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

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September 2, 2021 Afternoon Session

HEARING TRIBUNAL

J. Lees	Tribunal Chair
W. Pavlic	Internal Legal Counsel
Dr. L. Aldcorn	ACAC Registered Member
Dr. D. Martens	ACAC Registered Member
D. Dawson	Public Member
A. Nelson	ACAC Hearings Director

ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

D. Lawrence	ACAC Complaints Director
B.E. Maxston, QC	ACAC Legal Counsel

FOR DR. CURTIS WALL

J.S.M. Kitchen	Legal Counsel

K. Schumann, CSR(A) Official Court Reporter

(PROCEEDINGS RECOMMENCED AT 1:18 PM)

THE CHAIR: This Hearing Tribunal is back in session. It's 1:15, and I believe we are at the

point where Mr. Maxston on behalf of the College Complaints Director will have Dr. Todd Halowski take the stand to provide testimony.

Dr. Halowski, I'm going to ask the court reporter to swear or affirm you in, whichever is your preference.

A I'm happy to affirm.

DR. TODD HALOWSKI, Affirmed, Examined by Mr. Maxston

Q MR. MAXSTON: Good afternoon, Dr. Halowski.

MR. MAXSTON: Just for the Tribunal's benefit, I'm going to be asking Dr. Halowski questions in six areas. The first is some -- the first area is some very brief questions about his background. The second area is going to be some questions, again relatively brief, about his role as Registrar at the College. Third area I will be asking questions about is generally the functions of the College. The fourth area I'm going to ask questions about are the educational background for chiropractors and to ask Dr. Halowski to discuss briefly the educational information the College has on its registration file for Dr. Wall. The fifth area I'm going to take Dr. Halowski to are the CMOH orders and the Pandemic Directive and what I will call the ACAC notices and web blasts and things that were sent out to the members, which are Exhibits C-1 to C-22. And then the final

sixth area I'll be asking questions of Dr. Halowski about is his specific involvement in the Wall complaint.

So skipping to the first area then, Dr. Halowski, I understand that you are the Registrar for the College. Are you also a licensed practicing chiropractor?

A I am.

Q Can you tell me about what your chiropractic education is and your employment history in the profession?

A Yeah, I graduated from Palmer College of Chiropractic in 2005. Since then, I entered private practice in September of 2005 and have been a practicing chiropractor until 2019, when I left full-time practice and became the Registrar of the College.

I am still currently practicing in a part-time capacity, with my role as Registrar demanding the majority of my time, and right now I'm practicing part time in Sherwood Park as an associate in a clinic.

Q Thank you. Going to the secondary, I think you mentioned you became Registrar in 2019 then?

A M-hm, yes.

Q Okay, can you tell me before you became Registrar, did you have any positions or other involvement with the College?

A Yeah. I had started volunteering with the College I

think in 2007 or 2008 -- or with the ACAC. At that time, I was on a fee negotiating committee, which is an association activity versus the College.

In 2014, I was asked to become an investigator for the ACAC, which is a College activity. I received investigator training with Field Law at the time, and I think I started into investigations shortly thereafter, where we would participate as an investigator under Part 4 of the HPA. In 2015, I was trained also as a member of a -- to be a member of a hearing tribunal. During that time, I actively participated in investigations but never served as a member of the hearing tribunal.

Q Now, I understand you have the title of Registrar and you carry out Registrar duties, but there is also a, I'll call it a management or administration function you carry out as well. Can you tell me what -- first of all, what your duties are as Registrar?

A Yeah, the Registrar, we primarily focus -- that role primarily focuses on registration and registration decisions and also membership renewal in a year, so we're making sure that those people that are joining the profession meet the requirements that are set out by council or under the Health Professions Act, and then we also, for renewal, we perform that same duty, and that would be very specific to the Registrar role.

Beyond that, I'm also the director of regulatory, and in that capacity, I oversee the regulatory programs administered by the College. Specifically, I look at -- I work with the complaints, and I am aware of what's going on in the complaints department, I work in the continuing competence. I also oversee things like professional corporation and some of the other duties that go on on an ongoing basis like professional corporation renewal and membership renewal and the other things that go on in a year that the College administers on behalf of the members.

Q You've helpfully gone to my second area of questioning here, which is what your other duties are over and above Registrar. In your -- I'll call it your management or administration duties you described, do you work with council at all?

A Yes, I attend all council meetings, and one of the roles that I have is, because I am a clinician, I advice council on clinical matters as well, so for consideration. Our council is composed right now of six chiropractors and two public members. We are waiting for more public members to be appointed so that that does go to an equal representation.

So my role is also in providing practice information and being a consultant to council on areas of that and advising council on policy -- recommending

policy to support the safe practice of chiropractic in the Province of Alberta.

Q And I take it -- I'm going to take you to Pandemic Directive in a few minutes, but I take it you were given assignments from time to time to become involved on certain projects and things like that?

A That is a hundred percent correct.

Q Okay, I'm going to go to my third area of questioning, which is just to talk a little bit about the College. Can you explain the role of the College and what its mandate is?

A Absolutely. The best -- you know, if we look at it very high level, a college, a regulatory college has two duties: Protection of the public and professional competence. And at a high level, protection of the public comes down to setting standards, Codes of Ethics and bylaws that set the guidelines and direction that members must follow when they're practicing.

And then there's the whole aspect of complaints that a college oversees. So when a complaint or concern comes from the public, how we address it and how we respond is one of the primary functions that is in the Health Professions Act.

And then the other is the competence component, is identifying the competence programs that are there, how they're operating, is it meeting the intended goals,

highlighting what competencies may need extra attention from members due to -- our practice visit program will observe patterns or trends in practice, and that may result in recommendations to counsel on ways that we can improve the competence requirements that the profession meets as part of being a regulated member.

Q In keeping with your comment about sort of a high-level view of the College and its role, I don't need you to go to this section of the HPA, the Health Professions Act; are you familiar with Section 3 of the HPA?

A That is -- that defines specifically the roles that a college must fulfil or the reason that we exist.

Q Is public protection part of the College's role?

A That is -- absolutely. That's -- when we talk about that public protection is our -- the primary mandate that we have is making sure that we are producing -- or protecting the public in -- is our primary consideration.

Q You talked a few minutes ago about the College creating bylaws and Standards of Practice and Codes of Ethics, is the creation of a Code of Ethics and a Standard of Practice is that a mandatory duty under the HPA?

A Yes, it is. It's mandatory, and they need to be consulted with members but adopted by council, and once they are adopted, they do become binding upon the membership. And it's the standard under which, when we

look at it, that we enforce conduct based on the Standards of Practice. And some people look at standards are -- you know, really, one of the considerations there that's really important, and it's a discussion often is that they're meant to be the minimal acceptable level of performance that our members must meet.

Q Okay. I'll get to this later in some more detail, questioning with you on the Pandemic Directive and some other things, but are some of those Standards of Practice, are they mandatory in nature?

A That's a great question. I would say all Standards of Practice are meant to be mandatory. There is specific languaging in them that highlights -- when we see the word "must", they are mandatory; that is an absolute that must be followed.

Sometimes you'll see the word "may", which is meant to leave that to the professional judgment of the member, and so -- but they are meant to define practice.

Q I'm going to move to then the fourth area of questions I wanted to chat with you about, and that is, again, the educational background for chiropractors generally and what Dr. Wall's education is reflected in the College's records. So I'll just start off with a general question, are you familiar with the education

generally required to become licensed as a chiropractor?

A Absolutely. Yeah, would you like me to describe that for you?

Q Yeah, if you could.

A Absolutely. So the majority of chiropractors are trained here in North America. Most, who are in the entry school, have some form of undergrad education with -- meaning they'll have a Bachelor's degree or some have advanced degrees in Masters of Science or other components.

A chiropractic program has very set requirements to go through that are defined by the council -- well, they're defined by the regulators, but they're put forward by the council on chiropractic education, and chiropractic colleges are -- must be accredited, or a chiropractor that practices must be accredited and leave an institution that's accredited in order to be eligible to licence in Alberta.

And so -- but those requirements cover over aspects of delivery of health care and broad ranges of topics that prepare us to be clinicians.

Q As part of the education that chiropractors receive to get their degree, is there a required component for public health education?

A There is, yeah. So we do have a very, very -- we do

have two courses that may apply. We have one in kind of microbiology, which is a component that is considered. And then we actually have specific courses in public health, and more of an introductory -- I would call an introductory course. They are not meant for chiropractors to be prepared to manage public health situations; it's meant to understand kind of the implications of public health and to understand how our role is relative to public health.

Q Are there any specific training or educational requirements then in any of these approved programs relating to infection prevention and control, for example?

A There would be, relative to practice, there would be things like hand hygiene and so on like this. Never during our training initially would we have been exposed to things like PPE or personal protective equipment. It wasn't a consideration because chiropractors are not typically working with an infectious population; you know, we're not having people come in that could be highly infectious or contagious with different things. So we tend to run and work from that point of view of -- around neuromusculoskeletal conditions.

And so with that, PPE isn't typically used, nor do we work with body fluids typically. Gloves may be

another thing we're exposed to; i.e., if we're working in or around the mouth or on the face in treating, chiropractors may use gloves to work with in the mouth or in intraoral situations.

Q Is there any required training then in these programs for how to address viral outbreaks or pandemics?

A I -- so I'll speak personally, I graduated in 2005. I took my public health training in 2003 or 2004, and we were not advised to any such learning during education. It is something that is, I would say, has been a gap in our education up to now, and given the current environment that may adapt, but I can't speak to that.

Q I'm going to ask you a question about the chiropractic profession sort of generally, but are there chiropractors who take the position that chiropractic care can strengthen the immune system?

A There is. That is an issue within the profession where some chiropractors do believe that by providing chiropractic care that they may prevent illness or prevent infections. We do know that there has been research focused on that in the last couple of years that has come out and said that there isn't evidence to support the position that chiropractic care is an effective treatment for many immune-based disorders such as infections or common colds or flus.

Q Okay, I'm going to switch gears a little bit here in

this fourth area I'm asking you questions about. Have you been able to review Dr. Wall's registration file with the College?

A I did go through and look at that just to confirm the details for this file, yeah.

Q Can you tell me where Dr. Wall was educated?

A Yeah, Dr. Wall was educated at Palmer College of Chiropractic in Iowa, the same place I was.

Q And do you know when he graduated?

A On his transcripts, it identifies October 18th, 1996.

Q And do you know when he became licensed with the Alberta College?

A Yeah, that, in our records, indicates that he was originally -- his initial joining with the College was December 2nd of 1996.

Q Now, you mentioned before that you were involved in managing the required continuing competence program for chiropractors, and I should say that's a mandatory requirement, to maintain your continuing competence?

A M-hm.

Q And to meet the College's requirements for continued competence?

A That's correct. Yes, we have set requirements on an annual basis, and so annually all chiropractors are required to complete a minimum of 24 continuing competence credits. That's usually obtained through

seeking further development in courses, seminars, or different things. Those could focus on anywhere from assessment right through to treatment in that, or they could be more informationally based in their presentation.

And further, that we also currently have required recordkeeping, we have a required -- all members must demonstrate competence in first aid, right? And then we -- since the introduction of Bill 21, all members must annually demonstrate that they've taken trauma informed training.

Q When you look through Dr. Wall's continuing -- well, I should go back, did you look through Dr. Wall's continuing competence history with the College?

A I have reviewed Dr. Wall's continuing competence history in his profile, and in reviewing that, I did look back to see what kind of continuing competence, and there is no record of Dr. Wall completing any continuing competence around the treatment of infection, nor anything to do with practicing during a pandemic or any kind of public health training.

Q Okay. I want to go to the next area of my questions for you, which is the CMOH orders and the Pandemic Directive. I'm going to take you to the CMOH orders specifically and the Pandemic Directive specifically, but I'd just like you to begin with some -- giving me

some background, some history about what was happening with the College in I believe late March of '20, 2020, and the CMOH orders that were coming out and what the status of the profession was at that point.

A Absolutely I can talk to that. So in -- I think it was right around the middle of March where there -- you know, there was -- we started to see some notices coming from Dr. Hinshaw about the presence of the novel Coronavirus here in Alberta. As that escalated, we kind of watched -- on March 27th, CMOH order I think it was 7 was issued that effectively closed all health care except to urgent care.

Once that came down, that was I think both a very psychological blow to Albertans but also, speaking to our profession, was a psychological blow to many of my colleagues, right? It was a very tough time to see us shut down. You know, it wasn't something that we planned for, prepared for, would have expected in our lifetime.

One of the things that became very acutely aware is that our members didn't have any skill set around practicing in a pandemic, and there was a lot of confusion. This was novel. There was a lot of discussion around how it -- you know, the risk, the severity, all those things like this, but one of the things we set about doing as a college right away, and

we advised council and were given direction to go in that direction is to prepare a guide or directive for members to follow during the pandemic so that they would know how to practice safely and have kind of a guideline to practice during a pandemic.

And so we set about doing the research, reviewing the documents that Alberta Health was publishing, other information that was available at that time. Ultimately though, we did look at Alberta Health as a guide, because they were advising practice and health care workers in the province on how to practice safely during a pandemic.

Q So that's late -- I think you said March 27, that's late March where you're starting this effort or looking at this question, this issue. Did you consult with any other regulators in the province or outside the province about what they were doing for the -- their response to pandemic issues?

A Absolutely. During that time, in Alberta, there's something called the Alberta Federation of Regulated Health Professions, and that would be kind of like -- it's like a -- I don't want to call it a working group, but it's a federation, we actually work together and address issues together. And many regulators face common issues, and so I know there was discussions going on amongst Alberta regulators in that group on

exactly the impact to the environment introduced by the novel Coronavirus.

Also at that time, the ACAC as a member of the FCC, which is the Federation of Chiropractic Colleges, which is all the Canadian chiropractic regulators across the country. And all provinces were shut down at that time as a result of Coronavirus, and so why was -- one of the things that we were doing was sharing what we were looking at in developing.

And during that time, in Alberta, we're really lucky, we actually have one of our members, who is a published microbiologist who we were able to consult with, we consulted with our competence committee, because we really wanted to contextualize how to practice safely during the pandemic to chiropractors and make those considerations.

So we consulted with regulators to understand kind of the environment, the Alberta regulators, which are not chiropractors, but every other profession, on practicing safely, and then we consulted with chiropractic regulators from across the country and were very proactive in developing kind of a plan and a guide. And, you know, it took us a lot.

What we ended up with is what I would call a summit of documents. So there was a lot of information, and we kind of compiled it into different

areas, things like hand hygiene, we compiled it into areas on physical distancing, we compiled it into areas on personal protective equipment, and, you know, infection prevention and control. And what would we require, what would we not require.

And then once we developed all of that, we actually initiated a member consultation where all members had an opportunity to review what we developed and provide comments.

In addition to that, that was conducted via two things, we had town halls where we could talk and listen; we also had a digital consultation, where members were able to provide responses. And then once we had those consultations, we took the information back and prepared revisions to what we put forward. We listened to the membership, and we had a lot of information to contextualize, how to inform safe practice during a pandemic.

And then -- so that's kind of where we went to. That was April 22nd, 23rd, we were consulting. The next week, by April 29th, we were meeting with council with what was a plan, which we do call the Pandemic Practice Directive. And so that was by -- and then that was published, we reviewed that, council had some corrections. We came back to them a day later, and they adopted that, which we were then able to prepare

and publish to the membership.

Q Okay, I want to skip back to something you said before that -- and I think you used the word "direction", that you felt it was important to give clear direction to chiropractors. Why was it important to do that?

A Well, one of the things that we experienced and we had to be really clear with the membership, and I think some of that goes back to, one, we're not trained to practice; we were never trained to originally practice in that environment. It wasn't a consideration of our training.

The second one is that within the profession, we do see a diversity in membership, where, you know, some members, even to this day, I think really struggle with the idea that they shouldn't be offering adjustments to treat COVID. And so when I look at that, like that direction was required in order to provide -- and for us, our primary concern was making sure that what we were doing was going to be safe for the public to meet our mandate as a College. We have that obligation to protect the public, and so we needed to provide a way for our members to practice as safe as possible for the public during a pandemic.

