all of these pathogens that we're talking  
3   about, the flu and everything else. One of the reasons  
4   why it spreads so rapidly in all of our populations and  
5   workplaces and schools is because we don't acknowledge  
6   the fact that we are actively sick, that we're sneezing  
7   and coughing, or that we have our kids that are  
8   sneezing, coughing, and we send them into these areas,  
9   and, of course, that's going to spread the pathogens.  
10   Sick people spread pathogens. That's how it works.

11           So what I like to highlight as an immunologist is,  
12   for some reason, we've gotten into this mindset that  
13   somehow asystematic people are doing this, spreading.  
14   And this is there the -- I would say this is where the  
15   biggest disagreement -- this is the crux of the whole  
16   problem when it comes to some earlier interventions,  
17   like masking, is what is actually happening with  
18   asymptomatic individuals -- I can explain that, if you  
19   want, at another time, because it's not -- just so  
20   you're not -- directly relevant to this question, but  
21   keep that in mind, because prior to two years ago, the  
22   term that we used instead of asymptomatic is we used  
23   the term "healthy people". Right, if somebody didn't  
24   have signs or symptoms of illness, I mean, if you go --  
25   so, you could be asymptomatic with anything, if you go  
26   to a physician and you're asymptomatic, and they say,

1     Okay, what are your signs, you know, what are your  
2     symptoms. And I mean, so they can assess signs, as  
3     what we mean by signs. Signs is something somebody  
4     else can see that provides evidence that you're sick.  
5     Symptoms are things that you feel that can provide  
6     indications that you're sick. So signs and symptoms  
7     are used.

8             So a physician cannot see a lot of your symptoms,  
9     you have to describe them. So, for example, if you're  
10    feeling pain, unless it's severe pain, a physician  
11    isn't going to be able to see that you're in pain,  
12    unless it's severe, and then we might need facial  
13    grimacing that let's them know. Otherwise, you can  
14    have a pain that they have no idea, they have no idea,  
15    you have to tell them that.

16            So that's why -- if you were traditionally to go  
17    to a physician and say, I have no symptoms, they're not  
18    going to investigate you for a disease, right, because,  
19    again, I'd like to highlight, people who are  
20    asymptomatic are healthy.

21            So what I would -- so this is the interesting  
22    thing, what I would say is the number one thing that we  
23    have done to prevent this has been to not allow sick  
24    people to go around others. So the one thing I would  
25    say has worked very well is the screening, the  
26    screening that ultimately got implemented, which

1 basically is asking, Are you sick, right? And if  
2 you're sick, don't go into work.

3 So I would agree, scientifically, rock solid data,  
4 because if you're not -- if you're coughing and  
5 sneezing, of course, you're going to be spreading a  
6 pathogen, and if you're not, you can likely go in -- go  
7 in to work.

8 So that's the only thing, that stay at home if  
9 you're sick that I would say -- and I would say this is  
10 going to be effective all over the place. What people  
11 don't realize is, this is fascinating, I would --  
12 because I think most of you are in Alberta, so go to  
13 your Alberta public health website and start looking at  
14 the SARS-Coronavirus-2, look at the -- on the  
15 SARS-Coronavirus-2 data page, they actually have a  
16 link, the influenza page, go there, and I encourage you  
17 to look at the cases.

18 What you will see is huge waves of the flu. They  
19 only have the last five years currently showing  
20 publicly on your web page. 5, 4, and 3 years ago, they  
21 show the classic huge waves of the flu coming through  
22 Alberta. And you know what's happened in the last two  
23 years? No flu, no cases of the flu. It's not because  
24 the flu disappeared; it's because we have told people,  
25 If you're sick, stay home. Right? Because we have  
26 always left the flu, for some reason, and encouraged

1 people to go to work and go to school, or at least not  
2 discouraged them enough when they're sick, and the flu  
3 kills people, and the flu is dangerous.

4 So to me, I hope and pray that when this is all  
5 done, the people will remember, You know what, if  
6 nothing else, if I'm sick, don't go around other  
7 people. That is the simple -- that is the -- that is  
8 going to help public health enormously moving forward  
9 with all infectious agents that we've ever been living  
10 with. So, yeah, that's the number one thing.

11 And I know that those of you who are here today  
12 specifically are most interested in masking, so let me  
13 comment on the masking specifically. I am -- masks do  
14 quite a good job at preventing the spread of infectious  
15 diseases under a certain circumstance, when people are  
16 sick.

17 And (INDISCERNIBLE) so -- (INDISCERNIBLE) -- so I  
18 told you, I have to admit, myself, I am guilty as  
19 charged about going in to work sometimes when I'm sick.  
20 One of the things I try and do is I do try and isolate  
21 myself in my office. I do tell people, if they come to  
22 my office, I do tell people -- if they come to my  
23 office and knock on my door, I tell them, You might  
24 want to chat through the door, I'm sick. You know, and  
25 when I do have to go around people, I will wear a mask.  
26 I have done that, when I've gone in to sick -- and to



1 work sick previously, because these masks are  
2 reasonably well-designed to capture the large water  
3 droplets that come out of our respiratory system when  
4 we cough and sneeze.

5 The only way -- so if somebody's not sick, that  
6 means they're not coughing and sneezing, so the only  
7 theoretical way that a virus then could come out of our  
8 respiratory tract is through what we call aerosols,  
9 which are super tiny droplets that the cloth masks and  
10 surgical masks that we have been using, they're not  
11 designed to filter that out, and so this is an  
12 intuitively -- like we even know this intuitively.

13 If you've ever been really sick, so I know this  
14 because I have been respectful of those around me, and  
15 if I'm actively coughing and sneezing, I will wear a  
16 mask if I feel that I have had to go around people  
17 because I don't want to miss a critical deadline. And  
18 I'll also tell you from my own experience, those things  
19 end up slimy and disgusting inside the mask if you are  
20 doing a lot of coughing and sneezing. Why? Because  
21 they're very good at capturing those large water  
22 droplets, and so you have to change the mask quite  
23 quickly. I will also tell you that if I'm not coughing  
24 and sneezing, they don't get wet and slimy; they're not  
25 capturing robust amounts of the moisture that's coming  
26 out of our lungs.

1           There's a huge amount of moisture that comes out  
2 of our lungs during regular breathing throughout the  
3 day. We know -- just that's what happens. So in  
4 Alberta, you'll notice like in Ontario, especially  
5 during the winter, one of the phenomena are the  
6 humidity goes way down, right? Cold air humidity tends  
7 to be very low, and so if you don't have a humidifier  
8 in your home, typically what happens during the winter  
9 is you'll notice that when you wake up in the morning,  
10 you will tend to have a much dryer throat than at any  
11 other time of the year, and that's because there's so  
12 much moisture that's given off, and all night long,  
13 it's the air is wicking moisture as you breathe it out,  
14 and your body's actually having trouble replenishing  
15 it. You end up much more dehydrated in the morning  
16 than -- and during the winter than you do at any --  
17 during any other seasons. So there's a lot of  
18 moisture, and the fact that it's not getting soaking  
19 wet tells you that. So, again, a long answer, but I  
20 want you to fully understand.

21           So to summarize, in terms of what's been  
22 implemented, I think the number one effective strategy  
23 has been keeping sick people away from others, and  
24 hopefully that continues, and the masking. So if  
25 people were to have to go around other people when they  
26 have SARS-Coronavirus-2, masks would definitely help

1 prevent the spread of SARS-Coronavirus-2.

2 But in healthy people, I have never been able to  
3 recommend masking of people who are not actively  
4 coughing, sneezing, you know, who are not sick. So, in  
5 other words, if you pass the screening that you're  
6 supposed to do every morning before you go in, in my  
7 professional opinion, there's nothing a mask is going  
8 to do to protect yourself or others around you at that  
9 point, because you are not -- you are not and nor are  
10 those around you expelling the type of  
11 infection-spreading water particles that spread  
12 disease.

13 Q So symptomatic masking is rational and effective?

14 A 100 percent. I believe -- again, I hope that that will  
15 be highly encouraged for everybody around the world  
16 moving forward, that if they are going to make the  
17 decision to send their child to school when sick or if  
18 they're going to go in to work when sick, for the  
19 respect of the health of others, yes, put on a mask,  
20 100 percent.

21 Q But is asymptomatic irrational and ineffective?

22 A Yes, for the reasons that I said, because then you're  
23 not spreading those large droplets that masks are  
24 designed to stop.

25 Like -- so a lot of people don't realize, like  
26 when you think about even a surgical mask and you think

1 about a surgeon, right, there's been studies that have  
2 looked at this, this context, what people don't realize  
3 is what those surgical masks are designed to do. It  
4 doesn't sterilize your breath in any way, right? What  
5 it does is it stops any large droplets. When a surgeon  
6 is working over a surgical area, an open wound, it's  
7 making sure that -- now, this is the other thing, any  
8 surgeon who is doing surgery ideally should not be  
9 doing the surgery if they are sick. But literally what  
10 they're there for is to stop large water droplets.

11 It would be to -- and literally, for example, one  
12 of the reasons for wearing the mask is drops, spittle.  
13 Hey, we've all experienced that embarrassing time where  
14 we're talking, and then, all of a sudden, a little bit  
15 of spit comes out, and we're like, oh, I hope nobody  
16 saw that, right? That's literally one of the reasons  
17 why they wear the mask, to make sure large water  
18 droplets, including spittle, don't drop out into the  
19 surgical wound. So they're not designed, like I said,  
20 again to filter out with any kind of efficiency the  
21 aerosols, which are these super tiny water droplets  
22 that are far tinier than the pore sizes in these masks.

23 And so, again, to highlight this, there's  
24 something else that's important, because, again, this  
25 comes back to the idea of symptomatic versus  
26 asymptomatic or what I would call healthy people. Now,

1    what happens is in order for somebody to get sick, they  
2    have to initially be infected. As I pointed out, the  
3    infection does not necessarily equal sickness or  
4    disease. And the other thing that's important to note  
5    is infection certainly does not mean immediate disease.  
6    Because you have a pathogen in your body, so you might  
7    be -- so when people get sick, this is what happens,  
8    when we do get sick, this is the sequence of events:  
9    We have to be exposed to a certain threshold of the  
10   pathogen, which is not once. Our bodies, we have  
11   innate -- like we have physical barriers that  
12   immediately protect us from infection. For example,  
13   one of the things we have in our airways, our airways  
14   are lined with mucous. That's one of the reasons why I  
15   just said we have so much moisture coming out of them,  
16   we're constantly covering all of the membranes  
17   throughout our respiratory tract with mucous.

18        So if we have a pathogen come into our body, for  
19   example, one of the immediate lines of defence is that  
20   mucous, it will get buried in the mucous, and that  
21   mucous constantly gets removed from the body. Even if  
22   you're healthy, if you never clear your throat, you're  
23   eventually going to have to clear your throat because  
24   our airway is full of -- or your cells with these  
25   specialized hairs on them, we call them cilia, and  
26   their job is literally to, like fingers, to move this

1 mucous up. Because if you think about it, since our  
2 airways are constantly producing mucous, if we didn't  
3 have any way of getting that mucous out of the body,  
4 under gravity, the force of gravity that would migrate  
5 down into our lower airspaces, and we would literally  
6 drown. They would fill up our lower airways, and we  
7 would no longer be able to facilitate gas exchange. So  
8 these little hairs push the mucous up and out of our  
9 body. That's why, you know, it may end up getting --  
10 accumulating in our throat so we can cough it out, or  
11 if it's in our nose, we'll end up, you know, with the  
12 mucous accumulating where you've got to blow it out of  
13 our nose.

14 Now, if it's a pathogen that has been able to  
15 bypass those barriers, our immune system has set up  
16 what are called sentinel cells. These are cells that  
17 are strategically located at critical entry points for  
18 pathogens into the body, so they're distributed all  
19 throughout our airways underneath the mucosal surface,  
20 below that -- you know, the mucous that's on the  
21 surface of our cells. And if a pathogen can get by  
22 that, these sentinel cells very quickly identify that  
23 there's a pathogen and start our immune response to  
24 start clearing this.

25 Now, there's two parts to an immune response. One  
26 is we call it the innate response. So, first of all,

1 we have to understand, actually there's three  
2 technically in terms of timing. The one is physical  
3 barriers that I just talked about like the mucous or  
4 cell barriers, right, that a virus would have to get by  
5 to get into the body. Those are always present. There  
6 is no immune response that has to be mounted. That's  
7 why, for example, burn victims, that they lose a large  
8 amount of their skin, are highly prone to infections  
9 because they've lost that physical barrier.

10 Now -- so in the lungs, these sentinel cells, if  
11 the pathogen gets past these initial physical barriers,  
12 and so that's why you have to have a certain threshold.  
13 One viral will not cause disease; you have to bombard  
14 these natural barriers with high numbers of the virus,  
15 so you have to have it delivered to you, you have to  
16 inhale a threshold dose, and that changes depending on  
17 the infectivity of the virus.

18 But so you have to -- if you get that threshold  
19 dose and your physical barriers can't deal with it, you  
20 have those sentinel cells that will immediately start  
21 detecting that virus and starts penetrating in -- and  
22 starts infecting cells past those physical barriers,  
23 and that they will start -- and trigger a whole series  
24 of events that lead to what we call innate immune  
25 responses, so those are very rapid, short-term  
26 responses. And then if they fail to clear the

1 pathogen, then we mount the types of responses that  
2 we're trying to get with these vaccines.

3 We call them acquired or adaptive immune  
4 responses, and the key effector mechanisms there, the  
5 key weapons are T cells, which could kill off  
6 virus-infected cells so they can't serve as virus  
7 replication factories and antibodies, which can block  
8 viruses from getting into other cells. Now, those  
9 latter things can take up to -- it takes about two  
10 weeks for those T cell and antibody responses to peak,  
11 so the innate response is very fast.

12 And so if you have an infection of the lungs, one  
13 of the first things these sentinel cells start to do in  
14 terms of communicating is they get these cells to  
15 produce the mucous, to start producing lots of it,  
16 because it -- we've got a virus that's bypassing this  
17 barrier, so let's make this barrier even more rigorous,  
18 a thicker mucous layer. And so that's why when we get  
19 an infection, as the virus starts replicating -- this  
20 is important -- so, in other words, early on in  
21 infection, yes, so if we were to take somebody who was  
22 infected early on, would we be able to detect the  
23 virus? Yes. Is that virus a replication-competent  
24 virus particle? Yes. Is it going to be able to infect  
25 and cause disease in other people? No, for two  
26 reasons: (a), a person has to reach a threshold level



1 in your own body such that you're delivering such a  
2 large enough quantity of the virus for another person  
3 to inhale that threshold dose to get them sick. The  
4 second reason is you could even have potentially a  
5 large amount of the virus in your body, but if you're  
6 not sending it out of your body, you're not going to be  
7 able to infect anybody else, and so this is the thing.

8         So our immune system -- so viruses take advantage  
9 of this early immune response for the transmission  
10 process. So because what happens is this mucous  
11 secretion starts increasing, and so that means we have  
12 a lot more mucous being brought up into our throat and  
13 into our -- and our nasal passages, right, producing a  
14 lot more of this. And so the body, to try -- you know,  
15 what it wants to do is get rid of as much of the viral  
16 particles as it can, because the fewer virus particles  
17 it has left in the body, the more easily it's going to  
18 be able to clear that infection.

19         And so the way our immune system gets it out of  
20 the body is it causes us to cough out all this mucous  
21 that's accumulating, all the liquid that's full of  
22 these viral particles, and we sneeze it out of our  
23 nose. That's literally -- we're trying to dump as much  
24 of the viral particles out of our body as we can. That  
25 is when we become an infection hazard to other people.  
26 And that's why I say these masks are awesome at

1   stopping the transmission when this transmission is --  
2   when there's the high risk of this transmission, and  
3   that's when people are actively coughing and sneezing.  
4   As long as you have the virus contained in your own  
5   respiratory tract, you know, you're not doing that.

6           So in theory, you can -- so this is actually kind  
7   of interesting. Much more so than viruses like the  
8   influenza viruses that we live with, the  
9   SARS-Coronavirus-2, there's been a lot of literature  
10  suggesting, therefore, that one of the ways the virus  
11  might spread is through aerosols, right? And so  
12  that's -- because if you're not coughing, and you're  
13  not sneezing, then the only way the virus theoretically  
14  can get out of your body is being carried on the small  
15  water droplets that come out of our -- come out with  
16  our breath, right, with every exhalation we give.

17           So then that means that the masking, therefore, if  
18  somebody is not symptomatic, the only thing that it  
19  could potentially have to stop in terms of the virus  
20  leaving the body would be these aerosols. And like I  
21  said, while -- you know, I've got lots of figures and  
22  pictures to show that, you know, the pore sizes of  
23  these masks are not designed, they're not nearly small  
24  enough to stop these viral particles from getting  
25  through, that the water droplets that could potentially  
26  have the virus on them, the pores are way, way, way too

1 big to stop that.

2 Now, granted, so, for example, I noticed in  
3 Dr. Hu's report that he mentioned that -- actually  
4 maybe it wasn't even his report, but some have pointed  
5 out that it -- and I agree, it's not like it's one  
6 pore, if the virus gets past one pore, it's out of the  
7 mask. So, example, the surgical masks actually have  
8 three layers. So what it is more like is it's having  
9 pores all offset from one another. There's a whole  
10 bunch of pores that the virus would have to navigate.  
11 It would be like going through a maze.

12 So what these masks can do with aerosols is it can  
13 slow down the transit time it takes to navigate this  
14 maze of large pores that are all offset before it  
15 leaves the mask, but it doesn't stop it from leaving  
16 the mask. And, in fact, what ends up happening, this  
17 is the predominant thing, this is also in my figures is  
18 because it has to navigate this sort of complex maze to  
19 get through all the open doorways, that provides  
20 resistance, and any gas will follow the path of least  
21 resistance. And that's exactly why when we wear our  
22 masks, the vast majority of what we exhale never even,  
23 unfortunately, gets through the filtering material,  
24 again, which isn't designed to filter out these  
25 aerosols, but rather bypasses it.

26 And we've all seen that phenomenon; I mean, you

1 know, I wear glasses, especially now is not a great  
2 time, so I encourage anybody, put on a mask with  
3 their -- so what's especially -- what I especially  
4 recommend, if you -- so I have this every time I go to  
5 the grocery store, go outside for a little bit, let  
6 your glasses, you know, accommodate to the temperature  
7 around, right, so they get nice and cold; then go into  
8 a store, go into a warm location and put on your mask,  
9 right, put on your mask and step through the door into  
10 a warm location. Now your glasses are such that any  
11 moisture that's coming out is going to readily  
12 condense. I find it so frustrating because I can  
13 hardly shop. It takes me about 10 minutes before I can  
14 start shopping because I'm constantly taking my glasses  
15 off and wiping them because of all the fogginess  
16 happening. That's the aerosols, and that's, of course,  
17 because of the mask. Even with the pinch piece, if you  
18 have a good mask, a surgical mask that have the middle  
19 pinch piece, very difficult to get a seal properly  
20 around your nose. And so when you exhale, because  
21 we're slowing down the progress of the air through the  
22 filtering material, it'll just simply exit alongside  
23 the nose; that's where we see the fogging.

24 Now, the other place a lot of people don't realize  
25 is even the surgical masks are not designed to fit  
26 properly around -- by -- in front of the ears, and so

1   you almost always have these large, relatively large,  
2   triangular gaps at the back of the mask where it loops  
3   over the ears. And so literally when we exhale with  
4   these masks, the vast majority, when we exhale, fires  
5   up past the nose and out past the ears, and so there is  
6   no filter. And then, like I said, the limited amount  
7   that does come through the filter, it's not designed to  
8   stop these aerosols.

9       Like I said, if it did -- like, again, I can take  
10   off my glasses right now, and, for example, watch  
11   (UNREPORTABLE SOUND), I just breathed on my glasses,  
12   and you can probably see it's fogged quite a bit  
13   compared to my other lens, right? That's one exhale.  
14   So you can imagine if I was wearing a -- had been  
15   wearing a mask and go -- in some cases, I've had to,  
16   you know, because of these requirements, if I'm wearing  
17   a mask, there's not much aerosol coming out in just one  
18   breath. You can imagine how much liquid would  
19   accumulate in your mask if it is, in fact, filtering  
20   that out. If it's filtering it, it means it has to  
21   stop them from getting out in the air, from going  
22   through. If it's not getting into the air, then it's  
23   staying in the mask, the masking material. But I can  
24   wear these masks, if I'm not coughing and sneezing, I  
25   can wear them, and my mask will not get wet.

26       So, again, it's just intuitive to the point

1    where -- I like to use -- I'll just finish with this,  
2    an example which I think is helpful to consider this.  
3    Early on in the pandemic, in fact, every time I went to  
4    get my hair cut, and thankfully I was able to, you  
5    know, after quite some time, because my hair was  
6    horrible, like many of us, for the longest time, but,  
7    you know, when I actually first went and understanding  
8    this, out of respect for the hairdressers, I tried to  
9    explain this to them and actually asked them if they  
10   wanted me to take my mask off, because if they were  
11   worried about aerosolized transmission, right, the mask  
12   for filtering this stuff, I tried to point out to them,  
13   If it's my breath that you're worried about, do you  
14   want me to take my mask off. Because they always cut  
15   my hair from behind, right, and that way, if they're  
16   afraid of my breath, I'm directing it away from them.  
17   And they -- you know, but, no, because of the policy,  
18   said no, no, no, no, everybody has to be masked to  
19   keep -- you know, to keep us safe, and I tried to  
20   explain.

21           And so the best way is -- again, to envision this,  
22   again, if you go out in the winter time, cold air, and  
23   you put your mask on, you'll see exactly what I'm  
24   saying -- I put a picture of this in my report --  
25   you'll -- because you can see these aerosols, because  
26   these tiny water droplets, when it's really cold, will

1       condense, right? Again, if water -- the gaseous water  
2       as -- when it's cool, it will turn into liquid. And so  
3       winter time is a great time because you can see the  
4       aerosols condensing in the cold air around you. And so  
5       when you breathe out in the winter, you'll see the --  
6       it blasts up, you see this fog essentially as the  
7       aerosols are condensing, blasting up past your nose and  
8       out past your ears just like I said.

9               And I've shown people, if you're a hairdresser,  
10       what it does is it encases your head in this huge cloud  
11       of aerosol, all right. I've tried to point this out to  
12       my hairdressers is that if you are genuinely afraid of  
13       my breath, you know, as an asymptomatic individual, do  
14       you not realize that the whole time your hands are  
15       immersed in my aerosols by you forcing me to blow them  
16       around my hair instead of away from you.

17              So I'd just like to highlight that, because,  
18       again, that's kind of science meeting the reality that  
19       we currently have and how the two just simply don't  
20       align. So I'll --

21       THE CHAIR:                               Dr. --

22    A       -- just stop there.

23       THE CHAIR:                               -- yeah, Dr. Bridle, I think  
24       it's now 10 after 12, Mr. Kitchen. I think it's time  
25       for a break.

26       MR. KITCHEN:                            Yes, I agree, however, I do

1 want to ask one question.

2 Q MR. KITCHEN: And, Dr. Bridle, I invite you  
3 to answer this in 5 minutes or less, and we can come  
4 back to it after the break, but I want to ask this  
5 question, because it's connected to the conversation  
6 we've had. Dr. Bridle, so you've said now that where  
7 we're really at is endemic, but I think the burning  
8 question we all have is was SARS-CoV-2 ever actually a  
9 pandemic? Right? You said declared pandemic, and you  
10 said that there was a (INDISCERNIBLE) severity for it  
11 to actually be really a scientifically a pandemic. So  
12 was SARS-CoV-2 ever a pandemic, and if so, when did it  
13 cease being a pandemic scientifically?

14 A Okay, yeah, that's an interesting question, but I can  
15 keep this short, yes. Sorry about that, you're getting  
16 the typical, you know, scientific, we like to make sure  
17 that all the details are relayed. But in this case,  
18 so -- this is -- the pandemic was declared again,  
19 assuming that the -- sorry, Karoline --

20 (AUDIO/VIDEO LOST)

21 MR. LAWRENCE: Sorry, can we just -- sorry to  
22 interrupt, Dr. Bridle -- I think we've lost a Tribunal  
23 Member --

24 A Oh, okay.

25 MR. LAWRENCE: -- Dr. Martens, I don't see  
26 her. Could we just --



1 MR. KITCHEN: Well --

2 MR. LAWRENCE: -- (INDISCERNIBLE) for a

3 minute. Oh.

4 MR. KITCHEN: Dr. Martens, if you need us to

5 break, we can, you know, we --

6 THE CHAIR: Dr. Martens is here.

7 DR. MARTENS: No, yeah, I came back, yeah,

8 sorry.

9 A Okay, great --

10 THE CHAIR: Thank you, Mr. --

11 A -- I don't think I said anything --

12 THE CHAIR: -- Lawrence.

13 A -- that you missed, Dr. Martens. Did -- what was it --

14 yeah, I think I was just starting to answer, so I'll

15 just start again --

16 THE CHAIR: Sure.

17 DR. MARTENS: Yeah, just when you were going

18 to answer the question, yeah.

19 A Oh, okay, great.

20 DR. MARTENS: Thank you.

21 A Yeah, so this pandemic was declared with, again, on the

22 initial concern that the infection fatality rate might

23 be as high as 10 percent, and, again, as I've said, an

24 infection fatality rate certainly between 1 and 10

25 percent. I don't think there's very many scientists

26 around the world that would agree that that would be a

1 pandemic situation provided the pathogen is genuinely  
2 dangerous, because then you're, you know, talking  
3 about -- well, the infection fatality rate, that is an  
4 indication that it's going to be dangerous to far too  
5 many people.

6 But the reality is, just like I said, as we have  
7 come to appreciate the size of that denominator, which  
8 we didn't know at the beginning, we now know that  
9 the -- the real infection fatality rate is in the --  
10 was in early 2021 in the ballpark -- and we're not even  
11 sure it's the full estimate because we don't have a  
12 full understanding of how big the denominator was. But  
13 at that time, it was estimated to be about .15 percent.

14 So to put that in perspective again, that was  
15 dealing with the earlier variants, which is when the  
16 pandemic was declared, in that context. And, again, at  
17 .15 percent, that is not a problem of pandemic  
18 proportions. It is -- it just simply is -- that's a  
19 fact.

20 And so it's not a case -- and then, again, that's  
21 for the entire population. And if we go to the  
22 demographics that we know, which is the vast majority  
23 of the people that are in the -- and the lower-risk  
24 demographics, it would be much lower. Again, I can't  
25 say exactly how much, but it would be lower.

26 So, again, to put that in perspective of .15

1 percent, that is in the same realm as a bad flu season  
2 and -- for which we never declare that to be a  
3 pandemic, despite the fact that, you know, the flu  
4 spreads around the world, nor is it declared an  
5 epidemic, even though it certainly meets that  
6 definition in terms of its spread throughout Canada.

7 Now -- so the thing to understand -- and now, as I  
8 point out, as far as Omicron, it would be even lower,  
9 but that's because there's been some biological changes  
10 as well to the virus, right, that's made it less  
11 deadly. So if I was going at .15 percent, because  
12 that's dealing with the earlier variants where -- which  
13 were relevant when the pandemic was declared, just to  
14 clarify, it's not that we went from an infection  
15 fatality rate of 1 to 10 percent to .15 percent, right,  
16 because that would require some kind of biological  
17 change or effective intervention that's completely  
18 stopping those deaths. And, no, it's the initial  
19 estimate was, the initial concern was that it was that  
20 high.

21 So what happened is the mathematics became more  
22 accurate by the time this paper was published. That  
23 same math applied to the beginning of the pandemic.  
24 So, in other words, if we knew by early 2021, you know,  
25 what the accurate -- if we had those same accurate  
26 numbers at the beginning of the pandemic, the pandemic

1 would not have been declared; it would not have been a  
2 problem of pandemic proportions. As I've pointed out,  
3 the flu is -- equals this, a bad flu season.

4 So, in my opinion, and based on our own policy,  
5 health policies in Canada, this would not have  
6 qualified as a pandemic. It qualified as a pandemic  
7 because we thought the infection fatality rate was much  
8 higher than what it really has been and what it has  
9 proven to be.

10 And the point that I'd like to make as well is,  
11 because a lot of people have probably heard of this  
12 term with the emergency use authorization in Canada for  
13 the vaccines, in Canada, we called it the authorization  
14 for interim use, but it means the same thing.

15 And the reason why that's important is because  
16 that's something -- and this whole -- actually, this  
17 whole concept actually we have right now of overriding  
18 constitutional freedoms, and we're hearing about this  
19 all the time, what a lot of people don't realize is,  
20 you know, this imposition where the Government can  
21 start dictating things and overriding potential  
22 individual, you know, constitutional policy rights is  
23 often -- is based on the perception -- like the impact  
24 of something on Canada. Technically it has to  
25 incapacitate the ability for Canada to operate in a  
26 certain way.

1           So a classic example would be if we were at war.  
2   At war, that's where you can have overriding executive  
3   decisions, right, and if Canada is at risk of being  
4   destroyed, being overtaken, right, being taken over.

5           So at a 10 percent or even 1 percent, that would  
6   have a dramatic impact on Canada, you know, death rate;  
7   that would have a dramatic impact on Canada to be able  
8   to function as a country. But at 0.15 percent, we've  
9   never done -- like I said, we have that for the flu  
10   routinely.

11           So, again, I hope that helps put it in some  
12   perspective. So, again, based on the science, the  
13   publications, my, you know, summarized answer to you,  
14   Mr. Kitchen, is that, with the math corrected, this has  
15   not been an issue of pandemic proportions, true  
16   pandemic proportions.

17   MR. KITCHEN:                   Thank you. We'll leave it  
18   there for lunch.

19           Mr. Lees, I'm fine if you want 45 minutes or an  
20   hour, an hour-and-15, I'm fine either way. As much  
21   as -- we'll definitely finish today. I think we're  
22   going to be a while yet, but we will finish today.

23   THE CHAIR:                    Okay. Let's take an hour;  
24   let's come back at 1:15. I think we all -- we went  
25   straight through from 10:00, so I think an hour is  
26   fine, and we'll see everybody at 1:15.

1           And do we need to caution the witness in any  
2   respect, Mr. Pavlic?

3   MR. KITCHEN:                   You're muted.

4   MR. PAVLIC:                   I've got it now.

5           Other than --

6   THE CHAIR:                   Okay.

7   MR. PAVLIC:                   -- he's not supposed to  
8   discuss his evidence with his counsel or anyone else --

9   THE CHAIR:                   Yeah.

10   MR. PAVLIC:                  And I'm sure --

11   THE CHAIR:                  Thank you.

12   MR. PAVLIC:                  -- Mr. Kitchen has given that  
13   warning in advance.

14   THE CHAIR:                  Okay, we'll see everybody at  
15   1:15.   Thank you.

16   \_\_\_\_\_

17   PROCEEDINGS ADJOURNED UNTIL 1:15 PM

18   \_\_\_\_\_

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1 Proceedings taken via Videoconference for The Alberta  
2 College and Association of Chiropractors, Edmonton,  
3 Alberta

4

5 January 28, 2022 Afternoon Session

6

7 HEARING TRIBUNAL

8 J. Lees Tribunal Chair

9 W. Pavlic Internal Legal Counsel

10 Dr. L. Aldcorn ACAC Registered Member

11 Dr. D. Martens ACAC Registered Member

12 D. Dawson Public Member

13 A. Nelson ACAC Hearings Director

14

15 ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

16 B.E. Maxston, QC ACAC Legal Counsel

17

18 FOR DR. CURTIS WALL

19 J.S.M. Kitchen Legal Counsel

20

21 K. Schumann, CSR(A) Official Court Reporter

22

23 (PROCEEDINGS RECOMMENCED AT 1:16 PM)

24 THE CHAIR: We will be back in session for

25 the afternoon, and just before I ask Mr. Kitchen to

26 continue, I just remind you, Dr. Bridle, that you are

1 still under oath.

2 A I understand, thank you.

3 THE CHAIR: Okay. All right, Mr. Kitchen.

4 DR. BYRAM BRIDLE, Previously sworn, Examined by

5 Mr. Kitchen

6 MR. KITCHEN: Thank you. And, Chair, I'll

7 try to be mindful of the time. If we get an hour or so

8 into it, and we're still going, I'll try to find a good

9 time for a break.

10 Q MR. KITCHEN: Dr. Bridle, thank you so much  
11 for all that information prior to the lunch break, but  
12 to continue where we left off, the question I had is we  
13 talked -- you talked about how isolation works, masking  
14 for asymptomatic doesn't work, and then we didn't get  
15 into any other restrictions yet, but I'm very curious,  
16 if isolation at home does work, and you said,  
17 intuitively, it does, can you give some insight as to  
18 why Omicron is still spreading the way it is unabated?

19 A Yeah, so, first of all, just to clarify, meaning  
20 isolating at home when symptomatic, right, when  
21 actually sick. I don't recommend that people have to  
22 stay away from others if they're not sick.

23 So, yeah, in terms of the Omicron, you know, so  
24 it's a multi-faceted answer, I guess. And so, first  
25 of all, I guess I'll start off with the, you know, the  
26 related topic of the vaccines, because that was



1     purported to be -- you know, we were hoping that was  
2     going to be the number one strategy for stopping the  
3     spread of this. And then the idea being, you know, the  
4     concept was that only those who were vaccinated would  
5     not be capable of transmitting the virus, and those who  
6     were unvaccinated would be capable of transmitting the  
7     virus, and, hence, you know, the isolation, kind of  
8     segregation that's been occurring in society.

9             But so one needs to understand a little bit about  
10     vaccines to understand that aspect because that's  
11     critical, because, again, like I said, that was  
12     supposed to be the number one strategy for stopping  
13     transmission.

14            So these COVID-19 vaccines -- so, again, I mean,  
15     I'd like to highlight and my record shows for itself,  
16     being a publication record, that I've been actively  
17     publishing in the area of vaccinology during the  
18     declared pandemic. I am a vaccinologist. So, again,  
19     you know, my expertise is in viral immunology, and  
20     specifically I focus heavily on vaccinology.

21            So I am actually strongly in support of the  
22     concept of vaccine mandates, but these COVID -- current  
23     COVID-19 injections look nothing like and they perform  
24     nothing like any historically mandated vaccines. And  
25     that helps to understand a large part of the question  
26     you're asking.

1           So what I mean by that is we're all probably  
2       familiar with the vaccines that are mandated during  
3       childhood, so the childhood -- what we call the  
4       childhood series of vaccines. So that's things like --  
5       things like the mumps, measles, and Rubella vaccines,  
6       the ones we -- you know, we get for tetanus that get  
7       updated every 10 years and so on, chicken pox as of  
8       2010.

9           And so all of these previously mandated vaccines  
10      have a quality that we refer to, as immunologists, as  
11      conferring sterilizing or near sterilizing immunity.  
12      And what that means is technically if somebody's  
13      vaccinated, they can still get infected because  
14      infected means you the get the pathogen in your body.  
15      But what sterilizing and non-sterilizing --

16      THE CHAIR:                   Dr. Bridle, Dr. Bridle --

17    A    Yes.

18      THE CHAIR:                   -- you're frozen.

19      MR. KITCHEN:                He's not frozen.

20      THE CHAIR:                   Yeah, he's back now.

21    A    Okay, do I need to repeat anything?

22      THE CHAIR:                   Just the last sentence.

23    A    Oh, okay, thanks. So previously mandated vaccines  
24      confer what we call sterilizing or near-sterilizing  
25      immunity. And so sterilizing immunity means like, in  
26      all cases, a pathogen can still get in your body. So a

1 respiratory pathogen like SARS-Coronavirus-2, obviously  
2 we can still inhale it. If we had sterilizing  
3 immunity, it would mean that we have the appropriate  
4 type and quantity of antibodies in our upper  
5 respiratory tract to be able to fully neutralize that  
6 virus, meaning the antibodies would bind to the virus.

7 And that's one of the reasons why we've been  
8 targeting the spike protein. The spike protein is the  
9 thing that sticks up on the surface of the virus that  
10 grabs onto the receptor on our cells, the same receptor  
11 I was telling you about earlier that children express  
12 at much lower concentrations, which is why they're  
13 inherently protected.

14 So if you have an antibody that binds to the spike  
15 protein, then that spike protein can't grab onto our  
16 cells. And if the virus can't get into our cells,  
17 there can be no replication whatsoever and, therefore,  
18 no risk of disease and no risk of transmission. That  
19 would be sterilizing immunity.

20 Near-sterilizing immunity means that the virus,  
21 probably there would be a lot of neutralization of the  
22 virus, but the virus might still be able to infect a  
23 limited number of cells that we would have sufficient  
24 additional immunological mechanisms to clear that virus  
25 from the infected cells, things like T cells, which are  
26 very good at this, and it would clear the virus again

1 before it would replicate to that -- to a quantity that  
2 would reach what I referred to previously as the  
3 threshold dose required to infect somebody else. So  
4 that would be what we call near-sterilizing immunity,  
5 meaning you can get some infection yourselves, limited  
6 replication, but you're not going to get sick because  
7 there hasn't been enough replication to cause illness,  
8 and you're not going to transmit, because, again, you  
9 haven't reached that threshold dose that needs to be  
10 delivered. So that's what all our historical mandated  
11 vaccines look like; they do this.

12 Oh, and the other thing they do is they -- they  
13 not only confer this type of immunity but for very long  
14 periods of time. So when you think about it, once we  
15 are done our childhood vaccination series, except for  
16 the, you know, update every 10 years for things like  
17 diphtheria and -- for example, the -- and tetanus, we  
18 never have to be vaccinated again, we don't have to get  
19 boosters. So we call that robust or long-lasting  
20 immunity. So that's the nature.

