

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.

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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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