Q So before the Pandemic Directive was created, was there any type of significant training or exposure in PPE that chiropractors would have had?

A I don't -- not to the degree that was required during the pandemic. I would say, you know, some chiropractors were very aware of when to use gloves, but as far as things like face masks, face shields, gowns, or other PPE, there was a low level of uptick in consumption amongst members.

Even now, I can speak to members, and some of them, you know, around some of -- they kind of go, Oh, this has actually been really helpful. It's really helped me reframe how I'm going to practice and how to make considerations for safe practice going forward.

And one thing too, Mr. Maxston, that we have to consider is that a lot of the information we present here is actually in our standard of practice. Like there's nothing that we presented that was new. We just provided direction per the Health Professions Act on informing practice according to the standard of practice.

Q I want to skip back. You talked about two communication modes you used. I think, I'll let you clarify the time period, but I think it's March and April of last year being town halls and digital consultations. What was the purpose of having that communication?

A We wanted to -- you know, it's really important for us, like we are a very transparent organization, and you

know, like just like our members, this was novel for us, and so we were doing our absolute best to make sure we provided a safe environment for the public, but we also needed to make sure that it's enforceable.

Remember, when we talk about Standards of Practice or practice direction has to meet a minimally acceptable level. It's not about ideal or being aspirational; it's a minimal acceptable level of performance and in the context of practicing safely. And so, you know, well, we go there, we want that perspective from all of our membership.

And so we did conduct two consultations. We had town halls that, you know -- where they could actually ask questions, provide feedback in a live way. We could go through, listen to them, respond, and all those kinds of communications.

And the second is we used a platform called ThoughtExchange, which allowed us -- you know, they could read the whole practice directive and then provide any feedback they chose to anonymously. We had a high uptick, we had over 356 unique IP addresses provide feedback to that. I'd like to think that that was significant, considering our membership at the time was probably around between 1150, 1200 members. You know, so I think that that's at 25 percent of our membership were actively providing feedback.

And it came on a spectrum at that time as well. It wasn't all like, This is great. Some people really challenged and helped to inform, you know, and maybe some of the things, hey, this shouldn't be used now, or we should do this now.

So where we got to after consultation was a place that really represented -- it was a great way for us to understand the climate of the membership and also to advise council on how to adopt a directive that was going to keep the public safe.

Q I think I want to skip back again, was there a particularly -- was there a large or significant risk that you identified when you were putting together the pandemic derivative?

A The risk for our membership, there was a couple. One is that, you know, if I speak about it, there's kind of two ways I can look at this, so even during the development of it, we would have -- we receive emails from people going, Oh, this is -- you know, why are we doing this, we shouldn't be shut down. One of the biggest concerns for chiropractors, we should be considered essential services, and essential services didn't have to shut down during COVID, right? And so that was -- we got a lot of communication around that.

When we started looking at it and asking, well, what do you mean; you know, a lot of our membership

wanted to understand, well, we want to be safe, how do we practice safe, why weren't we considered to be safe at this time. And so there was obviously some questions around that that came in, but a lot of it was also around things like, you know, like hand hygiene.

You know, one of the practices we identified is that chiropractors really need to be consistent in their hand hygiene, when they apply it, how to apply it. PPE was one that we recognized that the membership really needed to -- we needed to be able to advise a member on the safe and effective use of PPE according to the evidence that was available.

And so the -- we really went through the stuff that the Medical Officer of Health was instructing, who was obviously the lead -- leading the response to the public health crisis or pandemic that we were experiencing, so we looked at that kind of feedback.

Q Was close body contact a concern?

A It was for us, because we do work very close -- I mean, when we're actually delivering care to a patient, the hands-on care that chiropractic is known for, we're right over top. We stand and breathe on a patient, sometimes like less than a foot away from their face.

Similar like -- to contextualize it, some members on the Hearing Tribunal may have been to a chiropractor, some, they haven't, but think of like

when a dental hygienist or a dentist is working on you, where they're leaning over top, when we're caring for patients, we're right there, and so that close contact is there. There's other things where we do work are maybe not as close or our faces aren't in close proximity. Sometimes when we do assessments, like ophthalmological assessments or doing some of the other things, we're like face to face and mouth to mouth -- well, close to mouth to mouth with patients. So that was an important consideration we had to make.

Q I should go back, was masking intended to address that risk?

A Absolutely. Masking was identified in what we were looking to be a measure that would ensure that we reduce the risk of transmission of COVID.

Q I'm going to take you to CMOH Order 16-20 [sic] in a little while, but I'll just stay in this area of the Pandemic Directive and how it was developed. I understand that under Order 16-2020, you are required to or were required to send your directive to government for review; did that occur?

A That did. We sent that and submitted that to government on May 1st. So prior to the releasing of that, we had some opportunities to have phone calls with Dr. Hinshaw and a couple other representatives. I believe Martin Tyre [phonetic] was one of them as well,

who was head of the emergency operations centre at that time. And they were very specific to us in the guidelines that they were looking for, and that we would need to submit that in order for our practitioners to be able to return to practice when things opened back up.

Q Give me a moment, Dr. Halowski.

A Okay.

Q Did you receive any feedback from the CMOH about the Pandemic Directive before you adopted it then?

A No. We were able to adopt it and advised our membership that they could return to practice right away.

We did have one follow-up inquiry specific to what we were advising employers, but we did point them to the section of the practice directive that covered that, and they were satisfied.

Q In your consultation with CMOH, did they ever ask about an exemption for members under the masking requirements of the Pandemic Directive?

A There was no expectation in any of the Alberta Health literature we reviewed in developing that us in the proximity, because we're always going to be breaching that 2 metre physical distance that has been identified very early on, that there would be exemptions for that close of practice.

We did recognize, like -- yeah, so there was never any thought of an exemption, because we are always going to breach when delivering physical care to a patient, that 2 metres.

Q I'm going to skip ahead. I'll ask you some more questions in a little about this, but did the College recognize or identify in any way that treatment could be provided outside of that 2 metre space?

A Yeah. So one of the things that we did do in very early March -- I was so focused on the practice directive, I forgot to mention it, but we had developed and council had adopted Telehealth, and so Telehealth and Telerehabilitation is a practice. It's not obviously the same as providing physical care, but it was a way for us to consult with patients, it is a way for us to instruct patients on movement, exercises, and shown to be effective for mitigating many common MSK conditions through education and instruction.

Q And "MSK" means, just for those of us --

A Oh, yeah --

Q -- who aren't chiropractors?

A -- fair enough, I apologize. So "MSK" or NMSK means neuromusculoskeletal, so the common conditions that chiropractors do see patients for.

MR. MAXSTON: Mr. Chair, I'm going to ask you and your colleagues to turn to Exhibit F-1, which

is the government relaunch document. Just wait a little bit to make sure everybody's literally and figuratively on the same page, and I'm going to be looking at the top of page 2 of that 5-page document.

Q MR. MAXSTON: Dr. Halowski, are you familiar with this document?

A I am. This document actually -- I'm very familiar with it, because when they first announced, it was very contentious because they did not specifically list chiropractors to be able to return to work on May 4th, and so we had to seek clarification to provide that for our members.

Q Well, that's right where I was leading you. On the top of page 2, there's a second bullet. Maybe I'll just ask you to read that.

A (as read)

> Dental and other health care workers, such as physiotherapist, speech-language pathologists, respiratory therapists, audiologists, social workers, occupational therapists, dieticians, and more will be allowed to resume services starting May 4th as long as they are following approved guidelines set by their professional colleges.

Q So just two questions. We talked about "and more", I

take it you received confirmation that chiropractors were in the "and more" category?

A We did, yes.

Q And as long as they were following approved guidelines, did they tell you that was mandatory then, the CMOH?

A Yes, that we had to actually submit that before our membership could return to practice.

MR. MAXSTON: So, Mr. Chair and Tribunal Members, I'm going to ask you to go to CMOH Order 16-2020, which is Exhibit F-2.

Q MR. MAXSTON: Dr. Halowski, you weren't present for Dr. Hu's testimony, but I took him through this, but I'm going to ask you some specific questions about it, given your direct role in the College in this regard.

Are you familiar with this document?

A Yes, I am.

Q Can you tell me what the second numbered paragraph, number 2, says?

A Would you like me to read it?

Q Sure.

A (as read)

> Effective May 4th, 2020, and subject to Section 6 of this order, a regulated member of a college established under the Health Professions Act practicing in the community

must comply with the attached workplace guidance for community health care settings to the extent possible when providing a professional service.

Q Does that attached guideline that's attached to this order, does it require masking?

A It does. There's two references to it in there, and specifically, I'll just find them and share them with the Tribunal. On page 3 of Appendix A for that, for prevention, it does highlight personal protective equipment. And then on page 9, it does go further into defining that: (as read)

> All staff providing direct client/patient care or working in client/patient care areas must wear a surgical/procedure mask continuously at all times and in all areas of the workplace if they are either involved in direct client/patient contact or cannot maintain adequate physical distancing [which they defined as 2 metres] from client/patients and co-workers.

Q I'm going to ask you to skip ahead to paragraph 6. Can you tell me what that says in this CMOH order?

A Yes: (as read)

> Section 2 of this order [meaning the section that we just read] does not apply in respect

of a regulated member under the Health Professions Act whose college has published COVID-19 guidelines as required by Section 3 of this order.

Q So let's go to Section 3 then. I'll ask you to look at that, read that in, and tell us what that means to you.

A Yeah: (as read)

Subject to Section 5 of this order, each college established under the Health Professions Act must as soon as possible publish COVID guidelines applicable to the regulated members of the college that are substantially equivalent to the guidance set out in the workplace guidance for community health care settings developed by Alberta Health along with any additional guidelines to the usual practices of the regulated profession.

Q So the option here was, under item 2, you could use the guidance document that they have with mandatory masking, or the College could create its own?

A Yes.

Q And was this a condition to re-opening?

A That was what was indicated to us, and that is the information we had from the Medical Officer of Health, so the -- so that was our exact understanding that this

was a condition.
Q So was it a requirement to practice then?
A Yes, and it was adopted by council motion.
Q Can you tell me what paragraph 4 -- paragraphs 4 and 5 say?
A Yeah: (as read)

> Each college must provide the Chief Medical Officer of Health with a copy of any COVID-19 guidelines published in accordance with Section 3 of this order.

And then Section 5 says: (as read)

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

Q I think a few minutes ago, you told me that you complied with Order Number 4, you provided to the Minister of Health, and just to be clear, did you receive amendments from the CMOH; did you get any amendments from them?
A We did not amend our practice directive due to any feedback from the CMOH. There was no feedback provided that we needed to amend anything or make further

considerations to reduce the risk of COVID-19 in chiropractic practice.

Q I'm going to ask you to go to CMOH Order 38-20, which is Exhibit D-8. This is a November 24, 2020 CMOH order. I'm going to ask, Dr. Halowski, you and everyone to go to part 4 on page 4.

THE CHAIR: Sorry, which number was this? D --

MR. MAXSTON: Sorry, Mr. Chair, this is Exhibit D-8.

THE CHAIR: Okay.

MR. MAXSTON: And it's CMOH Order 38-20.

Q MR. MAXSTON: So, Dr. Halowski, I'm just going to ask you to go to paragraphs -- well, I've taken you to page 4, which talks about masks and the geographic application of this order, but I'm going to ask you to go to paragraphs 23 and 24, and can you tell me what those two sections mean or what you interpreted them to mean?

A Yeah. So we took a very literal look at this: (as read)

> For the purpose of part 4 of this order, a "public place" has the same meaning given to it in the Public Health Act but does not include a rental accommodation used solely for the purpose of a private residence.

And then 24 says: (as read)

> For the purpose of this order, a "face mask" means a medical or nonmedical face mask or other face coverings that cover a person's nose, mouth, and chin.

When we saw this and had an opportunity to read this, one of the things that we did look at is is a chiropractic office a public space. And at that time, we were under direction that appointments were by -- or if we were to control our environment, so who was coming into the office was by schedule. And we interpreted this, and the interpretation was that chiropractic offices are, for the intent of this, a private space, meaning that we control who's in the office or can control who receives care at the time.

And then face masks under this order, one of the things when we looked at this, we reviewed and recognized that, you know, when they start talking about cloth face masks and the other, we knew that this didn't specifically apply to chiropractors as the requirement was that we had to wear at least a Level 1 surgical procedural mask as identified in the practice directive.

So when we saw this section, we saw it as applying not to our profession but to the public and more of a guidance for the public on what they should be doing.

And I think this is when the Province started to institute their provincial face mask guidelines and requirements.

Q So let's go to paragraph 26 of this order, and we there have a -- I'm going to ask a question -- but it says: (as read)

> Subject to Section 27, a person must wear a face mask at all times while attending an indoor public place. For greater certainty, an indoor public place includes any indoor location where a business or an entity is operating.

Chiropractic clinics would be covered by that?

A Correct.

Q There's an exemption in paragraph 27(c) of this order. You're aware of that exemption?

A I did read that, yeah. We had read that when it was published.

Q Okay, I'll have some questions for you later on about the exemption and the Pandemic Directive ultimately.

I'll get you to now go to and everyone to go to Exhibit D-9, which is CMOH Order 42-20, and the date of that order is December 11th, 2020. And, Dr. Halowski, I will get you to go to paragraphs 23 and 24, which are on page 5 of that CMOH order.

A M-hm. Yeah, I'm there.

Q I could ask you to read these in, but are these substantially similar, if not identical, to the equivalent provisions in the last CMOH order we looked at?
A Yes, they are, on a quick reading, yes.
Q And there's the same exemption there in 24(c)?
A Correct.
Q So we have these two exemptions then or two references to exemptions. Was there ever any consideration about whether those exemptions should apply to chiropractors?
A We did look at that in consideration. Based on the guidance that Public Health had provided, that we could not maintain a physical distance of 2 metres, the consideration was made that this wouldn't apply because we can't maintain a physical distance of 2 metres when providing in-person or close contact care.

And I remember communicating this to our members and using the example that this is probably more meant for situations like in the public, like if you were going to a grocery store where you could maintain a physical distance, or in the public where you can space yourself appropriately from somebody. But when we're -- as a practitioner, when we're face to face, we are not maintaining that distance of 2 metres, which was identified as one of the risks for transmission during COVID.

Q I'm going to ask you to go to the Exhibits C-20, 21, and 22, which are the three versions of the Pandemic Directive. They are dated I believe May 5, 2020, May 25, 2020, and January 6th, 2021. Just broadly speaking, can you tell me why there are three directives?

A That's a great question. So obviously the first one was published, this is the one we had originally submitted to government when they had alerted us that we would have to provide this for our members to be able to return to practice on May 4th, and so that was published and sent to them for review.

On May 25th, we had done some review and revisions and included the practice of mobile chiropractic for chiropractors to be able to provide chiropractic care in mobile settings. And for a percentage of our population, our members, they do provide mobile care, where they go and provide care in different settings outside of their office. And, originally, we had not allowed it, and so council had made the decision that this would be allowed as long as they were following the Pandemic Practice Directive. And then --

Q Then --

A Sorry, yeah, I'll stop.

Q No, you go ahead. I was just going to say January 6th.

A Yeah, oh, yeah, January 6th, that one was published,

that was right in the middle of the second wave of COVID or the one that was identified as being significant, and there had been a significant number of cases. And so we did continue to regularly review the Pandemic Practice Directive with council.

And one of the recommendations we made on this one was to include the requirements -- or, sorry, include the recommendation of PPE to include a face shield or eye protection. And that specifically -- and one of the unique things about that is this is one of the first considerations we specifically made for members to be protected, because it was -- some of the information that was published in an advisement that we had had was that eye protection was seen as protective against the Coronavirus.

Up until this time, the practice directive was focused on public protection. With the introduction of the eye protection, that was one of the pieces that and one of the few that we actually specifically put -- meant for the protection of the member only, and that was to consider the use of eye protection.

Q I'm going to take you through the portions of the Pandemic Directive in a couple of minutes when we deal with masking and social distancing and plexiglass barriers. Through those three versions of the Pandemic Directive, were there changes about masking and social

distancing and the plexiglass barrier requirements?
A There was slight -- I believe there were some slight changes, nothing significant. Some of it may have been wording.