21 Now, we're all probably seeing -- you know, we're  
22 already, in Canada, rolling out -- well on our way to  
23 rolling out third doses. We've actually been  
24 implementing fourth doses in some long-term care  
25 facilities where there's been a complete inability to  
26 control the spread of the Omicron variant. Israel, you

1 know, of course, is large -- most of their population  
2 has got four doses.

3       So this highlights something, this is three to  
4 four doses in well under a year. So that -- so,  
5 clearly, they don't -- they don't have the duration of  
6 immunity; they don't provide the, you know -- a  
7 reasonable length of protection. That alone means  
8 these vaccines will never be able to stop the  
9 transmission of this virus, because there's no way we  
10 can get the whole world vaccinated and under three  
11 months, such that the people, you know, no longer -- we  
12 haven't reached the point where people have lost  
13 protection. Otherwise, if you get only -- if it's only  
14 through part of the population by three months, by the  
15 time you're vaccinating new people, the people who were  
16 vaccinated at the beginning are going to be susceptible  
17 again. So that's one of the problems.

18       The other problem is that -- I already explained  
19 this, that the immunity is -- just really protects the  
20 lower airways. And the Omicron variant, we're talking  
21 about a version of the virus now that preferentially  
22 stays in the upper airways, so there isn't that --  
23 those aren't those neutralizing antibodies in the upper  
24 airways conferred by this vaccine that would confer  
25 that sterilizing protection.

26       So on that basis -- oh, and the other thing is

1     that there's been so many mutations in the spike  
2     protein of the Omicron variant that the immunity  
3     conferred by this, which is spike-protein specific, is  
4     largely irrelevant. A lot of those antibodies can't  
5     even physically bind to the spike protein anymore  
6     because it's changed too much.

7             So for all those reasons, that's one of the  
8     reasons why we're seeing the vaccine [sic] circulate  
9     freely, because it's largely then the unvaccinated that  
10    have been -- that have been -- or have continued to be  
11    asked to isolate and have been basically -- you know,  
12    segregated from society. So they are, you know, stay  
13    at home, not being able to go into the workplaces and  
14    so on.

15            So the fact -- and like I said, I've said this  
16    before as well, some of the -- for those in school  
17    settings or work locations, we're talking about people  
18    where almost everybody is vaccinated, but the virus --  
19    like I said, despite that, we had this record peak for  
20    cases with the Omicron variant. So that's one of the  
21    reasons, because the vaccines, unfortunately, have  
22    failed to meet their goal.

23            If these conferred long-lasting sterilized or  
24    near-sterilizing immunity, I may have had to have  
25    retracted my earlier statement about this becoming  
26    endemic. We may actually have had a chance of

1     eradicating this virus. But, you know, because of  
2     these weaknesses in what an ideal vaccine should be --  
3     I should even point out that even the very definition  
4     of a vaccine was altered about a year ago to  
5     accommodate these inoculations that we're providing,  
6     because, again, the definition of a vaccine was one  
7     that conferred sterilizing or near-sterilizing  
8     immunity. They were originally designed to not blunt  
9     the most severe forms of disease but actually prevent  
10    disease and prevent transmission to others. So that's  
11    why -- that's a primary reason why we're seeing this  
12    virus continue to circulate.

13           So now when you think about that, it's annoying  
14    that the vaccines are now largely irrelevant in terms  
15    of their ability to stop transmission; at the same  
16    time, we have kept -- we have remained -- keeping the  
17    vaccinated individuals from workplaces, we continue to  
18    require them to wear masks and do the physical  
19    distancing. So -- and, again, the fact that we've been  
20    doing this all along, but the waves of cases just keep  
21    getting progressively higher, although, like I said,  
22    the virus is progressively less -- that's the good news  
23    in all this. As that happens, the virus becomes -- has  
24    become less dangerous. So despite the spread, there is  
25    less potential harm to people. So I always want to  
26    remind people I don't want to be instilling unnecessary

1 fear.

2 But nevertheless ever increasing cases, and since  
3 the focus is on cases, that means that we've been  
4 trying to stop our cases. And, again, I won't say  
5 cases of COVID-19, that is what we ultimately want to  
6 prevent, but what we're actually measuring, again, are  
7 positive test results for potential infection with  
8 SARS-Coronavirus-2.

9 So what it tells us is that the masks and the  
10 physical distancing, despite the fact that we have not  
11 only maintained that all the way through but actually  
12 removed the vast majority of people from the population  
13 who are unvaccinated tells us that that combination of  
14 those critical three, which are supposed to be the  
15 three things to -- to end this pandemic, the  
16 vaccination, the masking, and the physical distancing,  
17 you know, that's real world evidence, you know, that  
18 we've all seen that really we can't -- argue doesn't  
19 exist, right, because we see it in our workplaces and  
20 schools. It clearly shows those aren't working. They  
21 can't be working while we're actually having, during  
22 this process of maintaining those three strategies,  
23 while removing most of those who are unvaccinated from  
24 those scenarios, when you actually see ever-increasing  
25 peaks in the, you know, recent waves, that clearly  
26 suggests that these are not working efficiently, right?



1 They're not -- they're certainly not efficient  
2 solutions to resolve the problem as we have it.

3 That's why many people are working right now on  
4 trying to develop vaccine strategies that ideally would  
5 be sterilizing or near-sterilizing because that would  
6 provide, potentially, an ideal way to prevent this.  
7 But then one even argues whether it's necessary if the  
8 virus isn't dangerous enough because -- this is  
9 something I teach my students -- one of the questions I  
10 get asked all the time, with all the vaccine  
11 technologies that we have, why don't we have a vaccine  
12 for the common cold. Well, the reason is simple, no  
13 medical intervention, no medical intervention comes  
14 with zero risk. So you always do a risk-benefit  
15 analysis.

16 And so the primary reason why we have never  
17 developed a vaccine against the cold that we try and  
18 implement is the cold in the vast majority of people  
19 again is not a major issue. And so if people aren't at  
20 substantial risk of harm from a pathogen, we're not  
21 going to introduce an unknown potential amount of harm  
22 from a novel medical intervention, and so that's why  
23 we'll never have vaccines for the common cold.

24 But, nevertheless, I just wanted to bring that up  
25 there, that that might be a viable strategy, if needed,  
26 if we were to get a future version of the -- you know,

1 future variant or strain of the virus that were to  
2 attain more dangerous characteristics again. But with  
3 the current tools that we have, we have seen the  
4 Omicron variant, the spread, the transmission go  
5 completely out of control. So, yeah, I'll end it  
6 there.

7 Q MR. KITCHEN: Well, thank you. But let's  
8 talk about prevaccine, let's talk about 2020. My  
9 understanding is, you know, the vaccine really didn't  
10 start to get up to -- until January of 2021, so about a  
11 year ago, you know, and the time that's really  
12 relevant, of course, for this case is, you know, from  
13 May 2020 till December 2020. That's when the  
14 chiropractors were allowed to work, that's when  
15 Dr. Wall was working, and that's when there was a  
16 mandatory mask requirement in place by the College.

17 So let's talk -- and as far as I can see, that's  
18 prevaccine. So let's talk back then. What's your take  
19 on why these measures, no vaccine, why measures like  
20 physical distancing and masking didn't work back then?

21 A Okay, so this leans heavily on what I already  
22 explained. So pathogens are a spread, there's risk of  
23 spreading it to somebody else when we're actively  
24 releasing large enough quantities from our body to meet  
25 the threshold dose needed to infect, bypass the initial  
26 physical barriers, and initiate disease -- or initiate,

1     sorry, what we would call a productive infection that  
2     would result in disease, because, again, disease is  
3     when there's the onset of signs and symptoms.

4             And so the reason why these largely haven't  
5     been -- weren't effective there, so outside of the  
6     scope of vaccines, is because we were keeping people  
7     out of the workplace who weren't sick. Again, I keep  
8     emphasizing that. If you're not around sick people,  
9     you tend not -- you're going to tend not to get sick.

10            And again -- so, again, these masks do a  
11     reasonable job at preventing the spread of illness when  
12     somebody's coughing and sneezing. That's what they're  
13     really designed to do, that's what the pore size is  
14     designed for in these masks.

15            And, otherwise, if -- so then the only argument  
16     that remains then for why these masks attempt to  
17     restrain the virus if somebody's not symptomatic would  
18     be, again, the concept that they have -- the assumption  
19     that they have a high enough dose of the virus in their  
20     respiratory tract but are not yet sick because of it  
21     and, therefore, exhaling large enough quantities, a  
22     threshold dose, through aerosols, right? That's the  
23     only physical way that a healthy person could,  
24     therefore, be spreading this, and as I've explained  
25     because of the pore size. And, more importantly, the  
26     pore -- really, the pore size is irrelevant if you

1 don't have a proper fitting mask, such as the vast  
2 majority is exiting the body unfiltered. You know, the  
3 virus isn't going to respect the masking, nor --

4       And then when it comes to the physical distancing,  
5 this is a complex process because some physical  
6 distancing theory can help if you can control, if you  
7 can control, because this is the thing, physical  
8 distancing was primarily implemented -- and, in fact,  
9 it's largely -- one can even argue what should be the  
10 appropriate distance. Many studies would suggest that  
11 an appropriate distance would only be 1 metre rather  
12 than 2. So it's a rather -- beyond 1 metre becomes  
13 rather arbitrary if you can -- if you pick a number  
14 beyond that.

15       But what people need to understand is that the  
16 reason this physical distancing was also selected was,  
17 in the context of sick people who were actively  
18 transmitting the virus by coughing and sneezing, it's  
19 this idea of large water droplets again. And the  
20 reason why 1 metre has always been recommended as the  
21 minimum distance to try and minimize your chance of  
22 getting infected -- so I would definitely recommend if  
23 somebody is around somebody who is coughing and  
24 sneezing, I would never recommend that you -- if you  
25 want to keep yourself healthy, I would recommend that  
26 you never go within 1 metre of their personal space,

1 and the further away you are, the less risk there is.  
2 And that's because people -- you know, when we cough  
3 and sneeze, the large droplets that we dispel land on  
4 the ground approximately a metre away from us, up to a  
5 metre away, so that's where that came from. But,  
6 again, that's for people who are symptomatic and  
7 meaning they're actively coughing and sneezing and  
8 projecting these large water droplets.

9       Otherwise, we're talking about aerosols. And when  
10 we're talking about aerosols, aerosols can travel very  
11 large distances, massive distances, in fact, depending  
12 on the environment. So, for example, there's very few  
13 indoor places anymore, like work environments, that  
14 have modern -- and even houses, you'll notice, most of  
15 the -- most modern buildings now have air circulating  
16 all the time, and so that creates currents, air  
17 currents, all the time in our homes. We're often  
18 unaware of these, but, you know, you know that you can  
19 get the test kits to look at smoke detectors or even  
20 smoke. If you ever put the smoke in a room, for  
21 example, in air vents and so on, you can often see that  
22 there are these air currents that are circulating. So  
23 we can't see that, so where these aerosols go is going  
24 to be dictated by the air currents that are around us.

25       So as an extreme example, and I've pointed this  
26 out to people, you know, kind of in a half-joking way,

1   only half-joking because it is actually serious, so,  
2   you know, I, from time to time, I've used -- you know,  
3   I use a bus. I've got a bus stop not far from my home,  
4   and again the best time -- the best time to see this,  
5   there's two ways to actually visualize this, one is  
6   observing smokers and the other one is observing people  
7   breathing but in the winter time, where you -- again,  
8   you can see the aerosols because of the condensation in  
9   the cold air.

10       And so one of the things that I always, always do,  
11   because I'm a nonsmoker myself, is if somebody's  
12   smoking, I always stand upwind from them, right? There  
13   is no defined distance at which smoke dissipates to --  
14   and which it's safe, if there's a wind. If you can be  
15   5 metres downwind of somebody at a bus stop, and you're  
16   going to be inhaling their smoke if the wind's taking  
17   it that way, because, yes, these aerosols dissipate,  
18   but if you have a wind that's moving quickly, you're  
19   going to be inhaling, you know, a reasonable amount of  
20   smoke, secondhand smoke. So many of us recognize that,  
21   and so if we don't want to inhale the smoke, we stay  
22   upwind, and that's what I'm talking about with these  
23   aerosols and air currents carrying this.

24       And so it's the same thing, if you have somebody  
25   that's, for example, let's say, unmasked and breathe  
26   out, if you -- if there's -- if the air is what we call

1     stale, is not moving, you're going to see a cloud that  
2     forms in front of their mouth, and it's going to  
3     dissipate as it moves out. In that case, the aerosol's  
4     probably going to dissipate, pretty low concentrations,  
5     right, per volume of air space at not too far a  
6     distance. But, again, if you're standing, you know, 3  
7     metres downwind of the person and, you know there's a  
8     reasonable breeze, those vapours, you can see them  
9     coming right by, right by your face. And so you're  
10    actually inhaling, you know, reasonable concentrations  
11    of the air being expelled by that individual. So  
12    that's how, you know, is -- that's a good way to look  
13    at it.

14           And so it's the same thing, so -- and worse, this  
15    is the other thing, so I point out again that, in  
16    fact -- so you combine that, we're talking about  
17    aerosols with the masking, and the very frustrating  
18    thing there is -- again, I try to point out -- if I'm  
19    standing at a bus stop, and there's people sort of  
20    downwind of me, and I want -- and if I were to feel  
21    that I had to protect them from an aerosol, I would  
22    actually rather have to take my mask off so I'm  
23    projecting the aerosol ahead when then maybe it gets  
24    dissipated, you know, down in front of the crowd of  
25    people. By putting on the mask, I'm actually making  
26    sure that I'm blowing lots of unfiltered air out past

1 my ear and actually firing it basically in the  
2 direction of the people, right, or right beside me. So  
3 that's what I mean.

4 So this is the problem, this is the problem when  
5 it comes to the mask. We're not properly control --  
6 and, in fact, it -- when you think about it, it's --  
7 it's not logical, we don't think logically, because we  
8 think about -- we've all seen our breath in cold air,  
9 so we think if we're going to control our breath -- I'm  
10 going to use the example, bad breath. If you want to  
11 avoid somebody detecting bad breath, one of the things  
12 you do you don't breathe on them, right? So you find a  
13 way of making sure the breath goes some other way.  
14 Even if you're looking at them, some people will sort  
15 of breathe out the side of their mouth, change the  
16 shape so it kind of directs it away from the person.  
17 And this is inherently because we know that we can't  
18 alter the direction that it goes, but so we're always  
19 thinking of breath coming out from our mouths.

20 And so what the interesting thing is what people  
21 often do, out of reflex, is in order to -- when they  
22 have the masks on, in order to avoid having any of  
23 these aerosols hit them or their breath hit them, they  
24 tend to look away from them. And as I pointed out,  
25 because of the -- what the direction -- the air -- the  
26 air actually coming out, you know, by the ears, by



1 looking away from somebody, you actually redirect the  
2 unfiltered air in their direction.

3         So an example, in my workplace, we were actually  
4 told -- because it turns out that our hallways are less  
5 than 2 metres, so we were actually -- what we were  
6 actually asked to do was if we passed one another in  
7 the hallways, we'd go belly to belly or chest against  
8 the wall, like kind of inch our past one another with  
9 our backs turned. And all time we're do -- all I --  
10 you know, all I'm doing by doing that is, you know, at  
11 least if I have the mask on and I'm looking at the  
12 person, I'm directing the air away from them. As soon  
13 as I turn my back on them, again, I'm directing air  
14 toward -- in their general direction.

15         So this is the problem, and this is why we've had  
16 trouble with the masking and controlling the spread of  
17 aerosols, and why distancing, why distancing is quite  
18 arbitrary in the context of aerosols. So, again, there  
19 have -- there was a published scientific study in a  
20 peer-reviewed journal that clearly showed with these  
21 aerosols, they can travel -- they can travel, again  
22 with the air currents, up to 30 metres, you know, if  
23 they're carried on an air current that's swift enough  
24 and going in a certain direction rather than swirling  
25 air.

26         So it's all dependent on air currents, it's

1 dependent on the direction that the unfiltered air is  
2 going. So we're talking about -- again, again, I would  
3 say -- you know, I saw Dr. Hu's report, I agree 100  
4 percent with him on the efficacy of masking with  
5 symptomatic individuals, you know. But we're talking  
6 about -- but, again, what you asked is people who are  
7 going into the workplace who are asymptomatic, masking  
8 to prevent the spread of aerosols and control the  
9 direction in which they're going is not -- does not do  
10 the job, not in the context of aerosols. So that's why  
11 this virus has been spreading.

12 And I'd like to point out again, if you -- if  
13 we -- if that is true, if the masks -- if the virus, it  
14 could potentially spread on aerosols, and there's  
15 some -- lots of studies have suggested that maybe it  
16 can and -- but masks were doing their job, then we  
17 would expect that people would have been protected.  
18 But like I said, the actual -- in the study that was  
19 published looking at immunity in healthy individuals,  
20 people who never had any evidence that they were  
21 infected or knew they were infected with the  
22 SARS-Coronavirus-2, showed many healthy adults  
23 acquiring immunity for the virus, and so that's been  
24 occurring despite the masking.

25 Q Well, I need to ask you a couple questions about  
26 asymptomatic transmission, because -- and symptomatic

1 transmission for that matter. Let me ask you this: Of  
2 all the transmission of SARS-Coronavirus-2 or  
3 SARS-Coronavirus-2, roughly how much comes from  
4 asymptomatic people and roughly how much comes from  
5 symptomatic people?

6 A So the subtotal of scientific literature would suggest  
7 very little comes from asymptomatic individuals. It is  
8 not zero. There is some asymptomatic transmission that  
9 can occur.

10 One of the studies that often gets highlighted was  
11 a -- again, it was a peer-reviewed scientific paper  
12 published in an high-impact journal. It was actually  
13 studied in a huge population in China, about 10 million  
14 people, and the conclusion from that study was among a  
15 sample size of 10 million people. They found no  
16 substantial evidence of asymptomatic transmission.

17 And, again, it's not surprising, because, again,  
18 for all the reasons I already explained, so I won't go  
19 into them again in any detail, but just very quickly,  
20 you have to have the virus in your lungs at a  
21 sufficient quantity to be -- such that your body is  
22 releasing enough to exceed that threshold dose needed  
23 to cause illness in somebody else, and that almost  
24 always requires active expelling of the virus from the  
25 body through coughing and sneezing, but not always.

26 There is the theoretical scenario where you could

1 have somebody who's still not actively coughing and  
2 sneezing, so they don't know that they're sick, it  
3 might be a little bit threshold dose. When it comes to  
4 biology, anything is possible. I'll never say anything  
5 is impossible. So it is certainly theoretically  
6 possible, and, in fact, I would argue it is a real --  
7 real thing, but it would be high -- it's highly  
8 improbable, meaning a rare event.

9 And there has been like a lot of agreement,  
10 generally speaking, including among major public health  
11 bodies, like the World Health Organization, there's  
12 many organizations that, after a while into the  
13 pandemic, we're starting to recommend just end the  
14 testing, testing for evidence of SARS-Coronavirus-2 and  
15 asymptomatic people for this very reason, because, you  
16 know, again, we recognize you're testing healthy  
17 people.

18 And what was being recognized though -- so  
19 although there's very few cases, documented cases of  
20 clear-cut transmission from asymptomatic people of  
21 infectious viruses that may be at a dose that can cause  
22 disease, it's definitely not a substantial driver of  
23 this pandemic in any way, shape, or form.

24 So even, I'd like to point out -- so I notice  
25 that -- you know, like Dr. Hu cited some peer-reviewed  
26 scientific articles, and that's great, because, again,

1     that's the, you know, best type of evidence for this,  
2     but even there, the important thing is looking at what  
3     was actually measured.

4             So when you actually look, when they were  
5     measuring some of the -- in some of those masking  
6     studies, it was -- they were looking at, again, doing  
7     genetic testing essentially, like PCR testing, to look  
8     for evidence of the genetic material from the virus,  
9     and so this -- you have to be very careful again  
10    because -- okay, so this requires a little bit of  
11    background in terms of measuring, measuring, how you  
12    measure whether a virus is being filtered.

13            So with this PCR test that we've all probably  
14    heard about, it's called polymerase chain reaction.  
15    What it is is this concept that we can use little  
16    pieces of genetic material that recognize sections of  
17    the genetic material from the virus, and so if the  
18    genetic material from the virus is present in a sample.

19            So, for example, if you put a mask on an  
20    individual like -- and you ask them to breathe, and you  
21    capture those samples, you can run this test to look  
22    for evidence, you can ask is there any evidence of the  
23    virus based on genetic material being present. And  
24    when you do that, this test can detect small segments  
25    of the genetic material from the virus, and then it --  
26    this gets amplified, you run it for a number of cycles.

1 And if genetic material is present, you keep amplifying  
2 it with each cycle, somewhat exponentially, until you  
3 get enough of it, you can literally visualize it in a  
4 test. So you can ultimately amplify it to such an  
5 amount that you can visualize the genetic material, and  
6 then you say, okay, so that genetic material seems to  
7 have been present.

8 The problem with this is and the problem we've --  
9 you know, I don't -- I can't comment on why this has  
10 happened, because it's -- it's against all historical  
11 standards, but we have relied on just the PCR test in  
12 Canada for some reason, and we have arbitrarily picked,  
13 in most cases, cycle cut-offs.

14 Because what happens, when you go to very high  
15 cycles, your amplify -- you can -- what can end up  
16 happening is you can end up amplifying background, you  
17 get background signals we call it. And so you think  
18 you see a causative result, but it's actually just  
19 background. And we've been calling, running these  
20 tests and calling -- so, for example, in Ontario, up to  
21 38 cycles, if you can then detect a signal from this  
22 test, we're calling that a positive test result for  
23 SARS-Coronavirus-2.

24 But this is how it's supposed to work: We do  
25 actually -- PCR is not a gold-standard test for  
26 detecting it. Like it's a fabulous technology, but

1    like anything, all technology, it has limitations. It  
2    is able -- what it's not able to do is detect -- it's  
3    not able -- it's only going to tell you if a portion of  
4    the genetic material -- material is present. It can't  
5    tell you if there are replication-competent, intact  
6    virus particles, in other words, virus particles that  
7    have the potential to infect somebody.

8           But we do have a gold-standard test for that, a  
9    virology assay. Remarkably, we abandoned this early on  
10   in Canada. And specifically what's supposed to happen  
11   is in order to validate your test, in order -- in other  
12   words, in order to say, okay, my test, the results that  
13   I'm showing in this test are proving -- or are  
14   suggestive, highly suggestive that what I'm detecting  
15   is infect -- or are virus particles with the potential  
16   to infect somebody else. What you do is you take your  
17   sample, and you split it into two, and with one, you  
18   run your PCR test, and you determine at what cycle  
19   number you get a positive result.

20           And in the other one, you do -- that uses  
21   gold-standard virology test, which is actually a  
22   functional test. What you do is apply the sample to  
23   cells. You let these cells grow, you grow them on  
24   plates, and we grow them for what's called confluence,  
25   which means the entire bottom of the plate is covered  
26   with these cells; you can't see the plate at the bottom

1 of the plate anymore.

2 And then what you do is you add your sample.

3 These are a special type of cell, we call them  
4 permissive cell lines, and what they are are they are  
5 cells that are stripped of all their anti-viral  
6 properties, they're not able to protect themselves from  
7 viruses, so that if there is a virus in your sample, it  
8 can very efficiently infect these cells, and it will  
9 start replicating and spreading, and it will kill the  
10 cells. We call this cytopathic effect.

11 So what you do is you look at your cells under a  
12 microscope, and you make sure, before you add your  
13 sample, that the entire bottom of the plate is covered  
14 with the cells, then you add your sample. If there's  
15 any replication-competent virus there, which also  
16 means, therefore, that it would have the potential to  
17 infect and cause disease in somebody else, when you  
18 look under the microscope later, you will see those  
19 cells removed from the -- those cells have been killed  
20 off, and now you'll be able to see the bottom of the  
21 plate. And what you do is you find the cycle number at  
22 which your samples no longer cause any damage to that  
23 cell layer, and then that is how you prove,  
24 objectively, the cutoff for your PCR.

25 And what's interesting is we actually did this --  
26 I did. Our micro -- National Microbiology Laboratory,



1    which is part of the Public Health Agency of Canada.  
2    It's located -- it's one of our -- it's a Containment  
3    Level 3 and 4 facility in Winnipeg, Manitoba, they did  
4    this at the beginning of the pandemic, and -- which was  
5    the appropriate thing to do, and remarkably -- and this  
6    is published, this is a peer-reviewed published paper  
7    that they issued early on in the pandemic. And what's  
8    remarkable there is they set the cut-off at 24 cycles.  
9    Now, that doesn't mean anybody running a PCR test has  
10   to have their cut-off at 24 cycles. The -- the actual  
11   cycle cut-off, any person running this test should,  
12   first, establish what the cut-off is for themselves, with  
13   their particular protocol, their set of reagents, and  
14   their particular technical expertise.

15        So the cycle number should act -- for the cut-off  
16   should change from laboratory to laboratory, but  
17   everybody should be able to show you that gold-standard  
18   virology assay and the results from it to provide the  
19   rationale as to why they picked that particular  
20   cut-off.

21        But nevertheless, it -- because it's not going to  
22   stray too far from that. And so my point is the  
23   National Microbiology Laboratory showed that the proper  
24   cut-off in their hands of the PCR assay was at 24  
25   cycles. In other words, this paper, if you go and you  
26   read it, our own public health scientists that

1 published this, what they found is that if the PCR test  
2 came up positive at cycle numbers higher than 24, those  
3 samples, they were unable to infect the cells in that  
4 gold-standard virology assay with those samples.  
5 Meaning, there was no evidence of replication-competent  
6 or -- virus particles that had the potential to infect  
7 anybody else.

8       So if they were running the diagnostic tests, for  
9 example, to the PCR, therefore, they would set the  
10 cutoff at 24. They would say anybody with a positive  
11 test result up to 24 -- and they wouldn't have to run  
12 this assay again, you don't have to do it every time,  
13 and it makes no sense to do so -- they would then, with  
14 high confidence, be able to say anybody who tests  
15 positive up to a cycle number of 24 almost certainly  
16 has infection of -- replication-competent viruses in  
17 their body with the potential to infect others. But  
18 the reverse of that conclusion is anybody with the test  
19 result that is cycle number above 24, they would have  
20 to conclude that those people are not able to infect  
21 anybody else.

22       And so this is the problem, because a lot of the  
23 publications that relied on this genetic test, and,  
24 therefore, there is, without the gold-standard test  
25 being run in parallel, there's no way to tell whether  
26 their positive results were false positives, or even --

1 the thing I like to point out, there are genuine  
2 positive tests but that do not -- but -- in which those  
3 individuals, so they're genuinely detecting, they're  
4 truly detecting genetic material from the virus, but  
5 those people actually aren't infectious, and that's  
6 actually people who have mounted immune responses.

7 This is very important to understand, because what  
8 happens is one of the things our immune system does --  
9 I didn't go into the details, but some of you may  
10 recall when I was explaining kind of line of defences,  
11 I mentioned that once the virus penetrates the physical  
12 barriers and starts affecting cells, we have these  
13 sentinel cells which will detect infection and trigger  
14 these subsequent immune responses.

15 Well, these sentinel cells, one -- and a couple  
16 other cell types, what they're designed to do very  
17 on [sic], in order to detect these viruses is they  
18 gobble them up, they actually consume them. We call  
19 this phagocytosis, right? So they actually basically  
20 eat, consume the virus, and then what they do is they  
21 take the virus, and they break it into pieces, and then  
22 they take these pieces, and they actually take it to  
23 the draining lymph node, and they show it to our B and  
24 T cells, to say, Look, here's a dangerous pathogen that  
25 you need to go and try and clear from the body.

26 And then we get our B cells and T cells activated.

1 The B cells are the ones that then produce the  
2 antibodies. And you know that this process is  
3 happening when your lymph node swells, because if those  
4 B and T cells are being activated, they start  
5 proliferating in large numbers, so we have an army, an  
6 army that's designed to go and recognize the pathogen.

7 So that's why if you're sick, like you have a  
8 throat infection, you can often palpate the lymph  
9 nodes, right, just behind your jaw, or your physician  
10 does that. That's what they're looking for for  
11 confirmation, because your lymph node is swelling; that  
12 means you're actively mounting an immune response  
13 against the pathogen, and it's clear evidence that  
14 you're infected.

15 But, so, this is what you have to understand, this  
16 is the key, to get to that process, we have to have  
17 cells that gobble up the virus and carry it to the  
18 lymph node and show pieces of it. These cells will  
19 hold on to that so that virus is no longer  
20 replication-competent. It's inside the phagocytic  
21 cells and -- but it -- they will hold onto this for up  
22 to weeks, even sometimes months, and that is to make  
23 sure that there is always a supply of the target that  
24 the immune system needs to respond to to protect the  
25 body.

26 So it can take -- usually it doesn't take months,

1 but certainly, for sure, at least two to three weeks,  
2 they'll be holding onto this material in case -- and  
3 that's the case, the immune system has to keep  
4 responding, in case they have to keep getting more  
5 effectors recruited, depending on how virulent the  
6 virus is.

7 And so in many cases, that -- then what you get is  
8 you get a true positive test result with the PCR.  
9 There's actually, you know, viral particles present --  
10 or partial viral particles, at least pieces of the  
11 general genetic material present in the body, but as  
12 you can imagine, that's not ever going to infect  
13 anybody, right? It's inside the cells of our immune  
14 system that use that to educate the rest of our immune  
15 system.

16 So this is why it's important to understand how  
17 this works. Yeah, so I'll leave it at that.

18 Q Thank you. All right, so I need to go back to -- you  
19 established that SARS-CoV-2 spreads by aerosols; we've  
20 established that the masks don't stop aerosols; we've  
21 established that they do tend to stop the bigger  
22 droplets, we've established that asymptomatic spread is  
23 rare. And that leaves the question then, forgive me,  
24 but if I'm listening logically to what you're saying,  
25 then, when symptomatic people wear a mask, they'll end  
26 up spreading SARS-CoV-2 through aerosols; is that

1 correct?

2 A Yes. Again, there's evidence this virus can spread  
3 through aerosols. So one thing, just to clarify what  
4 you said just a moment ago, the -- so, yes, there's  
5 evidence that the virus spreads by aerosols, but I also  
6 want to make it clear, the virus is going to spread  
7 very efficiently through the large water droplets with  
8 the coughing and sneezing as well, as well as contact  
9 media transmissions.

10 So I notice in Dr. Hu's report, you know, he had  
11 mentioned that as well -- he had mentioned all three --  
12 all three occur. He placed more emphasis on the large  
13 water droplets and the contact transmission, so I don't  
14 disagree. I just want to make that clear. But again,  
15 those are symptomatic individuals; we're talking about  
16 large water droplets and contact transmission, those  
17 are people who are actively -- you know, actively  
18 releasing large amounts of the virus.

19 And so with a contact transmission, actually I  
20 have additional concern there, because I agree that  
21 contact media transmission is an issue, and that's  
22 where I'm concerned when we -- when we're old -- when  
23 we're making people use these masks only in the context  
24 of aerosol media transmission, because, again, those  
25 who are actively sick are isolated, what we're doing  
26 with these masks, because of the contact -- or

1 potential contact is where we -- people are constantly  
2 handling their masks, right? So if there is any spread  
3 of virus, we're actually bringing their hands to their  
4 mask.

5 I have been -- I am unable -- I wear a mask on a  
6 regular basis, clearly for some of the, you know,  
7 surgical work that I do as part of my research program.

8 I -- when I'm doing the surgical stuff, I do tend  
9 to be very careful, you know, very mindful of that.  
10 And even there, it's very difficult not to touch a  
11 mask, but you're taught, you know, when you're doing  
12 surgical work not to touch it. But, otherwise, unless  
13 you're doing surgery, I'm not able to -- especially if  
14 I'm -- unless I'm focused on it all the time, I'm not  
15 able to avoid touching my mask. In fact, the average  
16 person cannot talk for any substantial period of time  
17 and not have to touch their mask because it causes  
18 bunching of the mask, you know, and it pulls off the  
19 chin or it pulls off the nose. So there's very few  
20 people who get through an eight-hour workday without  
21 handling their masks over and over and over and over  
22 again.

23 And worse, many people, unlike a surgery, where  
24 you would then discard your mask, and then if you have  
25 another surgery, you would put on a fresh one, there's  
26 a lot of people who keep reusing their masks over and

1 over. So that potentially enhances the contact media  
2 transmission. So I just want to be clear on that, that  
3 it's not just the aerosol, it's contact media  
4 transmission and large droplets. And wearing a mask  
5 for the large droplets can handle that, but you don't  
6 want to be handling the mask or else you're promoting  
7 the contact via transmission. But, again, I highlight  
8 that's symptomatic people, and we're screening those  
9 individuals out, so they're not supposed to be in the  
10 workplace, so that leaves, therefore, just the aerosol  
11 media transmission.

12 And so, yes, I agree with you that in the context  
13 of the aerosol transmission, an asymptomatic person  
14 leaving their home and then donning their mask to try  
15 and prevent the aerosol media transmission for all the  
16 reasons that I just cited prior to this is not going to  
17 be effective at preventing transmission by that route.

18 Q The question that I'm left with and I think many people  
19 are if they have the masking in place, and we have the  
20 screening in place, and yet what we've seen in the last  
21 year-and-a-half that we've had masks, because we didn't  
22 have it the first few months of the declared pandemic,  
23 the last year-and-a-half that we've had masks, we've  
24 just seen the spread increase and increase and increase  
25 and increase. And yet, what you're telling me is that  
26 it is effective with symptomatic people because it --



1           somewhat because it stops their droplets and spittle.

2           And I'm left with that question, right, of if  
3           masks are somewhat effective with symptomatic people,  
4           and symptomatic people are supposed to be removed, and  
5           it seems like they sometimes are, and yet we still have  
6           all this increase in spread, all right, so people --  
7           nonscientific people like me are left scratching their  
8           head.

9    A    Would you like me to address that point?

10   Q    Yes.

11   A    Yeah, so it's for the reason that we've been talking  
12           about is the aerosol media transmission.

13   Q    Okay.

14   A    So I've cited in my report, there's a large number in  
15           there. I mean, that's exactly what was looked at. So,  
16           again, just to make this clear, there's a big  
17           difference between SARS-Coronavirus-2 and the viruses  
18           that we're familiar with. This is why I took some time  
19           to investigate it.

20           So what seems to relatively unique about the  
21           SARS-Coronavirus-2 is this aerosol media transmission.  
22           That's something else they should clarify. Previous  
23           viruses historically -- because -- so this is again  
24           why, initially, the masking seemed to make sense, but  
25           only in the context of symptomatic individuals is  
26           because we assumed that the primary mode of spread was

1 the coughing and sneezing and contact media  
2 transmission. So that is pretty much what most of the  
3 previous viruses and our other viruses that we're used  
4 to causing respiratory infections, they usually fall  
5 into that category.

6 For the flu virus, for example, that is the  
7 primary way by which it is spread. It's not  
8 recognized. In fact, it's well recognized that the  
9 influenza viruses don't spread very efficiently via  
10 aerosols. So that's what's unique to this virus.

11 So, again, like all our historical studies and the  
12 masking studies, again, this is a strategy that is  
13 designed to stop those kind of respiratory pathogens,  
14 and that type of transmission, but not aerosol  
15 transmission, and so that's why we've been seeing this.  
16 And that's why I say when you take sick people away  
17 from other people, that's the most effective way, but  
18 the problem is with the aerosol transmission, people  
19 are still able to go out there, right, and transmit  
20 this virus.

21 And the issue here is with the -- yeah, the  
22 masking in particular. So this is something that I  
23 hadn't highlighted, which I think is important, because  
24 what it comes down to then is what would a protective  
25 mask look like or what would really protective masking  
26 look like in the context of aerosol media transmission.

1           So as a researcher, this is something that they  
2   deal with all the time. My entire laboratory is rated  
3   as a Containment Level 2 laboratory, so all of my  
4   entire research space. So this is because we work with  
5   what's called Containment Level 2 biosafety hazards.  
6   So -- and there's a certain amount of protection  
7   that -- that we implement to protect us. So these are  
8   not particularly -- these are not dangerous; these are  
9   not dangerous pathogens; these are not disease-causing  
10   agents, or, at most, if somebody were to get a large  
11   dose of them, it would cause mild disease at the most.

12           But so -- but what we have to do all the time when  
13   we are -- design a research program, I -- we're  
14   constantly policed in the sense that I have to get a  
15   biohazard permit in order to conduct my research. So I  
16   have to describe how I'm conducting my research and  
17   what protections are in place to make sure that people  
18   aren't put at unnecessary risk from the Containment  
19   Level 2 to agents that we work with.

20           The SARS-Coronavirus-2 -- and so I'm very  
21   familiar, therefore, with biosafety strategies, right,  
22   and personal protective equipment that one would use in  
23   these scenarios. And like I said, I've done  
24   collaborative research on the SARS-Coronavirus-2.

25           For the one publication that we published recently  
26   dealing with the novel vaccine, that involved a

1 challenge study with the SARS-Coronavirus-2, where  
2 animals were vaccinated and then challenged with the  
3 virus. So that work is done, and it can take -- what  
4 we call Containment Level 3. So SARS-Coronavirus-2 is  
5 considered a Containment Level 3 pathogen.

6 Now, this is interesting because this then says --  
7 so we have -- the Public Health Agency of Canada has  
8 told us what the appropriate protection is against a  
9 Containment Level 3 pathogen, and I have that in my  
10 report. So, in fact -- not people to look at it, but  
11 if you want to take a note and look at it later, I  
12 would refer everybody to Figure 7 on page 13 of my  
13 report, because what I've done there -- what I've shown  
14 is a picture of a stereotypical personal protective  
15 gear that one would wear to protect themselves against  
16 infection with a Containment Level 3 pathogen.

17 And so what I can tell you is -- I mean, it would  
18 be laughable if I ever put on a surgical mask or a  
19 cloth mask and then asked to go in and challenge our  
20 animals with a SARS-Coronavirus-2 wearing that. I  
21 mean, I would get myself in serious trouble. I'd  
22 probably have my biohazard permit revoked for showing  
23 such lack of understanding of personal protective  
24 equipment, because I'd be putting myself at incredible  
25 risk of being infected with the SARS-Coronavirus-2,  
26 because a lot of the procedures that we're doing create

1 aerosols. So if you're pipetting, which is a -- it's a  
2 scientific tool for allowing us to deliver precise  
3 quantities of fluid; that's known to create aerosols.

4 So a lot the work and manipulation we do -- and  
5 we're working with high doses of viruses as well,  
6 remember, in those kind of settings with lots of  
7 potential for aerosol production, so I'm very familiar  
8 with what it takes to protect one from a pathogen  
9 that's been aerosolized.

10 And if you can refer to this picture, the first  
11 thing you'll notice is the individual has the pathogen  
12 in a tube, a closed tube, and these tubes will only be  
13 opened inside this special unit that their arms are  
14 inserted into. It's called a biological safety  
15 cabinet. And if you can see the picture, you'll notice  
16 that just in front of the individual's elbows, there's  
17 a grate. There's a solid stainless steel surface  
18 inside the hood, and what's in the front of it is a  
19 grate.

20 And what happens is this has special air flow, and  
21 what happens is air actually blasts up from this grate  
22 and then up into the cabinet and then goes through a  
23 HEPA filter -- actually a number of HEPA filters.  
24 HEPA -- so unlike the masking material in the low-cost  
25 masks like the surgical masks and the cloth masks,  
26 which have very large pore sizes, HEPA filters have

1 extremely small pore sizes that are designed to filter  
2 out most pathogens. And so what that air, therefore,  
3 is -- so what it does is creates a wall of air in front  
4 of you that is basic -- essentially sterile air. So  
5 you actually run these things for 20 minutes, so if  
6 there's any contaminants in it, after 20 minutes, the  
7 air that's running is essentially sterile. So then  
8 when you put your arm -- you put your arms in slowly,  
9 because you don't want to disrupt the air flow too  
10 much. By doing so, you're literally going through an  
11 air barrier, so no aerosols can come out of that  
12 cabinet.

13 But in case any does, however, say for example,  
14 that individual were to make a mistake and insert the  
15 arm too quickly to disrupt that air flow excessively  
16 and allow a little bit, potentially, of aerosol to come  
17 out, that's why they have the rest of the personal  
18 protective equipment, the gloves and the gown, is to  
19 minimize the potential for contact media transmission.  
20 You don't want spills on your personal clothing, right,  
21 such that, you know, if you go home, you know, you  
22 might be touching your clothing, then touching other  
23 things, so that's to protect against that contact media  
24 transmission.

25 But you'll notice they don't -- they aren't  
26 wearing a cloth mask or a surgical mask; they're

1   wearing a mask -- and as you can see, very different --  
2   this is actually a requirement interestingly. I would  
3   not be able to go into this facility with the mask  
4   that's in this picture. And so if you notice what the  
5   difference is between the individual wearing that mask  
6   and me, I've got a beard. And so this is very  
7   important to note. So if you look at their mask,  
8   you'll see it has elasticized material such that it  
9   provides a tight seal along the skin everywhere. And  
10   then around the hair, you'll see a headband. And then  
11   what you see is you see a tube coming out from the back  
12   of the -- the headpiece, and what it goes to is a  
13   little unit that mounts on the belt at the back of this  
14   individual, and this actually actively filters air.

15         So what that -- what that has is has a fan in it,  
16   and it has HEPA filters, and so it's actually drawing  
17   in air from the environment, from the room this  
18   individual is in, passing it through HEPA filters and  
19   then into that hood and specifically the face mask area  
20   so that what they're breathing is HEPA filtered air.

21         And like I said, so this individual -- so often,  
22   people working in these facilities are required to  
23   shave so that their mask can actually make proper  
24   contact, right? Because right now, I'm allowed to wear  
25   a cloth mask right now, and I'm not -- and I like to  
26   have a beard, and it's winter time, and I'm not

1 required, but I'll tell you the -- and because I know  
2 of the futility of masking in the context of aerosols,  
3 but the reality is, you know, if I were to wear a mask  
4 right now, I mentioned about how air would escape past  
5 the ears and the nose, well, also around my beard  
6 because the beard is holding the mask away from my  
7 skin, and I can guarantee that my beard has far larger  
8 pore sizes in it than the masking material.

9       So I just want to point that out, because that's  
10 our own government agency that's designed for telling  
11 us how we safely interact with Containment Level 3  
12 pathogens, of which SARS-Coronavirus-2 is, that is how  
13 one would protect themselves from aerosolized mediated  
14 transmission of a Containment Level 3 pathogen, and as  
15 I'm sure you can appreciate, it's not a cloth or a  
16 surgical mask.

17       Again, I can't emphasize enough that if I were to  
18 try to enter this facility and conduct this type of  
19 research with that, I would almost certainly have my  
20 biohazard permit rescinded and my ability to conduct  
21 that type of research removed, at least temporarily,  
22 until I underwent training to demonstrate that I  
23 understand how to truly protect myself from a  
24 Containment Level 3 pathogen.

25       And this isn't just for the individual of course.  
26 The key thing, in any of this strategy should be both



1 protecting the individual and also the people around  
2 them. You don't want a researcher coming out of a  
3 Containment Level 3 facility potentially spreading  
4 Containment Level 3 pathogens to the public.

5 Q Is there any logical or scientific reason to think that  
6 masks are more effective at preventing transmission of  
7 the virus by asymptomatic people in one place than  
8 another?

9 A No, no. They're physically -- they're operating based  
10 on the same physical principles. Now, I have seen the  
11 argument made that maybe the environment can  
12 potentially put an individual at greater risk. So, for  
13 example, in the health care environment, again,  
14 masking -- the physical protection conferred by a mask  
15 doesn't change based on the environment that they're  
16 in, but the potential risk of exposure does.

17 So a health care worker working with actively  
18 infected individuals certainly might be at increased  
19 risk of potentially being exposed. All the more reason  
20 why I would argue that they actually need proper  
21 protective equipment, so beyond the cloth mask, like  
22 something that would actually be designed to filter out  
23 this, and those are things that could not be worn for  
24 long durations of time. That would, for example, be  
25 like a rubber mask that could be fit-tested, again, to  
26 seal on the face; you wouldn't be allowed the beard,

1 and would have -- potentially the filters mounted to  
2 it. But you'll find that those devices, very difficult  
3 to breath with those devices for long periods of time.  
4 But that's the type of thing that might be appropriate  
5 in those settings. So, no, this type of masking isn't  
6 going to help in different settings.

7 But what I want to point out is -- so one of the  
8 things I noticed actually in Dr. Hu's report is that he  
9 brought this up in terms of health care workers. I  
10 mean, I'm no expert with chiropractors, but I agree  
11 with him that a health care worker working -- and he  
12 used the example of people who are -- were known to be  
13 actively infected and potentially infectious with  
14 diagnosed COVID-19. Where, I guess, I differ on  
15 this -- and, again, I'm not an expert in the world of  
16 practicing as a chiropractor, so I could be  
17 corrected -- but my understanding is that the average  
18 chiropractor is not being expected to work with a  
19 symptomatic COVID patient, diagnosed with COVID-19, so  
20 I would -- especially in that case, I wouldn't have a  
21 concern.

22 If -- so if a health care worker is working  
23 with -- is asymptomatic, and the patient they're  
24 working with is asymptomatic, having a mask just  
25 doesn't seem to make logical sense to me. A mask that  
26 is designed to effectively prevent transmission because

1 of lack of sickness doesn't make sense to me.

2 Q Forgive me, you've answered so many of my questions, I  
3 have to do a bit of a review here.

4 Okay, so I'm going to ask a couple questions here  
5 about aerosols and droplets, and then I think maybe we  
6 can leave that behind, because there seems to be  
7 contention on this. Would you say that the balance of  
8 the available academic literature supports aerosol  
9 transmission?

10 A So this is interesting, the -- it's debatable. This  
11 aspect is debatable about the aerosol-mediated  
12 transmission. Certainly without the act of coughing  
13 and sneezing, it would be difficult to get a, again, a  
14 threshold dose needed to infect somebody out with the  
15 aerosols, and there was -- earlier on, in order to  
16 explain this spread and the spread despite masking,  
17 that that's where a lot of the publications were geared  
18 towards were showing this aerosol-mediated  
19 transmission, that's been questioned now as well. So  
20 it's actually a little bit difficult to say  
21 definitively, based on the scientific literature, it's  
22 an active area of debate I would say.

23 And like I said, especially because, as we now  
24 have two years of experience and despite this strategy  
25 having been implemented throughout the duration, right  
26 from the beginning, but the ongoing spread of

1           increasingly --

2           (AUDIO/VIDEO FEED LOST)

3           MS. NELSON:                        Sorry, I don't mean to  
4           interrupt, but Dr. Martens has dropped off the call, so  
5           if we could just pause until I get her back, please --

6    A    Yes.

7           MS. NELSON:                        -- that would be great.

8    Q    MR. KITCHEN:                        Thanks, Dr. Bridle.

9                        Dr. Bridle, I welcome you to continue.

10   A    Okay.

11   Q    But I just want to make sure I have this right, are  
12           there three potential or likely areas of methods of  
13           transmission: Droplet, aerosol, and contact; is that  
14           accurate?

15   A    Yes.

16   Q    Okay.

17   A    Now, I guess, yeah, in the context of SARS-CoV-2. If  
18           we're talking about pathogens in general --

19   Q    Right.

20   A    -- (INDISCERNIBLE) like sexually transmitted diseases,  
21           but, yes, certainly SARS-CoV-2, for example --

22   Q    Yes.

23   A    -- those would be the three primary potential modes of  
24           transmission.

25   Q    Okay, well, let me ask you this, and, again, you can  
26           continue going on about aerosols and droplets and all

1       that, but I -- what, if any effect on contact  
2       transmission do masks have?

3     A   Potentially increasing it for the very reason that I  
4       said. I have -- I mean, I'm not going to excuse any  
5       individual, because there might be individuals who,  
6       miraculously, are able to wear a mask for very long  
7       periods of time and never touch it. I'm not going to  
8       say that's an impossibility, but I have watched  
9       hundreds of people throughout this pandemic, you know,  
10      because it's an area of interest of mine, because  
11      everybody's been instructed to not touch their masks  
12      because of the acknowledgment that there's  
13      contact-mediated transmission. I know it's in Dr. Hu's  
14      report that he -- you know, he mentioned that as a key  
15      potential way to transmit.

16             And I have yet -- I have yet to observe any  
17      individual who has not touched their mask multiple  
18      times within certainly let's say within an hour. I  
19      have not once seen anybody not touch their mask  
20      multiple times during a one-hour span. And, again,  
21      it's just natural with these masks. There are masks  
22      that are designed to stay in place. Again, if you  
23      refer to Figure 7 that I have in my report, that type  
24      of mask will stay in place; it's got very firm  
25      headbands, and it's designed to, you know, to seal.  
26      It's got -- you'll notice that the material, if you'll

1 notice the material, it's elasticized, and it's  
2 flexible. So, for example, this individual would be  
3 able to talk, you can envision his jaw moving up and  
4 down, and all the material that's attached to the  
5 plastic face shield, it is flexible -- or not flexible  
6 but loose enough that it allows that movement.

7 And see the differences with the mask, if I'm  
8 talking to you -- if I put on a mask right now, as I'm  
9 talking to you, within -- I don't exact time, but  
10 probably within 30 seconds, the mask, again, will have  
11 migrated off my nose or off my chin, and I'll have to  
12 do an adjustment. So unless you're sitting with these  
13 masks, never use -- never chewing, like not chewing on  
14 gum, not talking, it's going to be very difficult. And  
15 even at that, you know, people get itchy noses and so  
16 on. And depending on how they take their masks on or  
17 off, there's actually -- I mean, there's proper  
18 training procedures even for putting masks on and off.

19 Especially for surgery, right, you want to keep  
20 everything sterile, you want to keep your gloves  
21 sterile, you want to keep any masks that you put on  
22 sterile, right? So the proper thing would be just to  
23 handle the mask by the straps that go over the  
24 earpiece, right, and nothing else. But people, all the  
25 time, are grabbing their mask, you know, or taking  
26 their mask and grabbing it, you know, and stick in

1       their pockets or whatever. This is not the way these  
2       masks were designed to work.

3               Again, originally, remember, these masks came out  
4       of the concept of surgery and trying to make -- keep  
5       surgical fields as clean as possible. And if you watch  
6       how a surgeon dons and doffs their surgical equipment,  
7       including their mask, it's very different from what the  
8       average individual is right now, because we haven't  
9       trained, we haven't trained the general public in that  
10      kind of, you know, what we'll call sterile technique.

11              So, no, wearing a mask in an inappropriate  
12      environment can potentially cause more harm. Again,  
13      I'm not concerned. I'm not concerned about that  
14      contact media transmission if the person isn't  
15      symptomatic.

16    Q     Right, so but, you know, I've heard you say, obviously,  
17           the masks don't work for asymptomatic, but I've heard  
18           you say they kind of work for symptomatic because  
19           they'll stop the droplets, but, in your opinion, do  
20           masks -- are they a net contributor to spread or a net  
21           inhibitor of spread when you balance out the  
22           contribution to contact spread with the reduction of  
23           droplet spread?

24    A     Okay, so I would think that the net would be  
25           potentially enhancing for the -- again, for -- again --  
26           and if it's an asymptomatic individual. And the reason

1 is if there is any --

2 Q Hold on, asymptomatic or symptomatic?

3 A The -- well, in both cases, right, they're going to do  
4 something for the -- well, again, if somebody's not  
5 sick, then I'm just not worried in general. If  
6 somebody is shedding the virus, if that's the scenario  
7 where somebody is shedding a virus, I think it's going  
8 to have a net negative result. And that's because,  
9 again, it's not designed to filter out the aerosols.

10 What happens when people put a mask on, there's  
11 well-established behavioural changes that occur, right?  
12 When we feel -- when we feel more protected, we tend to  
13 behave -- it's human nature to tend to behave in  
14 riskier ways.

15 So it's interesting, this is interesting: I play  
16 hockey, for example, I'm an ice hockey goaltender.  
17 Now, so one of the things is if you want to -- if you  
18 want a contact game -- or, sorry, a contact-free game  
19 of hockey, one of the general rules of thumb is you  
20 don't have people put on -- you put -- you have them  
21 put on the minimal amount of safety equipment. And  
22 what will often happen is because, following -- what  
23 often presents a very danger to the elbows is the elbow  
24 pads, but a lot of people will not wear the shoulder  
25 pads, because that's not a particularly risky area.  
26 And one of the reasons is is because it's



1 well-established behaviour, if you load yourself up  
2 with armour, you tend to be more risky in your  
3 behaviour, potentially more aggressive in a sport like  
4 that. And it's not different than everything.

5       And so what happens is when people -- when -- this  
6 is the problem, see if people mask, and they understand  
7 the limitations, they understand what they're designed  
8 for, where their strengths are and where their  
9 weaknesses are, you're fine. But the general messaging  
10 that people have received is that these masks are  
11 fabulous at preventing the spread of this. And so when  
12 you have that program in your mind, As long as I have  
13 my mask on, I'm not a risk now to anybody else, and  
14 they're not a risk to me; what you inevitably see is,  
15 on average, masked people will tend to interact closer  
16 than people who are unmasked, and that's just the  
17 reality.

18       And so if there is aerosol mediated transmission,  
19 if you're, on average, interacting in closer vicinity  
20 with somebody, there's the potential for greater  
21 aerosol mediated transmission than if you're not  
22 masked, you don't feel that, you know, (INDISCERNIBLE)  
23 extra protection.

24       And so that's what I argue, as a scientist, I  
25 mean, when I wear it, I know that it is -- you know, so  
26 I wear them because I have to when I go to the grocery

1 store and everything, but I recognize that they're not  
2 properly protecting against aerosol mediated  
3 transmission. And so if there can be aerosol mediated  
4 transmission, of which is active debate in the field,  
5 you know, I recognize -- I'll stay in my -- you know,  
6 far away from individuals. So that's one -- that's one  
7 potential harm.

8 So, yes, the net effect on average is the average  
9 person who is masked won't maintain as much distance,  
10 and so if they are transmitting, that could potentially  
11 be an issue. And then the other is that the contact  
12 that I just mentioned with the mask.

13 So, again, I simply -- I just am not concerned  
14 about asymptomatic or healthy people, period. But --  
15 so -- but if anything, the net result of masking --  
16 that's what I'm saying is especially if you're  
17 symptomatic, that's where the mask can stop the  
18 droplet -- the droplets, but there especially, you have  
19 to be very careful. Again, you know, if you're going  
20 to the workplace in, like I said, that I have, I have  
21 multiple masks that I change regularly, and, again, I'm  
22 mindful because I've been trained in this concept of,  
23 you know, sterile technique in the microbiological  
24 world and thinking from that perspective; because  
25 especially if you're symptomatic, you are spewing  
26 droplets into that mask, and it's getting soaked, and

1       it will soak through. This is material that's  
2       absorbant. You can think, especially with a cloth  
3       mask, it'll soak right through. And you can see  
4       that -- the wet stains. And so if you're grabbing that  
5       mask, you're going to dramatically enhance contact  
6       mediated transmission and -- and you have to be, again,  
7       mindful that when you have that mask on, although it's  
8       effective with the large water droplets, you don't want  
9       to go closer to people than necessary.

10           So, yes, you have to be very careful with masks:  
11       You have to recognize the strengths, their limitation,  
12       and you have to maintain other strategies that are  
13       independent from the mask. And by that, I mean, again,  
14       recognizing the inherent weaknesses of the masks and  
15       so, you know, not grabbing them, you know, not touching  
16       them and then, you know, touching others and that type  
17       of thing.

18       Q    So in your opinion, is this part of the reason why,  
19       after a year-and-a-half of masking, the cases and the  
20       infections just keep going up?

21       A    Yes, yeah. It's ineffective in the context of  
22       controlling the spread of SAR-Coronavirus-2. Again, I  
23       can't emphasize that enough. I use my own workplace as  
24       an example. We've prided ourselves on the fact that  
25       well over 99 percent are vaccinated, and I can tell you  
26       that the messaging both from the president of my

1 university and the Medical Officer of Health, who has  
2 presented in multiple town halls, have told us,  
3 although, again, it's -- this is -- it's often  
4 difficult to comment as a scientist, because there's  
5 the publicly acknowledged message, and then there's my  
6 message as a scientist, but --

7       So their message has been that the vaccines are  
8 excellent at protecting people, break-through  
9 infections are very rare, and it either prevents  
10 transmission or reduces that -- the number of viral  
11 particles that get transmitted, so excellent at overall  
12 trying to prevent transmission. So that's my campus  
13 community, more than 99 percent fall into that  
14 category.

15       And -- but everybody is still doing the exact same  
16 masking and the physical distancing, and yet  
17 SARS-Coronavirus-2 has ripped through our community.  
18 We recently had two -- two of our residences with  
19 outbreaks, declared outbreaks of -- so, you know --  
20 and, again, I always find it difficult. So the public  
21 messaging was those are outbreaks of COVID-19. What  
22 they really were outbreaks of people identify -- who  
23 had positive test results for SARS-Coronavirus-2. I  
24 can tell you the majority of the students, you know, we  
25 had no deaths. The vast majority of the students had  
26 mild cold-like symptoms for a couple of days.

1           I can also give you the example at my son's high  
2 school, the same Medical Officer of Health recently  
3 declared an outbreak at his school. One of the cases  
4 was confirmed, where sequencing was done, to confirm  
5 that it was Omicron. And so the whole school was shut  
6 down, right, and everybody went home. In that case,  
7 the individuals both had -- they reported mild  
8 cold-like symptoms for three days and then recovered.

9           But the whole point being in that school again,  
10 this is high school, so they've been actively promoting  
11 vaccination. It's not nearly close to a hundred  
12 percent, like in the university, where it's been --  
13 people are not allowed on campus if they're not  
14 vaccinated, but a large profession, and masking every  
15 day, right?

16           So this is all evidence -- and so that -- and  
17 again, I'll emphasize again, Omicron, that wave in  
18 terms of the number of people who tested positive for  
19 SARS-Coronavirus-2, it dwarfed, I mean, it shattered  
20 all previous records, you know, that we had in all  
21 previous waves, and this is despite not only the  
22 masking and the physical distancing that was there from  
23 the beginning but added to it what we hoped was this  
24 super strategy of vaccinating everybody. So even with  
25 that thrown on board, the masks have not stopped the  
26 spread.

1           So my professional opinion is and has been from  
2           the beginning that the way we're using these masks is  
3           not appropriate, it's not going to stop the spread, and  
4           worse, that there are harms. Again, I am not concerned  
5           in the context of symptomatic [sic] people, the masks  
6           necessarily promoting harm of spread because they're  
7           asymptomatic, they're not sick, but there are inherent  
8           harms to the mask itself, to individuals wearing them.

9           Would you like me to talk about that at all; is  
10          that something that's relevant?

11       Q   Well --

12       A   I have that in my report. I have it in my report if  
13          you're interested.

14       Q   No, and I see that. Well, I mean, you seem to talk  
15          about -- well, let me ask you this: This fact that  
16          masking potentially actually increases the spread of  
17          SARS-Coronavirus-2, would you identify that as a harm?

18       A   Yes.

19       Q   Now, I know you identified the harm of low oxygen  
20          levels, but you also, which I found interesting, you  
21          mentioned the harm of muffling speech and inhibiting  
22          communication between individuals. Do you identify  
23          that as a significant harm?

24       A   Yes, yeah. So I live in the world of special needs. I  
25          have two children with special needs, one of them does  
26          have speech difficulties. He has Down Syndrome, so I'm

1 around individuals with special needs all the time.  
2 I've interacted as a parent supporting work done by a  
3 speech therapist. And one of the things that I can  
4 tell you that has been particularly difficult, his  
5 speech through the speech therapy and also through  
6 sheer hard work, especially through my wife, his speech  
7 has dramatically improved, but this improvement has  
8 largely happened over the last couple of years. You  
9 know, he's in his formative years, he just turned 12.

10 It was exceptionally frustrating for him early on  
11 in the pandemic and frustrating us as parents to  
12 observe, because what a lot of people don't realize  
13 that when it comes to Down Syndrome, a lot of  
14 individuals have difficulty speaking. The best way to  
15 explain or for people to experience what it's like if  
16 an individual has Down Syndrome to try and speak is  
17 there's physical reasons for this. They tend to have  
18 smaller than average mouth cavities and larger than  
19 average tongues, size of tongues, often length. So I  
20 mean, my son, if he sticks out his tongue, a little bit  
21 like a snake, so long, but also very thick, and this  
22 combines to make it hard for them to speak like many of  
23 us. Again, it's difficult for him to physically get  
24 his tongue behind the teeth or the roof of the mouth,  
25 for example, because of the length and because of the  
26 size. So it's like if we were to stuff a couple of

1 marshmallows in our mouth and then try and talk, it  
2 muffles the speech.

3         So he had difficulty being understood at the best  
4 of times, and with the mask on, that further muffles  
5 the speech. So he went through a period where he  
6 progressed so well with his communication in school,  
7 and all of a sudden, for a long period of time, his  
8 teachers lost the ability to understand him for quite a  
9 while, and he had to learn with the mask to speak  
10 louder and to learn to annunciate even better to get  
11 that back.

12         So it was very hard for that -- to see that step  
13 backwards. You know, you have to understand for an  
14 individual, especially a young person, to lose the  
15 ability to communicate your thoughts and feelings  
16 becomes very difficult. So that's just an example on  
17 that side.

18         Even in terms of muffling the speech, so, again,  
19 I'll give an example to try -- you know, to try and  
20 convey, you know, an example of -- that we might be  
21 able to familiarize ourselves with. I personally like  
22 watching professional basketball. The Toronto Raptors  
23 are my favourite team. If anybody has watched the  
24 Toronto Raptors, one of the things that you'll know is  
25 that their coach, Nick Nurse, has got himself into  
26 trouble multiple times throughout the pandemic. He



1 always wears the mask, and he's always taking his mask  
2 off, and he gets in trouble for it, you know, people  
3 from the public complain that he's not wearing his mask  
4 or not wearing it properly. And the reason he gives  
5 every single time is he's the coach, he's trying to get  
6 critical instructions to his players, and they can't  
7 hear him or understand him. And you'll see it, it will  
8 be in the heat of the moment of a game, and he's trying  
9 to get instructions to his players, and that's when he  
10 pulls his mask off and is giving instructions to his  
11 players, and then he'll put it back on.

12 And that's the case, you know, we've all -- I'll  
13 tell you in the context of teaching, we've really had  
14 to adopt the whole concept of using microphones,  
15 because it's even very -- more difficult to project our  
16 voices to the back of the classroom. So, yeah, muffled  
17 speech definitely has that in impairing the ability to  
18 communicate.

19 MR. MAXSTON: Dr. Bridle and Mr. Kitchen, my  
20 apologies for interrupting, but I think we've gone a  
21 little far afield of the qualifications of this expert  
22 when we're talking about communication. We're here to  
23 talk and hear from him about transmission and efficacy  
24 and those kinds of things. I'm not trying to be  
25 unsympathetic to your comments, Dr. Bridle, but I think  
26 you haven't been called as an expert to talk about

1       those things.

2       A     Can I comment about the specific comments I had in my  
3       report?

4       MR. MAXSTON:                   I'll leave that up to the  
5       Tribunal.  It depends on what question Mr. Kitchen asks  
6       of you, but, again, I'm not trying to be difficult  
7       here, but you were qualified to speak about the  
8       transmission and efficacy of masking and physical  
9       distancing, and I don't think we're here today -- I'm  
10      not trying to be difficult, but I don't think we're  
11      here today to talk about communication problems --

12     A     Okay --

13      MR. MAXSTON:                   -- and those types of things.

14     A     -- and I respect that.  I'll wrap up then with  
15      something that definitely is in my realm of expertise,  
16      so --

17      MR. MAXSTON:                   I'll let Mr. Kitchen decide  
18      what he wants to ask you next maybe, but I just wanted  
19      to be clear we shouldn't go too far off what you were  
20      called to testify about.  So I might have an objection  
21      to what you're about to say too, if it's going to be in  
22      the same vein.

23      MR. KITCHEN:                   Well, let me jump in.  I have  
24      two comments:  One, Mr. Maxston, let me know if you're  
25      going to apply to strike that, because we'll have to  
26      deal with that.  Two, it doesn't take expertise to do

1        what he's doing: He's observing reality as a  
2        scientist. You know, if he told me that clouds were  
3        made out of water droplets, it's the same as saying  
4        that masks muffle speech. So I don't think it requires  
5        any expertise, but, nonetheless, I take your point.

6        Q    MR. KITCHEN:                        So, Dr. Bridle, let me ask you  
7        this: What would you identify as the three most severe  
8        harms of masking? Oh, hold on, you're muted.

9        A    Okay, yeah, I listed quite a few. Let me just go to  
10       these points if you don't mind.

11       Q    Yeah, I'm on page --

12       THE CHAIR:                        Excuse me, Dr. Bridle, what  
13       page are you on in your report?

14       A    Actually, I'm looking for the page right at the moment.  
15       Okay, so page 8 would be one. So page -- I've listed  
16       my concerns about the masking and potential harms on  
17       page 8, and then also I would like you to refer to page  
18       14, where I have some additional ones, and one that I  
19       would highlight perhaps is one of my biggest concerns,  
20       as Mr. Kitchen had indicated.

21                First of all, related to this, there's something  
22       that I was hoping to have the opportunity to say, it's  
23       directly related to this, in the expert report from  
24       Dr. Hu that I was able to look at, there was an  
25       accusation made against me actually with respect to  
26       these harms. Can I just address that for a moment?

1 Q MR. KITCHEN: Well, that's fine with me, but  
2 my friend might take issue with that, and I can  
3 understand why.

4 MR. KITCHEN So, Mr. Maxston, I was going  
5 to ask him a question on that. If you want me to hear  
6 him [sic] ask the question, I can do that if that's  
7 helpful to you.

8 MR. MAXSTON: Well, that might be helpful.  
9 I think it's fair for your client to comment on  
10 Dr. Hu's report, but I think it depends on the extent  
11 of your question or the type of your question.

12 A Okay, what I would like to do, if you don't mind, I'll  
13 just read something of the report and then see if  
14 you're okay with me just commenting on it. Just let me  
15 find this when it comes to the dangers.

16 Q MR. KITCHEN: Well --

17 A Okay, yeah, so the comment that I want -- the thing I  
18 want to comment on is in the -- Dr. Hu's report on page  
19 8, the one, two, third paragraph down. He says: (as  
20 read)

21 Lastly, both Dr. Dang and Dr. Bridle make  
22 unsubstantiated claims that there are  
23 numerous harms associated with masking.

24 And then states: (as read)

25 There are no known harms associated with  
26 masking.

1           So that is what I was hoping to respond to.

2       Q    Yes, well, I'll let you respond however you like,  
3           but -- well, let me ask you, I take it you would say  
4           that claim is inaccurate?

5       A    Yes, and I provided scientific citations to demonstrate  
6           that that I'd like -- there is one in particular I'd  
7           like to highlight that is clearly within my realm of  
8           expertise, and it's a serious concern that I have.

9       Q    And I want to hear your comments to that, and I --

10      A    Okay.

11      Q    -- invite you to, but I want to also ask you this:  
12           That claim coming from a public health doctor, is it  
13           merely inaccurate, or does it rise to the level of  
14           willful ignorance?

15      A    Well, yeah, that's -- yes, that's why I wanted to  
16           comment on it, and also accusatory, indicating that  
17           we -- you know, that we -- suggesting that we have  
18           failed to -- or that I have somehow failed to  
19           demonstrate harms associated with masking.

20           And, yeah, because there's numerous -- there are  
21           numerous potential harms with masking. So I guess  
22           this -- yes, and so I'll highlight. So if you like, I  
23           can pick three. I can think of two right off the top  
24           of my head, and I can look through the list.

25           But I guess what I would do is bring people to the  
26           attention of those two pages, because I list numerous

1 potential harms on page 8, and I mention several more  
2 on page -- as I said, page --

3 Q 14?

4 A -- 14. So it isn't that I failed to identify, and  
5 these are substantiated, and I have peer-reviewed  
6 scientific publications to back them up, so this --  
7 yeah, that's what I just wanted to mention is that is,  
8 I feel, a very untruthful statement and accusation  
9 against me.

10 So let me go on to some of the major concerns.  
11 I'll start with the hygiene hypothesis. So I just had  
12 been asked to comment on harms with the mask, so this  
13 one focuses on children. But what people need to  
14 understand, and I wrote an article about this early  
15 on -- after one year into the pandemic. I wasn't  
16 concerned when we were told it was two weeks, you know,  
17 and that was the original warning, even if it was a few  
18 months.

19 But after a year, I expressed this serious  
20 concern. It used to be called the hygiene hypothesis,  
21 but the concept is this is that we're designed to  
22 interact and interface with our microbial world. It's  
23 absolutely required for proper physiological  
24 development. For example, many people have shown --  
25 and this has been shown with what we call  
26 gnotobiotically delivered animals, so animals that have

1 no microbiome whatsoever. Behaviours are fundamentally  
2 altered. They have the -- the development of the  
3 central nervous system is altered. But one of the key  
4 things is the immune system does not develop properly  
5 if we don't have proper interaction, as we are growing  
6 up with the microbial world.

7       So a lot of people don't realize when we're  
8 born -- so, first of all, when we're born, we are  
9 immunologically naive. Unless there was some kind of  
10 in-utero infection, meaning infection of the fetus  
11 while in the mother, then when born, the vast majority  
12 of us are immunologically naive: We have not been  
13 exposed to anything in the microbial world up to that  
14 point.

15       But further -- so that means that our immune  
16 system learns to interact with the immune system  
17 following birth. Further, and because of that -- and  
18 actually because of that and to have that opportunity  
19 to learn what is dangerous and what is not dangerous in  
20 the microbial world, our immune systems do not reach  
21 full maturity, they are not fully developed until about  
22 the age of 16, and the vast majority of that  
23 development occurs between birth and the age of 6

24       And what we know is that if and especially young  
25 people are not allowed to be exposed on a regular basis  
26 to the microbial world, their immune system does not

1 develop properly, specifically the ability to  
2 differentiate between the non-dangerous microbes that  
3 we encounter all the time and the genuinely dangerous  
4 pathogens. And it's only the latter we want to respond  
5 to, because if you can imagine if we -- if our immune  
6 system is what we call dysregulated, and it thinks that  
7 non-harmful microbes are worth responding to, that's  
8 very dangerous, because we have non-harmful microbes  
9 all over and inside our body.

10 An individual who responds inappropriately, for  
11 example, to -- and it's -- and it's many things, it's  
12 in our environment, it's even the food that we sample,  
13 the air that we breathe, the dust particles that we're  
14 exposed to in the environment. If we're not adequately  
15 exposed and our immune system learns to tolerate these  
16 things, not respond, then we can end up with problems  
17 like chronic inflammation in certain locations.

18 So, for example, if somebody were to develop a  
19 food allergy, right, that food is something we should  
20 be tolerized against, that you're going to have chronic  
21 inflammation in the gut when exposed to it, or if you  
22 haven't been properly exposed to the environment, so,  
23 for example, a lot of people who are mainly -- you  
24 know, grow up in urban areas might have more of a  
25 propensity towards things like hayfever, because when  
26 young and their immune system was learning to



1 differentiate the dangerous things in our environment  
2 from the non-dangerous things, they weren't exposed to  
3 some of these things that you're exposed to in a rural  
4 environment.

5         And so what -- and so this is very important, and  
6 the reason why this is important is because one of the  
7 things that masks are exceptionally good at filtering  
8 out are large particles, like I said, large water  
9 particles, that also includes dust particles, so  
10 environment -- things we are exposed to in the  
11 environment that are not dangerous and also bacteria,  
12 especially bacteria. And a lot of this development is  
13 not actually around the virome that populates the body,  
14 but it is, in fact, the bacterial.

15         So, for example, in these gnotobiotic animals that  
16 have no microbiome whatsoever, if you want to correct  
17 the behavioural deficits that they will develop and the  
18 immunological deficits, we can repopulate their gut,  
19 for example, with a lot of these what we call like  
20 probiotic bacteria, the same ones you would get in  
21 yogurt, like lactobacillus, for example, so it's  
22 largely these bacteria, these non-harmful bacteria that  
23 allow us to, you know, to educate our immune system.

24         Without that, what happens is a child's immune  
25 system tends to become dysregulated, never learns to  
26 differentiate properly, and individuals are at a much

1 enhanced risk of developing autoimmune disease --  
2 anything that's disassociated with an improperly  
3 regulated immune response. So allergies, which is  
4 responding to non-dangerous things in our environment  
5 and causing inflammation against them; asthma is when  
6 you're responding to inert things in the air that you  
7 inhale and responding inappropriately to those, that  
8 cause asthma; and autoimmune diseases.

9 And so, and we know this is the case, because so,  
10 for example -- and this is largely looking at those who  
11 grew up largely in urban centres versus those who grew  
12 up on farms. Those who grew up on farms are much more  
13 exposed on a regular basis to a rich microbial  
14 environment. And so those who grew up in these urban  
15 area -- or, sorry, rural areas have a much lower  
16 incidence overall of allergies, asthma, and autoimmune  
17 diseases.

18 And so by -- so, again, by putting these masks on  
19 children, first of all, they're not at high risk of the  
20 most severe outcomes of SARS-Coronavirus-2, and I've  
21 already explained one of the physical reasons, they  
22 just don't -- simply don't express the receptors at  
23 nearly the concentration that adults do in their lungs  
24 that the virus uses to infect. But we have put masks  
25 that are effective at isolating their lungs from the  
26 microbial environment, and we, of course, isolated

1    them, kept them away from their friends, a lot of  
2    family members, and a lot of social interactions.  
3    Literally, for children, it's a good thing to get  
4    dirty, to get dirty, to have dogs lick their faces, to  
5    hug other people, that their immune systems need to  
6    interact with other microbiomes in order to develop  
7    properly. So that is an immunological concept that  
8    long-term masking -- and, again, nobody has any  
9    concern. I mean, kids get sick, and maybe they're at  
10   home, relatively isolated for a couple of weeks. It's  
11   not a problem if it's a couple of weeks or it's a  
12   couple of months. But once we start -- I wrote my  
13   article first about my serious concerns about that a  
14   year in. A year is getting too long. A year is a  
15   substantial amount of immunological development in a  
16   young person. And now we're at two years with no  
17   current end in sight. So that is a serious potential  
18   harm. By masking children, we are potentially, there's  
19   no question, we're going to have an unknown number of  
20   children with allergies, asthma, and autoimmune  
21   diseases in the future, and they're going to have those  
22   for the rest of their lives because we masked them for  
23   two-plus years. So that's one.

24           And then I guess another one that I would mention  
25   is this idea of carbon dioxide, because this is just  
26   intuitive, so, you know, fire fighters have the

1 equipment to do this. At my university, we have the  
2 ability to do this, look at CO2 levels, and we often do  
3 that when looking at how we adjust the air change rate  
4 in our rooms, especially the work rooms we work in a  
5 lot, like the laboratory space that we're in, the  
6 animal research rooms that we're in.