Specifically when we got the last one in January, we introduced the requirement that patients must be masked in the clinic as well. And that was in response to, one, the orders that we received, there was a lot of confusion from membership, going, well, do my patients have to mask, the practice directive doesn't say they have to mask. And so we implemented that patients are required to mask in that January 6th one, and then that has -- that persisted through to this summer.

MR. MAXSTON: Mr. Chair, I think as I mentioned earlier, I'm going to simply use the January 6th, 2021 Pandemic Directive in my questions for Dr. Halowski and other witnesses, so I'm going to continue that here.

THE CHAIR: Can you give us a reference number for that?

MR. MAXSTON: Yeah, it's C-22.

THE CHAIR: Great, thank you.

Q MR. MAXSTON: So I'd just like to summarize I think what are the more -- ask you questions about what are the more relevant elements of the personal

directive -- sorry, Pandemic Directive for today's hearing in the questions for you.

I'd like you to go to page 7 of the Pandemic Directive. And there's a heading "Physical Distancing", and I think the comments on this actually go over to page 8, but can you tell me what the requirements were in that regard in the Pandemic Directive?

A Yeah, that we were to, as much as possible, in this space ensure that physical distancing was provided for in treatment areas.

And one of the things that some of our members do operate is more an open-concept style where they'll have multiple tables in one area, so we wanted to make sure that patients receiving care were at least 2 metres apart in those spaces. In waiting areas, that the patients were provided a place, if they were waiting indoors, to be 2 metres from the next closest patient, right; or from staff that may be working behind the desk, right; in transition areas, i.e., you know, like hallways or there might be areas where patients are moving in and out of treatment rooms.

Then we did provide an exemption for people who lived together to be 2 metres, because they're obviously within the same cohort already, and there are patients that may present to the office who have care

givers or companions with them, and so they were exempted from that requirement as well. You know, we didn't feel that it was our place to separate, especially if somebody that needed a care giver, in the office environment.

And then we did talk about non-clinical employees in the public, right? So that would be the reception area. And if 2 metres cannot be maintained, that staff must be continuously masked, or the installation of a plexiglass or plastic barrier must occur to protect reception staff.

Q So, again, the word "must" is used, that's mandatory?

A Yeah, that's correct, "must" is a mandatory requirement.

Q Okay. I'm going to take you to the heading that says "Personal Protective Equipment", and I wonder if you can tell me about the opening paragraph, what it means.

A Yeah. So one is that we -- personal protective equipment is an essential element for the disease. Like that was identified early on that it was being novel and without an effective treatment, personal protective equipment would be essential in order to provide as safe an environment as possible.

We also wanted to alert members that if they were not using PPE appropriately, it could fail to prevent transmission and may facilitate the spread of the

disease.

Q So the next heading is "Staff and Practitioner PPE", and there's a quote from an AHS announcement. Can you tell us what that quote says, what it means?

A Yeah. So one of the things we were looking at in the development stage is what is the requirement or what are we going to look at around the use of personal protective equipment. And so this was very clear, it says: (as read)

> Effective immediately, AHS is advising all health care workers [which chiropractors are considered a health care worker] providing direct patient care in both AHS and community settings [chiropractors are in a community setting] to wear a surgical procedural mask continuously at all times and in all areas of their workplace if they are involved in direct patient contact or cannot maintain adequate physical distancing from patients and co-workers.

Q Can you take me to the next section "PPE Requirements" and tell me what those first three bullets say?

A Yeah: (as read)

> Surgical or procedural masks are the minimal acceptable standard.

And that's identified, because there's -- you know, one

of the questions that we had during the development is like do I need an N95 mask, which is a fitted mask meant for aerosol producing procedures. We wanted to be very clear that that was not a requirement.

Again, we always set minimally acceptable standards. So a minimal acceptable standard in this would be a surgical mask.

Q Okay.

A And then the next one: (as read)

> Chiropractors and clinical staff must be masked at all times while providing patient care.

That was very clear. Like if you're providing patient care, you must wear a mask. It wasn't a suggestion; it was a requirement.

And then the last one is: (as read)

> Nonclinical staff must be masked when a physical distance of 2 metres cannot be maintained.

And that would be like some offices are smaller, the reception desk may not be able to be isolated, the -- you know, or the receptionist is in and out from behind the desk because they have double duty in bringing patients to rooms or to cleaning or other aspects. We wanted to make sure that there was a safety provided for that person as well.

Q So I'm going to ask you to go ahead to page 9.
A Okay.
Q And at the top of that page, there's some requirements for donning and doffing masks. But there's a paragraph right after number 7 under "Doffing of Masks", and it starts off with: (as read)

> It is essential that all chiropractors and staff providing services in a clinic area are aware of the proper donning and doffing of PPE.

I just want to be clear here, who is responsible for, in a chiropractic clinic, for ensuring that staff complies with the Pandemic Directive requirements?
A That would be anybody, the chiropractor as a regulated member has a requirement to provide a safe environment for themselves and those that work at their direction.
Q Okay. I'm going to ask you when the masking requirement was developed, were you focusing only on the protection to patients, or were you also considering your members' protection?
A Obviously, there was member protection, but as a College, our first consideration is always the public as well. And so anything we could do to reduce the risk of transmission from a chiropractor who had acquired a COVID infection was our first consideration, followed by the safety of the member.

And I would say, you know, followed by, it's not like it was a large gap. You know, both were very, very important, but as a College, we had a requirement to definitely consider the needs of the public first.

Q Okay, we talked before about CMOH Order 16-2020 and the use of the guideline or opting into the Pandemic Directive and the mandatory guideline on masking or creating your own Pandemic Directive, in terms of masking and what you developed for your Pandemic Directive here, were less restrictive directives than requiring masking considered?

A We did look at all sorts of things. And I do remember the final meeting, the second -- on April 29th, when we met with council, I believe that was the Wednesday, they had -- that was one of their considerations. Like they had a question: Should masking be a recommendation or a requirement.

And after discussion, council felt strongly that masking was and should be a requirement of practice at that time. So it was discussed, but given the climate, given that this was novel, and given the risk of being close contact body workers, council ultimately did adopt the position that masking is required.

Q I note that -- well, I should ask you, does the Pandemic Directive contain an exemption for masking, social distancing, or plexiglass barriers?

A There -- let me see if I understand the question, so there is no exemption for masking at any time when we're providing care within 2 metres. The original one did allow -- the original one introduced did allow for them to not have a mask on if they were conversing over 2 metres apart, so i.e., on the other side of the room.

And the other exemption that was provided is that if you can't -- if you need to, you could use Telehealth as a form of care for patients to lessen the risk of spread for COVID-19.

Q Ultimately, why wasn't there an exemption for masking like we saw in the CMOH orders?

A You mean in the CMOH 38 and 42?

Q Yeah.

A Yeah, so the reason that we didn't ever consider an exemption is because we work face to face with a patient. We're not walking around in parks or open spaces; we're in closed rooms, sometime poorly ventilated, and we are breathing right on a patient, and patients are breathing right on us as well, but having a mask was meant to be protective for the patient as well as for the practitioner.

Q Are you aware of any other HPA colleges and their pandemic directives?

A Yeah. So one of the things that we did do after is we had an opportunity to read and review other colleges

and what they were directing. And to my knowledge, every college adopted a position of masking is a requirement.

I know recently that, talking to one of the registrars, who -- for I think it was ACSLPA, which is the Alberta College of Speech-Language Pathology [sic] and Audiologists. They had indicated that that had been very stressful for their members to practice during the pandemic when masking was required, because they need to observe the mouth and visualize it in order to respond or appropriately teach or provide interventions, but they also, in some of their interventions, identified that they produced more aerosols because they're -- of speaking and causing that, and so they had to maintain masking. And then up until the end of June or beginning of July this year, they amended it to become a recommendation. And that was one that had indicated it was stressful.

Physiotherapists from when I reviewed, the physicians when I reviewed, everybody else was requiring masking for providing that close care.

Q So I'm going to ask you to go a little bit backwards in this document. I'd like to go to page 1 -- actually page 2 of the Pandemic Directive.

A Okay.

Q And right after the introduction, the first paragraph,

there's a second paragraph that says -- actually it's an indent after the second paragraph: (as read)

> Note to chiropractors, this directive is current as of the date of publication and reflects the rules and requirements for chiropractors. In the event of a discrepancy between this information and the directives of Provincial Public Health authorities, the directions of the Provincial Public Health authorities take precedence.

Can you tell me what you meant by that language and --

A Absolutely.

Q -- what would or wouldn't take precedence, I guess?

A Absolutely. So when we look at that, one of the things that -- I think the word we could describe around COVID is it was a very fluid environment, and it seemed that information was consistently and constantly shifting or changing, or new information would come to light.

And so one of the things we wanted to make sure that our members were aware that, say, this was in place, and something came out from the Chief Medical Officer of Health that had a more stringent requirement, i.e., that maybe all practitioners were required to wear an N95 mask or were required to wear a face shield, that our members would know that they should follow that direction, that they should wear

something more stringent.
Q So -- sorry.
A No, go ahead.
Q So that comment is directed to chiropractors then?
A Yes.
Q Health care professionals?
A Yeah.
Q If we go a little further down, it says: (as read)

> As regulated health professionals, chiropractors are required to: 1. Follow all mandates and recommendations from Public Health and Government of Alberta regarding your personal and professional conduct. As a regulated -- [Mr. Kitchen, there is a question coming] -- regarding your personal and professional conduct. As a regulated health professional, you have a fiduciary responsibility to follow all civil orders that originate from any level of government.

And then number 2: (as read)

> Read to and adhere to all communication from the ACAC.

So what message are you sending to chiropractors there?
A Yeah, that's a great question. This was introduced for our regulated members, because, at one time, we were getting a lot of members calling in and going, hey, you

know, the City of Calgary has a masking mandate, or this city has a masking mandate; and what we were finding is people were calling us to interpret local legislation, so we wanted to inform them that they actually also have a responsibility to be aware of and follow legislation or requirements or orders, civil orders, that are introduced in the location where they practice.

You know, one of the ones I remember dealing with specifically was the City of Chestermere had ordered all clinics closed at one time, and our members that were there were calling and saying, But we're regulated. I said, You need to follow the civic orders that are introduced by your local government.

And so that was the intent of that, because those may change or have a crossover, an impact for the direction that we're providing. And we continually also informed members that we wanted them to follow the more stringent requirements. So that would be the part of it as well.

Q Okay, so I want to just explore that a little bit with, so if a local bylaw, for example, was more stringent, you were required to follow that?

A Correct.

Q If a Pandemic Directive was more stringent, you were required to follow that?

A Correct.
Q Dr. Halowski, you were not part of the discussion or not present when we talked about entering some new exhibits relating to Alberta Health Services, but I have provided those to you, and I'm just going to ask you to go through them briefly. They are again three documents.
MR. MAXSTON: And, Mr. Chair, you'll have those I believe in your File H [sic], and they're the AHS Guidelines for Continuous Masking, the AHS Personal Protective Equipment document, and the Alberta Health Services Directive Use of Masks During COVID-19.
A Mr. Maxston, I don't have those documents available right now. Can I obtain them? I apologize, I just don't have them here.
Q I wonder if Ms. Nelson can send those to you in the Dropbox, or we can have her forward them to you by email.
A Okay, I'll wait for her to provide those.
MS. NELSON: Yeah, I will email those out right now. Just the three AHS docs?
MR. MAXSTON: Mr. Chair, I wonder if this isn't a good time to just take a 5- or 10-minute break, just to allow some time for those documents to make their way to Dr. Halowski, and we'll make sure he's got them, and then we'll resume.

THE CHAIR: I was about to suggest the same thing. It's 25 after 2, so let's take a 10-minute break, and we'll come back at 25 to 3 and resume, and hopefully by then, Dr. Halowski, you'll have received and had a chance to look at the three documents. They're not lengthy.

MR. MAXSTON: And, Mr. Kitchen, I'm aware of the fact that I can't speak with Dr. Halowski about his testimony, but I am going to chat with him just briefly to make sure he's got the right documents if you're okay with that.

THE CHAIR: Okay, I'm okay with that. Mr. Kitchen, any comment?

MR. KITCHEN: I was muted, I'm sorry. Blair, it looks like we're going to have time for me to do my whole cross, and that's probably going to be it for the day. Is that what you're thinking?

MR. MAXSTON: Yeah, I'll see how far I've got to go. I still have to go through Exhibits C-1 to C-22 with Dr. Halowski. I'm not going to through every line of them; I'm going to highlight some things, but, yeah, I think we're making some good progress. So I'm just going to make sure he's got these documents, James. I won't talk to him about his testimony, but I want to make sure he's on the literally the same page, so --

MR. KITCHEN: That's fine, yeah.
MR. MAXSTON: -- okay, thanks, yeah.
THE CHAIR: Okay, we're in recess now, and we'll reconvene in 10 minutes, thank you.
(ADJOURNMENT)
THE CHAIR: The Hearing Tribunal is back in session, and Mr. Maxston is continuing with his direct examination of Dr. Halowski.
EXHIBIT G-1 - AHS - Directive Use of Masks During COVID-19
EXHIBIT G-2 - AHS - Guidelines for Continuous Masking
EXHIBIT G-3 - AHS - Personal Protective Equipment (PPE)
Q MR. MAXSTON: So, Dr. Halowski, you've got these three AHS documents in front of you?
A Yes, I do.
Q I'm not going to be very long with these with you. You talked before about the fact that council was monitoring the situation in terms of the Pandemic Directive. Were you and council considering AHS documents?
A We were considering them. That was one of the resources, one of the primary resources we used when evaluating the practice directive.
Q So I'm just looking at the first document, which is AHS

Guidelines for Continuous Masking, and the middle of the page, it says: (as read)

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

I take it that supports the Pandemic Directive from your perspective?

A It does, and it -- one of the things in reading this, and I remember having conversations with council about it is we would see these documents, and, you know, obviously these were developed specifically for the AHS environment, but we did pay close attention to them because they're advising how to keep their staff safe and how to limit the risk of spread between patients and between patients and staff.

Q The next document is the Personal Protective (PPE) document, and really I'm just going to take you to page 2, under the heading "AHS Guidelines For Continuous Masking and Use of Eye Protection". Again, there's a statement about AHS has a continuous masking directive in place, and, again, that would have been consistent with the directive?

A Correct.

Q The final document is the AHS directive on use of masks, and I'll take you to the principle section, and the first sentence there, I wonder if you can just read that, the one beginning with "Continuous".

A Yeah: (as read)

Continuous masking can function either as a source control, being worn to protect others, or part of personal protective equipment to protect the wearer to prevent or control the spread of COVID-19. Working collaboratively, we shall ask all individuals to assist us in limiting the spread of COVID-19 through the use of procedure masks in AHS facilities/settings.

Q So we talked --

A Okay, next paragraph? Okay, sorry.

Q No, that's fine. So we talked a little bit about this before. They're talking here about two things, source control protecting others and protecting the wearer; was that a consideration for the development of the Pandemic Directive?

A That is the consideration that we made to protect our patients and also to provide that protection for our members as well.

Q To your knowledge, has AHS ever granted an exemption from masking for the health care workers they regulate?

A No, and specifically during the pandemic, I did speak to members who raised concerns, i.e., one had a severe allergy to latex and was reacting to the mask. And I did reach out to AHS and had a conversation with them

about that, and they indicated that there was no substitution for a procedural mask available. And so even in the case of somebody that was having that reaction and actually having a like constant contact dermatitis reaction, there was no exception provided to masking.

Q I'm going to talk now about the manner in which the Pandemic Directive was communicated or distributed to members, and I'm going to, in a couple of minutes, I'm just going to ask you to go through some of the highlights of the documents C-1 to C-22, but I'll just -- I'll ask you to call those up.

When we look at C-1 to C-22, they are a series of -- they're entitled "Notice to Member", "Registrar's Report", "Council Updates". Can you tell me generally how the Pandemic Directive was communicated and what the purpose of these notices was?

A Yeah, no, and that's great. So a lot of -- I looked back, during COVID, we were highly communicative with our members, right from the time there was an identified pandemic declared, all the way up and to -- including the provision of the Pandemic Practice Directive, we were sending communications to members or notices to members once, sometimes twice a day, to make sure they had the most current information for their consideration.

And that would have been a blend of -- because we are a dual-mandate organization currently, that would have been a blend of both Association communications and College communications. And often they may -- that communication may have come from one, like clearly the Association or the College, or made a blended communication where we would have covered topics of both in that communication.

Q Okay, so when we look at these notices and the, again, Registrar's report, who sends them; how do they go out to chiropractors?

A Yeah, so those are sent specifically out of our patient -- or not our patient but our member database. So those are in there. We have -- we can see who we're sending to. They would have distributed to all of the regulated members at the same time.

One of the requirements of the College, of the ACAC is that members must receive our electronic communications because we're an electronic communicator.

Q So are you confident that Dr. Wall would have received all of these notices and updates?

A I am confident. It is our members' responsibility to ensure that their email address is up to date and on the College database. And I am confident, because when I did contact Dr. Wall, I did so using the email

address that's provided to the College when I first reached out to Dr. Wall in December of 2020.

Q We talked about the -- I'm going to take you through some of these, of course -- or take you through them in a minute. We talked about the fact that the Pandemic Directive had mandatory language for masking. Do these notices all have mandatory language in terms of masking?

A I would say that it depends on each notice. Some will say "must", some will say "may", but whenever we were being direct with members of what they were required to do, we always used the word "must". If they were allowed to -- professional discretion in a situation, then we used the word "may".

Q So I'm going to (INDISCERNIBLE) --

THE COURT REPORTER: That was all -- you were turned away from the camera. I did not hear a word of that, sorry.

MR. MAXSTON: I'm sorry, Madam Court Reporter.

Q MR. MAXSTON: Dr. Halowski, I'm going to take you or ask you questions about Notices C-1, C-10, and C-13, and they are the Telehealth notices.

MR. MAXSTON: I don't need, Mr. Chair, you, and the Tribunal Members, to go to all of them.

Q MR. MAXSTON: But I just wonder if you can

tell me what these Telehealth notices to members are, when they came out, and what they were intended to achieve.

A Absolutely. So C-1 specifically we sent to members. We had developed a framework for our members to be able to provide Telehealth, but one of the things that we were getting questions on was billing. And I say "we", often they would call me in looking to do that. The College cannot advise on billing matters, so then this would have been a communication that came from the Association but specific to needs identified, where they were asking, well, how do I bill for Telehealth, how do I, you know. And so they were looking for a way. So this was our advisement provided to members on how to bill when they're providing Telehealth services.

Q Okay. Was this something new for the profession, to be allowed to do Telehealth?

A Absolutely. This -- we had never provided Telehealth as a profession before, and so this was something that we developed as soon as -- we started working on this right away when things were -- when we saw where this was going so that we could offload or offset the risk for in-person care at that time. And so this was developed and adopted by a motion from council as a temporary Telehealth solution, which was intended to be reviewed in June of that same year.

Q Is Telehealth now a permanent allowed modality for treatment for chiropractors?
A It is a permanent allowed modality, and it's the intention of the ACAC to take and turn that into a standard of practice as time permits. Some of that's been restricted due to other legislative challenges within the system and introduction of other bills. So that is our intention to make that a standard of practice down the road.
Q Okay, I'm going to be mindful of the court reporter's caution to me, I'm going to keep looking at the camera here when I go to the next documents. I'd like to take you to C-2, which is an April 21, 2020 Notice to Members.
A Yeah.
Q Broadly speaking, when I look at paragraph 2, this addresses, at least in part, the return to practice plan. Can you tell me what paragraph 2 is talking about in terms of consultation or feedback?
A Yeah. So when we developed this, you know, we had done a lot of work to develop, but we wanted to inform members how we developed it, that we weren't pulling it out of a hat, we had spoken to other regulators, we had spoken to members of the competence committee, to specialists within the profession, and other regulators across Canada so that we had a framework for

chiropractors to reasonably practice during a pandemic.

And then what we did is that we were advising members that as -- we've done the work, but we're not just going to say here it is, we wanted consultation, we wanted their feedback.

Q The second paragraph talks about the platform you referred to before as ThoughtExchange, and there's a final sentence in that paragraph: (as read)

> This is your opportunity to engage in the development of this plan, so please participate.

Were you hoping for participation?

A Absolutely. We wanted feedback, and I believe we received robust feedback from members in the form of participation in the ThoughtExchange, during the town halls, and then also with direct communication from members to myself or to council during the time that we were developing that.

Q If you go to paragraph 3 in this notice, it talks about virtual member meetings on COVID-19 to be held next week, and the final sentence: (as read)

> There will be an opportunity for members to submit questions related to COVID-19 during the meeting.

Did you receive questions?

A I do, we did receive questions. During that, there was

a lot of questions ranging from like everything in the practice directive and other questions that were also other than College questions, there was Association questions, people worried about different aspects of practice and when could we go back.

As indicated when I spoke earlier, one of the concerns that chiropractors continued to voice was around the idea of why aren't we considered an essential worker, and so that was a question that was also raised during that meeting.

Q When we go to document C-3, which is a Notice to Members, the first line after that says: (as read)

> Participate in the member consultation on the draft return to practice plan.

Is this the mechanics of getting that access we were just talking about?

A Yeah, absolutely. We published it, which is what step 1 was so they could review the draft return to practice plan, and step 2 was to provide anonymous feedback to that draft practice plan.

Q There is a statement just above the heading "Registration for ACAC", and it says: (as read)

> If you have any questions or concerns about the plan or survey, please email Dr. Todd Halowski.

Were you available to take questions then about the

plan for re-entry?

A Absolutely. In addition to that, I received I would say upwards of a hundred emails from members, ranging and weighing in of topics of concern or consideration in regard to the Pandemic Practice Directive as presented -- as the draft was presented.

Q I'm going to ask you more about this in a moment, but do you recall if you received any communications or questions from Dr. Wall?

A I did review my email to see if Dr. Wall had submitted any feedback to the practice directive, and in all the emails that I reviewed, I did not see any feedback received from Dr. Wall.

Q I'm going to ask you to go to document C-4, "Our Clinics are Adjusting to Keep You Safe". What is that document?

A Yeah, so this is one of the things, this would be an Association style communication that was produced, and, again, this is more meant for marketing to patients, but it's also highlighting what chiropractors are going to be doing to keep them safe when patients return to practice.

And so this was developed and prepared, and you'll see the date on it was April 29th. That's when we knew that we were going to be going ahead, and this had been approved for distribution, so members could get these

posters prepared for use in their clinics when we had the opportunity to re-open.

Q Did this also go to chiropractors then, just so I'm clear?

A Yeah, yes, that was distributed to all members of the Alberta College and Association of Chiropractors.

Q Okay. I'm looking at the next document, C-5, it's a Notice to Members, and item 1, numbered paragraph 1, the last paragraph says: (as read)

> Chiropractors will not be able to open until the ACAC has received Public Health approval of the return to practice plan.

This is referring to the Pandemic Directive approval process we talked about before?

A That is correct, we wanted to make members very aware that that was a part of that.

Q If you go to number 5 on the next page, it's dealing with PPE, and can you tell me what the first sentence says and what it means?

A Yeah: (as read)

> The initial information from Alberta Health Services is that the appropriate use of PPE will be a requirement of return to practice for close contact practitioners. As mentioned in the --

Oh, sorry, I'll stop.

Q Sorry. This would have gone to all chiropractors?
A This was distributed to all chiropractors of the Alberta College and Association of Chiropractors.
Q Okay, I'll go to document C-6, which is a May 1, 2020 Notice to Members. And I'll just ask you to tell me what the first paragraph -- first couple sentences in paragraph 1 say.
A Is that starting with "Yesterday"?
Q No, numbered paragraph 1, I'm sorry --
A Oh, sorry.
Q -- "Status on".
A Yes: (as read)

> Status on the return to practice plan. Council approved the ACAC COVID-19 Pandemic Practice Directive today, which can be accessed here. This directive has been submitted to Public Health for review and approval as required by the Government of Alberta.

And then: (as read)

> Public Health must approve the directive before chiropractors can proceed with re-opening, and chiropractors can remain limited to urgent, critical, and emergency care until otherwise notified by the ACAC.

Q So was this the first communication of the Pandemic

Directive to members?
A It absolutely was, yes. And we did that because we wanted members to be able to review it so they could be prepared to implement it, because they weren't allowed to return to practice till they could implement it.
Q So that sort of takes us to the next document, C-7, which is a May 3, 2020 notice.
A Yeah.
Q And I wonder if you can just read the first three paragraphs, it begins with "We are", and tell me what this means.
A Yeah: (as read)

> We are excited to report that Alberta Health notified all regulated health professions today that effective May 4th, 2020, regulated health professions who are ready to execute all requirements of their respective regulatory college pandemic practice directives can return to practice.

Q And the next, I've got a question, tell me about the next two paragraphs, if you can read those.
A Yeah: (as read)

> The ACAC COVID-19 Pandemic Practice Directive is approved. Chiropractors who can completely implement the directive may re-open. Chiropractors who are unable to

fully implement the ACAC Pandemic Practice Directive may not proceed with re-opening until all measures are in place.

Q So compliance was a condition to re-opening?

A Absolutely.

Q And was that mandatory compliance, just to be clear?

A Mandatory, yes.

Q I'll go to the next document C-8, which is a May 25, 2020 Notice to Members.

A Yeah.

Q And in specific, I'll get you to go to page 2, and there is a heading "Why do Chiropractors need to wear masks". I'm wondering if you can just explain why this is being sent to members?

A Yeah, and so we did have some questions from members once we originally returned to practice who were wondering why we were required to wear masks, and so we wanted to make sure that we were answering that for members, and that that was that proper -- the observing PPE requirements protects chiropractors from mandatory self-isolation if they treat an asymptomatic patient who later tests position for COVID-19.

So when we returned to practice, what we did start to see is that members that were being deemed close contacts would have to isolate, and it was communicated via Public Health that chiropractors that were wearing

masks at the time would not be required to self-isolate if they were masked when exposed to a pre -- what Alberta Health termed a presymptomatic patient.

Q Okay, if we go to Notice C-9, it's July 24, 2020 Notice to Members, there's a reference on page 1 to the City of Calgary's mandatory face bylaw, but I'd like to take you to the top of page 2, and there's a bullet that starts off with "Exemptions", I wonder if you can just read that.

A Yeah. So: (as read)

> Exemptions to any bylaw are designated by each municipality.

And I should give context to that, at that time, only the cities were providing exemptions; there was no provincial exception -- our provincial bylaw requiring masking, sorry, not exemptions: (as read)

> A medical diagnosis that leads to an exemption may only be provided by practitioners who have the authority to grant exemptions.

So currently, chiropractors are not entitled to offer exemption from face covering to their patients.

Q So I'm going to stop you. Are you telling chiropractors there that they can't grant exemptions?

A Absolutely correct. One of our concerns was that chiropractors may attempt to write exemptions once

these were introduced, and so we wanted to be very clear that that is not in our scope of practice to exempt patients from a face covering when required by a bylaw.

Q And there's a sentence you read: (as read)

> A medical diagnosis that leads to an exemption may only be provided by practitioners who have the authority to grant exemptions.

The College was requiring a medical diagnosis then?

A No, so I think in the initial stages of the bylaw introduction, one of the things we were trying to be clear to our members is if a medical -- "that leads to an exemption may only be" -- so if there was a medical diagnosis, i.e., that somebody was -- because I -- like Edmonton required an exemption card, Calgary had a different way, but we wanted our members to know that they weren't authorized to provide any sort of -- exemption for a member of the public from a masking bylaw.

Q I'm going to ask you a question, but was -- did you ever -- that's okay.

I'll go to the next notice, C-10 -- sorry, we've talked about C-10, that's the Telehealth notice, my apologies.

I'd like to go to C-11, which is your August 2020

Registrar's report.
A Yeah.
Q And more specifically, I'm going to ask you to go to page 9.
A Okay.
Q And under the heading "Return to Practice Feedback Survey, I wonder if you could read that sentence.
A Yeah: (as read)

> We want to hear how implementation of the return to practice plan is going in your clinic. Please submit your feedback to us using this survey.

And that was another ThoughtExchange survey that was sent out for members to be able to make comments on.
Q So you had a line of communication for positive comments or negative comments?
A For any comment, and comments received could have been both positive or negative.

I can take a second and explain how ThoughtExchange works. So in ThoughtExchange, what happens is somebody gets to make a comment, and they could say, I love masking, or they could say, I hate masking. And when then they do that, then what happens is, once you get enough thoughts in there, people get to go and read the thoughts that are currently in it, and they can rank them; they can go this is actually

really important, or, oh, this is garbage, or they may flag inappropriate comments. So ThoughtExchange is meant for a much more interactive response than, say, the idea of a yes/no survey.

Q Okay. Let's go to document C-12, which is an August 11, 2020 Notice to Members.

A Okay.

MR. MAXSTON: Mr. Chair and Tribunal Members, I'm planning on going through these quickly. I'm assuming that once you're in that C file, you're able to click ahead fairly easily too. If any of you are not at a document, please let me know.

Q MR. MAXSTON: So, Dr. Halowski, I'm looking at C-12 again, and numbered paragraph 1 says: (as read)

> Chiropractors must adhere to the ACAC COVID-19 Pandemic Directive regardless of local bylaws.

What are you intending to communicate there?

A Yeah. So one of the questions that members were going, say -- they were asking what's the interplay between bylaws and what's the interplay between this. And so when we said this, that "Chiropractors must adhere to the ACAC COVID" ... "regardless of local bylaws", local bylaws only expand practice requirements. They do not remove the requirements of the practice directive.

And so we're saying like they may add things in, but they can't diminish the minimally acceptable level of performance that's put out by the practice directive.

Q Okay. We've already talked about C-13, that's one of the Telehealth directives, so I'm going to go ahead to C-14, which is a November 23, 2020 Notice to Members, and I'd just like you to, I'm on page 1, if you could read the last couple of sentences on that page, "As always".

A (as read)

> As always, as soon as we know more, we will advise you. If you have questions, please contact us at the ACAC office.

So we -- again, we were always very open and communicative with members, especially when questions were coming up. You know, speaking as a -- as the Registrar, I was often communicated to with questions. And speaking as a practitioner, this time, I think this is when we started to see kind of the development of that second wave, and practitioners were getting nervous, that, hey, we're going to get shut down again like we did when the first wave happened. And so they were often seeking clarification. We wanted to make them very aware that they could reach out and speak to us at any time.

Q Okay. So C-15 is a November 25, 2020 document.
A Yeah.
Q I'd like you to read the last sentence on the bottom of that page "As a health professional", that's what it begins with.
A Oh: (as read)

> As a health professional, it is your obligation to be informed of and to uphold all restrictions, bylaws, or other decisions that impact your clinic and the health and well-being of staff, patients, and visitors.

Q And then if you go to the next page, can you read the last sentence, "If you have"?
A Yeah: (as read)

> If you have questions, please contact the ACAC office.

Q So this is an opportunity for members to contact you again?
A Yes, it is.
Q Again, these would go to all members?
A Yes.
Q If we go to the next document, C-16, which is a November 25, '20 FAQ or frequently asked questions, I'm going to ask you to go to page 7.
A Okay.
Q And there's a heading "Do we need barriers for our

reception desks", and can you tell me what it talks about in that next paragraph?

A Yeah, I will read it, and then interpret it, if that's okay: (as read)

> Employees in the public should be 2 metres from each other. If 2 metres cannot be maintained at reception/payment area, other noncontact electronic payment means can be used or installed, or installation of a plexiglass or plastic barrier can be used to protect reception staff. Many local companies are retooling to do installations of barriers in local businesses.

One of the things that we wanted to make sure is that members knew how to obtain and provide for barriers for their staff, especially with the uptick in cases, that that was made available for members as a resource and also just to remind them that they have a duty to keep barriers in place when the physical distance of 2 metres can't be maintained or to separate them from the general public that was receiving care.