7 And so if you monitor the carbon dioxide level in  
8 front of your mouth without a mask and then with a mask  
9 on, it goes up. And this makes intuitive sense,  
10 because what you're doing by putting a mask on your  
11 face is you are restricting, you know, the free flow of  
12 oxygen. What you're doing is you're creating an  
13 additional dead space. When we exhale, when we exhale,  
14 there's always dead air. We cannot get all of the air  
15 out of our lungs, and we can't get all of the air out  
16 of our mouth. That's dead air. When we inhale, that  
17 dead air, when there's not been fresh air exchanged,  
18 gets inhaled back into the end of the lungs.

19 By -- so by putting on a mask, you're extending  
20 that dead air space a bit, and so it does increase the  
21 carbon dioxide level a little, not a lot, a little, and  
22 this creates a condition of very mild hypoxia, it's not  
23 severe hypoxia, but if you have high carbon dioxide,  
24 then the net result is you have slightly higher --  
25 lower oxygen levels. But, again, slight changes in  
26 oxygen concentration we know can have profound

1 physiological consequences.

2         So, for example, on the positive side, endurance  
3 athletes, especially if they know they're going to have  
4 to compete at a higher elevation will often go to train  
5 in areas with a higher elevation. There's not a  
6 massive change in the oxygen concentration, but by  
7 going there for a long period of time, being exposed to  
8 that lower oxygen concentration and training in that  
9 environment, their body gets more efficient at the  
10 oxygen exchange. Then they can perform better in the  
11 sporting activity at a higher elevation.

12         But so we're kind of expecting this from  
13 individuals. So we're putting masks on -- again, I'd  
14 like to emphasize, masks make sense if you're going to  
15 wear it to go into work for, you know, a little bit of  
16 time because you have to meet a deadline, but you're  
17 sick. They make sense when you're doing surgical  
18 procedures. You're doing a limited procedure, you  
19 leave, you take the mask off. They're not designed to  
20 be left on for long periods of time and exposing people  
21 to chronic low levels of hypoxia.

22         And, again, I'd like to highlight this is just  
23 kind of intuitive in the sense that -- like I know for  
24 myself, if I wear -- and I wear masks all the time  
25 except for surgical intervention stuff, but if I wear a  
26 mask for several hours, I start developing a headache,

1 constant thing and consistently. I need to take a  
2 break; I need to get out in the fresh air.

3 And I would encourage anybody, if -- just focus,  
4 put on the mask and go outside, because often that's  
5 where the air, you know, seems the freshest and  
6 everything, keep your mask on and take several deep  
7 breaths, right, and pay attention to what it feels  
8 like. Then take that mask off and take in a big deep  
9 breath; it feels so refreshing. And that's why,  
10 because we are impacting, albeit to a small degree, our  
11 ability to gas-exchange, by taking off that mask, we're  
12 removing some of the dead air space that we've created;  
13 we're reducing the dead air space.

14 And this has -- because we've never done this for  
15 such a long period of time, we simply don't actually  
16 know the extent of harm that we might be causing,  
17 especially to developing children again, I'd like to  
18 highlight, right, this constant, prolonged exposure to  
19 low-level hypoxia it might be causing.

20 So I think I'll leave it at that, if that's okay,  
21 Mr. Kitchen. I -- I mean, I could look through and  
22 provide another one, but those are probably my two top  
23 concerns at this point in general.

24 Q Thank you. I am going to try to bring you through  
25 pretty quickly, I want to give my friend a chance to  
26 cross-examine, and we are down to, you know, roughly

1     only two hours left.

2     MR. KITCHEN                             Well, Mr. Maxston, let me ask  
3     you this because I want to be mindful of this. How  
4     much time do you think you're going to want for  
5     cross-examination?

6     MR. MAXSTON:                         Mr. Kitchen, I expect I'd  
7     be -- and this is not a criticism of Dr. Bridle, but he  
8     seems to give expansive answers -- so thank you,  
9     Dr. Bridle, for that -- I would anticipate 20 minutes,  
10    maybe a little longer just because of the nature of the  
11    answers, but I don't think I'll need terribly long.

12             I'll leave it up to you in terms of how much you  
13    think you'll want to be, but it may be time to take a  
14    break right now as well, given how long you've been  
15    asking questions.

16    MR. KITCHEN:                         Yeah, yeah, I agree.

17    THE CHAIR:                            Yeah, it's, by my watch, 5 to  
18    3, so let's take 15 minutes, and we'll come back at 10  
19    after 3 and resume then, okay?

20    MR. KITCHEN:                         Thank you.

21    THE CHAIR:                            Just a reminder, Dr. Bridle  
22    you're still under oath.

23    (ADJOURNMENT)

24    THE CHAIR:                            And, Mr. Kitchen, we'll turn  
25    it back to you.

26    MS. NELSON:                           Sorry, Mr. Kitchen, we can see

1       you talking, but we actually can't hear your audio.

2       MR. KITCHEN:                    Sorry, I have a mute button on  
3       my mic, so I apologize, so you missed --

4       MS. NELSON:                    No worries.

5       MR. KITCHEN                    -- the last 10 or 15 seconds,  
6       sorry.

7       Q   MR. KITCHEN:               Dr. Bridle, I just have some  
8       specific questions about comments that Dr. Hu has made  
9       both in his report and in questioning.

10               Dr. Hu has stated that every country that has  
11       imposed masking has experienced decreased transmission  
12       of COVID; do you disagree with him?

13       A   Yes, I do. I'll point out again, you know, like -- you  
14       know, my expertise isn't epidemiological per se, but as  
15       a researcher, I certainly am qualified to look at the  
16       scientific literature and interpret some basic data.

17               I do know of numerous countries where the opposite  
18       is true. And, in fact, when we look at the United  
19       States, we see states where that trend is the opposite  
20       as well. I know that Dr. Hu did not like the example  
21       of Sweden, but I mean that is an example. He didn't  
22       seem to cite any science to -- he just said it's, you  
23       know, complex to interpret the reasons for observing  
24       differences, but, nevertheless -- and he didn't dispute  
25       either that Sweden is a classic example of, you know, a  
26       country where they went the natural immunity route, and



1       seem to have done just fine, and there's other  
2       examples. But, yeah, so, in other words, that all we  
3       need is one example to say that that is not true. So I  
4       do disagree with that overgeneralization.

5     Q   You just called it an overgeneralization. So is that a  
6       fairly absolute statement?

7     A   Could you remind me what page of that report is it on,  
8       just so I can look at it myself?

9     Q   I'm quite sure he said that in questioning, not in his  
10       report.

11    A   Oh, can you repeat --

12    Q   I do know --

13    A   -- (INDISCERNIBLE) --

14    Q   -- that he said it --

15    A   -- so could you repeat it again, please?

16    Q   So he said that every country that has imposed  
17       mandatory masking has experienced decreased  
18       transmission of COVID.

19    A   Okay, so, yeah, that's not an overgeneralization,  
20       that's incorrect. Again, when somebody has said  
21       "every", and all we need is one example where they  
22       didn't do it, and the -- you know, the outcome has been  
23       fine, like Sweden, so that makes it not just an  
24       overgeneralization, it makes it incorrect.

25    Q   Do you find it unusual that he makes such an absolute  
26       statement?

1     A     Yes.  So in the sciences -- so I even mentioned this  
2           before when I was giving examples of -- when we were  
3           talking about asymptomatic and transmission, right,  
4           I -- there is asymptomatic transmission.  It's not  
5           common, and it's not a driver in this.  And when I  
6           mentioned, when I talked about that, is when you're  
7           dealing with biology, there are no absolutes.  Biology  
8           is not an absolute science.  It's not black and white.  
9           It's not like mathematics, it's not like chemistry,  
10          it's not like physics.

11                 Biology, there are general ways that, you know,  
12           biological systems function, and there's almost always  
13           exceptions to the rule.  So there's what the dominant  
14           biology is, and then there's always exceptions to the  
15           rule.  So very rarely, if ever, can you make definitive  
16           statements like that when it comes to biology,  
17           especially when you're talking about fairly complex  
18           biology.  Because here, we're talking about -- we're  
19           not even talking about one biological system, like  
20           people, like humans; we're talking about the  
21           biologic -- the biology of people interfacing with the  
22           biology of a virus in the context of a complex  
23           environment.  So there's absolutely no way you can make  
24           absolute statements like that in the context of this  
25           current medical scenario.

26                 That's -- so, again, that's the -- you know, so as

1 a scientist, that's not the appropriate scientific  
2 approach. One has to be open to the fact that there  
3 are exceptions. What we always have to do, and also to  
4 explain, the way science and medicine is supposed to  
5 function is we should -- we need to weigh the weight of  
6 the overall evidence.

7       Again, because there often are not absolutes,  
8 often things are not intuitive or common sense, what  
9 often happens is -- I mean, so it's very clear in  
10 science, if somebody put -- as soon as -- so the first  
11 time a paper is published, that's obviously the first  
12 report on a given scientific issue, so it sets the  
13 tone. At that point, that becomes what the scientific  
14 community agrees at that point in time, early point in  
15 time, seems to be the reality. If the subsequent  
16 scientific literature is all in agreement, that's  
17 something that usually then gets enshrined in science  
18 as a -- as, you know, sort of as a classic paradigm in  
19 science. But as soon as you have disagreement, say the  
20 second publication find -- finds something different,  
21 at that point, you automatically need additional  
22 research to be done to sort out the problem.

23       And so at the end of the day, it's never about --  
24 and so especially one thing to keep in mind, you know,  
25 my advice to everybody with this is there's a lot of  
26 science that has accumulated over the past two years,

1       and, therefore, it's always about the weight of the  
2       science. They're not about citing one paper or, you  
3       know, two papers or selective papers. One has to look  
4       at the overall weight of the evidence, like on scales,  
5       and see what the balance of that evidence is. So,  
6       yeah, just by the very nature, we can't, in this  
7       scenario, make such conclusive statements.

8       Q   To give Dr. Hu, to properly and fairly characterize his  
9       position -- and my friend can interject if he disagrees  
10       with me -- Dr. Hu has said the evidence for the  
11       effectiveness of masking in reducing the spread of  
12       COVID-19 in a health care setting is overwhelming, and  
13       there's heaps and mounds of it. And then he says in a  
14       non-health care setting, well, it's less clear. He  
15       makes no distinction between asymptomatic or  
16       symptomatic; he simply says in a health care setting,  
17       it's guaranteed to work, we know absolutely it works,  
18       there's just no question, maybe there's a question  
19       about the community.

20               What I've heard you say is, Well, look, it doesn't  
21       work at all for asymptomatic people, it's just -- it  
22       just doesn't -- it's not even relevant, it's not even  
23       logical because they just don't spread it because  
24       they're asymptomatic, there's no asymptomatic spread.  
25       So, you know, you two, as experts, you're kind of  
26       talking at cross-purposes.

1           So I want to ask you about the health care  
2       setting, okay, and then the non-health care setting,  
3       because that's how he's done it, okay, to be fair to  
4       him.

5           So he says that the evidence for the effectiveness  
6       of masking in the health care setting is, quote,  
7       Overwhelming, and, quote, There's heaps and mounds of  
8       it. Would you agree with that or disagree?

9    A    Yeah, we wouldn't be here today hearing this case if  
10   there was universal agreement and if it was  
11   overwhelming evidence. This is an area of active  
12   debate. It's an area of active research. I looked at  
13   Dr. Hu's report, because the other experts have  
14   provided that. Where the misunderstanding comes in is  
15   this concept of asymptomatic transmission and this  
16   misnomer, this concept.

17           Where it's been most exaggerated, for example, is  
18   children. We've mislabelled children as somehow being  
19   these individuals that rarely get sick but are  
20   overflowing with large quantities of this incredibly  
21   pathogenic virus, right, so they can spread it to  
22   others. That's simply not the case.

23           So, again, I highlight, Dr. Hu and I are not far  
24   off in our view of masking. We're in complete  
25   agreement that masking makes sense if you're  
26   symptomatic, and it can very much help as a tool to

1 curb the spread if you're symptomatic, and you're  
2 choosing to go around other individuals in that state.  
3 But not asymptomatic.

4 I mean, this is again, intuitively, I guess, you  
5 know, again, to put it in a perspective that maybe the  
6 average layperson could appreciate, knowing what I told  
7 you about the Omicron variant, where the reality is the  
8 average flu is more dangerous than the Omicron variant  
9 for the vast majority of the people, especially the  
10 very young, for which SARS-Coronavirus-2 is not  
11 particularly dangerous, but, you know, we've never  
12 implemented this, if this asymptomatic transmission was  
13 always such an issue, and we were to accept this now as  
14 a paradigm, we'd have to apply this to every -- every  
15 infection -- we would never -- we would never know if  
16 somebody is ever, quotes, healthier or unable to  
17 transmit to anybody else. There would be no way of me  
18 knowing of somebody else who has no signs or symptoms  
19 has, you know, in their lungs, respiratory syncytial  
20 virus or a flu virus or Norwalk virus or any of the  
21 viruses that we face. So just from that perspective,  
22 it's counterintuitive.

23 And this is definitely within the realm of  
24 immunology, and it comes largely from a  
25 misunderstanding -- and, again, you know, with all due  
26 respect, the average physician who has been in a

1 position of authority, you know, to implement policies,  
2 and this is one of the reasons why -- a lot of people  
3 don't realize it, and this is an area I have expertise  
4 in as well because we have an emergency preparedness  
5 plan in our university for responding to a pandemic.  
6 We were required to implement this by the Government  
7 following the 2009 flu, declared swine flu pandemic,  
8 where people realized that there was initially -- the  
9 response was one of panic and realizing that we really  
10 did not have a coordinated response, we hadn't really  
11 prepared for such a scenario. Now, that turned out --  
12 that fizzled and that was not a true pandemic.

13 But so all the -- the Government made all publicly  
14 instituted -- institutions, including my university,  
15 come up with a pandemic preparedness plan. Our country  
16 came up with a pandemic preparedness plan. Every  
17 province and territory was required. We threw these  
18 out within the first week to two. At my institution,  
19 we threw it out within five days of the pandemic being  
20 declared, and we haven't been following any defined  
21 plan since.

22 And that applies at the Federal level as well.  
23 We -- like, if you look, we still don't know what the  
24 goalposts are. We don't know what the finish line is  
25 before we declare that we're out of this. In fact, the  
26 goalposts have kept moving.

1           And what I can tell you is that in those pandemic  
2       preparedness plans, none of them looked like this at  
3       all. They relied on the more traditional ways that we  
4       approach this kind of problem, which was you treat  
5       people who are sick as sick, and you keep them away,  
6       especially from the vulnerable populations, and you  
7       focus your protective efforts and your protective  
8       measures on the high-risk demographics if, if, and when  
9       a pathogen shows a predilection towards causing harm in  
10      limited demographics. And so, you know, we haven't  
11      reached that point here. You know, we didn't follow  
12      those kind of plans, and so this is where we've come in  
13      with these other approaches.

14           And what I do want to point out then is --  
15      actually to get back on track, Mr. Kitchen, can you  
16      remind me what your core question was? I was just  
17      coming to it, and I wanted to find something in the  
18      report here.

19    Q      Well, like I said, Dr. Hu says, end quote, heaps and  
20      mounds of evidence supporting the effectiveness of  
21      masks in --

22    A      (INDISCERNIBLE)

23    Q      -- a health care setting --

24    A      -- yes, and so -- so, no, that is a point of  
25      contention, and so his report even highlights this. So  
26      one of the things -- I mean, he hasn't -- he hasn't



1     cited heaps and mounds of evidence. It's a limited  
2     number of citations.

3             And this is -- so this is something that I want to  
4     deal with head-on just so that people, when  
5     interpreting the two reports, can understand. He  
6     accused me of solely leaning on outdated documentation,  
7     or maybe not solely but certainly leaning on outdated  
8     documentation when it came to my report. People are  
9     free to look at my reference section. I have lots of  
10    updated citations in there.

11            I want to highlight that, in fact, after accusing  
12    me of using outdated literature, the two things that he  
13    most emphasized when talking about this -- when talking  
14    about this concept of masking, the first one was a  
15    citation from 2011. So he actually set the record for  
16    the oldest cited paper with respect to masking and  
17    citing the one from 2011, a Cochrane review. And so --

18            Oh, and the other thing he said is he accused me  
19    of using examples from other viruses. And I want to  
20    point out that this 2011 one is the oldest -- second  
21    oldest reference of all the reports about masking and  
22    dealt with influenza virus, not SARS-Coronavirus-2.

23            And one where he spent half of a paragraph  
24    highlighting it was actually to describe what he felt  
25    was, you know, sort of break-through work that was  
26    done, and it's a study that was done in the early

1 1900s, which shattered records in this in terms of the  
2 oldest citation, and that certainly wasn't dealing with  
3 the SARS-Coronavirus 2.

4 So he's got that aspect wrong in terms of arguing  
5 that he's got the updated literature. And, in fact, I  
6 just want to highlight this as well, because this is  
7 overstated again, he actually said in his report, on  
8 pages 1 -- at the very end of page 1, the final last  
9 few words, onto page 2, he said: (as read)

10 A vast majority of literature [this means his  
11 literature] is from the years '20 to '21 with  
12 emphasis on literature published in 2021.

13 So I actually went to his reference section, because,  
14 again, I do lots of review of, you know, scientific and  
15 medical documentation, and I excluded some of these  
16 because they're not peer-reviewed articles. A couple  
17 of them are websites. One of them was a website where  
18 he -- that described the 2011 paper, the source of the  
19 2011 paper that he got.

20 And so, in fact, it turns out that of his  
21 citations, 19 of his citations about masking, of those  
22 19, 11 were from 2020 to 2021. That's 58 percent. So  
23 that's not a vast majority of the literature. And he  
24 then emphasized that most of it was from 2011. Well,  
25 in fact, only two of those is 11 -- sorry, two, the  
26 emphasis was on literature published in 2021, but only

1 two of those 11 papers were from 2021, 18 percent of  
2 the papers cited since 2020 were from 2021.

3 And so I think it's important, again, otherwise,  
4 it gives a misconception that somehow he's captured the  
5 recent, cutting-edge data, and I have -- again, people  
6 are free to look through -- I've got plenty of  
7 citations from 2020 to 2021, so that's not the case.  
8 It's not -- this isn't the case of somebody having --  
9 understanding current literature, and somebody else,  
10 myself, not understanding the current literature and  
11 only focusing on historical literature. I want to  
12 point that out.

13 Further, he even states in this, if I can find it  
14 here, and this is important because this is a very  
15 important thing for us to understand, because we're all  
16 hearing public messaging, and we're all trying to sort  
17 through this information and understand, and there is  
18 lots of misinformation, there's genuine information,  
19 and there's been messaging that's been changing over  
20 the course of this. And so this is very important  
21 because one of his critical sources of information  
22 about this are public health officials, especially  
23 Dr. Theresa Tam, and that's why I'm hoping I can just  
24 find this here quickly. Where is it?

25 Q He mentions Theresa Tam on page 8. I don't think he  
26 mentions her anywhere else.

1 A Okay, thank you. Oh, Dr. -- sorry, I mean Dr. Tan,  
2 sorry. Do you see the reference to Dr. Tan?

3 Q T-A-N?

4 A Yes.

5 Q 'N' as in "nothing"? No.

6 A Medical Officer of Health. Give me one second, because  
7 this is an important point.

8 Q Okay.

9 A Let me just pull up the document here.

10 Q Do a search on it.

11 A Sorry for the extra time, but I just want to make sure,  
12 because this is important.

13 Q I don't find anything for T-A-N.

14 A Okay, sorry, yes, that's why, I meant Theresa Tam. I'm  
15 getting her Medical Officer of Health, her name messed  
16 up here, it's Theresa Tam, Dr. Theresa Tam --

17 Q Yeah, page 8.

18 A -- so this is on page 8 just before the summary, the  
19 subheading "Summary", and this is when talking about  
20 that that I made unsubstantiated claims, that there are  
21 numerous harms associated with masking, there are no  
22 harms, but we've already discussed that.

23 And then -- this is very important, because --  
24 this is very important here, so what he states in that  
25 last sentence: (as read)

26 Indeed, public health experts, including

1 Dr. Theresa Tam, have walked back any  
2 statements alluding to the potential harms  
3 and increased infection risk of masking.

4 There's no scientific documentation there, so  
5 peer-reviewed literature, and what this is -- so what  
6 he means, what he means, and if we're blunt about it,  
7 is that Dr. Theresa Tam has completely contradicted  
8 herself in the context of this pandemic.

9 And specifically what he's referring to when he  
10 talks about walking back in his statements, it was that  
11 a lot of top public health officials, including  
12 Dr. Tam, Dr. Fauci in the United States, and others and  
13 agencies like Health Canada were actually discouraging  
14 the use of masks and widespread use of masks earlier on  
15 in the pandemic and widespread use of masks earlier on  
16 in the pandemic, and that was because of the scientific  
17 evidence available at the time.

18 So, yes, they later walked back the statements,  
19 and I can tell you that I have yet to know what the  
20 scientific foundation is for Dr. Theresa Tam walking  
21 back that statement. And I point out, as you can see  
22 by the wording here, you can ask yourself, it's not  
23 scientific, I don't know what walking back a statement  
24 actually means. She never rescinded the statement.  
25 Yes, I will agree that she downgraded the -- I guess,  
26 the importance she placed on that, you know,

1 down-playing of masking as an effective protective  
2 strategy in the context of SARS-Coronavirus-2 early on,  
3 but she never rescinded it. She did, indeed, dampen it  
4 or walked it back to some degree. And, again, I have  
5 yet to see, she hasn't produced any peer-reviewed  
6 scientific literature that I've seen.

7       Now this -- so this becomes very critical, because  
8 I'm not going to say -- I can tell you there's lots of  
9 literature to suggest there's harms of masking, and it  
10 doesn't work, and, again, this comes down to the whole  
11 disagreement is about asymptomatic transmission. And,  
12 again, I highlight that in the studies that are cited  
13 to support this, the vast majority of those studies are  
14 defining transmission based on PCR positivity, not  
15 proof -- not demonstrating with using the functional  
16 virology assay that I said, that there is definitively  
17 replication-competent viral particles in the sample,  
18 especially at a concentration that would meet the  
19 threshold required to cause infection in other  
20 individuals.

21       So a lot of those studies actually agree,  
22 potentially, with the outcome that made -- where they  
23 measured what they did, but they didn't prove that  
24 there was transmissibility of the sample that they were  
25 collecting. And so that's what it comes down to is how  
26 we interpret asymptomatic transmission in this.

1 Because like I said, we are all in uniform agreement  
2 that if somebody is sick, this makes some sense.

3 And then the other thing is, which I was very  
4 surprised, because often scientists who have been  
5 speaking out in a way that's perceived to be against  
6 the narrative, one of the arguments that constantly  
7 comes up is, well, you haven't proven your point with  
8 the randomized controlled trials.

9 So I want to explain to everybody, a lot of  
10 people, when it comes to clinical medicine, consider a  
11 randomized controlled trial to be the be-all and  
12 end-all. It's where you actually look at a relevant  
13 clinical setting, and you have your treated group and  
14 your placebo group or untreated group. If you're  
15 talking about masking and SARS-Coronavirus-2, it would  
16 be a compilation in the context of SARS-Coronavirus-2  
17 with the potential for it to be transmitted, and you  
18 would have a population that's masked and a population  
19 that is unmasked, that would be the negative control  
20 group, and then you actually see if there is an effect.  
21 So for everything that has not been accepted in the  
22 public health narrative, it's because there hasn't been  
23 a randomized controlled trial.

24 Let me give you an example. The same Dr. Theresa  
25 Tam told all of Canada that the concept of vitamin D  
26 reducing the potential for infection is fake science.

1 I can believe -- I'm an immunologist. I'm even left  
2 with -- I've actually sent a letter to my  
3 administration university telling me [sic] that am I  
4 going to get in trouble if I continue to teach  
5 immunology like I have during my whole career, because  
6 I can tell you vitamin D is a critical component of the  
7 immune system. There are -- it functions at such a  
8 basic fundamental level with so many aspects of the  
9 immune system.

10 Without it, it would be like if somebody is  
11 familiar with cars and a car engine, it would be like  
12 if you have a high-performing race car, say, a  
13 Formula One race car, there's no question, if you  
14 deactivate one of the cylinders in that engine, it is  
15 not going to perform as well as if it had that cylinder  
16 functioning. It's not going to be competitive in the  
17 race.

18 And that's the case with vitamin D. I mean,  
19 there's thousands and thousands of papers -- I can tell  
20 you -- I can give you 77 citations right now that show  
21 the benefit of vitamin D in the context of  
22 SARS-Coronavirus-2. That's why we have -- one of the  
23 reasons we have our annual cold and flu season. As an  
24 immunologist, I often don't refer to it as the cold and  
25 flu season, I refer to it as the low vitamin D season.

26 THE CHAIR: Dr. Bridle, I'm not sure that



1 vitamin D was really relevant --

2 A No --

3 THE CHAIR: -- to --

4 A -- no, I'll probably be back to it immediately, yes,  
5 thanks, I appreciate that. So my next comment  
6 immediately ties it in.

7 And the point being that it was declared that a  
8 randomized controlled trial, therefore, was needed to  
9 prove the effectiveness of vitamin D in the context of  
10 SARS-Coronavirus-2.

11 And so that's where this ties in. So when you  
12 have an area where there is definitely, clearly, far  
13 more debate going on and the science is -- it's why you  
14 have even more reason for a randomized clinical trial  
15 if you really want to sort out this issue.

16 Now, what I was honestly shocked by is in Dr. Hu's  
17 report, he acknowledged that but then went on to  
18 proceed to argue that a randomized controlled trial  
19 could not be done because this is such a cut-and-dry  
20 topic, because everybody is in such uniform agreement  
21 that masking works in the context of SARS-CoV-2. Well,  
22 clearly, that is not the case. If nothing else, my  
23 expert opinion disagrees with his expert opinion.  
24 There's evidence of nonuniform agreement right there.  
25 And when scientists disagree, we need further research  
26 to work it out.

1           Now, I want to highlight something, because this  
2   is very important to understand, randomized controlled  
3   trials has been -- that's been the basis for promoting  
4   anything to do with treating or protecting from  
5   COVID-19. So what we get to here, and I just want to  
6   go to this now -- I thought I'd have these better  
7   marked -- so I want to get to this where he talks about  
8   the randomized controlled trials, and I think this is  
9   in his rebuttal section. And it talks about -- he uses  
10   a -- an analogy there. Let me see here. Okay, yes,  
11   right here: (as read)

12           With respect to the evidence for  
13           effectiveness of masking [this is on page 7],  
14           Dr. Warren states that in the absence of  
15           evidence for randomized controlled trials in  
16           meta-analyses ...

17   And then it continues on, and that's -- so that's what  
18   he's responding to, this idea of randomized controlled  
19   trials. So he admits it is correct that there are a  
20   few randomized controlled trials on masking, and  
21   there's none in the context of SARS-CoV-2 as -- so  
22   we're talking about a fundamentally different virus.  
23   Then he says: (as read)

24           There is an overwhelming burden of evidence  
25           from other studies showing the benefits of  
26           masking. Furthermore, it's not ethical to do

1           RCTs on masking given its significant  
2           benefit.

3       Well, we've just talked about, there's potential harms,  
4       potentially even in the context of symptomatic --  
5       asymptomatic people, maybe more harm than good. And it  
6       doesn't, for all the reasons I've explained, doesn't  
7       help spread SARS-CoV-2 by the aerosol route. So none  
8       of that fits into play here.

9           And then he goes on to give an analogy that  
10       this -- to say why the randomized controlled trials  
11       can't and should not be done with masking. He says  
12       this is like parachute-jumping out of an airplane. We  
13       wouldn't run a study right now, right, none of us would  
14       ask for a study to be run asking people to jump out of  
15       a plane with a control group that is not given a  
16       parachute, right, and to the test the idea that  
17       parachutes stop people from dying when jumping out of a  
18       plane.

19           Well, this is not a fair comparison whatsoever.  
20       Worse, he got upset about one of the other experts. He  
21       actually says here: (as read)

22           Notwithstanding the factual error on page 6,  
23           it is fallacious and unscientific to equate  
24           death rates by age in the context of a global  
25           pandemic with those of car accidents, with,  
26           at a minimum, it is a false dichotomy and

1           then [et cetera, et cetera].

2       So he was really upset with the use of an analogy to --  
3       due to car accidents with deaths caused by an  
4       infectious agent in the context of a pandemic but then  
5       goes on and uses his own completely, arguably even far  
6       more inappropriate, analogy to argue that RCTs have no  
7       role to play when it comes to considering the benefits  
8       of masking.

9           And what do I mean by this? It's intuitive, I  
10       agree, we're not going to run a study to determine  
11       whether jumping out of a plane without a parachute  
12       increases the risk of dying upon impact with the  
13       ground, and we don't have to. That experiment has  
14       naturally been run multiple times. If people -- if  
15       somebody jumps from a large height, if they want to  
16       commit suicide, they know they can jump from a large  
17       height. Anybody who falls, plunges to the ground from  
18       a large height will experience death. We've had people  
19       with parachutes jump out of planes, and the parachutes  
20       failed to deploy, and they've died. So this is not a  
21       comparison.

22           The equivalent with -- the RC with masking would  
23       be that we know that, in the control group, if they do  
24       not wear the mask, they are going to die. Yes, that  
25       would be unethical. We do not know that. In fact,  
26       we're debating that very fact and whether it's actually

1       doing anything to protect these people from harm. And  
2       so I would actually propose that the precise thing that  
3       we do need scientifically to sort this out and  
4       especially if we're going to force people to follow  
5       this rule, we need to run a randomized controlled trial  
6       and sort out the science once and for all.

7               So again, you know -- I mean, I'm not going to  
8       apologize for the long answer, it's a thorough answer,  
9       and so, no, this is not a clear path. And I'm sorry,  
10      Dr. Hu has not cornered the market on, you know, the  
11      fact that, you know, being be able to state that  
12      everybody knows this, and everybody agrees on this  
13      fact.

14   Q   MR. KITCHEN:               Thank you, Dr. Bridle that  
15       answers several other questions that I had.

16               Since we're in that area on his report, on page 5  
17      of your report in the last sentence of your section on  
18      asymptomatic transmission, you kind of make a summary  
19      statement, you say: (as read)

20               There is no substantial evidence to suggest  
21               that people who are asymptomatic represent a  
22               substantial risk of causing COVID-19 related  
23               hospitalizations or deaths in others.

24      Now, as you know, Dr. Hu takes issue with this issue on  
25      page 7 of his report. He says that you have no  
26      scientific evidence for this statement. He also says

1       the fact that you would make such a statement, quote,  
2       proves a lack of understanding of asymptomatic  
3       transmission and its deadly effects on the community.

4               I have a couple questions on this. My first one  
5       is do you think there's any scientific evidence to  
6       support this statement that you made?

7    A    Okay, that I think I can answer quickly. People, first  
8       of all, can read page 5 of my report, see the citations  
9       that I have there, and then refer to everything that  
10       I've explained today.

11            I understand the science -- so again, with all due  
12       respect, when it comes to asymptomatic transmission,  
13       what we're talking about is we were talking about  
14       fundamental, hard core immunology -- or, sorry,  
15       virology at the interface with immunology. That is  
16       precisely my area of expertise. I'm a viral  
17       immunologist. This has nothing to do with public  
18       health or anything like -- it has public health  
19       implications, but the science behind this, this is how  
20       a host immune system interacts with a virus that  
21       dictates whether or not the outcome is going to be  
22       potential transmission and infection and causing  
23       disease in others. And I mean people can take my  
24       expert, you know, commentary or not. Like I said, I  
25       have the citations there, and I've talked at length  
26       about the science, the precise mechanisms governing

1     this.

2             And just so that you understand, I don't know if  
3     people can see, but I actually appreciate being asked  
4     the question, because I've got that very thing marked  
5     up, so I'm glad I actually got to talk about this,  
6     because, again, I have been called upon to review lots  
7     of literature, grant applications, scientific  
8     publications, right, manuscripts people want to publish  
9     in peer-reviewed journals. And sorry to be blunt here,  
10    but this -- this report from Dr. Hu was and --  
11    generally unprofessional, disrespectful in tone, very  
12    much highlighted here. That's why I have this actually  
13    underlined, because it's quite offensive. He uses  
14    language that is offensive, accusatory. He makes  
15    assumptions. He's hypocritical in areas of his report.  
16    And I can give examples of all of these so -- if I  
17    wish, and this is one of them. And he makes  
18    demonstrable -- you know, many claims that lack  
19    evidence, lacks citations or that are only backed up by  
20    hearsay evidence, and then makes these kind of  
21    statements, right, that as an expert in this area --  
22    and I'm sorry, but looking at the expertise, I am quite  
23    confident that I have deeper expertise in the area  
24    directly relevant to understanding asymptomatic  
25    transmission or lack thereof. And he's actually  
26    arguing that I am provide -- that I have no scientific

1 evidence. That is a lie. That is a lie. I provided  
2 the scientific evidence today. I have all these  
3 citations. I'm looking at page 5 of -- and I see all  
4 kinds of citations listed here and a description of the  
5 science. And he says this proves -- somehow this  
6 proves a lack of understanding. Like this means me,  
7 that I do not understand this.

8 This is unprofessional. I don't do -- write this  
9 way in any of my reports, so I'm sorry, this group  
10 needs to understand this. I have been involved in a  
11 lot of court proceedings. I have been involved in a  
12 lot of scientific proceedings. This is not a  
13 scientifically or medically acceptable document for  
14 interacting with other scientists or medical  
15 professionals, and this highlights it.

16 So thank you, because I didn't know if I'd have  
17 the opportunity to share with the group, but this  
18 statement is -- there's several others, and I'm not  
19 going to take the time, but if anybody has a question,  
20 I can prove what I just -- my overview of his report,  
21 but that is, certainly I had listed, as the most  
22 egregious statement against myself.

23 We have to respect one another as scientists and  
24 physicians. I do respect Dr. Hu's perspective. Like I  
25 said, I agree with much of his science, and I've  
26 acknowledged the peer-reviewed publications that he's



1       used as valid, you know, acceptable scientific  
2       publications. I think we need to be very careful, and  
3       this stepped over the line, in my opinion, in terms  
4       professionalism in this kind of environment.

5       Q   Thank you, Dr. Bridle. I am almost done. I know this  
6       might be obvious, is there an important difference  
7       between correlation and causation?

8       A   Yeah, absolutely. A massive difference. The burden of  
9       proof is vastly higher for causations. Correlation can  
10      contribute to the overall determination of causation,  
11      but causation means that you know for sure that one  
12      thing influences the outcome of another thing, directly  
13      influences it, not, you know, has a direct impact on a  
14      certain outcome.

15                So, for example, we know that SARS-Coronavirus-2  
16      is the causative agent of the disease we call COVID-19.  
17      If somebody is not infected with SARS-Coronavirus-2,  
18      they will not get COVID-19, and if we infect them with  
19      a different virus, they will not get COVID-19. It's a  
20      causative agent, right? So it's a cause-and-effect  
21      relationship.

22                A correlation means that something trends in the  
23      same direction as something else, you know. And a  
24      classic example -- and so I talk about this quite a  
25      bit, because when I teach actually my immunology  
26      students, because it is important to understand the

1 difference, so, for example, when it comes to -- you  
2 know, one of the correlations that does -- that is  
3 related and does have some link through causation, as  
4 we get older, people tend to have a greater risk of  
5 getting cancer. And there's two reasons:  
6 Scientifically one is we get exposed to more potential  
7 mutagens that can cause cells to turn cancerous; also  
8 our immunological function declines, and our immune  
9 system is very good at controlling cancers, right? But  
10 there's many other things that correlate with age as  
11 well, right?

12 So I don't know -- for example, as you get older,  
13 there's also a greater use, on average, of dental  
14 implants, right, as people lose their teeth, but that's  
15 not a causation to have cancer, for example. So that  
16 would be an example of a correlation, right, somebody  
17 getting older, where if something gets -- as they get  
18 older, there's an event that happens more frequently  
19 among that population, but that event doesn't  
20 necessarily mean that it's the cause of another event  
21 that increases in frequency in that older population.  
22 So, yeah, there's a huge difference.

23 Q Dr. Hu stated in his report that, quote: (as read)

24 A very, very, very large number of health  
25 care workers in Italy contracted and died  
26 from COVID in early 2020.

1       He concluded that part of the reason that happened is  
2       because the Italian health care workers ran out of  
3       masks. Now, in your opinion, is there a causal link  
4       between masking and what happened to the Italian health  
5       care workers, or is there only a correlation link?

6    A   Do you have a page number for that so I can take a  
7       quick look?

8    Q   That I think was in his examination. It's not in his  
9       report, but I can --

10   A   Okay, I didn't recognize it --

11   Q   -- invite my friend to --

12   A   -- that's fine. So, yeah, I -- yeah, that's fine, I  
13       can comment on that. I heard the question.

14       So, no, that's clearly not. So, again, if -- in  
15       that case, when you're talking about a clinical  
16       scenario, a complicated clinical scenario where there's  
17       other things happened, so what I mean by this is it's  
18       very different from a lot of the, for example,  
19       preclinical experiments that I run. I can run  
20       experiments in very controlled environments.

21       So, for example, if I run a study in mice, these  
22       mice are all genetically identical. They are all the  
23       same sex. They are fed the same food. They're housed  
24       in the same environments. They -- and so we can divide  
25       them, and we can have one treatment differ between  
26       them, one thing. And so it's very easy then to

1 attribute an effect to that one thing because  
2 everything else is controlled.

3         So in the scenario that Dr. Hu was talking about,  
4 the only way that you could potentially allude strongly  
5 to causation is with a randomized controlled trial.  
6 That's the whole point. And so the reason it's so --  
7 what randomized controlled trials are is they take  
8 account for these real life settings. So in the real  
9 world, when you're dealing with a clinical scenario  
10 where you're talking about an outbred population,  
11 you're talking about males and females, you're talking  
12 about old and young, you're talking about different  
13 lifestyles, different historical exposures to  
14 pathogens, et cetera, et cetera, and, therefore,  
15 different immunological programming and -- you know,  
16 and you're dealing with a pathogen and different  
17 potential exposures to that pathogen across that  
18 population, you're talking about many, many  
19 uncontrolled variables.

20         So what a randomized controlled trial is you try  
21 to account for all those variables by getting those  
22 variables equally distributed as much as possible among  
23 the two groups. That's why it's called a randomized  
24 trial: You literally random -- you can take two  
25 people, they randomly get associated to either the test  
26 arm or the control arm. And the idea of it's

1       totally -- if it is truly random, then at the end of  
2       the day, both arms of your trial should have people  
3       that represent the whole -- all those variables that  
4       exist in the real world should be --

5       THE CHAIR:                   Dr. Bridle, could -- I'm  
6       not --

7       A     Yes.

8       THE CHAIR:                   -- sure that this is really  
9       relevant. Could we get back to the question, please?

10      A     Oh, yeah, well, it is relevant because this is the way  
11      that Dr. Hu could have made his conclusion and should  
12      have.

13           And so with the relevant -- and so what I'm saying  
14      is with this randomized controlled trial, you equalize  
15      all those variables, it's very large because of all the  
16      variables, and then when you run those kind of studies,  
17      that is what allows you to draw strong conclusions  
18      about the potential causation of a variable, which, in  
19      this case, is masking.

20           In the scenario that you just posed, there's no  
21      way causation could be attributed to masking. There  
22      were far too many uncontrolled variables that were not  
23      accounted for.

24      Q     MR. KITCHEN:           I've only got one more  
25      question on this and then one final question, and then  
26      I'll be done.

1           Dr. Hu in his testimony, so in his questioning, he  
2 described the lockdown restrictions imposed in Alberta  
3 in November and December of 2020, so a little over a  
4 year ago now. He stated cases went up after the  
5 lockdown, but eventually later on cases went down. He  
6 then concluded that the lockdown did not cause the  
7 initial rise in cases, but that it did cause the  
8 eventual drop in cases. In your opinion, is this a  
9 logical or scientific conclusion?

10   A   No. So actually he had the latter part of that  
11 argument in his report highlighting -- trying to  
12 highlight that these lockdown measures, including  
13 masking a key component, had contributed to the  
14 dramatic decline in cases.

15           So more recent history demonstrates that that is  
16 patently false, that that's just the reality. That was  
17 looking sort of -- taking a snapshot in time. So  
18 again, first of all, it's correlative at best.  
19 Secondly, I -- at least it was in the report. I didn't  
20 see any peer-reviewed scientific -- I didn't see any  
21 citations attributed to his comments there. That's one  
22 thing that I had noted. And further, it's one snapshot  
23 in time; it was looking at the tail end of one of major  
24 waves of the pandemic -- waves of positive test results  
25 for SARS-Coronavirus-2.

26           And what I would like to highlight is that since

1 he highlighted that snapshot in time, we have had a  
2 record-shattering wave of the Omicron variant, where  
3 all the historical stuff that was being I guess  
4 highlighted as the reason for that decline, right, it  
5 was still in place, coupled with the fact that the vast  
6 majority of people were then vaccinated to add  
7 additional -- an additional layer of protection, we had  
8 record-shattering cases of Omicron.

9 So clearly, like -- and so again -- and I mean,  
10 I'm a scientist and when I have the data, make certain  
11 statements when there's overstatements or things  
12 misstated. I don't think it's incorrect for me, as a  
13 scientist, to declare something like that as being  
14 patently false.

15 Q Thank you.

16 MR. KITCHEN Those are all my questions on  
17 direct examination. So, Mr. Maxston, I've managed --  
18 (INDISCERNIBLE) --

19 THE CHAIR: Mr. Maxston (INDISCERNIBLE),  
20 would you like a few minutes?

21 MR. MAXSTON: I think, in fairness to Madam  
22 Court Reporter, we should take at least a 10-minute  
23 break. Again, I don't expect to be particularly long,  
24 but Mr. Kitchen may have some redirect, and I think we  
25 should take -- just take a 10-minute break if you're  
26 comfortable with that, Mr. Chair.

1 THE CHAIR: I'm fine with that. It's  
2 3:55, so we'll come back at 10 after 4. Thank you.  
3 (ADJOURNMENT)

4 THE CHAIR: Okay, I think we're all back,  
5 so Mr. Kitchen has completed his direct, and we'll ask  
6 Mr. Maxston to continue.

7 MR. MAXSTON: Thank you, Mr. Chair.

8 Mr. Maxston Cross-examines the Witness

9 Q MR. MAXSTON: Good afternoon, Dr. Bridle. I  
10 wanted to begin by saying that I was very displeased to  
11 hear your expert testimony on the effects of aging. I,  
12 however, will not use that to attack your credibility,  
13 I tend to agree with it, I have to admit, but,  
14 nonetheless, I thought that was something we should all  
15 not take into account in today's hearing.

16 I have a couple of clarification questions for  
17 you, Dr. Bridle. When I looked at your cv, and then I  
18 Googled you at the University of Guelph, I just want to  
19 be clear that your position is at the University of  
20 Guelph in the pathobiology department at the Ontario  
21 Veterinary College; is that accurate?

22 A That is accurate.

23 Q And that's part of the Doctor of Veterinary Medicine  
24 program; is that correct?

25 A Yes, that's correct, yeah, as alluded to before, a lot  
26 of my teaching is actually of the students enrolled in



1 the Doctor of Veterinary Medicine program.

2 Q Right.

3 A Yeah.

4 Q You had some discussions with Mr. Kitchen where you  
5 talked about what was occurring at Guelph University.  
6 Over the course of the pandemic, have there been any  
7 requirements at Guelph University for you as staff or  
8 perhaps students to mask if there's in-class settings  
9 or teaching?

10 A So just -- so, yes, just to clarify, not just students  
11 and staff but faculty as well. So actually I'm  
12 technically not a staff member. So just so people  
13 understand, yeah, there's three categories of people at  
14 the university: Faculty, who are the professors is  
15 what we're referred to; the staff -- we're represented  
16 by the University of Guelph Faculty Association is kind  
17 of the best way to distinguish; then there's our staff,  
18 and many of them are affiliated with fundamentally  
19 different unions; and then there's the student  
20 population.

21 But all three populations, yes, there have been  
22 masking policies that were implemented at the  
23 University of Guelph, yes.

24 Q And did you comply with those masking policies,  
25 Dr. Bridle?

26 A I did. I respect the law, and I respect rules, and so

1 even though I -- you know, what I've shared with you  
2 today, I respect those rules and adhere to them, yes.

3 Q I think you mentioned as well that when you went for a  
4 hair cut, you or the barber or the hairdresser had to  
5 wear masks, and that, I'm assuming, was because of the  
6 Chief Medical Officer of Health order or something like  
7 that; would that be correct?

8 A That is correct, yes.

9 Q So you observed that as well, that masking requirement,  
10 I should say?

11 A Oh, yes, I acknowledged that masking requirements have  
12 been implemented in many places, yes, including my  
13 public health area, yes.

14 Q Yeah, and more to the point, when you went to see the  
15 barber or to get a hair cut, you complied with those?

16 A I did so I'd get my hair cut, yes.

17 Q I think you were very fair in saying, Dr. Bridle, that  
18 there were I think some fairly significant areas where  
19 you and Dr. Hu were, I think you'd even said, a hundred  
20 percent in agreement, and I think that was in the  
21 context of masking and persons who are symptomatic and  
22 the benefits of masking. I think that's what you said  
23 anyhow.

24 I think, isn't it fair to say, that for a  
25 chiropractor, that person treating a patient can't  
26 definitively know whether the patient is symptomatic or

1 asymptomatic; would you agree with that?

2 A Well, okay, so from a technical -- from a technical  
3 standpoint, nobody can know without screening or asking  
4 whether somebody is symptomatic. So again, as I  
5 explained earlier, but I can explain again because it's  
6 a common area where people don't quite understand the  
7 distinction, so a sign is something that somebody  
8 external to the individual can identify, can use to  
9 identify that somebody is sick. A symptom is something  
10 that a person experiences that's associated with  
11 sickness.

12 So specific -- so nobody -- so, in other words, by  
13 definition, nobody upfront can identify whether  
14 somebody has a particular symptom, but you can identify  
15 if somebody has a particular sign. And again, so --  
16 and I can't comment beyond that in terms of  
17 chiropractors. I -- that's not my area of expertise.  
18 I'm not sure exactly how it works, but --

19 So, for example, in my field of expertise, that's  
20 why we've been using the prescreening, and again it's  
21 asking the questions. By asking the questions, if  
22 people have -- are experiencing any symptoms or showing  
23 any signs, then they are not to go in, you know, to the  
24 workplace, my workplace, for example. I can't comment  
25 on what happens in a chiropractor's office though.

26 Q Okay. I'm not going to take you through all the

1 exhibits that are in front of the hearing relating to  
2 mask mandates and mask requirements, but -- and I'll  
3 indulge -- hopefully my friend will indulge me a little  
4 bit, rather, I'll just tell you that there have been  
5 some exhibits from entities like Alberta Health  
6 Services and the Chief Medical Officer of Health in  
7 Alberta which set out mandatory masking and social  
8 distancing, and I'm talking about the typical blue  
9 medical masks, not N95s and things like that, and that  
10 you referred to Dr. Tam as well.

11 It's probably fair to say, isn't it, that you  
12 disagree with those type of mandates?

13 A In the context of asymptomatic individuals, yes. I  
14 agree with them in the context of symptomatic  
15 individuals for all the reasons that I've stated  
16 earlier.

17 Q I'm wondering -- and again you may not have had the  
18 chance to review this in detail, I'm not going to take  
19 you towards it -- but one of the key documents in this  
20 hearing is a Pandemic Directive that the College of  
21 Chiropractors created that, among other things,  
22 required social distancing and masking.

23 I'm assuming that, in your work, you do have  
24 contact with members of regulated professions, perhaps  
25 physicians, maybe lab techs, CLXTs, others. Are you  
26 familiar with generally the concept of self-regulation

1 for professionals?

2 A Yes, I have, yeah, multiple clinical colleagues, so,  
3 yes, through them, I understand this to a certain  
4 degree.

5 Q And I don't want to go into a lot of detail, but if you  
6 were to look at the Ontario Regulated Health  
7 Professions Act, which I understand is an omnibus  
8 legislation, it sets up a college like the College of  
9 Physicians and Surgeons, the CPSO, and is it your  
10 understanding that that organization sets up  
11 registration requirements for physicians that they have  
12 to meet before they can become registered as  
13 physicians?

14 Sorry, you're muted.

15 A So I -- honestly, I can't comment in much detail on  
16 that. I mean, I know that my clinical colleagues are  
17 licensed by a body, for example, in Ontario, like you  
18 said, like the College of Physician and Surgeons of  
19 Ontario, but the actual licensing process and the  
20 administrative structure and how that's managed, I --  
21 I'm sorry, I don't have the expertise to comment on  
22 that.

23 Q Yeah, and fair enough. I didn't want to take you  
24 there; I was just trying to, you know, get your sense,  
25 I mean, in your work, that you're aware of the fact,  
26 for example, that a physician has to register with the

1 CPSO before they can practice as a physician.

2 Are you also generally aware that, again, a member  
3 of the CPSO has to have annual, continuing competence  
4 requirements, has to meet recordkeeping requirements,  
5 and those type of things established by the CPSO?

6 MR. KITCHEN: Mr. Maxston, look, we all know  
7 where you're going, and tomorrow I have a member of the  
8 CPSO up, and I'm not going to object. You're going to  
9 ask him these questions, I'm not going to object  
10 because he's a member of the CPSO. Dr. Bridle --  
11 (AUDIO/VIDEO FEED LOST)

12 THE CHAIR: You've gone -- you're frozen,  
13 Mr. Kitchen.

14 MR. KITCHEN: -- have him talk about  
15 regulated members when he's not one.

16 MR. MAXSTON: Mr. Kitchen, you just froze  
17 there a bit, so I'm not going to proceed with that line  
18 of questioning then, that's fine.

19 Q MR. MAXSTON: In your -- as your job and in  
20 your area of expertise, I'm assuming you've looked at  
21 the Ontario equivalents to, broadly speaking, the  
22 Alberta Chief Medical Officer of Health masking and  
23 social distancing requirements; is that fair to say?

24 Oh, I think you're muted, sorry.

25 A It's not showing that -- can you hear me?

26 MR. KITCHEN Yeah.

1 Q MR. MAXSTON: Yeah.

2 A Okay, yeah, so I -- yes, yes, is my answer.

3 Q Would it, keeping in mind your comments to me about  
4 your visit to the barber and what happened at the  
5 university, your university in terms of the masking  
6 requirements, would you think that it's important to  
7 comply with CMOH orders?

8 A So could you clarify that question? What do you mean  
9 exactly, like in which context? I mean, if I want to  
10 get food from a grocery store to feed my family, of  
11 course, I think it's important to comply so that I can  
12 get food.

13 Do I think that I need to be masked in those  
14 scenarios? No. Do I take every opportunity to not  
15 wear my mask where it's allowed? Yes. You know, so  
16 I'm not quite clear. That's how I would answer that.  
17 Maybe a more specific form --

18 Q No, I was looking -- I'm sorry, I was looking to ask  
19 you some questions about the masking components of  
20 Medical Officer of Health orders, but I think you  
21 answered that before when we talked about the policies  
22 at the University of Guelph.

23 MR. MAXSTON: Those are all my questions for  
24 you, Dr. Bridle. Thank you very much.

25 A Okay, thank you.

26 Mr. Kitchen Re-examines the Witness

1 Q MR. KITCHEN: Dr. Bridle, I just have two  
2 questions in redirect. When you wear a mask because  
3 you have to to get groceries or work (INDISCERNIBLE),  
4 do you do so willingly or is it (INDISCERNIBLE)?

5 THE CHAIR: Mr. Kitchen, you're frozen,  
6 and you broke up with your question.

7 MR. KITCHEN Okay, I apologize, I'll ask it  
8 again.

9 A I did -- I heard the question, but did the rest of the  
10 members would like -- would you like them repeated?

11 MR. KITCHEN No, Karoline didn't hear it,  
12 so I'll have to ask it again. I apologize.

13 Q MR. KITCHEN: When you wear the mask, you  
14 just referred to wearing it to do groceries, you  
15 referred to wearing it at work, at the University of  
16 Guelph; when you wear it, do you wear it against your  
17 will?

18 A 100 percent, yes.

19 Q Do you think the prescreening questions that are pretty  
20 typical in your office and would be typical in  
21 Dr. Wall's office and any other chiropractor's office,  
22 do you think those questions are pretty effective at  
23 keeping symptomatic people out of the offices?

24 MR. MAXSTON: Mr. Kitchen, I'm going to have  
25 to object to that because Dr. Bridle has already said  
26 he knows nothing about chiropractic clinics, so I



1       really don't think he can answer that question, at  
2       least --

3       MR. KITCHEN                               Okay.

4       MR. MAXSTON:                           -- the second part of your  
5       question anyhow.

6       MR. KITCHEN:                           Point taken.

7   Q   MR. KITCHEN:                           Dr. Bridle, let me ask you it  
8       this way:  You have -- you said you have prescreening  
9       questions for your laboratory; do you think those  
10      prescreening questions are effective at keeping  
11      symptomatic people away from the laboratory?

12  A   Yes, absolutely.  So as I explained, symptoms are  
13      something that somebody experiences, and the only way  
14      to understand whether somebody's experiencing them is  
15      to ask questions.

16               So, for example, if you go to a physician, that's  
17      what they're designed to do, there are certain signs  
18      they can look for.  So a sign, again, would be  
19      something -- so, example, when they take your  
20      temperature, they're looking for evidence of fever.  
21      That's something they can objectively assess  
22      themselves.  You don't have to tell them that you have  
23      a fever, and then that's something that's a sign -- or,  
24      sorry, a -- yeah, a sign, therefore, of sickness.

25               Symptoms -- and symptoms can precede, can precede  
26      a lot of the signs.  So that's the best way to actually

1 screen is for symptoms, which is something somebody is  
2 experiencing and an objective third party cannot  
3 directly observe. So the only way to get that out,  
4 whether you go to a physician or anything else is by  
5 asking the relevant questions.

6 And the -- so, for example, so the one that's used  
7 for my workplace was designed in consultation with  
8 physicians, who are experts at asking the relevant  
9 questions about symptomology, to assess whether  
10 somebody is sick -- and in my experience, that has been  
11 very effective. For the first time since those  
12 questions were implemented at the university, and it's  
13 the first time in the history of my laboratory that I  
14 have consistently not seen, not even once, one of my  
15 lab members come into work sick, whereas it was a  
16 relatively common occurrence prior to that.

17 Q Is there any logical reason to think that if Dr. Wall  
18 was to ask the same questions of his patients that it  
19 would be any less effective for him than it is for you?

20 MR. MAXSTON: I'm going to object to that  
21 too, Mr. Kitchen; it's just beyond his scope.

22 MR. KITCHEN: I disagree. I think it's  
23 perfectly legitimate. The way I asked it was is there  
24 any logical reason to think it would be any different,  
25 so that's not a scope question.

26 MR. MAXSTON: I don't think Dr. Bridle can

1 even comment on whether it's logical or not when he  
2 doesn't know what happens in a chiropractic office or  
3 what the specific requirements were for any screening  
4 that Dr. Wall carried out. I just think it's too far  
5 afield of what he can comment on.

6 MR. KITCHEN: Well, Chair, I put it to you;  
7 I think it's a perfectly legitimate question.

8 THE CHAIR: Okay, we will caucus and get  
9 back to you as quickly as we can.

10 (ADJOURNMENT)

11 THE CHAIR: The Hearing Tribunal has  
12 discussed the matter, and we've decided to allow the  
13 question.

14 Q MR. KITCHEN: So, Dr. Bridle, I'll just  
15 re-phrase it -- or not re-phrase it, re-ask it.

16 Is there any logical reason to think that if  
17 Dr. Wall, in his chiropractic office was using the same  
18 questions that you've been using that he would have  
19 different results?

20 A There would be no reason to expect different results.  
21 The expectation, what we were expected to do with ours  
22 is make sure -- let's put it this way: As long as the  
23 questions are comprehensive enough and thorough enough  
24 that a -- the average physician would be able to make a  
25 reasonable assessment as to whether or not somebody is  
26 or is not infected, that that's going to be an

1 appropriate questionnaire.

2 And just I guess maybe to help for you to  
3 interpret, one of the things that the -- well, yeah,  
4 let's just leave it at that. That's ultimately the  
5 litmus test: Physicians are the experts at diagnosing  
6 disease, and if they've designed a questionnaire that  
7 would allow them to get the same information that they  
8 would out of the individual, should they be a patient  
9 in their office, and they're screening for disease,  
10 yes, that questionnaire would be university applicable  
11 irrespective of the environment.

12 Q And my friend can object to this if he wants, but would  
13 you agree with me that those are administrative  
14 controls; is that an appropriate term to call those?

15 A Yes.

16 MR. KITCHEN: Those are my questions on  
17 redirect.

18 THE CHAIR: Okay, thank you, Mr. Kitchen.  
19 I think we'll just take a few brief minutes for a break  
20 just to see if the Panel has any questions for  
21 Dr. Bridle, so we'll be back with you as quickly as we  
22 can. If you could put us in our break-out, thank you.

23 MR. KITCHEN Thank you.

24 (ADJOURNMENT)

25 THE CHAIR: Okay, I think we're all back.  
26 Thank you for your patience.

1 Dr. Aldcorn does have one question she would like  
2 to ask Dr. Bridle.

3 The Tribunal Questions the Witness

4 Q DR. ALDCORN: Hi, Dr. Bridle. Just  
5 regarding the IFR, you commented that in 2019, there  
6 was a prediction that the -- that there could be as  
7 much as 10 percent with regards to COVID-19 in terms of  
8 those who are infectious who get the disease, right?  
9 And then you mentioned, in early 2021, studies had  
10 shown that it was about .15 percent, and now even less.  
11 So I'm curious to know if there's any research or  
12 studies or -- to the best of your knowledge, if you  
13 knew that there was any percentage given in the time  
14 frame that we're concerned about, which would be from  
15 May to December 2020.

16 A Yeah, in that -- so that study that I cited in my  
17 report includes that time frame. So it would include  
18 everything from -- I was assessing everything from the  
19 beginning up until -- so the very earliest that it  
20 would have included data, and I'm not even certain --  
21 I'd have to go back, and I have -- and double-check,  
22 but the earliest would have been, you know, like maybe  
23 January 2021, but the data would have been all from the  
24 start of the declared pandemic up until the end of  
25 December for sure.

26 It wouldn't have anything much newer than that,

1   because the way publications work, the publication  
2   process, just so you can understand the timing  
3   therefore, is normally what happens is when we have a  
4   manuscript ready, we submit it to a journal. And then  
5   what will happen is an editor will be assigned, then  
6   they'll try and recruit reviewers. Once they've  
7   identified reviewers for it, that paper gets sent to  
8   the reviewers. So there's a review process.

9         Normally reviewer -- so that process -- that  
10   process right there often takes a week, and then the  
11   review process always takes a minimum of two weeks,  
12   depends on the journal. Some like report back in two  
13   weeks, some three weeks, and sometimes they don't get  
14   them back when requested from reviewers, and they have  
15   to solicit them and try to remind the reviewers to get  
16   it in.

17         But so the point is, ideally then, they're going  
18   to get those initial reports after one month from the  
19   initial submission, and almost always, it's very, very  
20   rare for a manuscript to be accepted immediately with  
21   no revisions. So almost always, if a manuscript is  
22   going to be accepted, it is with revisions, and then,  
23   depending on how much revision they feel is necessary,  
24   that's going to dictate the -- dictate the time the  
25   authors have to go back and revise their manuscript.  
26   So for example, if they had to generate new data or run

1 new experiments, it's going to be -- it could be months  
2 they're given.

3 But for an article like this though, it would  
4 usually be a matter of weeks, and then that revised  
5 version goes back, and then, often, their reviewers  
6 have one final review, and then if they're satisfied  
7 with the changes, they'll approve it, the manuscript  
8 will be accepted. And then, at that point, it's called  
9 what we call in press, and then a short time thereafter  
10 it will be published. So --

11 Q So, sorry, so just -- so the question then, it was  
12 released or -- in some capacity in 2021. It --

13 A Exactly.

14 Q -- was based on the information from 2020 --

15 A Exactly because --

16 Q -- so the --

17 A -- even though it was several months into 2021, the  
18 data that they would have had available when they first  
19 submitted it would have been for -- mainly from that  
20 duration you're talking about.

21 Q Sure. So in the latter stages of 2020, would we have  
22 had -- would you or the population or whatever have any  
23 idea that 10 percent wasn't the number that we were  
24 looking at in the middle of 2020?

25 A Yes, yes. Yeah, that was very quickly obvious. So,  
26 again, what I mentioned is it wasn't a prediction that

1 the infection fatality rate would be 1 to 10 percent;  
2 it was that initial like immediate concern that it  
3 could potentially be that. It wasn't like any kind of  
4 modelling was done. This was high profile public  
5 health officials, like Fauci, like Theresa Tam,  
6 expressing this potential concern, but we very  
7 quickly -- it didn't take much time before we knew, we  
8 really started to narrow down the high-risk  
9 demographics.

10 And so we knew very early on, again, that the  
11 highest risk demographics were the frail elderly, those  
12 who are immunosuppressed, those who are obese, and  
13 those who have multiple comorbidities. And for the  
14 rest of the people, we knew, so very earlier on, that  
15 the risk of fatality from infection from this  
16 particular virus was quite low, yes.

17 DR. ALDCORN: Thank you.

18 A No problem.

19 MR. KITCHEN: I'm going to ask for  
20 permission to ask a follow-up question.

21 THE CHAIR: Okay.

22 Mr. Kitchen Re-examines the Witness

23 MR. KITCHEN: And I'll give you the  
24 question, and then you can let me know if you're okay  
25 with it.

26 Q MR. KITCHEN: Dr. Bridle, what do you mean



1 by "very early", right? Because it came in March 2020.  
2 So the Pandemic Directive came out in May of 2020, so  
3 it's important that we know what you mean by what's  
4 "very early", that we knew it wasn't going to be as  
5 high as 1 percent.

6 MR. KITCHEN And, Chair, is that okay that  
7 he answers that?

8 THE CHAIR: Mr. Maxston, do you have any  
9 objection?

10 MR. MAXSTON: I don't object.

11 A Yeah, so that's a good question. It was prior to the  
12 implementation of the policies that we knew that, in  
13 the low-risk demographics, it wasn't going to be  
14 anywhere close to 1 percent infection fatality rate.  
15 So prior to May, right? The virus was first identified  
16 in late 2019. It was only -- it only took a couple of  
17 months to start identifying that this was -- so  
18 basically what we refer to this as is this is a  
19 virus -- we talk a lot about discrimination, you don't  
20 want discrimination -- but this is a virus that very  
21 much discriminates. And we knew that within a couple  
22 of months, meaning, a potentially, a very dangerous  
23 virus that would have a high infection fatality rate,  
24 would indiscriminately kill people.

25 This virus is very discriminatory. We knew within  
26 a couple of months of the -- when it was -- after the

1 virus was first identified. So by "very early", I mean  
2 like by January, by the end of January 2020, we already  
3 had a good idea that there was a limited number of  
4 demographics that were at particularly high risk from  
5 this virus.

6 THE CHAIR: I think we should leave it at  
7 that. We're talking in generalities now.

8 MR. KITCHEN: I'm going to ask for  
9 permission for one more question.

10 Q MR. KITCHEN: Because I want to -- I want  
11 you to be able to answer Dr. Aldcorn's question.

12 At what month in 2020 did scientists know that the  
13 IFR was going to be below 1 percent?

14 MR. MAXSTON: Mr. Kitchen, I'm going to have  
15 to -- I don't want to be difficult here, but that is a  
16 very vague question. When we say scientists knew,  
17 which scientists, when, how did they know? I think  
18 we've explored this a little bit, but I'm reluctant to  
19 let it go much further than that, because it's just a  
20 broad topic to begin that -- and, of course, in  
21 fairness to Dr. Bridle, he can't speak to what other  
22 people thought.

23 So I think my request to you is that you've  
24 explored this enough, and I think you shouldn't go any  
25 further, and I hope you're comfortable with that.

26 MR. KITCHEN: I'm going to ask Dr. Bridle --

1 Q MR. KITCHEN: -- when did you know?

2 A I was quite confident that -- about that by the end of  
3 January 2020.

4 MR. KITCHEN: And I'll leave it there. I  
5 think that was helpful for answering everybody's  
6 questions.

7 THE CHAIR: Okay, I think that brings  
8 today to a conclusion. We'll be back at 9:00  
9 tomorrow morning. Mr. Kitchen, you can discharge your  
10 witness, and thank you very much, Dr. Bridle, for a  
11 very long and informative day.

12 A Thank you. Take care.

13 THE CHAIR: So we're back on at 9 with  
14 your witness tomorrow morning, Mr. Kitchen, that's  
15 correct?

16 MR. KITCHEN: That's right.

17 THE CHAIR: Okay. Very good, well, we  
18 will recess until tomorrow morning. Thanks everybody,  
19 and we'll see you then.

20

21 PROCEEDINGS ADJOURNED UNTIL 9:00 AM, JANUARY 29, 2022

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1 CERTIFICATE OF TRANSCRIPT:

2

3 I, Karoline Schumann, certify that the foregoing  
4 pages are a complete and accurate transcript of the  
5 proceedings, taken down by me in shorthand and  
6 transcribed from my shorthand notes to the best of my  
7 skill and ability.

8 Dated at the City of Calgary, Province of Alberta,  
9 this 21st day of February, 2022.

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Karoline Schumann

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Karoline Schumann, CSR(A)

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Official Court Reporter

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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

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DISCIPLINARY HEARING

VOLUME 8

VIA VIDEOCONFERENCE

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Edmonton, Alberta

January 29, 2022

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1 Proceedings taken via Videoconference for The Alberta  
2 College and Association of Chiropractors, Edmonton,  
3 Alberta

4

5 January 29, 2022 Morning Session

6

7 HEARING TRIBUNAL

8 J. Lees Tribunal Chair

9 W. Pavlic Internal Legal Counsel

10 Dr. L. Aldcorn ACAC Registered Member

11 Dr. D. Martens ACAC Registered Member

12 D. Dawson Public Member

13 A. Nelson ACAC Hearings Director

14

15 ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

16 B.E. Maxston, QC ACAC Legal Counsel

17

18 FOR DR. CURTIS WALL

19 J.S.M. Kitchen Legal Counsel

20

21 K. Schumann, CSR(A) Official Court Reporter

22

23

24

25

26

1 (PROCEEDINGS COMMENCED AT 9:08 AM)

2 THE CHAIR: Well, good morning, everybody.  
3 We've got one witness I believe to examine today,  
4 Mr. Kitchen, and just before we do that, Mr. Maxston,  
5 anything to raise?

6 MR. MAXSTON: No, thank you for asking, but  
7 I should mention, Mr. Kitchen, you'll probably speak to  
8 this, but he has sent Mr. Lawrence and I his proposed  
9 qualification for his expert witness, and I don't think  
10 there will be an issue.

11 Mr. Kitchen, I would have responded to you, but I  
12 needed to run that by my client, and I just saw it this  
13 morning, so I'll let you know that in advance.

14 MR. KITCHEN: Thanks.

15 THE CHAIR: Okay, let's turn the floor  
16 over then to Mr. Kitchen, and you can bring your  
17 witness in, and I just remind everybody to mute  
18 yourself, please, and hopefully we'll have enough  
19 bandwidth today that we don't have any interruptions.

20 MR. KITCHEN: All right. So, Dr. Warren,  
21 I'll just do some introductions because we have so many  
22 people, and I don't know if you can see everybody on  
23 the screen. I've got mine on gallery view so I can see  
24 everybody.

25 The four Tribunal Members are Dr. Dianna Martens,  
26 Dr. Leslie Aldcorn, those are chiropractic members of

1 the Tribunal; and then Mr. Jim Lees and Mr. Doug Dawson  
2 are public members of the Tribunal. So there's four in  
3 total.

4 Walter Pavlic is the lawyer for the Tribunal,  
5 probably won't hear anything from him, but he's the one  
6 that advises the Tribunal, so if they caucus, he goes  
7 caucusing with them, and don't wonder at that.

8 Mr. Maxston is the lawyer for the -- what I will  
9 refer to as the prosecutor in this case. So we have  
10 the College, we have the Tribunal, those are separate.  
11 The College is bringing the action against Dr. Wall,  
12 and that's happening through the Complaints Director,  
13 that's David Lawrence. His lawyer is Blair Maxston, so  
14 he'll be the one that cross-examines you.

15 And then, of course, there's the Hearings  
16 Director, you won't see her, but that's Ms. Nelson.

17 And then have our court reporter, Karoline.

18 And then of course, Dr. Wall is here. You won't  
19 see him or hear him, but he's listening. And that's  
20 everybody.

21 So with that, Karoline, could you please swear him  
22 in.

23 THE CHAIR: Dr. Warren, just before  
24 Karoline swears you in, I'll just -- we tell this to  
25 everybody, Karoline is a court reporter. She's making  
26 a verbatim record of the proceedings, and so we would

1 ask that you try not to speak real quickly. I have no  
2 idea whether that's your speech pattern or not, but if  
3 you could just keep that in mind, please.

4 THE WITNESS: Sure.

5 THE COURT REPORTER: And please wait for  
6 Mr. Kitchen and Mr. Maxston to finish their entire  
7 question before you answer. Do not interrupt them.  
8 It's just makes the audio very difficult for me, so ...

9 DR. THOMAS WARREN, Sworn, Examined by Mr. Kitchen  
10 (Qualification)

11 Q MR. KITCHEN: Dr. Warren, I just have a few  
12 questions for you about your background, and then I'm  
13 going to tender your qualification, and then we'll go  
14 from there, so I don't imagine that it'll take too  
15 long.

16 A Sure.

17 Q Dr. Warren, do you have a medical degree?

18 A I do.

19 Q And what have you done for residencies and fellowships?

20 A Sure. So I did four years of medical school at the  
21 University of Western Ontario, graduated in 2005. Then  
22 I did three years of residency at the University of  
23 Ottawa in internal medicine. And then I did two  
24 fellowships in infectious diseases and medical  
25 microbiology from 2008 to 2011. So I'm Royal College  
26 certified in three different specialties.



1 Q Thank you. This may come up in your questioning, but  
2 I'll ask it now, can you give us an idea, just briefly,  
3 of what infectious disease, what that speciality is?

4 A Sure. So I'm an infectious disease specialist and a  
5 medical microbiologist. People can be one or the other  
6 or both.

7 So as an infectious diseases specialist, I treat  
8 patients with infections, so diseases caused by  
9 viruses, bacteria, parasites, fungus. So about  
10 two-thirds of my practice is clinical work, taking care  
11 of patients with infections, mostly in the hospital but  
12 some outpatient work as well. And then about a third  
13 of my practice is more administrative-type work. So as  
14 a medical microbiologist for ten weeks, I manage the  
15 microbiology laboratory in the hospital that I work in.

16 I also am responsible for covering the infection  
17 control service at the hospital I'm at for about ten  
18 weeks a year.

19 And then my primary administrative responsibility  
20 is something called antimicrobial stewardship, and so  
21 that's really just monitoring antimicrobial, antibiotic  
22 use within the hospital, ensuring that it's appropriate  
23 and controlling its use and intervening when needed.

24 Q Excellent, thank you. Are you currently enrolled in a  
25 graduate program?

26 A Yes, I'm doing a Masters in science and epidemiology at

1 the London School of Hygiene & Tropical Medicine, which  
2 is part of the University of London, England, and I'm  
3 in my fourth year, so I should finish later this year.

4 Q Thank you. Do you teach in any capacity?

5 A Yeah, I have an adjunct appointment at McMaster  
6 University as an assistant clinical professor, and so  
7 in my ten years of full-time practice and my eight  
8 years of my appointment with McMaster, I've had all  
9 levels of learners from medical students, first-,  
10 second-, third-year medical students, all the way up to  
11 infectious diseases fellows.

12 Q Now, I know you mentioned you work at the hospital, but  
13 could you tell us in more detail what your current  
14 occupation is?

15 A Like as an infectious diseases specialist?

16 Q Yes, yeah, exactly, we want to know --

17 A So --

18 Q -- about just what that actually looks like.

19 A Okay. So I have hospital privileges at Halton  
20 Healthcare Services, which is a medium-size hospital  
21 just west of Toronto. It has three campuses, an  
22 Oakville campus, a Milton, and a Georgetown campus.  
23 And so I am oncall for 17 weeks a year for infectious  
24 diseases, which is 24/7 call, can be quite busy.

25 And then other than that, as I said, I have a fair  
26 amount of administrative responsibilities, which is

1           basically the rest of my time, apart from vacation and  
2           being oncall. And then I have a small outpatient  
3           practice, which would involve things like hepatitis C,  
4           latent tuberculosis, HIV management.

5    Q    Thank you. Are you a member of the CPSO?

6    A    I am.

7    Q    Have you been an expert witness in legal proceedings  
8           before today?

9    A    Yes, I have.

10   Q    And have you prepared other expert opinion reports  
11          regarding SARS-CoV-2 and/or COVID-19?

12   A    Yes. I prepared I think nine expert reports in five  
13          provinces for -- regarding COVID-19 for SARS-CoV-2.

14   Q    Thank you.

15           MR. KITCHEN                           Those are all my questions.

16                   Mr. Maxston, did you want to ask any questions  
17           before I tender the qualification I want?

18           MR. MAXSTON:                        I don't think so, Mr. Kitchen.  
19           Thank you.

20           MR. KITCHEN:                        Chair, I want to qualify  
21           Dr. Thomas Warren as an expert in the areas of  
22           infectious diseases and medical microbiology, in  
23           particular, SARS-CoV-2, COVID-19, and the efficacy of  
24           masking, physical distancing, and other restrictions  
25           intended to prevent transmission of SARS-CoV-2.

26           MR. MAXSTON:                        Mr. Chair, as I mentioned

1 before, Mr. Kitchen provided this to me and my client  
2 in advance, and we're not going to object to it.

3 I will repeat our prior comments with respect to  
4 Dr. Wall's expert witnesses that we, again, don't  
5 believe this is a hearing about mask efficacy and  
6 social distancing, et cetera. We've placed that same  
7 qualifier for all of Dr. Wall's witnesses as we have  
8 before.

9 MR. KITCHEN: And I'll provide the same  
10 response: It's borderline nonsensical to say such a  
11 thing when the Complaints Director has submitted an  
12 expert on the very issue of masking from a scientific  
13 and medical perspective, and that was in response to  
14 Dr. Wall's experts. So I understand my friend wants to  
15 continue to fill the record with that, but I guess I'm  
16 going to have continue to fill the record with saying  
17 that I don't understand how it makes any sense to say  
18 so.

19 THE CHAIR: You're both on the record on  
20 that point, so I don't think we need --

21 MR. MAXSTON: And, Mr. Chair, I'm sorry, I  
22 just want to make one comment, I've said this before  
23 and I'll say it again, we called an expert because  
24 Dr. Wall was calling experts, and we didn't introduce  
25 Dr. Hu at our own initiative. It was to respond to  
26 what we understood would be expert testimony, so I just

1 wanted to be clear about that. We didn't introduce  
2 Dr. Hu for anything other than to rebut the expert  
3 witness testimony from Dr. Wall. We've covered this,  
4 but I wanted to mention that.

5 THE CHAIR: Let's get back on track and  
6 deal with Dr. Warren. I just had one question I would  
7 like to ask Dr. Warren.