Q Just below that, there's a heading "Personal Protective Equipment (PPE), and it has some Q and As again about wearing masks, et cetera. Is this a reminder to members of your profession?

A Yeah, absolutely, because we were getting not only

questions about that but questions around things like, Do I have to wear a mask, or, Do I have to wear gloves or gowns when treating. So we wanted to just be very mindful and remind them of the duty that a surgical/procedure mask must be worn by the member when treating patients and a physical distance of 2 metres cannot be maintained.

Q If we go to page 10 of that document, there is a heading "Who should I contact if I have questions", I wonder if you can read that paragraph?

A (as read)

> If you have questions, please contact the ACAC at office@albertachiro.com, and we will respond to you as quickly as possible. If you have a question, it's likely that other chiropractors are having the same question. We'll answer your question if we can. Follow up with the Government on anything that requires further investigation, and continue to update you on any news.

And that's one of the patterns that we saw, like if we started to get one member asking a question, usually we'd get three or four questions. That's one of the ways we identified some of our FAQs, because if somebody was asking it, we'd get multiple questions along the same line around topics like that.

Q And there's a reference here to an email address so members could communicate with you by email as well then?
A That's correct.
Q I'd just like to go to the next document very briefly, C-17, which is I think an ACAC website update, and it's entitled "Adjusting for you". I'm assuming this is something that was intended to go to the public or more for public consumption?
A Yes, yeah, this is more of an Association style communication relative versus a College style.
Q And the second page has a heading called "Wearing Masks", can you tell me what that is telling the public, members of the public who might read this?
A Yeah, so if you look like -- like if we -- and for a second, if you juxtapose this to the practice directive, this language is meant to be clear, like everyday language so that chiropractors are wearing personal protective equipment such as masks during treatments.

We're letting the public know that that's what chiropractors are doing, because in the directive, we're very clear that that's a requirement, and we thought it was reasonable to alert the public that chiropractors are wearing masks.

Q I'd like to go to the next document, which is C-18, a

Notice to Members dated December 9, 2020.
A Yeah.
Q And about halfway down the page, maybe two-thirds of the way down the page, there's a paragraph that begins with "Masking is mandatory", and there is a sentence sort of about a third of the way down or half of the down that paragraph that says: (as read)

> There are no exemptions to chiropractors and staff masking.

Was that consistent with the Pandemic Directive?
A That was a hundred percent consistent with what we had indicated to our members.
Q So this is another reminder to members?
A Yes.
Q If you go to page 2, there's an impacts -- sorry, "Impacts on ACAC operations", and there's a paragraph that begins, it's the third one: (as read)

> If you experience a COVID-19 emergency.

Can you tell me what that paragraph says?
A Yeah, so at that time, with the -- right now, the province was in the full, like kind of a ramp-up up to that second wave of COVID-19, and we were shutting down operations, and so we wouldn't be answering the phones live, so we wanted to make sure that our members knew how to reach us and how to contact us and that we were there to receive their communications.

And so when you look at that, they could email the Registrar, email directly. Under that, this contact information, where you see the underlined in blue, where it says "Dr. Todd Halowski" or "Sheila Steger", those lines, that provided a direct link to our personal emails. And then also that was the extension of the phone number, if they called the College office, it would come to us, and we received all voice mails electronically at that time.

Q So they can communicate by email or by phone?

A We were available to be communicated to at all times.

Q C-19 is a Notice to Members, and I'm just going to get you to go to the third page of that three-page document, and I'd like you to read the last sentence literally above your signature. It says "We are here to support you: Can you read that sentence?

A Yeah: (as read)

> We are here to support you. If there are COVID topics that will benefit the profession that you believe the ACAC should cover, contact me.

Q So this is another opportunity for members to contact you?

A Yes.

Q I just have to grab a binder, just bear with me for one moment.

I'm looking -- I'd like to take you to File F, File Folder F and, in specific, F-3, the ACAC Registrar report from July 5 of 2020, and more specifically, I'll just get you to go to page 5 -- sorry, 2021, thank you. Mr. Lawrence just reminded me.

And on page 5, there's a reference to a simple rule. Can you read that sentence?

A I'm just going to pull it up on the 'K' drive here.

Q And, again, that's the --

A Registrar's report.

Q -- yeah, July 2021, yeah.

A Yeah, okay.

Q So I've asked you to go to page 5, and the second complete paragraph has a sentence about the "simple rule". Can you just tell me what the "simple rule" is?

A Yeah: (as read)

> The simple rule to follow to maintain compliance is that the more stringent requirement applies to chiropractic practice in Alberta.

And that's -- we communicated that: (as read)

> For example, if Public Health relaxed a restriction, but your local municipality maintained their bylaw, then the bylaw would be considered more stringent and would need to be followed. If your local --

Q Okay -- yeah, I'm sorry.
A Oh, so, yeah, this is part of that line of communication. Like it's the more strict. The baseline, the minimal accepted level is the practice directive. If there was a more strict requirement introduced, it was the requirement of the member to follow the more strict requirement.
Q And just finally, very quickly, the next document, F-4, is an FAQ from July 7. I'll just let you get to that. I'm not sure if you have it handy or have to go through your computer to --
A I have it, I have it handy.
Q Okay. There's a question on the first page: (as read)

> Why are we still required to do all this when the rest of the province is back to normal.

Can you tell me what the answer is?
A Yeah, we are a regulated health profession. We're not -- not to diminish the work or role that anybody else plays, but we have a responsibility as a health care provider to act first for the safety and protection of our patients and to consider their health needs.

> And so when we're looking at that, we have a duty to maintain the privilege that we're offered as a regulated health profession, and part of that is to make sure that we're following the highest standard in

ensuring public health and safety.
Q So I've taken you through a number of documents --
MR. MAXSTON: Thank you, Mr. Chair, for your patience, and Tribunal Members --
Q MR. MAXSTON: -- that have talked about the communication efforts and the feedback efforts from the College.
I asked you this question before, but I'm just going to confirm, you did receive feedback from the membership?
A I did receive feedback from the membership.
Q I'm going to talk with you in a couple of minutes about your communications with a lady named Ms. Ho and how the Dr. Wall complaint arose.
After -- or in April and May, when the Pandemic Directive was being created and thereafter, did you receive any communication from Dr. Wall?
A I received -- in preparing for this, I was reviewing and I didn't see any communication via email directly to myself or the College from Dr. Wall. And all communication around COVID was always forwarded to me for a response and -- and review and response of the College, and I have no record of Dr. Wall emailing the College.
Q Just so I'm clear, no emails or phone calls?
A No phone calls either.

Q Before the introduction of the Pandemic Directive, did Dr. Wall contact you about pandemic concerns?

A I didn't -- prior to this, I didn't have any communication from Dr. Wall about the pandemic.

You have one communication in my record that I had received from Dr. Wall in early March, just when the thought of the pandemic was coming.

Council had recently introduced some direction on discussion of vaccines and that -- chiropractors, we wanted to be very clear with our members that, you know, we don't have it in our scope of practice to administer, educate on vaccinations, and so we had tightened up a position statement that directed our regulated members to send questions direct -- send patients with questions directly to Public Health or their medical doctor in order to receive the appropriate answer and education.

One of the things that we know is that vaccine misinformation or -- can elevate vaccine hesitancy and put the public at risk especially in the times of communicable disease. And Dr. Wall had written a letter saying that, you know, that he was -- he said that he recognizes that chiropractors are governed under the Health Professions Act, and he intends to follow any guidelines and rules put forth to our profession through Standards of Practice and bylaws.

But then he was also expressing frustration that chiropractors couldn't speak up about vaccines, that he indicated that he doesn't believe in vaccines to the same extent that Public Health does and that he thinks that, you know, it's a shame that we were being limited in our ability to communicate about vaccination. So he provided feedback to a policy that council had put forward that he disagreed with.

Q And that was before the Pandemic Directive though?

A Absolutely.

Q I'm not going to take you to these documents to look at, but Exhibits D-3 to D-7 are a series of CMOH orders, and I'll just ask you, are you generally familiar with those?

A I believe so, yes.

Q And just to close off a discussion on the Pandemic Directive, did the College review CMOH orders as they came out?

A We did, we did review them and consider them in our policies that we were maintaining and the direction that council was providing.

CMOH orders were an essential part in looking at, reviewing, and advising council so that council had the best information when they were making their decisions.

Q Was the Pandemic Directive a fluid document?

A It was fluid in the sense that when a change was

required, we would make a change. As we reviewed that, there was no need to change the directive relatively -- when it first came out, we were very -- we wanted to think big picture with it, so we wanted to have a document that would stand during a pandemic. I didn't want the idea of tinkering it. It's difficult for members to have to adapt if we were reviewing it every two weeks and going, What about this and what about that.

So we really did develop a document that was able to stand during a pandemic and provide and inform members' practice relative to the standard of practice.

Q I understand that there was change to the Pandemic Directive in early July of 2021; is that correct?

A I think -- oh, this year, yeah, sorry. There was. That was changed -- sorry, I was thinking back to last year. I don't think anything happened in 2020, but 2021, that's correct, we did introduce new direction for the members based on the current environment and current information and the medical orders that were in place from the Medical Officer of Health at that time, so ...

Q So mask --

A Yeah, we amended specifically, we changed and we maintained requirements around infection prevention and control in the office, but specifically, you know, hand

washing and some of the other measures in around screening as well.

We did remove the requirement for masking and eye protection but did maintain a strong recommendation that members consider to continue to use the masking for themselves and the eye protection for themselves as well.

Q So, Dr. Halowski, a while ago when we were first talking, I think you mentioned to me that the Pandemic Directive, at least in part, was based on Standard 4.3 --

A Yes.

Q -- that was already in place. I'd like you to go to and the Tribunal Members to go to Exhibit A-11, which is an excerpt from the -- or, pardon me, it is the Standards of Practice for the College, and I'd like everyone specifically to go to page 15 and Standard 4.3, which is "Infection Prevention and Control". So, again, that's Exhibit A-11, and I'd ask all of you to go to page 15.

Dr. Halowski, this is a bit of a lengthy standard. I'm more interested in -- most interested in the opening statement and then the bullets that appear on page 16. I'm wondering if you can take me through this with as much detail as you need to. Can you tell me what the standard of practice says?

A Yeah, so this is our infection, prevention, and control standard. It was adopted in 2010 and revised in 2014 specifically.

And, again, one of the things that, Mr. Maxston and the Hearing Tribunal, is that I cannot stress enough that Standards of Practice represent our minimally acceptable level of performance. These are not aspirational; they're meant to designate the low bar for practice.

And so when we look at that -- and that's the same in every profession, that's not unique to us as chiropractors or unique to physicians or physiotherapists, dentists, or anybody; Standards of Practice are the minimal acceptable level of performance, and it's kind of how we measure if somebody has met the threshold of professional conduct. And if they're at or exceed the standards, then that's one of the considerations.

So when we look at that and go through this, the standard does lay out specifically what the requirements are for our members to be minimally acceptable, to: (as read)

Remain current in generally accepted routine practices and infection control protocols relative to their current practice context.

And practice context can be what's internal in the

environment and what's external to the environment.

In the case of something like a novel Coronavirus, none of us have practiced that in that environment, and so that's where we saw a need that we would have to provide direction for membership, right?

The next one: (as read)

Develop, incorporate, and keep up to date infection control policies to promote the use of infection control measures, which may be unique to their personal professional practice style.

That's a -- so that's incorporating that they need or are required to have an infection prevention control policy in their office that highlights how they execute and practice to keep in consideration of infection and infectious disease, right?

(as read):

Ensure that their clinic is fully equipped, operated, and maintained to meet generally accepted infection control guidelines.

And that's a really important one is the "generally accepted". You know, it's not -- we're not looking to set a bar higher for the chiropractic profession than any other profession; these are measures that are generally accepted.

Like, you know, hand washing is a great example.

The World Health Organization continues to identify that hand washing is the single most effective way to break the transmission of disease. Every standard of practice I review from other professions highlights the importance of hand hygiene before and after care.

And so that's -- and you look at that in our practice directive: (as read)

> Hand hygiene, which must include the use of hand cleaner or a hand washing -- or hand washing before and after each patient contact.

We're very consistent as a generally accepted measure: (as read)

> Use of protective barriers as standard practice whenever contact with blood and body fluids is likely to occur during patient contact. Barriers must also be used when a patient's personal care equipment is likely to have been contaminated with potentially infected fluids, like wheel chairs or walkers.

So protective barriers, and that's defined specifically in here as personal protective equipment: (as read)

> Specialized equipment or clothing used by health care workers to protect themselves from direct exposure to client's blood,

tissue, or body fluids. Personal protective equipment [and here's where we leave it to practitioner discretion in the standard of practice] may include gloves, gowns, fluid-resistant aprons, head and foot coverings, face shields or masks, eye protection, and ventilation devices, for example, mouth pieces, respirator bags, pocket masks.

And the reason that it's left to practitioner discretion in a standard of practice is -- and if we required our practitioners to wear gloves, to wear a gown, fluid-resistant aprons, and head and foot coverings for every patient interaction would be significantly oppressive to practice and to the practice style that we practice in. You know, chiropractors tend to work with non-infectious patients, we tend to work with patients that are coming in with neuromusculoskeletal conditions or NMSK as I indicated earlier.

We go on to talk about: (as read)

Internal environmental cleaning, disinfecting and sterilizing equipment and facilities, and managing waste and materials contaminated by body fluids [which we use Appendix A to define all of that].

And I'm happy to review that as part of this, right?

And highlights of that is measures practiced in appendix -- I'm going to jump over to that, and then I'll come back to the bullets. But: (as read)

> Measures practiced by health care practitioners intended to prevent spread, transmission, and acquisition of agents or pathogens between patients, from health care practitioners to patients, from patients to health care practitioners n the health care setting. Infection control measures instituted are based on how an infectious agent is transmitted and includes standard, contact, droplet, and airborne precautions.

Cleaning is really the physical cleaning of a space, right? Disinfection is using different things that we know are -- during contact time are meant to kill or -- kill the pathogen, right? Sterilization is a two-step process not typically applied in practice, but there may be some practitioners who use metallic pinwheels, and those require sterilization versus, say, a disposal one.

And then we really highlight as well as part of Appendix A that we have to consider our policies in light of both external and internal practice environments. External would be: (as read)

Any locale beyond the internal practice environment and may extend to municipal, provincial, national, or international borders, depending on the nature of the infection risk being considered.

Specifically when I look at that, that just specifically speaks about a novel infection. There was so much information that was lacking at the onset of the pandemic that we -- this is where we again identified that we really need to be -- get the information and provide the information that's relevant to practice.

And then when you come back, we are adamant that our members must: (as read)

Adopt appropriate -- [and this is a minimal level] -- but adopt appropriate infection control measures, including contact management protocols and monitor their use and effectiveness to identify problems, outcomes, and trends; provide infection prevention and control training for clinical staff and monitor implementation of that.

So, again, they are highlighting, to a question you had asked earlier, Mr. Maxston, part of this standard is that our members have a responsibility to make sure their staff are trained and monitored in their use of

infection prevention and control procedures, which -- excuse me for a sec -- which does include the use of personal protective equipment.

And then to: (as read)

> Conduct ongoing assessments of current risk of infections and transmissions to patients, staff, colleagues, and other health professionals, and take appropriate remedial action in a timely manner consistent with professional requirements --

Right? And when I look at that word "professional requirements", you know, that is the Pandemic Practice Directive, that was the professional requirement that council put in place in respect of the novel Coronavirus that -- pandemic: (as read)

> -- and the applicable law based on consideration of the following: The assessment of the treatment [so this is speaking to, you know, assessing what's going on]; the health condition of the patients; the degree of infection and risk currently present in the internal practice environment; the degree of risk presently in the external practice environment; and current best practice infection prevention control protocols relative to his or her practice.

Again, going back to, you know, if -- what they're doing with patients.

For instance, we have some practitioners that work intraoral or do work inside of somebody's mouth, they're going to wear gloves. There's a risk that they could be closer or developing aspirations or -- from the patient or where they would need face shields. So that was a significant portion of that.