8 The Chair Questions the Witness (Qualification)

9 Q THE CHAIR: Good morning, sir, thank you  
10 for joining us.

11 A Morning. Thank you.

12 Q I was just looking at your résumé and your cv, and I  
13 noted that peer-reviewed publications, the last one is  
14 noted as 2015. Have you shifted your focus away from  
15 research in the last few years?

16 A Yeah, usually most people in academia have either one  
17 of two streams: One is research-based or  
18 teaching-based. And so my appointment with McMaster is  
19 a teaching-based appointment.

20 THE CHAIR: Thank you for clarifying that.  
21 Ruling (Qualification)

22 THE CHAIR: Okay, I don't know that  
23 there's a need for us to caucus to consider approving  
24 Dr. Warren as an expert witness in the fields noted.  
25 The College has no objection.

26 So, Mr. Kitchen, I'll ask you to continue with

1 your direct examination of Dr. Warren.

2 MR. KITCHEN: Thank you.

3 DR. THOMAS WARREN, Previously sworn, Examined by  
4 Mr. Kitchen

5 Q MR. KITCHEN: Dr. Warren, just going to  
6 start with a couple standard questions. Do you know  
7 Dr. Curtis Wall personally?

8 A No.

9 Q Do you have any financial interest in the outcome of  
10 this case?

11 A No.

12 Q And do you understand your duty today to provide this  
13 Tribunal with your expert knowledge and opinions in an  
14 objective and neutral manner?

15 A Yes.

16 Q And then the last thing is this: Do you understand  
17 that if and when, in the likely event we're going to  
18 have a break, you and I are not permitted to speak  
19 until your testimony is done?

20 A Yes.

21 Q All right, well, I'm going to start with your report.  
22 In the second section of your report, and that starts  
23 on page 1, you identified three factors that are  
24 driving SARS-CoV-2 transmission and mortality and state  
25 that those factors are, quote, non-modifiable. Now,  
26 I'm going to ask you about the factors, but, first,

1 could you please explain what "non-modifiable" means?

2 A "Non-modifiable" means that they can't be changed. For  
3 instance, I speak about a person -- or a person's age,  
4 you can't change someone's age or you can't change the  
5 age structure of a population. So non-modifiable means  
6 it cannot be changed by some sort of intervention.

7 Q The first non-modifiable factor you discuss is the  
8 timing of peak virus transmission or wave of  
9 transmission. You say the timing is primarily affected  
10 by seasonal patterns. First, I want to ask you, since  
11 your report is almost a year old now and we're two  
12 years in experiencing this with SARS-CoV-2, has your  
13 opinion in this regard changed in any way since  
14 drafting this report?

15 A It only changed in that I'm more certain of it. In the  
16 last nine or ten months since I wrote my report,  
17 there's been even much more accumulating evidence to  
18 show that SARS-CoV-2 is similar to essentially every  
19 other respiratory -- important respiratory infection in  
20 humans, in that it follows a seasonal pattern. We can  
21 just even see that in our Canadian data that -- and I  
22 mentioned it in my report, but other Coronaviruses have  
23 their peaks in January, and across Canada, this  
24 January, 2022, we have another peak of SARS-CoV-2.

25 Q Now, I know you cited to a lot of literature in your  
26 report, of course, and you just said that there's even

1 more literature since, but can you give us an idea of  
2 what is that literature that supports your position?  
3 Just a -- I know you can't go into every study, but  
4 please give us an idea of what that literature is.

5 A Specifically about seasonal patterns?

6 Q Yes.

7 A Yeah, so I quoted, I don't know, probably about a dozen  
8 studies or so, yeah, at least seven or eight, that  
9 talked about or showed that SARS-CoV-2 follows a  
10 seasonal pattern, which was fairly early, because by  
11 the time I wrote the report, it had only been around  
12 for just over a year, I think 15 months.

13 And so similar to those studies, there have been  
14 more studies looking at the timing of SARS-CoV-2 in  
15 different jurisdictions. So some of the studies I  
16 quoted were country-specific, others were global. And  
17 those similar types of studies, because we have one  
18 more year of data have continued to accumulate and been  
19 published in the peer-reviewed literature.

20 Q These are peer-reviewed academic articles, is that a  
21 good way to describe them?

22 A Correct.

23 Q And can you explain how or why these seasonal or  
24 cyclical patterns are, in fact, non-modifiable?

25 A Well, the weather is non-modifiable, and so we know,  
26 for instance, with influenza, that it kind of usually



1 starts in the southern hemisphere and moves to the  
2 northern hemisphere. Maybe potentially the time of  
3 year or the exact time in the winter, the colder  
4 season, when the peak occurs might be different, might  
5 be December one year, might be January the next or  
6 February, but it's always kind of in the winter months  
7 in the northern hemisphere.

8 And so the climate and the temperature is not  
9 something that can be changed, and that affects  
10 multiple things. It affects how often people are  
11 inside. It affects transmissibility, because the  
12 relative humidity in the air affects water droplets,  
13 which is, you know, aerosol droplets is one of the --  
14 the primary way that SARS-CoV-2 and many other  
15 respiratory viruses are transmitted. So those type of  
16 factors can't be changed, but we're going to have a  
17 winter in the northern hemisphere every year around the  
18 same time, you know, between November and March, and so  
19 we can expect a peak of respiratory viruses to occur in  
20 that time frame.

21 Q So the theory that lockdowns or restrictions work based  
22 on the theory of being able to modify that or being  
23 able to work notwithstanding that?

24 A The main -- well, the main purpose, I guess, of  
25 lockdowns would be to reduce the frequency of contacts  
26 and then, therefore, infection, with the goal, you

1 know, it's usually the stated purpose of not  
2 overwhelming health care capacity.

3 But in my second point, I talk about population  
4 density. And the number of infections in a  
5 geographical location is primarily going to be  
6 influenced by population density, and I give an example  
7 of New York. Like in the first wave, there was a huge  
8 number of infections in New York City, because it's so  
9 population-dense, and you can't change that. You can't  
10 take 8 million people in New York City and put them in  
11 upstate New York, distribute them along upstate New  
12 York. So you're still going to have 8 million people  
13 in a small number of burrows in New York City, and even  
14 though there's a lockdown, you still have large  
15 apartment buildings with people in very close quarters.  
16 So you're not modifying the population density, which  
17 is the most important factor.

18 Q So the idea behind restrictions is not that  
19 restrictions can change that factor but that  
20 restrictions can work notwithstanding the presence of  
21 that factor?

22 A That's the idea. The idea would be by having a  
23 lockdown restriction, you're reducing the number of  
24 people that you would come in contact with and,  
25 therefore, the number of potential infectious contacts  
26 or the statistical risk of someone being infected.

1           What I'm arguing in this and what I think some of  
2           what the literature clearly shows in the studies that I  
3           quoted is that it has a negligible effect in a place  
4           that is already population-dense.

5           And so you have a rural location, those people  
6           already are going to come into contact with much fewer  
7           people. Let's just say, you know, give a number of 8  
8           or something per day, whereas you have a  
9           population-dense place like New York City, I'm just  
10          throwing it out there, but you have people on a random  
11          day coming into contact with 80 people, you know what I  
12          mean.

13          And lockdown is modifying that slightly, like  
14          you're taking in a rural location, 8 down to 5, and  
15          then New York City, 80 down to 60. You still have a  
16          very population-dense area. When you go out to buy  
17          groceries in New York City, you're passing by lots of  
18          people, and so you can't modify that population  
19          density. And that, as I showed in the studies I  
20          quoted, is a very important factor to predict the  
21          number of infections in the current wave.

22          The timing is going to be predicted by season.  
23          The number of infections is going to be predicted by  
24          population density, and the mortality is going to be  
25          predicted by the age structure.

26    Q     So is part of the reason why we keep getting wave after

1 wave after wave because the cyclical pattern just can't  
2 be stopped even by intense interventions?

3 A Yeah, SARS-CoV-2 is now the fifth seasonal Coronavirus.  
4 There have been four prior to SARS-CoV-2, and now it's  
5 the fifth. And it will continue to cause infections  
6 and waves in a seasonal pattern just like the other  
7 four do.

8 And so just like we can't prevent influenza or  
9 other seasonal Coronaviruses, we can't prevent the  
10 waves on a population level, we're not going to be able  
11 to prevent SARS-CoV-2 waves. We haven't been able to  
12 in the past two years, and we won't be able to going  
13 forward.

14 Q So at this point in time, are any attempts, any human  
15 attempts to try to stop SARS-CoV-2 from continuing as  
16 the fifth Coronavirus, are they just futile?

17 A Yeah, to stop it circulating within the community like  
18 globally, yeah. Like trying to stop it, the whole  
19 notion of zero COVID makes no sense. It can be done  
20 for short periods of time in places like New Zealand,  
21 which can -- are literally in the middle of the ocean  
22 and can hibernate themselves from the rest of the  
23 world. But even there, you see places like Australia  
24 that were able to maintain that for periods of time,  
25 but now it's circulating in Australia like anywhere  
26 else in the world.

1           And so, yeah, it would be utterly futile to say  
2           that we tried to stop the circulation of SARS-CoV-2  
3           right now, like on a global level within the community.

4    Q    So even if an entire nation went into, you know, a  
5           complete, you know, locked in your house kind of  
6           lockdown for a year on end, it wouldn't matter, because  
7           as soon as you lifted that, Coronavirus would come in;  
8           is that what you're saying?

9           MR. MAXSTON:                   Mr. Kitchen, I'm sorry, I  
10          don't want to interrupt, but I got the sense on the  
11          last three or four questions that there's a lot of  
12          lead-in, and I don't want to cramp your style here, but  
13          I think there's a lot of lead-in on some of these  
14          questions. I wonder if you could consider maybe  
15          rephrasing them a little bit.

16          MR. KITCHEN:                   That's fine.

17    Q    MR. KITCHEN:                   Dr. Warren, just give me a  
18           second; you've already answered so many of my  
19           questions.

20                So let's talk about the -- I mean, you've already  
21                touched on this, but let's talk about the third factor.  
22                And I think I understand this better now, you say the  
23                third non-modifiable factor is just how old people are.  
24                But the first question I have for you to help us  
25                understand is what is infection fatality ratio?

26    A    Okay, let me just bring that up here on my report.

1 Q Yeah, it's on page -- end of page 2, it's the third  
2 portion of that section.

3 A So the infection fatality ratio, so that's the number  
4 of people with the infection that died or the  
5 percentage. It's a ratio, so it would be a percentage.

6 Q And do you have any idea roughly what that is right now  
7 with COVID?

8 A It's unchanged from what I say in my report. So in my  
9 report, I say that persons over 80, the IFR is  
10 approximately a thousand times greater than the IFR in  
11 those under 20, and so the age of a patient is by far  
12 the most predictive measure of the risk of mortality.

13 Q In your opinion, is the IFR of people above 80 more  
14 relevant than the overall IFR?

15 A Well, I think the IFR in any age group is going to be  
16 important, so if we look at -- if we compare the  
17 mortality risk in persons under 20, I think that helps  
18 shape policy for that age group, so that's school-age  
19 people. And we know and it's clear from the literature  
20 now, it was when I wrote my report, but it's much  
21 clearer now, that the actual risk of death from  
22 SARS-CoV-2 infection is lower for that age group,  
23 persons under 20, than for seasonal influenza.

24 And so when you're considering policy in that age  
25 group, that's important to look at. It's also  
26 important to look at what the IFR is in other age

1 groups as well, but it's important to be able to break  
2 that down. And so, likewise, when we look at the IFR  
3 in persons over 80, that helps us form a policy for  
4 that age group, whether it's care homes, nursing homes,  
5 retirement homes. It matters what the IFR is in other  
6 populations, but it's very helpful to break it down,  
7 because each age group and demographic is going to have  
8 different policy implications, because policy  
9 implications for a school should be very different than  
10 a policy implication for a nursing home.

11 Q We've heard in the proceedings so far that the IFR  
12 overall for all age groups for COVID is about 0.15 or  
13 less now, but what we've heard, at least at one point,  
14 it was 0.15. Do you have any reason to agree with that  
15 number?

16 A No, that's roughly accurate. I would say it's probably  
17 lower now, having gone through the Omicron wave.  
18 Omicron has been much less severe with regards to  
19 mortality. There are various factors regarding that,  
20 but, yeah, that number is roughly accurate. Again, it  
21 really depends. When you talk about an IFR in a  
22 sub-Saharan African country, which has a much lower  
23 population, it's going to be quite different.

24 So in statistics, we use age -- like there's a way  
25 of age-standardizing when you compare different  
26 countries, and that would always have to be done when

1       you compare or when you discuss these things, because  
2       if you calculate an IFR of the Canadian population,  
3       without age-standardizing it and then comparing it to  
4       another country like say Nigeria, which is much  
5       younger, you're comparing apples to oranges. And so  
6       there's clear statistical methods if you want to do  
7       that comparison.

8               And so generally, when you talk about an IFR  
9       overall globally, well, then you have kind of  
10       standard -- well, what's your standard population  
11       scale, and then you normalize it to that. So it's not  
12       an easy answer, but that's a roughly good ballpark  
13       number, but I would say it's maybe slightly lower now.

14    Q    Okay. So if I'm understanding you, in sort of  
15       nonscientific language, the more old people you have in  
16       your society, the higher the IFR in that society?

17    A    Yeah, absolutely. If you're calculating it just based  
18       on your country, yeah.

19    Q    And it's lower in Nigeria because they have less old  
20       people?

21    A    Yeah, the age structure is different. So the  
22       proportion of, say, persons in over 70 in a younger  
23       country, and that would often be countries in  
24       sub-Saharan Africa or different places in Asia, it's  
25       going to be different, yeah.

26               And people discussed this with regard to the



1       Omicron wave in South Africa, because the South African  
2       population is quite a bit younger, and so people  
3       rightly said, okay, well, we need to compare apples to  
4       apples here, rather than apples to oranges. And there  
5       are standard statistical ways of kind of doing that  
6       comparison. There -- and I won't get into that, but  
7       you can still do it.

8       Q     So when I look at your report, you say 95 percent --  
9       we're in Canada -- 95 percent of deaths are in persons  
10      over 60. So do I understand correctly then that 95  
11      percent of what contributes to that overall IFR of 0.15  
12      is from people over 60?

13     A     That's right.

14     Q     So if we took those people out of the equation, instead  
15      of 0.15, we'd have something that might look like  
16      0.00000 et cetera; is that accurate?

17     A     Yeah, it would be -- if you look at the IFR of only  
18      persons 60 and under, it's substantially less, yes,  
19      that's right.

20           And again -- and then -- you know, it's  
21      affected -- there are other factors, right? There are  
22      comorbidities, and, you know, the CDC had a good study  
23      just recently that was published that just -- that  
24      looked at both age but then comorbidities as well. The  
25      risk of death increases significantly when you go from  
26      zero to one comorbidity and then to two and then to

1 three.

2 So you have someone who is over 80 with, you know,  
3 two or three comorbidities, their risk of death is very  
4 high and substantially higher than -- orders of  
5 magnitude higher than someone, you know, much younger  
6 with no comorbidities. And, you know, statistically,  
7 it's closer to zero once you get below a certain age  
8 with no comorbidities; it's for all intents and  
9 purposes zero.

10 Q Okay. So the IFR differs dramatically over age groups  
11 then?

12 A Yes.

13 Q Now, and this has been a big issue in this hearing, the  
14 overall IFR, was it ever much higher than this 0.15  
15 figure even in the beginning?

16 A Well, it's changed, so if you -- it can be tracked over  
17 time, and what you'll see is that, very early on, it  
18 was very high because the number of infections detected  
19 was much lower very early on because testing was  
20 limited, but quite soon after the first wave, the IFR  
21 came down significantly.

22 So if you look at the very beginning when people  
23 were (INDISCERNIBLE) in the spring of 2020, it was  
24 quite high, but over time -- I mean, you could -- there  
25 are graphs of this, but over time, the IFR has been  
26 going down and down and down, and actually, you know,

1 quite significantly dropped in the Omicron wave,  
2 because you have a whole bunch of infections but  
3 relatively fewer deaths, and so it's been going down  
4 over time.

5 Q That IFR rate early on, so let's say early 2020, is  
6 that a highly reliable figure?

7 A No, because it was -- in statistics, you know, we talk  
8 about things like bias, like so that would be selection  
9 bias. And so early on, it was only the most evident,  
10 so symptomatic, the sickest who were being tested, and  
11 so you had a selection bias early on.

12 But as with -- in most things in statistics, the  
13 larger sample size, the more accurate it's going to be.  
14 And so now that we've got, you know, hundreds of  
15 millions of cases worldwide that we can reliably make a  
16 much better estimate as to what the true IFR is.

17 Q Is it possible that, in early 2020, a very large number  
18 of people were infected, but nobody really knew about  
19 it?

20 A Yes. It's hard to know that for sure, because there  
21 are a number of different factors, one of which just  
22 being limitations of testing, particularly in different  
23 places in the world.

24 Even in our institution, I remember for the first  
25 few weeks at least, if not longer, like we had quite  
26 significant limitations on who we could test, who we

1       could only run a certain number of tests per day. But,  
2       yeah, there have been other studies that have been done  
3       subsequently to say and estimate at least how many  
4       other infections are there apart from the ones that  
5       we've actually picked up with positive testing, for  
6       instance.

7               The estimates varied from, again, the country and  
8       various separate testing procedures or protocols, or,  
9       you know, who can be tested, who not. Because even  
10      here in Ontario, we've changed who's going to be  
11      tested. Our Chief Medical Officer of Health says  
12      that -- now said, you know, if you have minor symptoms  
13      and, you know, are otherwise healthy and stuff, you  
14      don't necessarily have to be tested, you just assume  
15      you have COVID and stay home. So over time there has  
16      been changes to testing protocols and stuff, and so  
17      that's going to change how many people are actually  
18      detecting.

19             So certainly very early on, there would have been  
20      a fair number of people who had the infection but were  
21      not detected, because we know the asymptomatic rate is  
22      about 10 to 20 percent as well, I said that as well.  
23      So at least early on, unless they were close contacts  
24      and similarly infected, they probably weren't being  
25      tested.

26   Q      Now, obviously any IFR is, I guess, concerning or

1       upsetting, because that ultimately means people die,  
2       but can you help us understand, give us a figure of  
3       what would be considered in the medical community as a  
4       dangerously high IFR?

5     A   Well, you know, that's a bit of a tricky question, but  
6       like I think what we're seeing now, I think one of the  
7       important things to say with regards to the IFR of  
8       SARS-CoV-2 is that, overall, what we're seeing is that  
9       the IFR is approaching seasonal influenza, and seasonal  
10       influenza varies quite a bit from year-to-year, and  
11       some years are very bad, other years aren't.

12               And actually they're related, because what happens  
13       is if you have a bad flu year, because many elderly  
14       people, no matter what, are -- in the end, are going to  
15       die of a respiratory tract infection.  Canada's  
16       greatest physician, William Osler, kind of referred to  
17       it as -- respiratory infections, at least overall, as  
18       the old man's friend.  It was just kind of something  
19       that just took off the elderly.  So whether it's  
20       bacterial pneumonia, influenza, Coronaviruses, the  
21       frail elderly and, you know, with heart disease or  
22       cancer or other things that have debilitated them, it's  
23       the heart disease or the cancer that's debilitated  
24       them, but the thing in the very end, the last few days,  
25       that they might actually die of, is going to be a  
26       respiratory tract infection.  And so it's very common

1 in that age group.

2 And so influenza, we know that if you have a bad  
3 influenza year, the next year is often going to be  
4 light, and one of the reasons is that the previous  
5 severe season has, unfortunately, killed many of the  
6 most vulnerable, and so you've now removed a good  
7 proportion of the most vulnerable from the population,  
8 and so the next year, the flu, at least in that  
9 population may be -- the IFR at least may be relatively  
10 low. And so there's multiple different factors going  
11 on here.

12 But what we're seeing is that now, overall, the  
13 IFR of SARS-CoV-2 is approaching and very similar to  
14 seasonal influenza.

15 Q So when you say a bad year, so the IFR for influenza  
16 fluctuates then?

17 A Absolutely from year-to-year. So you -- and during  
18 pandemic years, the IFR is going to be very high. So  
19 if we're just talking about 1919 to 1920, like the 18  
20 months from late '17 to, you know -- or late 2018 to  
21 2-thousand -- or, sorry, 1918 to 1920, during the  
22 Spanish the flu, the IFR would be huge, but there are  
23 other years when influenza IFR is quite low. And so  
24 you can talk about it on a yearly basis or a strain  
25 basis, or we can talk about it over years or decades.  
26 And if we kind of generally talk about it over years

1       and decades, then the IFR of SARS-CoV-2 is now  
2       approaching the IFR of influenza.

3               But, yes, the estimated mortality of influenza  
4       year-to-year can change by two or three times in a  
5       season even in Canada. And, again, that's affected by  
6       multiple factors. One of the factors, as I said, is  
7       the previous year and the proportion of vulnerable  
8       people, but it's also going to be the natural mutation,  
9       the strains of influenza. We would call them strains.  
10      Now, you know, we call them for SARS-CoV-2, it's  
11      variants, but it's the exact same process. It's  
12      natural mutation of a respiratory virus.

13    Q   Right, but you used the word "pandemic" in describing a  
14       bad influenza year. Are you aware of what number,  
15       what -- you know, the IFR we know for low influenza  
16       must be somewhere around 0.15, but what's the number,  
17       roughly, for a bad influenza year or a pandemic  
18       influenza year? What's the IFR rate? I mean, you  
19       know, it could be 50 percent, it could be 25 percent.  
20       You know, we don't know because we don't look at this  
21       on a daily basis, and so I -- you know, it would be  
22       very helpful to have some sort of number to work with.

23    A   Yeah, I don't know the exact number for Spanish flu,  
24       but the most kind of reasonable estimates for the  
25       Spanish flu is that between 50 and 75 million people  
26       died, so we're talking an IFR in the global population

1       was not that high, so we're talking an IFR of at least  
2       1 percent in that case, if not higher.

3       Q    Okay, so 1 percent is high?

4       A    Well, it would be -- you know, I think the global  
5       population at that point was about 2 billion, so we're  
6       talking an IFR probably at that time of about 2  
7       percent. Yeah, and these are just rough estimates. I  
8       know that the most conservative estimates of the  
9       mortality was about 50 million, so that's an example.

10      Q    So has the IFR of COVID ever exceeded the IFR of a bad  
11      flu year?

12      A    Yeah, certainly early on. And with different variants  
13      and as it starts to circulate, it's -- it doesn't  
14      happen all the time, but the general way a virus  
15      circulates is that it attenuates as it goes through a  
16      population. So SARS-CoV-2 was a new virus in the human  
17      population, and there's some cross-protection from  
18      seasonal Coronaviruses, there's some cross-immunity,  
19      but because it's a new virus, early on, it's going to  
20      be more severe.

21               But what we've seen, especially with the Omicron  
22      variant, and what happens with many new virus  
23      infections within a population is that they attenuate  
24      over time, because it's to the evolutionary advantage  
25      of that virus to do that, because it infects more  
26      people.



1           Just like one of the reasons we don't see massive  
2       Ebola outbreaks is because it kills too many people too  
3       quickly, and so it just burns itself out.

4           So we saw that with the Spanish flu. The flu we  
5       have now is a descendant of that flu. And what  
6       happened is, over time, the virus itself attenuated  
7       itself, so as it just started passing through just  
8       millions of people, it became less severe. And one of  
9       the reasons for that is that -- a virus -- the  
10      evolutionary advantage for a virus is to find kind of  
11      that balance between causing some disease but not  
12      killing the people too quickly, and so we've seen that  
13      with SARS-CoV-2 as well.

14           It would be expected. It's not unexpected at all  
15      for a variant like Omicron to occur, because Omicron,  
16      for a variety of reasons, but one of the primary ones  
17      it that it has less severity, infects way more people,  
18      and that's expected.

19    Q     Okay, you said early on -- I need you, if you can, to  
20      try and give me months and years -- so what would be --  
21      you said, you know, it was severe early on, well, when  
22      was that, and when did that period end?

23    A     Well, we know, looking at the variants that there was a  
24      variant, even -- I don't know if I referenced it in my  
25      report, but there was a variant even just within the  
26      first few weeks of the pandemic that quickly switched.

1 I can look up the name. It wasn't given a name like  
2 Alpha, Beta, or Delta and stuff. It was given a name  
3 based on the base pair change. It was 'D' something,  
4 something, changed to 'G' something, I think. It was  
5 where the mutation was. So as the variants changed,  
6 they're going to have different IFRs, and we've kind of  
7 seen that. It does seem as though Delta was a little  
8 more severe than, say, Alpha. But that change started  
9 very early on, within weeks, and then we started seeing  
10 things like Alpha and then Delta and now Omicron.

11 And so very early on, the IFR is going to be high,  
12 because the most -- again, various reasons, but the  
13 most susceptible are going to be dying, and then once  
14 you eliminate those -- the most frail and -- who have  
15 been infected from the population, you also have a less  
16 frail population, and so that's one reason. I don't  
17 want to oversimplify it here. One is inherent to the  
18 virus itself. There's a difference between Delta and  
19 Omicron, and so the IFR is going to change between the  
20 variants, but the population itself is going to change.  
21 And so if you have a complete naive population early in  
22 the pandemic, that's going to change once the first  
23 wave goes through, because, all of a sudden, the  
24 frailest population are no -- are, unfortunately, no  
25 longer in the population because they've died, and so  
26 you have a population change. And these are just two

1 factors.

2 It's complicated. I think one of the risks, at  
3 any point, is oversimplifying, but those are two very  
4 important factors.

5 Q Thank you. When did the first wave end roughly in  
6 Canada?

7 A Well, would have been the late spring of 2020, and I  
8 don't have the graphs ahead of me, but I certainly  
9 think by May absolutely.

10 Q At what point did the data indicate that the IFR was no  
11 longer severe or high or whatever word you want to use?  
12 You used the word "severe"; at what point did the data  
13 indicate that the IFR was no longer severe?

14 A Well, it was within a couple months as we gathered more  
15 data. By the end of the first wave, the idea of the  
16 dramatic difference in mortality between the young and  
17 the old was evident, and by the end of that first wave,  
18 you know, within the first kind of three months, we had  
19 a rough estimate at that point of what the IFR would  
20 be, and then since then, it's been just trending down.  
21 Again, as more and more people get infected, and,  
22 unfortunately, the -- you know, the oldest, the  
23 frailest have already died, the IFR has been trending  
24 down.

25 Q Would you say the official definition of a pandemic is  
26 objective or subjective?

1     A     Well, I think any definition, you know, you can get  
2           pedantic about it, but SARS-CoV-2 is clearly a  
3           pandemic. Some people define it as, you know,  
4           affecting multiple continents. Some people will argue  
5           the first pandemic was the Antonine plague in the '160s  
6           because it occurred in Africa, Europe, and Asia. And,  
7           at least based on the records we have, we don't know of  
8           any other infection before then that occurred on three  
9           different continents. So it depends on how you define  
10          your terms, but I think it's clear that SARS-CoV-2 is a  
11          pandemic; there's no doubt about it.

12     Q     Is it pandemic because it's "pan" because it's global?

13     A     Well, yeah. It comes from -- you know, "pandemic" just  
14           comes from the Latin root of "pan", which is all, and  
15           "demos", which is people, and so it's all people.  
16           We've seen that. Like it's even on Antarctica. I  
17           think this is the first pandemic in history that's been  
18           on all seven continents.

19     Q     Is there no severability criteria for determining  
20           something is or is not a pandemic?

21     A     Yeah, you know, I think for something like seasonal  
22           influenza, you have global infections every year, you  
23           have waves every year, and so you would talk about  
24           severity, so we would have a pandemic when -- in the  
25           scientific literature about influenza, we talk about  
26           antigenic drifts, which is the small changes that occur

1 year to year, and then antigenic shifts, which is the  
2 major changes.

3 And, generally, when there's an antigenic shift,  
4 we have a pandemic because we have a significant change  
5 in the virus, which then you have a large proportion of  
6 the population which don't have good cross-reactive  
7 immunity. And so whether it's swine flu in 2009 or  
8 previous pandemics in the 20th century, like 1968 and  
9 there's been others, but at least in influenza, yeah,  
10 it's not occurring on -- everywhere in the world,  
11 because that occurs every year, but it's a major change  
12 that increases the symptomatic infectivity, so  
13 morbidity as well as mortality.

14 Q So some years, influenza is severe enough to be  
15 pandemic and other years, it's not; do I have that  
16 right?

17 A Correct, yeah.

18 Q So you said that COVID was severe enough in the  
19 beginning to be, you know, at least as bad as a  
20 pandemic influenza, but is it now at the point of  
21 seasonal influenza? Is that a proper way to  
22 characterize it?

23 A Yeah, once it becomes endemic, that's a good question.  
24 Again, some of the definitions are going to be  
25 arbitrary. You'll talk to some experts now who will  
26 say, oh, COVID's already endemic, others will say no.

1 You know, a lot of people will say, okay, with Omicron,  
2 that's what we're seeing now, it's endemic, we have so  
3 many people infected. And others will say, well, no,  
4 we can't call it endemic.

5 There's essentially uniform agreement that it will  
6 be endemic, it's just kind of defining where that's  
7 going to be is somewhat arbitrary. But, yes,  
8 SARS-CoV-2 will be endemic, and whether you want to say  
9 that that's now or whether it's going to be three, six  
10 months from now, it's I think relatively arbitrary how  
11 you say it. It was pandemic; it's going to be endemic.  
12 Where you define that cutoff, I don't think it's easy  
13 to kind of say one particular --

14 How I would define is that we start seeing a  
15 different respiratory virus predominantly, because we  
16 haven't seen massive waves of influenza, and that's not  
17 unusual. So like in the hospital, we see different  
18 respiratory viruses at different times, and so we have  
19 a usual wave of influenza, say, in January, it's after  
20 influenza leaves that we're going to see some of the  
21 other important respiratory viruses in the waves of,  
22 say, parainfluenza or human metapneumovirus.

23 And how I would define the endemic state of  
24 SARS-CoV-2 is once we start seeing the return of waves  
25 of other important respiratory viruses, maybe it's in  
26 the spring with human metapneumovirus, I don't know,

1 but once that occurs, when we're having more cases of a  
2 different respiratory virus, I think we can safely --  
3 to me, that's an objective criteria of how to kind of  
4 define the endemicity of SARS-CoV-2.

5 Q At what point in time did you become confident that  
6 SARS-CoV-2 was going to be endemic?

7 A Once you have community transmission on every  
8 continent, yeah. So it would have been within weeks of  
9 the pandemic.

10 Q Okay, but just to clarify then, that would place you in  
11 January 2020?

12 A No, no. Like early April 2020.

13 Q Okay, so just to clarify, by early April 2020, you  
14 looked at the data and thought this is going to be  
15 endemic?

16 A Yeah, absolutely.

17 Q So at that point, attempts to completely stop the virus  
18 are futile?

19 A Yeah, absolutely.

20 Q At that point, were attempts to slow it down  
21 theoretically possible to work?

22 A No. I think each different thing can be judged based  
23 on the evidence, and that's what I do in my report. I  
24 think most interventions had little or no effect, and  
25 the evidence is bearing that out. We know that from  
26 previous similar infections and -- but each different

1 intervention would have to be judged on its own merits,  
2 so whether it's masking or lockdown, kind of  
3 shelter-in-place, or, you know, testing in isolation,  
4 each of those factors can be judged on its different  
5 merits. But I think what we've clearly seen is that  
6 the interventions put in place have not had a  
7 significant effect.

8 Q And you do realize that many people say that they have  
9 had a positive effect?

10 A Yeah.

11 Q And you disagree with them; is --

12 A I do.

13 Q -- that fair to say?

14 A Yeah.

15 Q And now, generally speaking, correct me if I'm wrong,  
16 but at least in Canada, aren't the vast majority, if  
17 not all, you know, public health agencies and  
18 government bodies and medical officers of health saying  
19 that, look, these measures did work over the last two  
20 years; isn't that right?

21 A Yeah, there's lots of people claiming that, but it can  
22 be debated endlessly as to what actual effect they did  
23 or did not have.

24 Q Well, at least for you personally, is there a debate  
25 happening?

26 A Yeah, there's actually really starting to be a debate



1 both in society generally but in the academic  
2 literature as to what effect these different measures  
3 had or didn't have, and again each one needs to be  
4 judged based on the merits of each different  
5 intervention.

6 But, yeah, both in the general public, I think,  
7 globally, we're seeing an openness to debating and  
8 seeing what the actual risk and downsides have been to  
9 each individual intervention, but we're seeing that in  
10 the academic literature as well.

11 Q In your experience, have the public health agencies and  
12 medical officers of health in Canada been open to  
13 having that debate.

14 A You know, I think most of the public health agencies in  
15 Canada have had similar strategies and have not kind of  
16 differed too much from themselves. I think if you look  
17 at somewhere like Europe or the United States, which  
18 have similar numbers of jurisdictions, a few dozen  
19 jurisdictions in each of them and there's been wide  
20 differences, and so looking at different states and  
21 comparing them and looking at different countries in  
22 Europe and comparing them can be helpful. But, again,  
23 that has to be done carefully, because, as I mentioned  
24 in my report, just doing that is the lowest level of  
25 evidence, and it kind of commits the ecological fallacy  
26 in statistics.

1           But, anyway, I do see quite a change in, you  
2           know -- for instance, right now, a big debate, you're  
3           seeing it in all sorts of media, whether it's the  
4           New York Times or The Atlantic but also in the academic  
5           literature just this week about, you know, masking  
6           school age children. Like the New York Times and The  
7           Atlantic, you know, having articles this week, it's  
8           just been in the last few days, saying, yeah, the  
9           evidence just isn't there, you know, we don't need to  
10          be masking young school age children in schools. And  
11          we're seeing these kind of studies come out in the  
12          medical, the academic literature as well.

13           And I think what happened in the past is that, in  
14          the absence of a lot of that evidence, assumptions were  
15          made, and we -- you know, the term for that is called  
16          medical reversal, and it's very difficult, once  
17          assumptions are made, to reverse kind of course, and so  
18          you're gathering a lot more information now and seeing  
19          both the risks and benefits of various different  
20          interventions.

21    Q    You just talked about how, once assumptions are in  
22          place, they're very difficult to reverse or change;  
23          does that help to explain why the public health  
24          agencies in Canada sort of refused to listen to experts  
25          like you and cease the restrictions?

26    A    Yeah, you know, there are many different reasons for

1        why things occurred, yeah. You know, that's a whole  
2        other topic, why one group was listened to and one not.  
3        But that evidence is accumulating now, and so that's  
4        why you're seeing a lot of jurisdictions treat this  
5        very differently. Once that evidence is becoming more  
6        and more clear, more and more robust, you're seeing a  
7        lot less restrictions.

8        Q    Those assumptions you mentioned, are they, for the most  
9        part, false or wrong or inaccurate?

10      A    Well, again, it really depends on what you're talking  
11      about I think. If you talk about, say, again masking  
12      children, there's next to no studies in that. We can  
13      talk about studies in masking adults. The masking of  
14      healthy children, there was just no studies prior to  
15      the pandemic, but the assumption is, well, masks are  
16      good for health care workers in high-risk settings,  
17      they must be good for children.

18                And as evidence accumulates, there should have  
19      been more. There -- no randomized control trials of  
20      children were done in the pandemic when they should  
21      have been, they should have done cluster-randomized  
22      trials of different schools and classrooms, just like  
23      they did the cluster-randomized trial in Bangladesh,  
24      and then we could have quantitated. But the assumption  
25      was made, oh, they must be good, so we're going to do  
26      it, but then as the evidence accumulates, we learn more

1       that there is no benefit, and so we shouldn't be doing  
2       it.

3               In fact, there's lots of harms with regards,  
4       particularly, with emotional and cognitive learning in  
5       children if you mask both the children and the  
6       teachers.

7       Q   Now, I'm going to ask you a little bit about one of  
8       those assumptions, and that's asymptomatic  
9       transmission. So this is on page 3 of your report, the  
10      third section. You say in your report that the rates  
11      of transmission from asymptomatic persons is  
12      substantially less than from symptomatic persons. So  
13      the first question I have for you, of course, is has  
14      the data or your opinion changed on that in the last  
15      year?

16     A   No, it has not changed.

17     Q   Now, what do you mean by "substantially less"? Give us  
18      an idea of how much less asymptomatic transmission is  
19      than symptomatic.

20     A   Well, I note a number of studies, but I think the most  
21      important one would be study 53, because it's a  
22      meta-analysis of household transmission, and household  
23      transmission is, by far, the most important location of  
24      transmission. So some estimates are as high as 80  
25      percent of all transmission occurs within the  
26      household, and that makes sense, this is where people

1 are in intimate contact with each other. So this study  
2 I think is very helpful and very reliable.

3 So it's looking at household transmission, which  
4 is the most important factor or place where  
5 transmission occurs. It had a large number of  
6 participants, close to 80,000, and the difference  
7 between -- and it can be controlled. Like a household  
8 is kind of like a unit, and so, again, I think this was  
9 a very good study and very representative of the  
10 literature and reliable, and it showed that the  
11 difference between symptomatic transmission and  
12 asymptomatic transmission was about 25 times. And so I  
13 think that would be where I would -- you know, get that  
14 word "substantial".

15 Q Thank you.

16 THE CHAIR: Mr. Kitchen --

17 MR. KITCHEN Yes.

18 THE CHAIR: -- I just wonder, is there a  
19 point, a logical point in your approach where we could  
20 take a short break?

21 MR. KITCHEN: Yes, I was planning to after I  
22 finished asymptomatic transmission, and I don't think  
23 I'm going to be on that very much longer --

24 THE CHAIR: Okay, thank you.

25 MR. KITCHEN -- so just a couple more  
26 minutes.

1 Q MR. KITCHEN: Dr. Warren, you further say  
2 that asymptomatic transmission does not warrant being  
3 considered a significant contributor to the overall  
4 transmission burden. Now, maybe that's obvious based  
5 on what you just said, but can you just explain why  
6 that's your opinion?