And then, you know, so this standard of practice is there -- there isn't a requirement in our Pandemic Practice Directive that isn't already considered in our standard of practice, but the Pandemic Practice Directive was contextualized to the information provided by Alberta Health and Public Health to practicing during the novel Coronavirus outbreak and was meant to -- as a requirement for our members to follow. Hence, why we use the word "directive" instead of "suggestions".

Q Okay.

MR. MAXSTON: Mr. Chair, it's about 3:30. The -- I have my last section of questions for Dr. Halowski is about his involvement in the complaint concerning Dr. Wall and a couple of I guess housekeeping questions after that, not many.

I understand from the College that the Hearings Director at 4:00 would need to hand over control of the

meeting hosting to someone else. I think I would propose to go another half an hour unless you need a break, and I don't think, unfortunately, we're going to get to cross-examination today by Mr. Kitchen, but I think I can finish with Dr. Halowski today. And then next Tuesday, we would resume with Mr. Kitchen. I, of course, wouldn't talk to Dr. Halowski about his testimony during that break.

Do you want to take a quick break now though for 5 or 10 minutes, or do you want me to just go ahead, and I'm fine either way?

THE CHAIR: No, I think my body doesn't like sitting in front of a computer screen eight hours a day, so I'd like to get up and stretch. So let's just -- I mean 5 minutes is fine, and then we'll --

Mr. Kitchen, does that sound fair to you in terms of a plan for the rest of today and for next week?

MR. KITCHEN: That's fine, yeah. We're not going to have time to do my cross, so that's fine.

THE CHAIR: Okay, very good. All right, well, if that's the case, let's break for -- come back at 20 to 4, and then we'll plow through the rest of the direct examination. So we're in -- session is in recess for now, reconvene at 3:40. Thank you.

(ADJOURNMENT)

THE CHAIR: The hearing is back in

session, and, Mr. Maxston, it's your floor to continue with Dr. Halowski.

MR. MAXSTON: Thank you, Mr. Chair.

I'm now going to turn to the sixth and final area that I wanted to have questions for Dr. Halowski on, and that is his involvement in the complaint concerning Dr. Wall. I'm going to ask you, Mr. Chair and your colleagues, to go to Exhibit A-2, which is a December 1, 2020 email from a lady named Heidi Ho at Alberta Health Services that was sent to Dr. Wall and was copied to Dr. Halowski, so I'll just let everybody get to that document, and then I'll -- I've got a few questions on that.

THE CHAIR: And, Dr. Halowski, do you have a copy?

A Yes, I do, thank you.

Q MR. MAXSTON: So, Dr. Halowski, I really, as I said, going to want to talk to you here about your involvement with this complaint and how things started. Can you tell me who Heidi Ho is at Alberta Health Services?

A Yeah. Heidi Ho is a community medical specialist, so she's like a ground-worker for Public Health, and so when Public Health complaints are received, then she would go out and investigate.

During the pandemic in the initial phase, we

received many contacts specifically from Public Health about the conduct of our membership, where we would investigate. That was something that I would often receive, initiate, and then follow up and let me them know that we'd investigated and any action taken.

So for Heidi Ho to reach out and communicate to me directly was an occurrence that wouldn't have raised on my radar from time to time, but it was a signal that Public Health had something that they wanted us to look into and be able to respond to them that our member was, in fact, doing what they should do, or if there was concerns, then we would raise them back to Public Health as well.

Q So the December 1, 2020 email, you're copied with it, it's going to Dr. Wall. Can you tell me what Ms. Ho is communicating to you in this email?

A Yeah. So she says: (as read)

> Alberta Health Services received a complaint indicating that the administration staff and yourself are not masking even when within 2 metres distance with patients. As per our phone conversation, you indicated you were mask-exempted as per CMOH 38-2020. Please indicate which exemption you would fall under; otherwise, you are required to be masking when within 2 metres distance with a

patient. As for your administrative staff, you indicated that there is no plexiglass barrier at the reception and that staff are not masking. Patients could be within 2 metres' distance when making payments. This is in violation of the CMOH Order 26-2020, where every person attending an indoor or an outdoor location must maintain a minimum of 2 metres distance from every other person. Your clinic must have control measures, physical barriers -- for example, physical barriers to promote physical distancing at all times; otherwise, the administrative staff must be masked as per CMOH Order 38-2020.

And then she just informs that she's copied me, and when I received this email, I was quite concerned that Dr. Wall was not following the practice directive, because we were very clear about what the requirements are, and masking was one of them, and Ms. Ho was also aware of that.

Q Okay. I'll ask you to go and everyone else to go to Exhibit A-3, which is your December 2, 2020 letter to Mr. Lawrence, in his capacity as Complaints Director. And I'll just -- you quote Ms. Ho's email in there in your letter, I'll just ask you to read the first

paragraph in your letter to Mr. Lawrence.

A (as read)

> It has come to the attention of the Registrar through Public Health on December 1st, 2020, at 4:17 PM that Dr. Curtis Wall is not following the ACAC Pandemic Directive and the CMOH orders regarding masking and the requirements to maintain 6 feet of social distance.

And I included that body of the email just for Mr. Lawrence's consideration.

Q Okay, and can you read the last two paragraphs -- I'm going to have questions for you on these, but can you read the last two paragraphs in your letter, beginning --

A Yeah.

Q -- with "Further to"?

A (as read)

> Further to the email from Public Health, in conversation with Dr. Wall, he indicated that he does not mask, and he has not provided for barriers in his clinic.

So I did, once I had this, send an email to Dr. Wall, letting him know I would need to speak with him. We did have a conversation on December 2nd.

> And so that's what that's referencing, that, in

conversation, he had communicated that he wasn't doing it and nor do he have intention to: (as read)

> I have serious concern for public safety as Dr. Wall refuses to mask when he breaches the physically distance of 6 feet with the public. He is not providing for or requiring his staff to mask when they are within 6 feet of distance.

Q Okay, so I want to turn back to this phone conversation you had with Dr. Wall, and can you just refresh my memory, what day did that happen?

A December 2nd.

Q And did he call you?

A I can't remember the exact -- I did imply that we would need to converse, and I believe that I did call him at his clinic, but I don't know off the top of my head.

Q Okay, I want to just be very clear about your conversation with him and what he said to you. You said in your letter he indicated that he does not mask?

A Yeah.

Q And that's accurate?

A That's what he indicated at the time, that he was not masking, and I also remembered he indicated he had no intention to mask because -- yeah, well, he did, for a brief moment in that conversation, describe how he didn't think that COVID was serious, and that it was --

we were overreacting with the Pandemic Practice Directive. And so he was indicating that he was not going to because he did not believe that he needed to follow this, that he would be just fine.

And somewhat at -- somewhat at the time, I think they've come to be known as COVID deniers in the public, that there was rhetoric, there was speech about how COVID's not real, how it's not serious, that it's no more than a mild flu, and some of that language that was common and has continued to be common about COVID during the pandemic.

Q Did he talk to you about his exemption from masking or his alleged exemption?

A He had talked about how he had originally worn a mask but then decided that he didn't like to wear it and that he -- you know, I think he said, you know, he just didn't feel comfortable wearing it, so he had been wearing it since May. And so at the end of May, I think, is when he indicated that he had removed the mask from what I recall of that conversation.

Q And, I'm sorry, what did he identify as the reason for not masking?

A He said he didn't like how he felt when he wore it, you know, he just didn't feel comfortable wearing it, which I believe were the words he used in that conversation.

Q Okay. Did he identify any other reasons for not

wanting to wear the mask?
A Other than, you know, I asked why, and I think that's when some of the conversation around COVID not being real and that this is, you know, we're just overreacting, and, in this environment, to have to wear a mask and that he wasn't comfortable doing that.
Q Did he mention any religious objections?
A I don't believe he did at that time; not that I can recall.
Q Did he argue that he couldn't practice because of the Pandemic Directive then?
A No, he didn't raise anything. You know, I tried to encourage him that masking is required, and he said that he wouldn't be masking, that he -- I think he then was -- yeah, I think, you know, part of it he was claiming he was now exempt from masking because of the City bylaws allowed him to be exempt. And I do remember having a conversation that that's not the intent of the bylaws, and the practice directive applies to you.

Hence, the follow-up communication to Mr. Lawrence, that we have a member that's not following the Pandemic Practice Directive.
Q We talked before about the Telehealth directives; were there some options for practice available to Dr. Wall if he didn't want to mask?

A Dr. Wall could have practiced Telehealth. Dr. Wall could have -- at that time, he could have had conversations with his patients to only mask when he was going to be within 6 feet, but Dr. Wall indicated that he wouldn't do that either.

Q I'm going to ask you some closing questions here just about I guess the regulatory function of the College and, more specifically, the regulatory roles that you occupy or have involvement with as Registrar.

Does the College have mandatory practice visits?

A Yes, that is a part of our practice. That's part of the rights given in our regulations that our competence committee has mandatory practice visits.

Q And can a chiropractor choose to opt out of practice visits?

A They cannot.

Q Does the College have a required continuing competence program?

A We do have a continuing competence program that requires a certain number of CC hours. Council has also directed that members have to maintain currency in first aid, that right now we have a requirement for a recordkeeping course that must be completed annually, and that members also must complete trauma-informed training on an annual basis.

Q Can a member choose to opt out of those requirements?

A Not if they would like to renew their practice permit.
Q So I take it that means, no, if they want to practice?
A That's correct, yes.
Q In his questions with a prior witness, Mr. Kitchen asked a question about whether chiropractic clinics are or are not health care settings; how would you respond to that?
A The way I would look at that is we're a regulated profession underneath the Health Professions Act, and we are health professionals, health care workers. We're regulated members of a health care profession, and that's what the Health Professions Act establishes. That's the level of expertise.

When people come to us, they're coming to us for health care problems. They're coming to us because they're seeking our care for conditions that impact their health. So I would say, in every sense of the word, we are health care workers.

Q Dr. Halowski, since the COVID-19 pandemic began, have any chiropractors died from COVID-19, to your knowledge?
A Yes. We've had two of our members that passed away as a result of COVID-19. We had one practitioner in his early 50s in Calgary that passed way as a result of it. We had one of our members in their early 60s passed away as a result of it. And during that time, I've had

an opportunity to speak to many of our members who acquired COVID as well.

MR. MAXSTON: Dr. Halowski, those are all my questions for you.

I see we're just coming to 4:00, so Ms. Nelson is still involved. I take it, based on our previous discussion, Mr. Chair and Mr. Kitchen, that what the intention will be is that next Tuesday, when we resume, Dr. Halowski's testimony would continue, and Mr. Kitchen would commence his cross-examination, I would do my redirect, if any, and the Tribunal would ask any questions of Dr. Halowski?

THE CHAIR: That's my understanding. I think that's the path that we shall follow.

The Chair Questions the Witness

THE CHAIR: But before we break for today, I had one quick question that I would like to ask Dr. Halowski, and this goes to the complaint that was received.

Q THE CHAIR: So the complaint was made by a patient to Alberta Health?

A It was made by one of Dr. Wall's patients specifically to Alberta Health, but Alberta Health communicated it back to us. They indicated that that patient would like to stay anonymous, as they had a -- often patients -- and that's very standard for a patient not

to want to be identified -- but when they made that complaint and with that follow-up conversation to Dr. Wall where I became aware of it, that's when we decided to action further.

Q Okay, so there was no further communication with the patient?

A No, at no time did we communicate with the patient; that came to Alberta Health from a patient.

Q Okay, I just was curious as to how -- what the path was for that complaint to end up where it did.

THE CHAIR: Did any other Members of the Tribunal have questions they wanted to talk about today? We can caucus and discuss those, or we can -- you have a chance to think about this and certainly raise them next week when we meet.

Okay, I think the Hearing Tribunal Members are fine; I'm fine.

So thank you very much, Dr. Halowski, for your time and your testimony today. Much appreciated.

Thank you, counsel, both counsel for your efforts. They are long days, but there's a lot to cover, and we shall pick this up at 9:00 on September 7th and continue, at that point, with Mr. Kitchen's cross-examination of Dr. Halowski.

And I would just ask, Mr. Pavlic, do we need to caution Dr. Halowski not to discuss his testimony, or

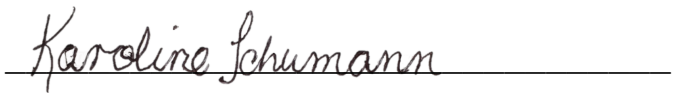
is that not an issue?
MR. PAVLIC: He should be provided the usual caution, but I think Mr. Maxston has already indicated that he will not be discussing any matters with him, so I think that will cover it off.
MR. KITCHEN: Okay, your comment, mine, and Mr. Maxston's.
THE CHAIR: Okay, that's great. Okay, thanks everybody. We will call this hearing to close for today, and we'll see everybody on the 7th. Have a good long weekend.

PROCEEDINGS ADJOURNED UNTIL 9:00 AM, SEPTEMBER 7, 2021

CERTIFICATE OF TRANSCRIPT:

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

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



Karoline Schumann, CSR(A)
Official Court Reporter

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

DISCIPLINARY HEARING

VOLUME 3

VIA VIDEOCONFERENCE

Edmonton, Alberta

September 7, 2021

TABLE OF CONTENTS

Description		Page
September 7, 2021	Morning Session	409
DR. TODD HALOWSKI, Previously affirmed,		410
Cross-examined by Mr. Kitchen		
Mr. Maxston Re-examines the Witness		441
The Tribunal Questions the Witness		450
Discussion		453
DAVID LAWRENCE, Affirmed, Examined by		455
Mr. Maxston		
Discussion		490
September 7, 2021	Afternoon Session	493
DAVID LAWRENCE, Previously affirmed,		494
Cross-examined by Mr. Kitchen		
Mr. Maxston Re-examines the Witness		526
Mr. Kitchen Re-cross-examines the Witness		547
Discussion		551
Certificate of Transcript		554

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

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September 7, 2021 Morning Session

HEARING TRIBUNAL

J. Lees	Tribunal Chair
W. Pavlic	Internal Legal Counsel
Dr. L. Aldcorn	ACAC Registered Member
Dr. D. Martens	ACAC Registered Member
D. Dawson	Public Member
A. Nelson	ACAC Hearings Director

ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

B.E. Maxston, QC	ACAC Legal Counsel

FOR DR. CURTIS WALL

J.S.M. Kitchen	Legal Counsel

K. Schumann, CSR(A)	Official Court Reporter

(PROCEEDINGS COMMENCED AT 9:08 AM)

THE CHAIR: Good morning, everybody. Thank you, Dr. Halowski, for coming back this morning.

A Thank you for having me back.

THE CHAIR: Just to remind everybody, we concluded on September 2nd with the direct examination of Dr. Halowski, and we will start this morning -- I should, first of all, remind everybody that the Hearing Tribunal is back in session, and we will start this morning with the cross-examination of Dr. Halowski.

And, Dr. Halowski, I would just remind you that you are still under oath. Very good.

Mr. Kitchen, I'll turn the floor over to you.

MR. KITCHEN: Thank you, Chair.

DR. TODD HALOWSKI, Previously affirmed, Cross-examined by Mr. Kitchen

Q MR. KITCHEN: Good morning, Dr. Halowski. Is it all right, if I call you Dr. Halowski?

A Yeah, that works for me.

Q Thank you. Well, I'm going to start with just a few questions about some of the things you had to say on Thursday, and I might refer to last Thursday, and that's just a reference to your direct examination with Mr. Maxston.

Now, Dr. Halowski, the primary form of care provided by chiropractors is physical manipulation of the musculoskeletal system of their patients; isn't that right?

A That is one form of treatment provided. There's also consultation. There's education. There's also soft

tissue immobilization. There's exercise instruction. And so one of the modalities of treatment that is used is physical manipulation as well as many others.

Q So you disagree that the primary form of care is manipulation?

A That is one of the modalities of treatment that we are taught. It may be that many chiropractors employ it. There are chiropractors that don't use that. So for me to speak for every chiropractor and the treatment plan they provide would be inappropriate in this setting, but it is one of the treatment forms that chiropractors utilize and are trained to utilize and recognized as a restricted activity that we are able to perform under the Health Professions Act.

Q Okay, and I appreciate that answer, but can you just confirm for me that you disagree that it's the primary; in other words, you would say it is only one form of treatment, it is not the primary; would you agree with that statement?

A I would say that historically, manipulation was the primary means of treatment. I would say in today's chiropractic. There are many approaches; chiropractors also provide acupuncture, they provide all sorts of different treatments that are physical or meant as for intervention. So I think that having me agreed to that statement or disagree to that statement, doesn't

provide the full context of care provided by chiropractors.

Q And I appreciate that you feel that way --

A No, that's the truth; it's not my feeling.

Q Okay, and I appreciate that you think that's the truth, but you are required to answer my question, and my question is do you agree that physical manipulation of the musculoskeletal system is the primary form of care? If you disagree, I'd ask that you tell me.

A I think I have answered that that is one of the forms of care, and it may be the most --

Q I didn't --

A -- commonly --

Q -- ask you if it's one form of care; I asked you if it's the primary.

A Again, then --

Q Do you agree it's the primary, or do you disagree?

A I would say I can't answer that question the way you're asking it.

Q So do you agree that you don't know the answer to that question?

A No, I think I do understand that that applies, and I did inform you as well as the Hearing Tribunal of the many different options that are available for treatment as offered by chiropractors.

Q I didn't ask you if you understood. I asked you if you

don't know. So is your answer to the question whether you agree that musculoskeletal manipulation is the primary form, is your answer I don't know?

A The answer is that would depend on each practitioner, and while that is we are trained and experts in providing manipulation as you're describing, or if we talked about osseous manipulation, then, yes, that is a primary treatment that we're trained to offer.

Q So you would agree that physical manipulation is a primary form but not the primary form?

A That's correct.

Q Well, do you agree that the physical manipulation of the musculoskeletal system is called an adjustment?

A That is one word that's used for it. Adjustment and manipulation are used interchangeably by practitioners, often recognizing that, you know, manipulation is what would be recognized by the majority of health professions. Adjustment is the term used by some chiropractors when they're describing manipulation.

Q Well, I'll use the word "manipulation" because it seems to be the one favoured by you. Now, manipulation is done by chiropractors by either touching patients with their hands or with small manipulation devices; isn't that right?

A That are -- yes, that would be the two, typically either instrument-assisted or hand-based adjustment or

manipulation as you call it.
Q Well, I'm calling it that, because you called it that. Adjustments cannot be done -- okay, sorry, let's call them manipulation. Manipulation cannot be done over the phone, can it?
A That is correct.
Q Manipulation cannot be done if a chiropractor is physically distanced from their patients by 2 metres; isn't that correct?
A That's correct.
Q You stated last Thursday that Telehealth is not the same as physical care, did you not?
A It is not the same.
Q I don't think you said last Thursday that Telehealth is shown to be effective, but you have produced no independent evidence of this effectiveness in the form of studies or reports, have you?
A I think I did report on a study that's forthcoming that's not yet published, but there is evidence and there is published evidence that treating musculoskeletal conditions with Telehealth has been shown for specific conditions to be effective, that depends on the condition.
Q You haven't produced that evidence for the purposes of this hearing, have you?
A I didn't -- no, we didn't produce that evidence. It's

not submitted as one of the articles.
Q Chiropractors don't generally work with people that have infectious illnesses, do they?
A They -- not typically, we don't. We don't seek out to treat patients with infections. Some patients may show up because they have an infection -- well, with an infection as a comorbidity.
Q But you said last Thursday, did you not, that chiropractors don't generally work with people that have infectious illnesses, didn't you?
A Yeah, we're not a primary treatment for those patients.
Q When the ACAC decided to include mandatory masking for chiropractors in the Pandemic Directive in May of 2020, it did not consider the statutory human rights and constitutional rights of chiropractors regarding mandatory masking, did it?
A We were taking the direction of Public Health around the requirements to protect patients. So if you're asking about it in that situation, it was one of the discussions; however, the primary decider was that we have a responsibility to practice in the safest way possible for our patients.
Q Thank you for that answer, but you didn't answer my question. My question was when you were deciding what to put in the Pandemic Directive, and you decided to include mandatory masking, this is in May of 2020, you

did not consider the human rights and constitutional rights of chiropractors, did you?

A I would say that the rights of the patient and our responsibility to provide a safe environment were considered above those rights. So it's not that it was not considered, the consideration was specifically that the patient's safety in a situation like that should come first at this time.

Q Sir, you agree that the human rights and constitutional rights of patients are very important?

A I do agree that we have a responsibility. I don't know if I'm an expert -- able to speak about constitutional and human rights. I do know that we had a responsibility to provide a way for our practitioners to deliver safe care. So while you're asking me about that, I don't feel that I'm qualified to speak about the human rights here in the aspect that you're pursuing. And what you're seeking is my opinion, and I don't know if my opinion really matters in the regard of making a decision of what's best and safest for a patient.

Q But you would agree, just to confirm what you just said, you would agree that the rights of patients are paramount over the rights of chiropractors?

A That the safety of patients is paramount in making a decision about how to provide for safe practice.

Q Right, but what you just said is that the rights of chiropractors are less important than the rights of patients; is that not what you just said?
A I don't believe it is.
MR. KITCHEN: Well, Madam --
A I think I spoke about the safety of the patient.
MR. KITCHEN: Madam Reporter, can you help us out with that? Can we just go back to what Dr. Halowski said there just a moment ago?
COURT REPORTER: (by reading)
A I would say that the rights of the patient and our responsibility to provide a safe environment were considered above those rights. So it's not that it was not considered, the consideration was specifically that the patient's safety in a situation like that should come first at this time.
MR. KITCHEN: Thank you.
Q MR. KITCHEN: So, Dr. Halowski --
A Yeah.
Q -- you would agree can with me that, from your perspective, the rights of the patients are paramount to the rights of chiropractors?
A When you say "paramount", can you give me the definition of how you're describing "paramount"?

Q You would agree with me that you just said that the rights of patients are more important to you in your role as the Registrar than the rights of chiropractors?
A I would say that the rights -- if you're going to use those words, the right or the responsibility of the College is to ensure public protection, public safety, and practitioner competence, and I believe we met those requirements by the decisions that were made in May last year.

So we did say that paid practitioners must be masked to provide care, because the evidence at that time was that masking was an effective way to limit the transmission of COVID-19 to patients that were receiving care.

Q So you would agree with me that the Pandemic Directive does a good job of prioritizing the rights of patients over the rights of chiropractors?
A I would agree with that.
Q When the ACAC decided to include mandatory masking for chiropractors in its Pandemic Directive in May of 2020, it did not consult a scientist who was independent of the Alberta Government, did it?
A We were -- we did not, other than the advice and recommendations of Public Health, consult anybody outside of that organization.
Q And by "Public Health", you mean the Public Health of

the Government of Alberta?
A Correct, and also the recommendations of the Public Health Agency of Canada.
Q Now, when the ACAC reviewed and revised the Pandemic Directive in January of 2021, it didn't then consult a scientist who was independent of Government Public Health to review the mandatory masking, did it?
A No, we continued to put our trust in the recommendations and direction received from Public Health in Alberta as well as that from Public Health of Canada.
Q Exclusively, correct?
A Yes, correct.
Q You said last Thursday, that it would be, quote, oppressive for the ACAC to mandate too much PPE too often; isn't that right?
A In the context of reviewing the standard of practice, I believe that is correct. When we talked about all of the different things, i.e., having to wear gowns, having to wear gloves, having to wear splash shields, all those different things would have been an excessive amount of PPE in the context of what we knew about COVID at the time.
Q Now, I'm going to take you and the Tribunal to Exhibit F-2. If you could just let me know when you have that in front of you. This is CMOH Order 16-2020.

A I will let you know as soon as I have it. Okay.
THE CHAIR: Does everybody have it?
MR. KITCHEN: Thank you.
Q MR. KITCHEN: Dr. Halowski, you're there?
A Yeah.
Q Now, Section 2 of this order, CMOH Order 16-2020, Section 2 never applied to Dr. Wall, did it?
A You're saying Section 2 of the actual order or Section 2 of Appendix A? Because when I read Section 2 of the order: (as read)

> Effective May 4th and subject to Section 6 of this order, a regulated member of a college established -- [so Dr. Wall is a regulated member of a college] -- established under the Health Professions Act practicing in the community must comply with the attached Workplace Guidance for Community Health Care Settings to the extent possible when providing a professional service.

I would say that does apply to Dr. Wall.
Q Let me take you over to the next page then. You see Section 6 there?
A Yeah.
Q Now, I'm going to read it to you, and then I'm going to ask you a question: (as read)

> Section 2 of this order does not apply in

respect of a regulated member under the Health Professions Act whose college has published COVID-19 guidelines as required by Section 3 of this order.

A Yeah.

Q You would agree that the ACAC Pandemic Directive was implemented on May 4th?

A It was -- that's when members could return to practice under the CMOH order. It was -- that's when it was effected. It was provided to members before that.

Q All right. Okay, so let me ask you again -- let's go back to Section 2 --

A Okay.

Q You would agree with me then that Section 2 never applied to Dr. Wall?

A Section -- the way you're reading it, yes.

Q And that's because of Section 6 and the fact that the ACAC implemented the Pandemic Directive on May 4th, correct?

A Correct.

Q So at no time did Dr. Wall ever contravene Section 2 of CMOH Order 16-2020, did he?

A I am answering; I'm just reading to make sure my answer is consistent with what I'm reading right now.

Q That's fine.

A Yeah, at that time, he would be under the direction of

the College. So your answer -- I think the way you -- can you restate your question, and then I will answer it specifically?

Q At no time did Dr. Wall ever contravene Section 2 of CMOH Order 16-2020; isn't that correct?

A He would have been -- so, yes, he would have been under Section 6 of the CMOH -- of this order at 16-2020, because the College had its own guide, but the answer is, yes, that said that.

Q Thank you. I'll take you to Exhibit D-8, please. D-8, and that is CMOH Order 38-2020.

A Okay.

Q You're familiar with this? I believe we discussed this last Thursday.

A Yes.

Q And I'll take you over to page 6. Now, Section 27(c) of this CMOH Order 38-2020 orders that individuals are exempt from wearing a mask if they are: (as read)

> Unable to due to a mental or physical concern or limitation.

Isn't that right?

A That's what that says right there.

Q Just going to go back to the Pandemic Directive, and just so everybody knows, there's three versions of the directive, of course, I think it's C-20, C-21, and C-22. C-22 being the January 6th version.

Now, Dr. Halowski, none of these three versions of the Pandemic Directive requires that patients wear a mask, do they?

A I think the first and second did not. I believe in the third version, we did start speaking to the direction that was provided in the CMOH orders. I would have to confirm that.

Q Well, why don't you do that.

A In here, we did not speak to patients. I do know we did -- and so that's why I had to review. I do know we communicated to the ACAC around patients and how to manage and handle patients that were not masking because those were at the time Provincial or Municipal orders.

Q I appreciate that, but you'll confirm for me that never in the directive, in the Pandemic Directive, did you mandate that patients must wear a mask?

A No, we don't regulate patients. We did not mandate it in there.

Q And none of the three versions of the directive required chiropractors to enforce that their patients wear a mask, does it?

A That was -- no, we don't have anything in the Pandemic Practice Directive around enforcement for chiropractors to make their patients mask in the clinic.

Q Now, I'm at that Personal Protective Equipment section,

okay, which stays largely the same for the three versions. Now, you would agree with me that nowhere in the PPE or the Personal Protective Equipment section in the directive, you would agree with me that nowhere does it say anything about chiropractors contacting the ACAC regarding masking if they think they have a human rights concern regarding mandatory masking?

A We don't have anything in there about our practitioners contacting us. We do -- and this directive didn't include anything about them contacting, because the expectation was that they would always mask when providing close contact care.

Q I heard you say quite a few times in your answers to Mr. Maxston on Thursday that the protection of the public is the top priority and primary consideration for the ACAC?

A That is what directs our policy decisions, yes, that is -- when council meets and council makes decisions, that is the consideration that's made is what is best for the public. That is that council -- both between -- so I would say, yes, that is an appropriate assessment that we do speak to the need for regulating members with the perspective of public safety first.

Q You agree that a key aspect of protecting the public is protecting their health, do you not?

A Yes.

Q You agree that the principle of, first, do no harm is a vital part of protecting the health of members of the public; do you not?
A That would be part of what we do and aim to do with the provision of care as chiropractors.
Q You agree that each patient of every chiropractor is a member of the public, do you not?
A Yes.
Q You agree that the interests of each patient, each forms a part of the broader public interest; do you not?
A I would say I guess so if we're going down this -- where you're going is that each patient's, you know -- but again there, I'm trying to understand the reason of the question, other than, yeah, we have that each patient's safety is paramount, but we only interact with a patient that's in the office.
Q You agree from the perspective of the ACAC, because that's -- I'm not asking this question, I'm not asking any of these questions about you as a chiropractor. I know you've practiced; you mentioned that on Thursday.
A Yeah.
Q But you're here in your role as Registrar.
A Yeah.
Q Okay, so that's what I'm talking about.
A Okay.

Q So you would agree from the perspective of the ACAC that the interests of each patient, each chiropractor, each forms a small part of the broader public interest, correct?
A Yes. I would say the public as a whole, yes.
Q Do you think -- would you agree that if the interests of one individual patient were impacted, that in some small way the broader public interest as a whole is impacted?
A Perhaps. I mean, can you give me an example of a situation that you're thinking of? Because I can think there would be positive and negative for impact, I think that's a consideration.
Q If I did that, Mr. Maxston would tell me I can't ask you a hypothetical, so I'm not going to do that.
A Okay.
Q You would agree that the public interest is not merely an ideal, correct?
A The public interest, I think that's the decision-making, it's not -- it's meant to be realistic for the public and how they receive care or how we interact or how we provision for the -- it's meant to be realistic, yes.
Q Exactly, and the public is made up of many individuals, correct?
A It would be, yeah, everybody, like I said, the --

society in its entirety.
Q So the interests of each individual chiropractic patient, a conglomeration of those interests make up the public interest, correct?
A Perhaps, yes, that would be -- I guess so, yes.
Q The ACAC expects chiropractors to prioritize the protection of the health of their patients above all other priorities; isn't that right?
A That we do expect that they practice with safety as their primary concern, whether it's safety to deliver the care at that time, whether it's safe to -- safer to not provide care, whether it's safer to refer the patient. All of those are considerations that an individual chiropractor must make based on the presentation of the patient. So in the full context, yes.
Q Okay, thank you, but I didn't ask you about safety, so please try to listen to the words that I use.
A Okay.
Q And if you don't agree with me, that's okay, just say so, say, I don't agree with that, or just say, That's not right. You can give whatever answer you want, but I am asking you, and you are required to answer the question that I ask you.
A Okay.
Q The ACAC expects chiropractors to prioritize the

protection of the health of their patients above all other priorities; is that right or is that wrong?
A Yes, that's right.
Q Even above their own interests, correct?
A That would be -- I'm going to say there is context -- no, yes, that would be true.
Q You agree that the principle -- again I'm asking you in your capacity as the Complaints Director, okay? I'm not asking your personal opinion --
A I'm not the Complaints Director, but I'm the --
Q Sorry.
A -- Registrar, yeah.
Q Forgive me. That's exactly --
A That's okay. No, that's okay, I just wanted to make sure that that was clear that I'm not pretending to be the Complaints Director.
Q So you agree, from your perspective as the Registrar of the ACAC, that the principle of chiropractors protecting the public from harm is more important than the principle of protecting the reputation of the chiropractic profession, do you not?
A Public safety is what is the key and essential in the decision-making, so I don't know if I would separate the two because I do believe that protecting the patients protects the reputation of the profession. So that would be I disagree with the way you stated the

question.
Q Okay. As far as you're concerned, those two things could never come in conflict?
A So when you say "those two things", you're talking about patient safety and the public reputation. They, at times, they do come in conflict, and patient safety would be above the professional reputation at the time in the sense that, you know, we actually -- when we govern or when council governs under the Health Professions Act, their consideration is the public above the profession.
Q So you've agreed that public safety is above the reputation -- or above the interest of protecting the reputation of the profession. Do you agree that protecting the public from harm is also above protecting the reputation of the profession?
A I think that, in my mind, the protecting the public and protecting them from harm is very similar. I don't know if I understand the distinction you're trying to make there.
Q Well, again, I asked the question, and I didn't use the word "safety", but you used the word "safety" in answering, which --
A Okay, you said public -- versus public, protecting the public and protecting the public from harm, is that what you used?