7 A So it can be -- my opinion can be considered in a  
8 number of domains. The first is just the number  
9 itself. So if we're talking about something that's 25  
10 times less important, I think that's one domain. The  
11 other domain, you know, relates to the point we've  
12 already discussed, which is the fact that the virus is  
13 going to be around forever, and kind of related to that  
14 is the idea of treating an asymptomatic person as  
15 diseased. I think that has huge, kind of moral,  
16 philosophical, whatever implications. And so you have  
17 something that's going to be around forever, you can't  
18 treat the entire population, you know asymptomatic, as  
19 potentially infected with regards -- just on a moral --  
20 in my opinion, of course, but on a philosophical level,  
21 you can't -- it's dangerous I think, societally, to be  
22 treating everybody who otherwise looks healthy as a  
23 potential germ carrier for an infection that's widely  
24 prevalent and going to be around forever.

25 Q But is it, nonetheless, scientifically accurate?

26 A What's scientifically accurate?

1 Q That there are a large number of asymptomatic healthy  
2 people going around that, you know, are harbouring  
3 something that can make people really sick, and they're  
4 likely to transmit it even though they're healthy?

5 A Well, I think it's just best to use numbers like I use  
6 in my report. Like I think the best evidence that we  
7 have is that asymptomatic transmission is 25 times less  
8 than symptomatic transmission, and to me, that -- you  
9 know, that's -- statistically that's a relatively large  
10 number. I'm happy to call that substantially  
11 different.

12 Q So it's not a good assumption that -- that most healthy  
13 people could transmit this thing?

14 A No, I don't think it's justified, based on the  
15 evidence, that we should be treating every healthy  
16 asymptomatic person as a potential -- potentially  
17 infected with SARS-CoV-2. You know, I think -- again,  
18 everything to be qualified, if you're talking about  
19 someone who is in very close contact, you know, of  
20 course. And so, of course, there's going to be  
21 exceptions to the rule, but it just proves the rule.  
22 But I think, generally, at a population level, I don't  
23 think the evidence warrants treating everybody in the  
24 population who is asymptomatic as a potential  
25 transmission risk for SARS-CoV-2.

26 Q Now, I'm going to come to masking after the break, but

1       just help me out, isn't that the assumption behind  
2       mandatory masking of all healthy people? Like  
3       (INDISCERNIBLE) --

4     A   That's -- yeah, that's certainly one of the assumptions  
5       for masking the healthy general public, absolutely.

6     Q   Almost done before we break. Now, as you know, Dr. Hu  
7       on page 6 of his report says your opinion regarding  
8       asymptomatic transmission is, quote, contradicted by a  
9       CDC report which says that 60 percent of COVID  
10      transmission is asymptomatic. Now, Dr. Hu does not  
11      provide the citation for this report, but are you aware  
12      of what report he is referring to?

13    A   No, I'm not aware.

14    Q   Do you find that strange that he didn't cite to the  
15      report?

16    A   Well, I can't comment specifically on that, but  
17      generally if you're going to cite a number or a  
18      statistic or discuss a number or statistic in either  
19      the academic literature or a formal document such as  
20      this, you would provide a reference, like I did with  
21      all of mine.

22    Q   Well, do you think the -- I guess you've already  
23      answered this, but, just to clarify, do you think the  
24      balance of the scientific literature that is available  
25      supports your opinion that symptomatic transmission is  
26      way more prevalent than asymptomatic?



1     A     Yes, that's what I state in my report, and I don't --  
2           my opinion has not changed, that symptomatic  
3           transmission is substantially more important than  
4           asymptomatic transmission.

5     MR. KITCHEN:                         So that's it for me for the --  
6           you know, we can break now, and then I'll have some  
7           more when we come back. I'm, you know, probably  
8           halfway through, maybe a little less, but close to  
9           halfway through.

10    THE CHAIR:                            Okay. Thank you, Mr. Kitchen.  
11           And, Dr. Warren, we're going to take a 15-minute break,  
12           and you can put your connection -- you can mute and  
13           turn your camera off during this period, but please  
14           don't break the connection to the meeting and don't  
15           speak with Mr. Kitchen, and we will see everybody in 15  
16           minutes. 25 to 11 I think.

17           (ADJOURNMENT)

18    THE CHAIR:                            Mr. Kitchen, the floor is  
19           yours once again; we'll resume your direct examination  
20           of Dr. Warren.

21    MR. KITCHEN:                         Thank you.

22    Q     MR. KITCHEN:                    Dr. Warren, from pages 3 to 5  
23           of your report, you discuss the evidence for lockdown  
24           measures, generally speaking, including physical  
25           distancing. Prior to the year 2020, was there much  
26           scientific evidence or academic literature in support

1 of the effectiveness of physical distancing?

2 A No, there was essentially none, and that -- I think I  
3 gave a quote in -- yeah, there's a systematic review  
4 published in -- it was a Cochrane systematic review,  
5 and towards the end of page 4, I quote: (as read)

6 There was only one randomized controlled  
7 trial of quarantine and no trials of  
8 screening and (INDISCERNIBLE) or for physical  
9 distancing.

10 So the highest level of evidence, as I discussed in  
11 other parts of my report, are randomized controlled  
12 trials or meta-analysis of randomized controlled  
13 trials, and there was just none of that evidence with  
14 regards to various lockdown measures prior to the  
15 pandemic.

16 I can discuss that one randomized trial that they  
17 discuss there, but -- in a quote. There was a  
18 randomized controlled trial in influenza in Japanese  
19 persons. What they basically randomized Japanese  
20 workers to is that home quarantine while they were  
21 symptomatic or not. And what it found is it had no  
22 significant difference on overall rates of influenza.

23 So what happened is these Japanese workers, who  
24 were quarantined at home, did -- their offices, their  
25 co-workers had lower rates of influenza, but it was  
26 counter-balanced by higher rates of influenza within

1       these quarantine workers' families. And so in the end,  
2       it made no overall difference, because it just shifted  
3       the number of infections from one place to the other.

4               And there are some interesting papers out there to  
5       suggest the same thing happened in COVID-19, because  
6       the household is already the highest -- or the most  
7       likely case -- a place of transmission, when you have a  
8       whole bunch of people sheltering in place, either  
9       you're just transferring infections from one place to  
10      the other, or, in fact, there's some people that would  
11      argue that infections may have been increased because  
12      of that.

13             Particularly in congregate settings, because  
14      you're -- places like nursing homes, group homes, other  
15      places where people are living but within close  
16      proximity to others that we have these shelter-in-place  
17      restrictions, it may actually increase the numbers of  
18      infection.

19             But, again, the evidence there isn't clear.  
20      There's lots of people kind of debating that, but prior  
21      to COVID-19, there was essentially no evidence for the  
22      positive effect of various different lockdown measures,  
23      including physical distancing, isolation -- or, you  
24      know, sheltering in place.

25    Q       So is it basically there was a hypothesis that this  
26       could work, and then that hypothesis was implemented;

1 is that sort of what happened back in the -- you know,  
2 early 2020 in Canada?

3 A Yeah, there are a lot of different things going on  
4 here, I'm happy to talk about that, but, number one, a  
5 lot of the decisions were based on modelling. And as  
6 part of my Masters, I've done some modelling courses.

7 And one of the key metrics in modelling is this  
8 factor called Beta, which is just the average number of  
9 interactions a person in the model is going to have  
10 with other people. And by changing that one number in  
11 modelling, at least, you can change the size of waves  
12 or the number of infections and things like that.

13 So because a lot of decisions were based on  
14 modelling, and that one factor is so important in the  
15 modelling, the idea was if we can decrease the number  
16 of interactions people have with other people, then  
17 we're going to greatly decrease the number of  
18 infections. Again, I think there's various problems  
19 with that: Number one, the idea that most transmission  
20 occurs in households and kind of really isn't  
21 considered in that; number two, as I talked about in  
22 population density, in very population-dense areas,  
23 even sheltering at home, you're actually not reducing  
24 the number of -- significantly reducing the number of  
25 people, other people you are going to interact with,  
26 because you're still going out to walk your dog, you're

1 still going to the grocery store. You know, if I'm in  
2 downtown Toronto, and I'm walking two blocks to the  
3 nearest grocery store, I'm interacting with a lot of --  
4 I'm going by a lot of people, and -- anyway. So that's  
5 one thing number one.

6 Then the other issue is that policies were  
7 going -- at least early on, very early on, were going  
8 to be heavily influenced by what happened with  
9 SARS-CoV-1. And what happened with that infection is  
10 that various different quarantine -- there were no  
11 lockdowns, but that infection was able to be controlled  
12 with various public health measures, mostly just the  
13 usual stuff: Sick patients are kind of quarantined to  
14 learn better; testing and tracing, so testing and  
15 tracing all of their contacts. But that infection,  
16 didn't last long, occurred -- recurred briefly in  
17 various places like Singapore and different cities in  
18 China and stuff.

19 But I think early on, because it wasn't that long  
20 ago, it was I think only 16 years previous, a lot of  
21 the policy was heavily influenced from that, and  
22 pandemics have a deep kind of social history, right?  
23 Like when you talk about things like the Black Death,  
24 in a lot of places in Europe, you know 50 percent of  
25 the population died from that pandemic and from plague,  
26 and there have been many others and stuff as well.

1           So deep within the societal consciousness, you  
2       know, there's fear of major infections. And in some  
3       cases, in different infections historically, lockdown  
4       or lockdown-like measures have worked, and you think of  
5       things like smallpox and quarantine. So you had, you  
6       know, a boat with -- you know, you think of 1720s  
7       Boston, and there's evidence, you know, of this, you  
8       have a -- and there's no smallpox in Boston, but you  
9       have a boat coming in over from England where there's  
10      people with smallpox on it, well, that boat is  
11      quarantined, it's locked down in the harbour for  
12      several weeks until there's no more transmission of  
13      smallpox. And I can give many other examples from  
14      history.

15           And so it's a complicated issue with regards to  
16      lockdown, quarantine, things like that, so I think  
17      those are kind of the three main ones that I just  
18      addressed.

19    Q     Thank you. I mean, I guess you've touched on this, but  
20       just to be specific, has the evidence, you know, over  
21       the last two years substantiated the theory that  
22       physical distancing is effective?

23    A     No, but, again, it's a hotly debated topic because we  
24       don't have the best evidence. The best evidence is  
25       randomized controlled trials, and those trials could  
26       have been done. And, in fact, in small instances, they

1 have.

2 So most of the evidence, what we're doing is  
3 ecological studies, so comparing one jurisdiction to  
4 the other. And as I mentioned with regards to masks,  
5 there's all sorts of statistical problems with that.

6 And, you know, debating various different lockdown  
7 measures kind of with the type of evidence we have is a  
8 whole other discussion, but the best evidence,  
9 randomized controlled trials, which should be done for  
10 everything, we just don't have that evidence.

11 But I give an example of one that was done, and  
12 it's something that should have been done more, so in  
13 Massachusetts, they did a randomized controlled trial  
14 of school children of 3-feet distancing versus 6-feet  
15 distancing, and there was no difference. Okay, so it  
16 was a cluster-randomized trial, much like the  
17 Bangladeshi mask study, so you randomized classrooms  
18 versus -- rather than people. That's the standard way  
19 of doing this type of intervention. And they showed  
20 that there's no difference between 3 feet and 6 feet.

21 And so that study kind of proved the point that  
22 that type of study can be done and should have been  
23 done everywhere throughout the pandemic, looking at a  
24 variety of different interventions. And when that type  
25 of study is done, what it will show, and what it showed  
26 prior to, as I talked about with that Japanese worker

1 study in influenza, which I think was 2010 or so,  
2 somewhere around there, when those types of studies are  
3 done prior to COVID and the very few that have been  
4 done during, they don't show much of an effect of these  
5 different lockdown-type procedures.

6 Q Thank you. Now, I want to ask you some questions about  
7 masks. On page 5 of your report, your section on the  
8 evidence regarding masks, you refer to, quote, healthy  
9 people, and I think we've touched on this, but just to  
10 be clear, for you is asymptomatic the same as healthy?

11 A Well, asymptomatic, I think you're -- yes, I guess.  
12 Again, it's depends on how you define your terms. If  
13 we're talking asymptomatic with regards to SARS-CoV-2,  
14 they could be unhealthy otherwise. They could have  
15 heart failure and diabetes and advanced-stage cancer; I  
16 wouldn't call them healthy, but they're asymptomatic  
17 with regards to respiratory symptoms.

18 Q So healthy in regards to not having cold flu symptoms?

19 A Right, yeah.

20 Q Okay. Is a mandate that all chiropractors wear a mask  
21 at all times in their office, is that effectively a  
22 mandate that all asymptomatic chiropractors wear a mask  
23 at all times in their office?

24 MR. MAXSTON: I'm going to have to object to  
25 that, Mr. Kitchen. I think that's a pretty central  
26 question for the Hearing Tribunal to decide.



1 MR. KITCHEN: Well, you're going to have to  
2 explain that.

3 MR. MAXSTON: Well, we can't ask this  
4 witness to comment on the College's mandate and its  
5 broader implications of it. I think your question is a  
6 little too broad, Mr. Kitchen.

7 MR. KITCHEN: Well, I'll rephrase it again,  
8 just -- not rephrase it, but say it again, because I'm  
9 struggling with that. I'm asking him is it logically  
10 accurate that a mandate that all chiropractors wear  
11 masks at all times in their office is a mandate that  
12 all asymptomatic chiropractors wear a mask at all times  
13 in their office? I'm asking if those two things are  
14 logically equitable. That's got nothing to do with any  
15 determination that the Tribunal has to make.

16 MR. MAXSTON: I guess you can take this  
17 witness to the Pandemic Directive, Mr. Kitchen, and you  
18 could ask him to comment on that, but I'm not sure I  
19 agree with you. I think that that's a broader question  
20 that goes to I think one of the conclusions the  
21 Tribunal is going to have to make based on the issues  
22 you are raising.

23 MR. KITCHEN: That being --

24 THE CHAIR: Mr. Kitchen, the first part of  
25 your question is all chiropractors, right?

26 MR. KITCHEN: Right. And I, you know -- I

1 thought this was not contentious. Maybe my friend can  
2 tell me. I mean, as far as I know, there's no  
3 disagreement here that the Pandemic Directive says that  
4 all chiropractors must wear a mask at all times while  
5 in their office.

6 Do you take issue with my characterization,  
7 Mr. Maxston?

8 MR. MAXSTON: The Pandemic Directive says  
9 what it says in terms of chiropractors having to wear  
10 masks when they treat patients. But I think, in  
11 fairness, you'd have to take this witness to the actual  
12 wording in the Pandemic Directive and ask him what his  
13 interpretation of it is, and I might have some  
14 objections I suppose to that. But I think your  
15 question, as it's framed, I just think is too  
16 general --

17 MR. KITCHEN Okay.

18 MR. MAXSTON: -- or relates to one of the  
19 issues this Tribunal's going to have to decide on.

20 I don't have a problem with you asking questions  
21 about masking and asymptomatic patients, you know,  
22 that's not -- I'm not going to object to that, of  
23 course.

24 MR. KITCHEN: Well, do you have any  
25 objections to me reading to him what the directive says  
26 in that portion?

1 MR. MAXSTON: I don't think I would. I  
2 think I would have objections to you asking him about  
3 the -- I want to say it, how that applies in the  
4 chiropractic office vis-à-vis a chiropractor and  
5 patients.

6 MR. KITCHEN: Well, at least for this  
7 question, I'm not asking.

8 MR. MAXSTON: Yeah. Well, as I said, I  
9 think it's probably better to take him to the Pandemic  
10 Directive if you want to ask questions about the  
11 meaning and intent of the Pandemic Directive. That's  
12 all I'm saying here is it just seems to me that this is  
13 a little bit of a bigger picture issue that the  
14 Tribunal's going to have to decide on.

15 THE CHAIR: Would it be possible to put  
16 that directive up on the screen?

17 MR. KITCHEN: I don't know if Ms. Nelson can  
18 do that quickly. The only reason I don't want to --  
19 I'm just trying to save time.

20 MR. MAXSTON: And, Mr. Kitchen, you know, it  
21 says what it says --

22 MR. KITCHEN: Yeah.

23 MR. MAXSTON: -- I'm not -- if you want to  
24 ask your client about whether he thinks that directive  
25 is, you know, scientifically supported, you've been  
26 doing that already, I suppose, indirectly; I'm just a

1       little concerned about saying -- you know, asking him  
2       to draw a conclusion about this specific directive in  
3       the context of, I guess, the charges that are in front  
4       of the Tribunal.

5       MR. KITCHEN:                   Well, let me ask a series of  
6       open-ended questions, and maybe we can resolve this.

7       Q   MR. KITCHEN:               Dr. Warren -- my friend can  
8       intervene if he thinks this is a problem -- but there  
9       are approximately 1150 regulated chiropractors in  
10      Alberta. That's somewhere in the record; I don't think  
11      that's contentious. Is it possible that -- well, is it  
12      possible that all of them are going to be symptomatic  
13      at exactly the same time?

14     A   I don't totally understand the question, but obviously  
15      not; I don't think there would be 1100 people  
16      symptomatic at the same time.

17     Q   And I can tell you this because it's in the record, I  
18      don't think it's contentious, chiropractors are not  
19      actually in the directive. I can't say precisely right  
20      now. Certainly in the relevant time period here which  
21      we're talking about, which is about May 2020 to  
22      December 2020, chiropractors weren't, in fact, allowed  
23      to be in their office if they were symptomatic, okay?  
24      So if there's a requirement -- and I'll read it to you  
25      if I have to, but, again, I don't think I'm  
26      mischaracterizing it -- if there's a requirement that

1       chiropractors wear a mask while in their office  
2       treating patients, and that requirement is static or  
3       universal, is that not a requirement that asymptomatic  
4       chiropractors wear a mask at all times in their office  
5       when they're treating their patients?

6     A    So from what I understand from the question, I'm not  
7       again entirely sure, but it sounds like the directive  
8       says that chiropractors may not practice or be in their  
9       office if they're asymptomatic [sic], and presumably  
10       that's the same for their patients as well with regards  
11       to COVID symptoms; and so I think the question then is  
12       if they're not allowed to be in their office or  
13       practicing -- seeing patients, if they're symptomatic,  
14       then, by definition, they're wearing a mask as  
15       asymptomatic persons while performing the chiropractic.  
16       Is that correct? And so that's what you're asking?

17    Q    That's what I'm asking, yes.

18    A    Yes, okay.

19    Q    I'm going to ask you a few questions about health care  
20       settings and non-health care settings, but let's first  
21       talk about non-health care settings. You say in your  
22       report that when limited to the strongest types of  
23       evidence, RCTs as we've discussed, there is no evidence  
24       in support of healthy or asymptomatic people wearing  
25       masks in non-health care settings. You've already  
26       explained all that.

1           Just to clarify, because I know that, you know,  
2           this is an issue with Dr. Hu, there are multiple  
3           peer-reviewed publications that support your position  
4           on that?

5    A    Yes, so as I state in my report, pages -- and page 5  
6           primarily, so prior to COVID, there was studies of  
7           randomized controlled trials of masking asymptomatic  
8           persons. Most of the studies were relatively small.  
9           Some showed marginal benefit, others didn't. And when  
10          those -- when randomized controlled trials are put  
11          together and all of the evidence and all of the  
12          patients are compared in one big group, it's called  
13          meta-analysis. And there's three meta-analyses, all of  
14          them done just prior to COVID, in fact, one of them,  
15          the Cochrane review, done during COVID but was only  
16          including studies done prior to COVID that showed there  
17          was no difference.

18               And so that's what happens, when you have  
19               randomized -- and the randomized controlled trials  
20               looking at masking healthy people primarily to prevent  
21               influenza were relatively small, and they're  
22               contradictory. Some would say, yeah, there's some  
23               marginal benefit, others no.

24               And so the standard way of kind of deciding the  
25               issue is a meta-analysis. And three meta-analyses said  
26               that the bottom line is that there is no evidence of

1       masking healthy persons in the community to prevent  
2       respiratory tract infection, and that was primarily  
3       influenza, but not -- see, that's tricky, it was  
4       primarily influenza, but it was influenza-like illness,  
5       ILI, which is a very standard, more or less symptomatic  
6       definition than a laboratory based definition, because  
7       never in history have we done such extensive testing on  
8       a respiratory virus than we've done on SARS-CoV-2,  
9       COVID-19.

10      Q   Now, to your knowledge, have there been RCTs done since  
11       writing your report, you know, on masking in the  
12       context of COVID?

13      A   Yeah, so in my report, I mention one randomized  
14       controlled trial done early in Denmark --

15      Q   Yeah.

16      A   -- with regards to masking, and it showed no  
17       significant difference. And since then, there has --  
18       there's been two performed, one of -- so one was in  
19       Africa, I forget the exact country, that has -- even  
20       the preliminary results haven't been published, but it  
21       just finished I think in November, Guinea-Bissau I  
22       think is where it -- anyway, I don't want to say for  
23       sure -- but it was a -- I think a large  
24       cluster-randomized trial as well.

25               But there was a large study that's been discussed  
26       in the media for the last few months, done in

1 Bangladesh. It was a cluster-randomized trial of over  
2 300,000 persons in Bangladesh. And so what they did is  
3 they randomized villages to wearing masks or not,  
4 rather than persons, but the number of -- total number  
5 of people was over 300,000.

6 It's interesting that study was finished last  
7 summer and published on the study investigator's  
8 website I think at least September 1st, but it hasn't,  
9 as far as I'm aware, even appeared in a preprint form,  
10 much less peer-reviewed literature, but it's widely  
11 discussed in the media, and there are certainly some  
12 conclusions that can be taken from the data that's  
13 available.

14 Q And what would those conclusions be?

15 A So the bottom-line conclusions were that -- so they  
16 cluster-randomized some villages to cloth masks and  
17 some villages to medical masks, and the overall  
18 benefit, if you include both those groups, was very  
19 small. So the absolute risk reduction -- I can just  
20 bring it up here -- the absolute risk reduction was  
21 from .76 percent down to .69 percent, so a 0.7 percent  
22 reduction. That's the absolute risk reduction.

23 So what that says is that -- and so there's some  
24 important features to consider when we're talking about  
25 this study. One of the most important things is what  
26 was the primary end point. So the primary end point



1 was not death, was not hospitalization -- at least in  
2 the initial report, they don't even mention that -- the  
3 primary end point was serologically confirmed symptoms,  
4 so people who had symptoms of COVID and then had a  
5 serology test indicating that they had the infection.  
6 Okay, so it's really produced -- it's really a study of  
7 where the end point is infection, okay?

8         And in the control group, no masks. The rate of  
9 infection was .76 percent, and in the treatment group,  
10 overall, it was .69. So relatively low rates of  
11 infection in both, but then we can compare them. So  
12 that's important.

13         But then when they broke that down into the  
14 treatment, and they broke it down into cloth masks  
15 versus medical masks, the cloth masks actually had no  
16 effect, no benefit whatsoever statistically. And then  
17 when they look at surgical masks only compared to  
18 control, which is no masks; in controls, again, it was  
19 .76 percent, in surgical mask villages, it was .67  
20 percent. So for an absolute risk reduction of .9  
21 percent.

22         And in randomized controlled trials, the absolute  
23 risk reduction is a very important number, because when  
24 we take the inverse of it, so we just 1 divided by the  
25 absolute risk reduction, we get what's called the  
26 number needed to treat; so if we did the same thing in

1 the study that they did, how many people would we need  
2 to treat without intervention to get one effect.

3 So if we take .09 percent and do the inverse of  
4 it, it's approximately 1100, just over 1100. And so  
5 what you need to do is take 0.009 and then take the  
6 inverse. So 1 divided by 0.009, you get 1100, okay?  
7 And so what that said -- and the study went on for  
8 eight weeks; you can find that in the "Methods".

9 So what that tells us is we need to -- in a  
10 general healthy population, we need to have 1100 people  
11 wear a mask for eight weeks to prevent one infection,  
12 not one death, not one hospitalization, but one  
13 infection. So 1100 people wearing a mask for eight  
14 weeks to prevent one infection, and that's a remarkably  
15 high number. Like if there's any sort of intervention  
16 that we're studying in cardiology or infectious  
17 diseases or, you know, in my -- like with antibiotics  
18 and bacteria or, you know, cardiology, that number is  
19 remarkably high. Generally something over -- between  
20 50 to 100 is high, but anything over that -- like  
21 anything under 50 would be kind of low.

22 And it's not a hard outcome. It's always  
23 important to say what's the outcome. And maybe it is  
24 worth masking 1100 people for eight weeks to prevent  
25 one death, but it's not; it's masking 1100 for eight  
26 weeks to prevent one infection.

1           So that's the best evidence we have in SARS-CoV-2

2   Q   Thank you. Now, on this vein, Dr. Hu compared  
3       conducting RCTs on masking in the context of COVID and  
4       health care workers to conducting RCTs on parachutes in  
5       the context of people jumping out of airplanes. You're  
6       aware of that, right?

7   A   Yeah, I read that.

8   Q   What's the likelihood that a person who jumps out of a  
9       plane without a parachute will live?

10  A   Presumably zero.

11  Q   What's the likelihood that a person who contracts COVID  
12       will live?

13  A   Depends on the age group, but, overall, in all persons,  
14       it's probably over 99 percent.

15  Q   Is it reasonable to compare the strength of evidence in  
16       support of the effectiveness of parachutes to the  
17       strength of the evidence in support of the  
18       effectiveness of masks?

19  A   No, not at all. This is how we answer questions in  
20       medicine; we do randomized controlled trials, and those  
21       randomized controlled trials have been done with masks  
22       and health care workers in lots of other contexts,  
23       including other important infections like influenza.

24           Yeah, there have been randomized controlled trials  
25       looking at is a cloth mask similar to a medical mask in  
26       health care workers in influenza, and it showed cloth

1 masks -- and just that study too, I don't know, it was  
2 done 10, 15 years ago, showed cloth masks are -- yeah,  
3 cloth masks were useless for health care workers. The  
4 medical mask was better for the health care worker  
5 taking care of a patient with influenza.

6       We've looked at masks in a lot of surgical  
7 contexts. So there's lots of places in the hospital,  
8 especially -- like prior to COVID, there's a lot of  
9 places in the hospital, a lot of contexts, where masks  
10 were not indicated, and it was studied. Yeah, I think  
11 a lot of surgical indications, they've tried to prevent  
12 surgical site infections with wearing masks, and there  
13 was no benefit.

14       We've looked at a lot of -- some pretty good  
15 studies published in the New England Journal and JAMA I  
16 think, again prior to COVID, in the context of  
17 influenza or influenza-like illness, comparing N95s to  
18 surgical masks for health care workers taking care of  
19 persons with ILI, the most -- prime-most influenza, and  
20 there was no difference, and so --

21       And I know that one of the main authors of that  
22 study was at McMaster, Mark Loeb, and he tried to do a  
23 randomized controlled trial in COVID, but just there  
24 was such a default assumption that N95s would be better  
25 for treatment of COVID that, as far as I'm aware, that  
26 they were not able to actually do that study, because

1 the assumption was made, even though I think in the  
2 absence of evidence, what you do look at is similar  
3 context, and in this case, similar context done by the  
4 same authors, looking at N95s versus surgical masks in  
5 the context of influenza showed that there was no  
6 difference. And so I think it was very reasonable,  
7 from a clinical equipoise, statistical equipoise to  
8 ethics to do that study in SARS-CoV-2 as well.

9 So there's been lots of randomized controlled  
10 trials in health care workers to define who and who  
11 does not need to wear a mask, and who and who does not  
12 need to wear certain types of masks, lots of areas  
13 where masks are not needed for health care workers,  
14 including in infections, think of things like  
15 c. difficile or MRSA, we don't mask health care  
16 workers, but we make them gown and glove because of the  
17 route of transmission is not the respiratory tract.

18 Q Dr. Hu is adamant that mandatory masking in a health  
19 care setting prevents the spread of COVID, although  
20 he's less certain about community settings. You refer  
21 to a large body of evidence in your report that  
22 mandatory masking of healthy people does not work at  
23 all in community settings, we've been discussing that,  
24 but do you have any reason to think that although  
25 masking of healthy people is completely ineffective in  
26 community settings, it might, nonetheless, be highly

1 effective in health care settings as Dr. Hu says?

2 A Sorry, I was looking at my report. Can you just  
3 restate that?

4 Q Sure. So, you know, Dr. Hu says, look, they're really  
5 effective in health care settings, probably effective,  
6 but less effective in community settings. That's  
7 basically his position. Your position, in your report,  
8 is that, well, look, it's completely ineffective in the  
9 healthy community, in the non-health care setting. So  
10 even though that's your opinion, and you have all this  
11 scientific evidence to back it up, do you, nonetheless,  
12 think that Dr. Hu might be right in that, even though  
13 it's not effective at all in the community setting, it  
14 could be really effective in the health care setting?

15 A Well, yeah, masks are effective in the health care  
16 setting, if that's what you're asking. Masks are  
17 effective in a health care setting, yeah, because it's  
18 been studied, but, again, it's totally  
19 context-dependent. And everything is context-dependant  
20 and should be studied with regards to its context. So  
21 we know, because we did the studies, that for taking  
22 care of influenza patients, health care workers should  
23 wear a medical mask, which is a three-ply mask. It was  
24 compared in a randomized controlled trial to cloth  
25 masks, and it was superior, and it was control -- and  
26 it was compared in multiple randomized controlled

1 trials to N95s, and there was no difference. So an N95  
2 was not needed, so a medical mask, no worse than an N95  
3 medical mask, no -- certain better than cloth, and so  
4 that context is clearly established. Health care  
5 workers taking care of patients who have influenza-like  
6 illness should wear a medical mask.

7 And so -- and there is definitely context in the  
8 health care environment where masks have shown, through  
9 randomized controlled trials, which are the highest  
10 level there is, that they're helpful, they're  
11 beneficial, but that evidence just does not exist in a  
12 community setting.

13 And also prior to COVID, studies have been done in  
14 other health care settings within the hospital with  
15 other types of infections that show that masks aren't  
16 universally necessary all the time, and it's totally  
17 context dependent.

18 Q Right, so the effectiveness of the masks is dependent  
19 on the context of there being interactions between a  
20 symptomatic patient and a health care worker?

21 A That's correct.

22 Q Let me ask you a few questions about, you know, the  
23 issue with health care settings and non-health care  
24 settings, and I know we've touched on this, but in a  
25 health care setting like a hospital, are there a large  
26 number of symptomatic people expected to be present?

1     A     Yeah, absolutely. That's -- hospitals are -- have  
2           lots, very high rates of symptomatic persons, and,  
3           again, it depends on what you're talking about.  
4           Just unhealthy, yeah, they have all sorts of aches and  
5           pains, and, you know, heart attack, stroke, the -- but  
6           also symptoms from respiratory virus, and, again, it's  
7           going to depend on the season, because, in the middle  
8           of the summer, we don't really see much viral  
9           respiratory -- viral respiratory tract illness, but we  
10          do see that, you know, in the winter months. So,  
11          again, it's going to depend on those other factors that  
12          I talked about as well.

13       Q     And that's been your experience working at the hospital  
14           you work at?

15       A     Yeah.

16       Q     And, forgive me, but hospitals are -- are they designed  
17           to receive patients symptomatic with a potentially  
18           infectious illness?

19       A     Yeah, there are other factors other than masks,  
20           obviously, there's ventilation, there's how rooms and  
21           wards are designed, there's cleaning, so lots of  
22           evidence about different cleaning things. So, you  
23           know, we have three main types of cleaners:  
24           Ammonium-type cleaners and bleach-type cleaners and  
25           peroxide; we talk about each of the different pros and  
26           cons of those, so -- and then different types of



1       ventilation systems: You have negative-pressure  
2       ventilation for certain infections like tuberculosis  
3       that are not required for other important respiratory  
4       infections like influenza.

5               Yeah, you have kind of distance between patients,  
6       whether they're in their own room or whether they can  
7       be divided by, you know, just a screen; you have other  
8       personal protective equipment like gloves or gowns.  
9       Yeah, there's a variety of different factors that are  
10      built into kind of the design and how a hospital works.  
11   Q   Are there any important differences between a setting,  
12       a health care setting or any setting, where symptomatic  
13       people are regularly present and then a setting where  
14       symptomatic people are not present and only  
15       asymptomatic people are present?

16   A   Yeah, I think so. Like, you know, there's -- I think  
17       of something like a hospital, even in that case, you  
18       know, there would be scenarios where it doesn't make  
19       sense to have everybody masked, even in the context of  
20       COVID. Like if you have an outpatient clinic, say a  
21       mental health clinic, where you have a psychiatrist,  
22       who is obviously healthy, he or she is not allowed to  
23       come to work if they have symptoms, and a healthy  
24       patient, you know, let's say with some anxiety issues,  
25       and there's cognitive behavioural therapy, which is --  
26       you know, they're talking, you have a context like

1       that, it's occurring in a hospital, but really that  
2       context, from a transmission risk point of view, can be  
3       considered like any other context within the  
4       population; and so you have them sitting 3 feet apart,  
5       they're just talking, they're both healthy, the risk of  
6       transmission, I would say it's even less than, say,  
7       that patient after discussing anxiety issues with the  
8       psychiatrist, going and getting their hair cut, because  
9       the person trimming their hair or giving them a haircut  
10      is actually closer to them than the psychiatrist.

11             And so even within the hospital, it's completely  
12      context-dependent. Even in kind of health care  
13      settings, it can be a relatively arbitrary definition.  
14      Yeah, it occurs in a hospital, but what's the actual  
15      risk, like how are these people physically relating to  
16      each other, what are their symptoms, and what's the  
17      actual risk?

18             So I would argue that the actual risk for the  
19      scenario I provided, you know, would be the same as  
20      essentially a similar type of scenario within the  
21      general public. Whereas it's completely different if  
22      you have symptomatic people on a ward that then -- the  
23      benefit of masking is theoretically there but then also  
24      proven by previous randomized controlled trials and  
25      influenza disease.

26   Q    Thank you. Dr. Warren, where you work, are you

1 currently required to where a mask because of COVID  
2 even when you're asymptomatic?

3 A Yes.

4 Q And are there any similar or extra requirements from  
5 the CPSO to wear a mask because of COVID even when  
6 you're asymptomatic?

7 A I'm not sure. I'm not sure entirely what you're  
8 asking, but I think most of the policies that I would  
9 follow, because I'm in infectious diseases, so I'm  
10 taking care of COVID patients and stuff, so I think  
11 most of the policies would be from my hospital rather  
12 than the CPSO. Yeah. Sorry, I'm just not entirely  
13 sure what you're asking there.

14 Q Well, I mean, certainly the general understanding is  
15 that most regulatory bodies, health professional  
16 regulatory bodies across the province have fairly  
17 sweeping requirements that their members wear masks  
18 regardless of their symptoms. You know, the College of  
19 Chiropractors has it, the College of Physicians and  
20 Surgeons of Alberta has it. So I'm just asking if  
21 you're aware if the College of Physicians and Surgeons  
22 of Ontario has a requirement like that.

23 A Oh, I'm sure they do, yeah. Yeah, and it probably  
24 doesn't really impact me because I'd be doing it  
25 anyway, taking care of patients with infections, so --  
26 but, yes, I'm sure they do. I haven't read it in

1 detail, but it wouldn't impact me like it might impact  
2 some other people who wouldn't routinely be wearing a  
3 mask anyway in the course of their work.

4 Q Okay, so do you now wear a mask a whole lot more now  
5 than you used to prior to COVID just because of the  
6 type of work you do?

7 A Yeah, absolutely. Yeah, I have to wear a mask in all  
8 contexts now, whereas before, it was context-dependent.

9 Q And do you think the requirements now are equally  
10 rational or equally logical to what they were before  
11 when they were context-specific?

12 A Well, as I discussed earlier, the evidence base is not  
13 there. And as I discussed earlier prior to COVID, the  
14 requirement or need for masking, different types of  
15 masking was based on the context. And in many of those  
16 scenarios, it was actually studied, the most important  
17 scenarios, things like TB and influenza. So now  
18 there's a requirement for masking in every context, but  
19 it's not substantiated by evidence.

20 Q In the new context, where you are required to wear a  
21 mask, do you, in fact, wear a mask even though you  
22 didn't used to before COVID?

23 A Yes, I wear a mask at all times when I'm in the  
24 hospital. But the type of mask I wear is still  
25 different based on the context. So it can be a Level 1  
26 mask in certain areas. When I'm actually in my office

1 with my door closed, I'm by myself, I don't wear a mask  
2 because I don't have to. But in other areas, if I'm  
3 just going to Tim Hortons to get a coffee, I just wear  
4 a Level 1 mask. In many clinical contexts, I can wear  
5 a Level 3 and then an N95 in certain clinical contexts.

6 Q When you wear a mask to go to Tim Hortons, do you do so  
7 because there's a law that requires you to do so?

8 A Yes.

9 Q Do you disagree with that law?

10 A I would say it's not based on evidence, universal  
11 masking. And so I would say when I'm standing in line  
12 at Tim Hortons, I would say that's similar to like a  
13 community setting. Presumably, you know -- well, yeah,  
14 people who have symptoms are not allowed to be in line  
15 at the Tim Hortons as you are at the hospital. If  
16 they're symptomatic patients, they need to, you know,  
17 reside in the rooms, and symptomatic staff are not  
18 allowed to come, not allowed to have symptomatic  
19 visitors, that kind of stuff. And so that would be  
20 considered community context, so as I've kind of argued  
21 in and out of places, the evidence base just is not  
22 there to say that that is required.

23 Q I'm nearing the end, believe it or not. I just have  
24 some more questions about Dr. Hu.

25 Now, from your observations, has the transmission  
26 of COVID decreased in jurisdictions of mandatory

1       masking as compared to jurisdictions with no masking?

2       So, you know, the classic example would be California

3       and Florida. Have you seen COVID transmissions

4       decrease in California because of mandatory masking?

5       A   Yeah, again, so this is a huge other wide body of  
6       literature and fraught with all sorts of methodological  
7       and statistical problems, but what work there is out  
8       there, there is no difference with regards to masking.  
9       You know, I think people can know that intuitively.  
10       Like we've had in Canada all of these mask mandates for  
11       15 -- yeah, probably 15, 16 months before Omicron hit,  
12       and then, you know, it just blew through the society,  
13       didn't make any difference.

14               I think intuitively no, but when we do ecological  
15       studies, which, again, have all sorts of methodological  
16       problems, I would argue that the evidence shows that  
17       there is no effect on transmission. And the best ones  
18       are, you know, looking at the different states, because  
19       you have 50 different states or Europe, because you  
20       have a similar health care systems, relatively similar  
21       population, things like that. And, no, I would argue  
22       that it does not.

23       Q   Dr. Hu has stated that every country that has imposed  
24       masking has experienced decreased transmission of  
25       COVID. Do you disagree with him?

26       A   Yeah, I don't know what that assertion is based on.

1 I'd love to kind of know what study he's referring to  
2 in that.

3 Q Well, that's my next question. So you're not aware of  
4 any academic literature that would support such a  
5 claim?

6 A No. Again, there's a wide literature in that, but it's  
7 fraught with all types of problems, and so one of the  
8 kind of classic fallacies is the progression toward the  
9 mean, and we see this all the time where in the middle  
10 of a wave, stuff is done, and then the cases come down,  
11 and then it's attributed to whatever was done, but  
12 that's just statistically wrong because there's always  
13 going to be a regression toward the mean. A wave is  
14 going to go up, and then it's going to come down, and  
15 you have to have a control group to decide whether your  
16 intervention -- those are kind of before/after  
17 ecological studies, which are even lower than, you  
18 know, ecological studies with regards to the value of  
19 the evidence. It's essentially -- it's  
20 hypothesis-generating at most, but very low quality of  
21 evidence.

22 And whatever -- what evidence there is out there,  
23 can be -- because it's some very low methodological  
24 quality, it can often be twisted all sorts of different  
25 ways. And there is -- and there is hundreds of  
26 publications in that area with low methodological

1       qualities, so ecological studies or before/after  
2       studies, which, by definition, are low methodological  
3       quality, showing both sides.

4               So there's lots showing one side, lots showing the  
5       other, but the best evidence is randomized controlled  
6       trials and meta-analysis that there's no benefit in  
7       masking a healthy general population.

8       Q   Well, I'm going to ask you if that's what Dr. Hu has  
9       done. I'm going to tell you what he said. He said  
10      that the lockdown restrictions imposed in Alberta in  
11      November and December of 2020, he said that those  
12      lockdown restrictions did not cause the initial rise in  
13      cases during the lockdown but did cause the eventual  
14      drop in cases. So did Dr. Hu do there what you just  
15      described?

16      A   Yeah, there's no statistical epidemiologic way of  
17      making that conclusion, because there's all sorts of  
18      problems with it, but -- before/after, like you have  
19      all sorts of bias and confounding, especially  
20      confounding, and that conclusion just can't be made  
21      statistically, it's just not good practice, that that  
22      is not a high level of evidence because there's so many  
23      confounding factors.

24             And we just know, and we've seen this all over the  
25      world now for two years that you have waves that go up  
26      and waves that come down, in many cases no matter what



1     you do. We've seen that in different provinces in this  
2     wave. You know, provinces like Quebec who had the most  
3     extreme measures are having more per capita cases than  
4     places like Saskatchewan, which are having many fewer  
5     restrictions.

6             And I would argue I know exactly why Quebec is  
7     having more cases than Saskatchewan because the  
8     population weighted density in Quebec is much higher.  
9     You have a lot of people living in a relatively small  
10    area in Quebec. So it's predictable why they're going  
11    to have more cases than Saskatchewan. And every  
12    jurisdiction in Ontario follows the same pattern we're  
13    seeing in other places, which is that the most  
14    important factor for number of cases is population  
15    weighted density.

16            And it's not just overall area divided by the  
17    people. So you look at places like Ontario, most  
18    people don't live up in the north; it's population  
19    weighted density, which is a specific measure. So you  
20    take -- so the idea is you take any random person in  
21    that population, how many people live near them. It's  
22    not take the whole area of Ontario and divide it by the  
23    people. That's just population density. But the  
24    people of Ontario are not evenly spread over the entire  
25    province.

26            Population weighted density is a statistical

1 method of determining if you take a random Ontarian,  
2 how many, on average, people is that person near within  
3 like, say, a square kilometre. And that measure is, by  
4 far, the best predictor of how many cases you're going  
5 to have. And we see that -- you have provinces that  
6 have low population density have lower numbers of  
7 cases. Populations with high -- provinces with high  
8 population density, like Quebec, having very large --  
9 Ontario as well, most people in Ontario live in the  
10 corridor between Windsor and Ottawa, and it's  
11 relatively population dense.

12 Q You said earlier something about reversal. You said it  
13 was very difficult to reverse (INDISCERNIBLE) trend.  
14 Does that help to explain that even though this data  
15 you're talking about is so obvious, does that help to  
16 explain why Quebec continues to do something that is  
17 very obvious doesn't work?

18 A Yeah. So it's difficult once there's an established  
19 practice, and we know this from thousands of years of  
20 history in medicine, it's very difficult once there's  
21 an assumed standard of practice to change practice.  
22 Now, I deal with that on a daily basis, and I have been  
23 for almost 11 years of practice now in antimicrobial  
24 stewardship, because my main role is to convince  
25 people, okay, we don't need to treat people with  
26 pneumonia with 14 days of antibiotics anymore. We've

1        had lots of randomized controlled trials that say three  
2        to five days is okay. But people are still practicing  
3        what they learned in med school 25, 30 years ago.

4            And so effecting that change is very challenging,  
5        and there's all sorts of books written about that and  
6        things like that. And so once a practice is assumed to  
7        be beneficial, even early on in the -- when there's  
8        clear evidence to the contrary, it's very difficult for  
9        medical practitioners, it's a psychological thing, you  
10       know, just part of humans and who we are as well, to  
11       change practice.

12    Q    Is that what's going on generally with COVID now?  
13        We've got this practice in place, you know, revolving  
14        lockdowns must be effective because we thought they  
15        were going to be in the beginning, even though the data  
16        shows they're not, we must keep doing them because we  
17        thought they were effective. Is that -- you know, the  
18        example that you gave with treating pneumonia, is that  
19        what's going on with COVID?

20    A    Well, you know, it's a very complicated topic. As I  
21        mentioned before, it needs to be looked at in the  
22        historical context as well, because as a -- you know,  
23        as human populations, we have gone through massive  
24        events that have decimated our populations that is  
25        still historically remembered in our social  
26        consciousness. And as I said, so you think of things

1     like the Black Death, as I said before, historically  
2     some sorts of quarantine, especially for things like  
3     smallpox and plague, frankly, have worked. Like when  
4     you kind of cut yourself off from the world, that  
5     actually saves a lot of lives with regards to smallpox  
6     and plague.

7             And so a lot of these things have very deep-rooted  
8     factors that come into play, but one of them is this  
9     medical reversal idea, and others kind of -- you know,  
10    the idea of some costs, like once you've invested  
11    billions or whatever dollars in something, you know,  
12    you really want that to work.

13            And it's political, right? Like it just comes  
14    down to politics, a philosophy of how things are done,  
15    whether you're interventionist or not, and people are  
16    interventionists in the economy, people are  
17    interventionists in the climate, people are  
18    interventionists in medicine, and to some degree,  
19    that's a political question as well. So there's many  
20    different factors.

21            I think there's a few problems that have occurred  
22    over the -- I think everybody will admit this that  
23    there's been some major problems that occurred over the  
24    last couple years. One is that, you know, we haven't  
25    subjected or made decisions based on enough evidence,  
26    and I think many people would agree on that, but I

1 think also that it's things are oversimplified. So I  
2 don't want to be one person that says, well, people do  
3 this because of one reason; I think it's very complex.

4 Q Right. Dr. Hu said quite a few times in his report and  
5 in questioning that the evidence supporting the  
6 effectiveness of masks is, quote, overwhelming and,  
7 quote, there's heaps and mounds of evidence. Do you  
8 find these statements to be reasonable?

9 A If he's referring to in the community, then, no,  
10 absolutely not, but I -- quite the opposite actually.  
11 So I don't have that direct quote in front of me, but  
12 if he's referring to masking healthy persons in the  
13 community, no, I would completely disagree with him.

14 Q Well, you know, to be fair, he's saying it in the  
15 context of health care settings --

16 A But, again, it's context-dependent, so, yes, for health  
17 care providers taking care of patients with influenza  
18 or influenza-like illness or tuberculosis or, you know,  
19 certain -- the context, then, yes, there is lots of  
20 evidence, but there's also lots of evidence for the  
21 fact that masks are not required in lots of health care  
22 contexts as well.

23 Q On page 7 of his report, Dr. Hu says that the issues of  
24 asymptomatic transmission, of symptomatic transmission,  
25 and the severity of COVID are not salient to the issue  
26 of the effectiveness of masking.

1 A Sorry, can you say that again?

2 Q Sure. And you might want to have it in front of you,  
3 on page 7 of his report, it's actually in the bold text  
4 in the third paragraph there of page 7, he says: (as  
5 read)

6 The severity of COVID-19 right through  
7 transmission of --

8 A His report, sorry, Dr. Hu's report?

9 Q Yeah.

10 A Okay. Let me just bring it up. Page 7?

11 Q Page 7, yeah, there's the bold text.

12 A Okay, got it here.

13 Q So he says: (as read)

14 The severity of COVID-19 rates of  
15 transmission amongst asymptomatic infected  
16 individuals, testing, et cetera, none are  
17 salient to the question at hand around  
18 whether or not masks provide benefit in a  
19 health care setting.

20 Do you disagree with him?

21 A I just have to look at this.

22 Q Now, mind you, we don't have a definition of "health  
23 care setting" of course, but ...

24 A No, I wouldn't agree at all. Like whenever we decide  
25 or whenever we're thinking conceptually about whether  
26 health care workers should wear masks, the severity of

1 the infection, the rates of transmission of the  
2 infection, whether asymptomatic persons can transmit,  
3 all of those are very important as to whether masks  
4 should be used in that context. I'm not arguing that  
5 masks shouldn't be used in a health care context. I  
6 would define that like as a hospital, you know, but  
7 health care providers should wear a mask when taking  
8 care of a patient who is symptomatic with COVID-19.  
9 I'm not disagreeing with that at all.

10 But this statement is not true, like whenever we  
11 think of, even in the health care environment, whether  
12 someone should be masked, we think of the severity of  
13 the infection, we think of the rates of transmission,  
14 we think of whether someone who is asymptomatic can  
15 transmit, absolutely.

16 Q I want to take you back to your comparison of a year of  
17 COVID death numbers to a year of vehicle fatality  
18 numbers. I think you do this on the bottom of page 2  
19 and the top of page 3 of your report.

20 A Right.

21 Q Now, the first question I have for you is, and you may  
22 not know this, but when did COVID-related deaths in  
23 people under the age of 60 first start occurring in  
24 Canada in 2020?

25 A Oh, it would have started occurring very early, yeah.

26 Q "Very early" being?

1 A April.

2 Q So I'm going to ask you some obvious questions, bear  
3 with me. How many months are there between April 2020  
4 and April 2021?

5 A 12.

6 Q And how many months were in the year 2019?

7 A 12.

8 Q Now, in your report, you say that there were 1,010  
9 COVID-related deaths in people under 60 years of age as  
10 of April 16th, 2021, and that there were 1,191 motor  
11 vehicle fatalities in 2018 in people under 55 years of  
12 age. Do you still hold the opinion that the risk of  
13 death from COVID to people under the age of 60 between  
14 April 2020 and April 2021 was less than the risk of  
15 dying from a motor vehicle accident?

16 A Yeah, absolutely. And, in fact, the first -- when I  
17 kind of look at the number -- what you need to do is  
18 look at basically the average number of deaths per day,  
19 and in this analysis, I'm actually being generous,  
20 because the first death in Canada I think was around  
21 March 9th, 2020, and so what you're talking about is  
22 over 13 months of data until April 16th, 2021, and  
23 there were less deaths in that age group than just 12  
24 months of persons -- and, again, it's under the age of  
25 55. So not only am I doing it longer with regards to  
26 COVID deaths, I'm -- have a slightly larger age group.



1           So the number -- and if you continue that on, and  
2           you always have to -- the denominator is important,  
3           like you always have to divide it by the number of  
4           days, and I counted from the day of the first COVID  
5           death in Canada, and this holds today, so the number of  
6           deaths in Canada in persons under 60, if we divide it  
7           by almost two years, the number of deaths per day on  
8           average is less than what we would expect in that same  
9           age group, persons under 60, the number of deaths due  
10          to motor vehicle accidents.

11       Q   Thank you. On page 6 of his report, Dr. Hu stated that  
12           you committed a, quote, factual error. He said your  
13           comparison was fallacious and unscientific. He went on  
14           to say that no scientist, doctor, or epidemiologist  
15           with a basic understanding of disease patterns would  
16           make this comparison.

17               Now, on cross-examination, Dr. Hu retracted his  
18           accusation that you have no basic understanding of  
19           disease patterns, but how do you respond to his claim  
20           that you made a factual error?

21       A   Well, the mistake he made is he continued to accrue  
22           patient numbers without dividing -- without changing  
23           the denominator. So he changed the numerator without  
24           changing the denominator. What I was saying was that  
25           in a year, and it was actually more, the numerator was  
26           1,000 -- what did I have -- 1,010, that was my

1 numerator, and my denominator would have been about a  
2 year, it was actually 13 months, but it was a year. In  
3 his report, he continues to increase the numerator, so  
4 1,475 as of June 29th, but then he has to increase the  
5 denominator as well. And if you change the denominator  
6 to the June 29th, so approximately 16 months, you're  
7 finding the same thing: You're finding the average  
8 numbers of death per day in that age group is still  
9 less. So it's --

10 And, you know, saying it's fallacious and  
11 unscientific, well, it's very important, we do this all  
12 the time in medicine; like if we're talking to people  
13 that have a potential rare effect of a drug or, you  
14 know, a particular intervention, like my obligation is  
15 to provide the patient with informed consent, and part  
16 of that informed consent is providing a contextual  
17 risk. This is done all the time. It's done all the  
18 time at population health bubbles as well, because  
19 everything in life has a risk, you know. Me walking  
20 into my bathtub or shower has a risk, you know; there  
21 are certain numbers of people that die every year  
22 because of that. And getting struck by lightning or  
23 whatever and --

24 In fact, driving a car is one of the riskiest  
25 things in, you know, persons under a certain age that  
26 they can do in Canada. It's one of the major

1 preventable causes of death. And so it's always  
2 used -- not always, but often used as a way of  
3 contextualizing a risk of death, and I think it is very  
4 helpful in COVID-19. If you have people under 60,  
5 that's all persons under 60, all persons under 60,  
6 their risk of dying of COVID is actually lower than  
7 their historical risk of dying in a car accident.

8 And, again, you can talk about sub groups and  
9 things like that if you have -- if you're talking about  
10 healthy people under 40 with no risk factors, like  
11 you're talking about a phenomenally lower risk actually  
12 with no kind of comorbidities and lowering the age  
13 group and stuff. But it's routinely done in many areas  
14 of life, not only medicine, to contextualize a risk.

15 Q Just a couple more questions. In your experience as an  
16 infectious disease specialist, do government bodies  
17 tend to be more factually accurate than non-government  
18 bodies regarding scientific issues?

19 MR. MAXSTON: Mr. Kitchen, I'm sorry to  
20 interrupt, but I struggle with how that falls within  
21 the efficacy of masking and other qualifications. I  
22 think that's almost political, sociological. I know  
23 where you're going, but I wonder if you could think  
24 about rephrasing that, because that's awfully broad and  
25 really doesn't speak to efficacy of masking; that's  
26 governmental society.

1 MR. KITCHEN: No, I'm simply asking if the  
2 evidence he's seen for government bodies and the  
3 evidence he's seen from non-government bodies, if the  
4 scientific evidence -- if governments tend to be more  
5 right than non-government bodies.

6 MR. MAXSTON: Well, it's pretty open-ended,  
7 which governments, what evidence, provincial, federal,  
8 municipal. I mean, that's a pretty broad question,  
9 Mr. Kitchen. That's my concern.

10 MR. KITCHEN: I can narrow it down to  
11 specific governments, if you let me do that.

12 Q MR. KITCHEN: Well, Dr. Warren, I'm not  
13 going to ask you about the Alberta government because  
14 you're not in Alberta, but the Ontario government,  
15 generally speaking, in your -- and you've only be doing  
16 this for 11 years, so in your 11 years of infectious  
17 disease experience, do governments tend to be more  
18 factually or scientifically accurate in Ontario, the  
19 Ontario government, does the Ontario government tend to  
20 be more factually or scientifically accurate than  
21 non-government bodies?

22 A What do you mean by "non-government bodies"; like what  
23 would be the comparative group?

24 Q Independent scientists, private universities, people in  
25 bodies that are clearly unrelated to government.

26 A Yeah, again, that is a hard question to really answer,

1       because it all depends. Like I've seen it every single  
2       different way. Sometimes I've seen how the  
3       Government's just way behind the times. Other times,  
4       they're way more accurate than a different -- like,  
5       again, it's completely context-dependent, so I really  
6       can't answer that question, to be honest with you.

7       Q   Do you think a scientific or medical proposition or  
8       theory is likely to be more accurate because it comes  
9       from a government source?

10      A   I don't personally think that, no. I always look at  
11      the underlying data, so the primary evidence. So, you  
12      know, if you talk about historical analysis, the  
13      primary evidence is people who were there in that part  
14      of history or the archeological evidence or whatever.

15                You know, in scientific stuff, it's the studies,  
16      it's the bench research or the randomized controlled  
17      trials, yeah. So that's how I would form my opinion.

18                So what different bodies say, governments,  
19      whatnot, like that would be part of kind of how I think  
20      about things, but it's certainly not the most  
21      important, but I would want to look at the primary  
22      evidence, and that's what I did in my report.

23      Q   So is the most important thing what the evidence and  
24      the data says?

25      A   Absolutely.

26      Q   What if government disagrees with that evidence and

1 data?

2 A Well, governments have, you know -- throughout the  
3 history of medicine, there's all sorts of examples of  
4 when governments got it wrong, different medical bodies  
5 got it wrong. You know, data is always accumulating,  
6 and so -- but, you know, lots of times they get it  
7 right, but, of course, they're going to get it wrong.  
8 Governments or any sort of political body or  
9 educational institution or even scientific community  
10 are not going to be infallible. Like there's lots of  
11 people that make mistakes, and evidence is going to  
12 change, you know, and they're influenced by a variety  
13 of factors. They are -- and things are influenced by  
14 cultural factors, things are influenced by political  
15 factors, so, yeah, it's a very complex thing.

16 (AUDIO/VIDEO FEED LOST)

17 THE CHAIR: Can we just --

18 MR. KITCHEN We've lost --

19 THE CHAIR: Yeah.

20 MR. KITCHEN I only have one more question,  
21 so if we get Dr. Martens back, then I'll be done.

22 THE CHAIR: Okay, we'll just wait a  
23 moment; I'm sure she'll be reconnecting.

24 (DISCUSSION OFF THE RECORD)

25 Q MR. KITCHEN: Dr. Warren, thank you, you've  
26 been very patient with me. My last question for you

1 is, as a medical professional working with infectious  
2 diseases, have you found the information or opinions  
3 regarding COVID restrictions coming from government  
4 sources such as the Public Health Agency of Canada to  
5 be well supported by real scientific evidence or not so  
6 well supported by real scientific evidence?

7 A So with regards to COVID-19?

8 Q With COVID restrictions.

9 A Yeah, I -- again, it's a complex question, but, in  
10 general, I would disagree with a fair amount of what my  
11 Provincial government has done. Like they've  
12 admitted -- you know, they were taping up children's  
13 playgrounds in two different waves, it just makes no  
14 sense.

15 But, again, it all depends on what we're talking  
16 about. Some things I do agree with, certain quarantine  
17 and testing and various treatment things I do agree  
18 with, other things I don't, but anything that I would  
19 have had issue with would have been found in my report.

20 Q So you don't agree with the masking and physical  
21 distancing, I take it?

22 A Yeah, my position is as it is in the report, and that  
23 would be quite different than what has occurred in my  
24 jurisdiction.

25 MR. KITCHEN: Well, those are all my  
26 questions.

1           Now, I know it's getting close to lunch, but I  
2   suspect Mr. Maxston's going to be quite brief, and so I  
3   propose that we go until lunch, but I leave that with  
4   Mr. Maxston.

5   THE CHAIR:                   I was just going to ask you,  
6   Mr. Maxston, if you have some idea of how long you  
7   might be.

8   MR. MAXSTON:                I think I'll be 15 minutes, I  
9   don't know, depending on how, you know, again  
10   Dr. Warren might respond, I might have some follow-up  
11   questions. My sense is, and I leave this up to you to  
12   decide, but people would probably, and I invite  
13   Dr. Warren's comments and your colleagues', we probably  
14   want to plow through into the lunch hour and maybe try  
15   to finish any redirect and any questions from the  
16   Tribunal before we break for lunch. Now, that's -- I  
17   don't want to see us going till, you know, 1:25 and  
18   missing lunch for everybody, but my sense is maybe we  
19   should try to press ahead here for 15 or 20 minutes,  
20   see where we're at. Mr. Kitchen may have some  
21   follow-up. Let's just try to make as much progress as  
22   we can before maybe 12:30 or something like that.

23   THE CHAIR:                   I agree with you, and I see a  
24   very vigorous nod from Dr. Warren; I think he's  
25   supportive of that. I'm going to suggest that we just  
26   take a 5-minute stretch, bio break now, and we'll come



1 back, and we'll -- nose to the grindstone and try and  
2 see where that takes us, okay?

3 MR. LAWRENCE: Sorry, can I just -- Amber,  
4 can you stick us in a break-out room? I just want to  
5 chat with Blair for a few minutes.

6 THE CHAIR: Think we'll be back at 10  
7 after 12, because I do anticipate there's going to be  
8 some discussion, so we'll see everybody in 15 minutes.

9 (ADJOURNMENT)

10 THE CHAIR: So we're back in session, and  
11 Mr. Maxston has some questions on cross-examination for  
12 you, Dr. Warren.

13 A Okay.

14 Mr. Maxston Cross-examines the Witness

15 Q MR. MAXSTON: Afternoon, Dr. Warren.

16 A Afternoon.

17 Q It's noon here now as well, so that's universal. Thank  
18 you for taking your time out of a Saturday. I don't  
19 have a lot of questions for you.

20 I just wanted to start off by confirming a few  
21 things you said to Mr. Kitchen, and the first was that  
22 the, I think, the infection fertility ratio varies over  
23 time; is that correct?

24 A Infection fatality ratio, yes, not fertility.

25 Q Thank you, not -- yes, thank you. And the IFR for  
26 COVID, I think you said exceeded a bad influenza year

1           when COVID-19 first began in Canada; is that correct?

2     A     Yeah, so what I was saying is that very early on,  
3           because it was really only symptomatic cases being  
4           detected and tested for, and there was still a very  
5           vulnerable population, the IFR was quite high. But  
6           over time, as COVID has infected more and more people,  
7           there have been different strains, including especially  
8           Omicron, the IFR has continued to drop over the past 21  
9           months or so --

10    Q     Yeah.

11    A     -- so --

12    Q     I think that --

13    A     -- I think it's graphed out in a number of places, and  
14           it's declining over time.

15    Q     I think you might have said that in April or May of  
16           2020, that was the first wave for COVID-19, and that's  
17           when the IFR would have been its highest; is that fair  
18           to say?

19    A     Correct, yeah.

20    Q     You had a discussion with Mr. Kitchen about the word  
21           "pandemic", and I think you said that COVID-19 is  
22           definitely a pandemic, and you supported that by saying  
23           that this is the first time we've seen a virus on all  
24           seven continents; is that correct?

25    A     Correct.

26    Q     You also said that there's going to be some debate

1       about when it's becomes endemic, and I think you said  
2       the decision about when it's going to become endemic is  
3       arbitrary, is that your evidence?

4     A   Well, yeah, different people are -- you see some people  
5       saying now that it's endemic, others are going to say,  
6       well, there's these and these criteria. There's no  
7       established criteria. I gave kind of what I think is a  
8       reasonable thing, which is that once it's replaced with  
9       a different virus, not entirely, because COVID-19 or  
10      SARS-CoV-2 will continue to circulate indefinitely, but  
11      once the predominant virus is something else in most  
12      regions, I think that's a good place to say, well, it's  
13      now endemic.

14    Q   You're kind of leading --

15    A   There's no established -- sorry, there's just no  
16       established definition as to when the pandemic ends and  
17       when the endemic phase begins.

18    Q   And you're kind of leading me to my next question,  
19       which was inasmuch as it's going to be arbitrary, it's  
20       probably going to be subjective as well, isn't it?

21    A   Yeah, you can use whatever term you want, arbitrary,  
22       subjective, yeah.

23    Q   You had, a number of times, interactions with  
24       Mr. Kitchen about how science has evolved with respect  
25       to each virus or pandemic, and that there is discussion  
26       and debate within the scientific community, and I think

1       you referred to different studies, and Mr. Kitchen took  
2       you through that. While that debate is occurring --  
3       and I'll be more specific, while that debate was  
4       occurring in Canada when COVID-19 started and is still  
5       continuing, it's up to governments to make decisions  
6       though and orders in terms of how we respond to the  
7       pandemic; is that fair?

8     A   Yeah, that's the role of government is to make  
9       decisions.

10    Q   Yeah, and what I'm getting at there, I believe this is  
11       consistent with what you said, the CMOH, and I'll use  
12       Ontario, for example, but it's the same here, it's the  
13       CMOH that issues those public health orders that the  
14       public is required to follow; is that fair to say?

15    A   Yes, the CMOH does have an important role -- or  
16       that's -- the CMOH has had an important role in Canada  
17       in different jurisdictions and provinces, but, yeah,  
18       it's still the government itself as well making certain  
19       things mandatory and usually will do so with  
20       consultation of the CMOH.

21    Q   And I'm not trying to be cagey here, I'm just trying  
22       to -- I want to be clear that there's a distinction  
23       between the scientific debate, which has people on both  
24       sides or multiple sides of an issue, versus the  
25       decision-making, which is done by government and other  
26       government entities, I suppose. That's really what I'm

1 getting at.

2 A Yeah, I would agree with that. I would agree with that  
3 a hundred percent, because policy is always very  
4 different than scientific rationale, and so --

5 Q Right.

6 A -- there's lots of policy decisions that have been made  
7 that are not justified by science.

8 Q Yeah, and I think -- you know, I was talking with you  
9 about CMOH orders, but I'm thinking in Alberta, and I  
10 know -- I'm pretty sure they had these in Ontario, we  
11 had various re-opening requirements issued by  
12 government. If you wanted to open your gym, your  
13 salon, what have you, there were certain requirements  
14 that have to be followed, and I think you probably  
15 agree that, despite the scientific debate going on,  
16 businesses had to follow those requirements if they  
17 wanted to re-open?

18 A Yeah, that would be their decision, but, yeah.  
19 Absolutely.

20 Q You had a very I think fulsome discussion with  
21 Mr. Kitchen about you and wearing of masks, and I think  
22 you said to him that you are required to wear a mask at  
23 work when you're asymptomatic regardless of, you know,  
24 symptoms; that was your evidence, I think?

25 A Yeah, when I'm working in the hospital, I'm required  
26 to -- except when I'm in my own private office --

1 Q Right --

2 A -- with the door closed.

3 Q -- right. And in fairness --

4 A (INDISCERNIBLE)

5 Q -- I'm really concerned about the situation where  
6 you're treating patients, because that's what our  
7 hearing is talking about, and I think you were pretty  
8 candid about that. Mr. Kitchen mentioned to you CPSO,  
9 College of Physicians and Surgeons of Ontario,  
10 requirements for masking, and I think you said -- he  
11 asked you whether you knew whether they had any, and  
12 you said, I'm sure they do. And I think you indicated  
13 you would follow them if they applied to you, and in  
14 fact, I think you said you are following them when you  
15 wear a mask in the hospital. Is that fair to say?

16 A That's correct.

17 Q Would you agree that, as a member of the CPSO, you  
18 can't pick and choose which of their requirements for  
19 your practice applies or doesn't apply for you?

20 A I don't have a choice in the matter, no. The CPSO and  
21 various other regulatory bodies can make requirements,  
22 my hospital can make requirements of something that I  
23 don't agree with or I think is not based on evidence --

24 Q That was going to be my next -- sorry, were you  
25 finished?

26 A Yeah.

1 Q Yeah. That was going to be my next question was, you  
2 know, there's situations, and I think masking might be  
3 one of them, where you would disagree with your  
4 regulator or maybe a hospital policy where you're at,  
5 but your evidence I think is that you, nonetheless,  
6 would follow those requirements?

7 A That's correct.

8 Q Mr. Kitchen and you engaged in a discussion about  
9 government and non-government bodies, and he asked you  
10 some questions about that. I just want to be clear,  
11 you gave some answers about your knowledge of the  
12 Ontario experience, but you don't have any knowledge of  
13 the Alberta experience in terms of how CMOH orders were  
14 issued or weren't issued; that's correct?

15 A I have some knowledge of Alberta, but certainly nothing  
16 like I would have here in Ontario, because -- like you  
17 know, this case or whatever else, I've got some  
18 knowledge of Alberta, but not nearly as much as I would  
19 have of Ontario.

20 Q And I think, again, and I'm not trying to be critical  
21 here, I just think it's factual, Dr. Hu, in his  
22 testimony and his expert report, was directly involved  
23 in working with the CMOH office on certain aspects of  
24 their orders in Alberta; is that your understanding?

25 A I know nothing about Dr. Hu.

26 Q You had a discussion about, and Mr. Kitchen can correct

1 me if I'm paraphrasing his words incorrectly, but I  
2 think generally he asked you about whether government  
3 or non-government entities can be -- are more accurate,  
4 or less accurate, or more correct or less accurate, you  
5 know, when we compare them, and I think you were pretty  
6 candid in saying that it's fairly divergent, and lots  
7 of times government gets it right, and lots of times  
8 non-government entities get it right; is that fair to  
9 say?

10 A Yeah, it's a very complex issue, and it's such a broad  
11 question that I don't think any kind of sweeping  
12 statements can be made.

13 MR. MAXSTON: Those are all my questions,  
14 Dr. Warren. Thank you for your time.

15 A Thank you.

16 MR. KITCHEN And I --

17 THE CHAIR: Thank you.

18 MR. KITCHEN: -- just have two in redirect.

19 THE CHAIR: Okay.

20 Mr. Kitchen Re-examines the Witness

21 Q MR. KITCHEN: Dr. Warren, you said there's  
22 no established criteria for establishing an endemic.  
23 Is there any established criteria for establishing a  
24 pandemic?

25 A I think the -- yes, there would be, you know,  
26 established -- you know, the WHO, different



1 organizations would have definitions for a pandemic,  
2 however you want to define a pandemic. SARS-CoV-2 is a  
3 pandemic, and there are certainly more definitions or  
4 clearer definitions for when there is a pandemic and  
5 when it's been established than when an infection  
6 transitions from pandemic to endemic.

7 Q How come only some flu years are pandemic and some  
8 aren't? I don't want you to -- I don't want to rehash  
9 what we did earlier. You said something about --  
10 something I didn't, frankly, understand. I think  
11 something about how the virus has changed. That's what  
12 I'm trying to get at. Is there --

13 A Yeah. So year to year, influenza changes, it mutates,  
14 we have different strains. It's equivalent to  
15 SARS-CoV-2, how we have different variants. They're  
16 both very -- they're similar viruses; they're RNA  
17 viruses; they mutate at approximately the same rate.

18 So in influenza, year to year, there's something  
19 called antigenic drift, which are minor changes that  
20 produce the seasonal yearly influenza. Every few  
21 decades, there's an antigenic shift, so not drift but  
22 shift, and that's a major reassortment of a virus,  
23 which generally causes more widespread illness, more  
24 severe illness, because many people in the population  
25 do not have sufficient immunity, and so that's, you  
26 know, swine flu 2009 would be kind of the last example

1 of that. The Spanish flu from a hundred years ago is  
2 another example. And there were I think three or so  
3 other pandemic influenza years in the 20th century.

4 Q When we go from variant to variant in COVID, is that a  
5 similar thing, or is that different?

6 A So that would be, if you want to make it analogous to  
7 influenza, that would be the antigenic drift part of  
8 influenza, and so that would be the -- kind of the  
9 yearly fluctuations, and we'll continue to have that,  
10 there'll be a new wave after Omicron, something of a  
11 new variant. In influenza, we called it the yearly  
12 strain. And so that's what the analogy would be with  
13 influenza. The variants are new -- are analogous to  
14 influenza antigenic drift.

15 Q And that's what we referred it to, COVID-19 or  
16 SARS-CoV-2, is one big long event, they don't -- we  
17 haven't chopped it up; we refer to it as one big long  
18 thing, that's -- because there's only drifting not  
19 shifting?

20 A That's correct.

21 Q Last question I think, if government has a role to  
22 impose measures to protect the public, do they also  
23 have a corresponding role to remove those measures once  
24 it's clear that they don't work or cause more harm than  
25 good?

26 A I think any policy decision needs to be based on

1 evidence, and I think the more significant a policy  
2 decision is, the more evidence should be behind it,  
3 because if you're going to make a policy decision that  
4 significantly impacts people's lives, there should be a  
5 lot of good evidence for that.

6 And so same with changing policy decisions, any  
7 time a policy decision is changed, it should be based  
8 on evidence. And again, I think the burden of proof,  
9 the more significant the policy decision, the more the  
10 higher burden of proof is on the evidence that that  
11 policy decision is based on.

12 Q And are you seeing that evidentiary burden being met  
13 for things like masking and distancing?

14 A Yeah, yeah, for sure. With regards to masking for  
15 sure. Like a lot of places -- a lot of places like  
16 Denmark, the UK, Ireland, many places in the States, a  
17 lot of jurisdictions are getting rid of masking because  
18 there's no -- like the evidence just isn't there.  
19 There was an assumption, and so the policy decision was  
20 based on an assumption, that I would argue flawed  
21 assumptions, but as evidence accumulates, jurisdictions  
22 are now starting to get rid of mask mandates, for  
23 example.

24 Q Logically speaking, if the virus is the same and the  
25 scientific evidence is the same between Florida and  
26 Alberta or between Canada and Denmark, then can it

1       logically be said that Canada's decision to keep  
2       masking in place is based on science, or is it based on  
3       something else?

4     A   Well, I argue in my report I don't think that -- I  
5       would argue in my report that there was never a  
6       justification to mask healthy persons in the general  
7       public. That evidence base was never there. I argued  
8       that from the meta-analyses and studies in flu, and  
9       that evidence continues to be accumulating specifically  
10      for SARS-CoV-2.

11    Q   So is it fair to say that places that are removing mask  
12       restrictions are following the science, and places that  
13       aren't are ignoring it?

14    A   Yeah, I think the word "the science" has been way  
15       misused in --

16    Q   (INDISCERNIBLE)

17    A   -- this last two years, so I won't use that term, but I  
18       would say the --

19    Q   How about the evidence?

20    A   The evidence, I would say the evidence never has --  
21       there has been no evidence that masking the general  
22       public is of any benefit, the healthy general public.

23    Q   So at some level, isn't it required of governments that  
24       are continuing to impose mask mandates that they're  
25       ignoring the evidence?

26    A   Again, policy and evidence-based decision-making are

1 often very different things. Policy is informed by  
2 many other factors other than evidence.

3 MR. KITCHEN: Thank you. Those are my  
4 questions in redirect.

5 THE CHAIR: Okay. Dr. Warren, the Members  
6 of the Tribunal may have questions for you. We're just  
7 going to take a 5-minute break while we discuss what  
8 questions, if any, we have for you. So if you can just  
9 bear with us for 5 minutes, I don't think we'll be any  
10 longer. Thank you.

11 (ADJOURNMENT)

12 THE CHAIR: The Hearing Tribunal is back  
13 in session. And, Dr. Warren, we'd like to thank you  
14 very much for your time and your expertise and your  
15 testimony today. Members of the Tribunal do not have  
16 any additional questions for you. We appreciate you  
17 participating in this process, and Mr. Kitchen will  
18 discharge you, unless there's anything else.

19 There's just one matter I would like to ask of the  
20 College. Ms. Nelson, we are concerned over finding two  
21 consecutive dates, and we would really appreciate  
22 seeing the Doodle poll go out as soon as possible,  
23 knowing how much pressure there is on various people's  
24 calenders, so we'll look forward to getting that in the  
25 near future.

26 And unless there's anything else, I'll declare the

1 hearing closed until we meet again, and we will meet  
2 again sometime in the spring.

3

4 PROCEEDINGS ADJOURNED

5

6 CERTIFICATE OF TRANSCRIPT:

7

8 I, Karoline Schumann, certify that the foregoing  
9 pages are a complete and accurate transcript of the  
10 proceedings, taken down by me in shorthand and  
11 transcribed from my shorthand notes to the best of my  
12 skill and ability.

13 Dated at the City of Calgary, Province of Alberta,  
14 this 22nd day of February, 2022.

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Karoline Schumann, CSR(A)

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Official Court Reporter

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