Q That's exactly what I used.
A And so what's the distinction? To me, I see them as the same.
Q You see safety and protection from harm as the same things?
A Again, you put the word "safety" in there, I didn't. When I was restating your question, I said public and public harm. And so when you're saying protecting the public, I think that encompasses protecting them from harm as one of the components. So I guess I would say, yes, in that aspect.
Q You agree that there are other threats to the overall health and safety, health and well being of chiropractic patients besides COVID-19, do you not?
A Absolutely, yeah. You know, that is -- I would a hundred percent agree that COVID-19 is not the only health threat that our patients face at this time or the public faces, because I'm not speaking about my years as a practitioner.
Q You agree that chiropractors are obligated to comply with the ACAC's requirements of practice even if those requirements are harmful to the chiropractor, do you not?
A I would say that the -- that the chiropractor must deliver care in a safe way, which is that to reduce the risk of harm.

Q I appreciate that, but that's not what I asked you.
A Okay.
Q You agree, do you not, that chiropractors are obligated to comply with the ACAC's requirements of practice even if those requirements are harmful to the chiropractor?
A I disagree with the way you've asked the question, and I know you're going to tell me I have to answer the question, and so I would agree that the patient's safety comes -- is paramount in the delivery of chiropractic care, and we would not set it up so that our chiropractors were in a position to be in physical danger when providing the care.
Q Dr. Halowski, if you don't agree with my questions, it's perfectly acceptable for you to answer and say you don't agree.
A Okay.
Q But you don't get to ask yourself a different question. I'm the one asking questions. I'm asking you questions, and if you disagree with the question that I have asked you, if I ask you if you agree with something, I'm asking you to tell me whether or not you agree. I'm not asking for you to ask yourself a new question.
A Okay.
MR. MAXSTON: Mr. Chair, I've got to make a comment. Mr. Kitchen is phrasing his responses to

Dr. Wall's [sic] answer in the format of, You're not answering a question. He may not like the answer that Dr. Halowski has given, but this constant repeating of you have to answer my question, Dr. Halowski is answering. It's not a question of does Mr. Kitchen like the answers. Dr. Halowski is providing his answer, and I just -- I would ask Mr. Kitchen to refrain from the repeated rephrasing of a question when the answer has been given.

MR. KITCHEN: And I appreciate that. The problem is that what we're seeing is the witness is making up his own questions and answering them; he's not even attempting to answer my questions.

MR. MAXSTON: Mr. Kitchen, you and I disagree, but when I think when Dr. Halowski gives an answer, he gives an answer, and you don't have to like it. You can press him on it. But I think you're going beyond that in reminding him repeatedly about what his obligations are. He's answering questions.

MR. KITCHEN: Well, I'll refrain from that, and I won't give that reminder again.

THE CHAIR: I think, Mr. Kitchen, that and, Mr. Maxston, that Mr. Kitchen's questions are being asked to solicit a certain answer from Dr. Halowski, which -- and Dr. Halowski, from my perspective anyway, is trying to provide the

information in his answer the best way he can, and I think perhaps there is disagreement on how the answer should be worded between Mr. Kitchen and Dr. Halowski.

But I agree, let's try and move forward with this. We seem to be hung up on splitting hairs about the use of a particular word. Thank you.

MR. KITCHEN: Thank you.

Q MR. KITCHEN: Dr. Halowski, I'm just going to ask this question one more time, and whatever answer you give, we're going to move on.

I'm simply asking you whether or not you agree, do you agree that chiropractors are obligated to comply with the ACAC's requirements of practice even if those requirements are harmful to the chiropractor? Do you agree with that, or do you not?

A Patient safety comes first in the delivery of care, so I would say that if there's the risk for harm for a practitioner in providing care, they shouldn't be providing care at that time. If providing safe patient care is going to harm the practitioner, that practitioner should not be providing that care at that time.

Q And you would agree that it's impossible for the ACAC requirements of practice to ever result in a lack of safety to the patients?

A Can you repeat the question once more?

Q You would agree it's impossible that the ACAC's requirements of practice would be or would result in a lack of safety to patients?
A Can I -- I'm going to say how I heard your question, and so that the way we require care may result in an unsafe environment for patients?
Q No, I'm asking you, you in your role as the Registrar, you regard it as impossible that the requirements of practice from the ACAC could ever result in a lack of safety for patients?
A I think the Standards of Practice -- so I'm going to contextualize this, the way the Standards of Practice are established and direction is meant to provide the safest way for a patient to receive care. If somebody's not following that, it may introduce an environment where the patient is not safe in receiving care.
Q The ACAC is obligated by law to only impose requirements of practice that are lawful; isn't that right?
A So I would, listening to that, I think that there's more meaning behind the words than I would be able to speak to. I do know our responsibility is to set Standards of Practice and to govern the profession -- and Codes of Ethics and govern the profession according to the mandate that the legislation provides.

So when we do that, the consideration is to be lawful in how we set up our direction as well as Standards of Practice and Code of Ethics.

Q Well, since you take objection to the words, let me get a little more specific.

A Okay.

Q You would agree with me that the ACAC is obligated to only impose requirements of practice that are consistent with the Alberta Human Rights Act, correct?

MR. MAXSTON: Mr. Chair, I'm going to object to that. Dr. Halowski has no knowledge of Alberta human rights legislation or requirements. This may be a question for another witness but not Dr. Halowski.

And, I'm sorry, and I might add that's the ultimate question that may be before -- or one of the questions that may be before the Tribunal.

THE CHAIR: I think Mr. Maxston makes a good point. Dr. Halowski is an expert on the College's work; however, I don't think he should be held to be an expert on human rights legislation.

MR. KITCHEN: And I would agree, and I wasn't asking about the content.

Q MR. KITCHEN: I was merely asking do you agree, Dr. Halowski, that the ACAC is bound by the statutes of Alberta?

A To the extent that we have authority under the

legislation, we have a responsibility to -- council has a responsibility to govern, given the -- what the legislation provides for us to govern.

So I think that, yes, but there's context there that's really important to consider. Like I don't get to decide what happens in somebody's personal life but -- or our director or -- I say "us", the ACAC doesn't get to.

What we actually have to specifically consider is how the legislation should be applied for chiropractors that are practicing in Alberta, and "legislation" being specifically the Health Professions Act.

Q The ACAC is bound to act according to the Constitution of Canada; isn't that correct?

A Again, there I wouldn't be an expert in that. I think we are bound -- we are entitled with the legislation under the Health Professions Act and act according to the direction provided in that document.

Q So would you agree with me that the ACAC is bound by other pieces of legislation besides the Health Professions Act?

A There are other pieces of legislation that do speak to the chiropractic profession, specifically things like the Health Information Act. We also are responsible for PIPA in our own conduct. Our members are responsible PIPA in their own conduct. So there are

other pieces of legislation that direct the conduct of what we have an opportunity to provide guidance, direction, or regulation on.

Q Thank you. Now, last Thursday, in response to questions from Mr. Maxston, you discussed what was said in an initial call between yourself and Dr. Wall. This occurred in early December; you would agree?

A December 2nd from my records.

Q Thank you. Now, you told Dr. Wall, during that call, that a decision may be made that he either wear a mask or sit out from practicing for the rest of the pandemic, didn't you?

A I don't believe I made that. I said that we would have to go further in inquiry at that time. I don't actually get to make the decisions, but that would be one of the decisions that would have been possible to be raised, so -- I don't have the transcript nor a memory of every word that was said in that conversation.

Q Well, Dr. Wall remembers the conversation, and I'm just going to put it to you that he is going to say that you said to him in that phone call that he either wear a mask or sit out from practicing?

A I think that if it was prefaced that way, it would have been an ask not a demand: So would you consider not practicing at this time if you're not willing to mask.

Q Well, I'm going to put it to you, Dr. Wall is going to say that you made that as a statement.
A All right.
Q So let me ask you: Do you confirm or deny that you said to him on that phone call that he either wear a mask or sit out from practicing?
A I don't -- I would disagree that I said it that way.
Q And, Dr. Halowski, you said that COVID killed two Alberta chiropractors; you said that, correct?
A That is what was reported to us from their families, so, yes, I did report what was communicated from my family out to our colleagues, so that our colleagues were aware of the impact of COVID on these families and fellow colleagues.
Q So you haven't viewed the death certificates of these two individuals, have you?
A I did view the death certificate of one; the other, I received the obituary from the -- and it wasn't a death certificate, like the Government death certificate; it was the one, like a -- I don't know what it's called, but a certificate of death, but like the notice that a funeral home or a mortuary would provide, confirming that they are in possession of this body is what we received, and we require that for some form of confirmation -- or we require some form of confirmation, and that is what we received in that

case, and the other was the obituary.
Q That document that you viewed, you haven't produced that as an exhibit in this case, have you?
A No.
Q You have no evidence of what comorbidities these two chiropractors had at the time of their death, do you?
A I don't. I didn't. It wasn't my place to ask these families specifically what comorbidities or health, that's their personal health information. They just informed me that COVID had killed their -- one was their husband, and the other was their father.
Q So you don't have personal knowledge that COVID was the primary cause of death in these two people, do you?
A I have what was reported to me. Is that not considered personal knowledge before the -- like I don't know what your -- is "personal knowledge" is a legal word or not? Like I would call that personal when I spoke to the wife and said that her husband was in the hospital for close to six -- I think four weeks, six weeks, received care at both the Rockyview and the Foothills, but eventually succumbed to complications due to COVID.

And the other, there was reports that there was -- from them, not from that person directly, somebody else who knew them, indicated that they may have had comorbidities and -- but the son said, Yeah, no, COVID is what killed my father.

So I mean, that's information. I didn't enter that as exhibits, other than the fact that both those families declared to me, in different ways, that their loved ones had been killed by COVID or as a result of COVID-acquired infection.

Q The basis of your belief that these two individuals died of COVID is based on what you were told by other people, correct?

A Correct.

Q And you don't know how these two people contracted COVID if they did; isn't that correct?

A I didn't ask. It was moot to the conversation, and I didn't feel it was my place to ask that question, so that is correct.

Q But you did feel it was your place to say, as part of your testimony, that you believe that two Alberta chiropractors died of COVID?

A I believe the reports that were provided by those people, so, yes, I did. And I think, again, for our profession, it only illustrated to me, as well as to our colleagues, the severity of COVID in our community.

Q Dr. Halowski, how many chiropractors are there in Alberta?

A It -- that goes up or down. Do you want an exact number today or just an estimate?

Q Is it greater than 1100?

A Yes, it is, and it would have been, at the time, it would have been 1150 to 1180.

MR. KITCHEN: Those are all my questions.

THE CHAIR: Thank you, Mr. Kitchen. I'll ask, Mr. Maxston, if you have any questions in redirect for Dr. Halowski?

MR. MAXSTON: Mr. Chair, I do, I have a few, but I wonder if we could just take maybe a 10-minute break; I just need to go through my notes and organize my questions a little bit.

THE CHAIR: Okay, it's 10:00. I think that's a good idea. Let's come back, we'll give you 15 minutes, Mr. Maxston, so we'll reconvene at 10:15. We'll take a recess for now and see everybody in 15 minutes.

(ADJOURNMENT)

THE CHAIR: The hearing is back in session, and, Mr. Maxston, it's your opportunity for any redirect with respect to Dr. Halowski.

MR. MAXSTON: Yeah, I have about maybe five or six questions for Dr. Halowski. It will be pretty brief.

Mr. Maxston Re-examines the Witness

Q MR. MAXSTON: Mr. Kitchen engaged you in a discussion about chiropractors, and his statement to you was chiropractors don't generally work with

patients with infectious illnesses, and your response was I believe that chiropractors are not a primary treatment for those types of patients.

When it comes to COVID though, chiropractors don't know whether a patient is or isn't infectious, even if they're coming to you for an adjustment for their back; is that correct?

A That is correct. We do have the screening questions as part of our thing, because we were concerned, right from the get-go, with chiropractors trying to triage patients coming in with infections that they shouldn't be in the clinic in the first place, and then we were concerned that practitioners may try and triage their symptoms and go, Well, this sounds like a cold or this sounds like something else.

So we were very prescript to begin with and had maintained that for the duration of the pandemic that those screening questions are important in part of the consideration of whether it would be safe to provide care at that time and --

Q And -- sorry.

A Sorry. Or have that patient in the clinic environment.

Q Is it fair to say --

MR. KITCHEN: Mr. Maxston, that was a leading question, and this is a redirect. So if there's any more leading questions, I am going to

object.
MR. MAXSTON: Sure.
Q MR. MAXSTON: Dr. Halowski, patients can be asymptomatic when they attend, asymptomatic for COVID when they attend at a chiropractor's clinic?
A That is correct.
Q I'll take you to a discussion you had with Mr. Kitchen where he commented that the Pandemic Directive contains no requirements for patients to mask. You don't have jurisdiction over patients, do you?
A Correct.
MR. KITCHEN: I object to that; it's leading.
Q MR. MAXSTON: Oh, I'm sorry, I'll rephrase that. Does the College have jurisdiction over patients?
MR. MAXSTON: You're quite right, Mr. Kitchen.
A We have no jurisdiction over patients. We regulate chiropractors.
Q MR. MAXSTON: Would the CMOH orders enforce a time that required patients to mask?
A Yes, there was times where either municipalities and CMOH orders required masking.
Q For patients?
A For patients, for the public, which patients are a part

of.

Q Including Dr. Wall's patients?

A Including Dr. Wall's patients.

Q Mr. Kitchen took you through a part of the PPE section of the Pandemic Directive and mentioned that it said nothing about the chiropractor having a human rights concern. Do you recall last week, last Thursday, when I took you through the Chiropractic College notices, Exhibits C-1 to C-22?

A I do remember.

Q Are there comments in those notices --

A I could review and look off the top of my head. I am not sure. I do know, if that's what I -- you would like me to do, I can definitely look through and give a quick look about that.

Q My question was going to be --

MR. KITCHEN: Mr. Maxston --

Q MR. MAXSTON: -- were chiropractors invited to contact the College if they had questions or concerns?

MR. KITCHEN: Mr. Maxston --

A Oh, yes.

MR. KITCHEN: -- you asked that in direct, okay, last Thursday, okay? So this is not new, and redirect is for new issues and --

MR. MAXSTON: Well, you raised the human

rights concern, Mr. Kitchen, and I'm responding to that.

MR. KITCHEN: Okay, but then the question's going to have to be phrased to be specifically dealing with the human rights concern that I raised in cross, not going back and re-asking the same question you asked last Thursday.

Q MR. MAXSTON: Well, I'll ask another question. Dr. Halowski, could a chiropractor contact the College about a human rights concern?

A At all times, chiropractors were able to contact the ACAC.

Q Dr. Halowski, you engaged in a discussion with Mr. Kitchen and his reference to I think a generally accepted principle of, first, do no harm; do you recall that?

A I remember that.

Q Who does the "harm" refer to in that, first, do no harm?

A That would be in consideration of the patient, that our plans and our treatment is specifically around ensuring that the care we're providing is safe, that our -- how we're providing that we're making those considerations that patients can, one, in our treatment be safe but also in the environment we provide that they're safe.

Q And what was the College's determination about

practitioners not masking?
A The determination, based on the guidance from Public Health and the evidence that we had in making those decisions, was that masking posed a risk to the public because there was the risk for transmission from the practitioner to the patient if the practitioner was not masked inside of that 2 metres distance.
Q Okay. Thank you for that. Mr. Kitchen asked you a question, and I'll paraphrase here, does the College expect chiropractors to prioritize the health of patients above all other priorities. Why does the College create Standards of Practice or Code of Ethics?
A Standards of Practice and Codes of Ethics, look, the Standards of Practice represent the minimal acceptable level of performance for our practitioners in delivering care. It's meant to provide that framework so that the obligations for the practitioner is spelled out that the public knows what they're reasonably going to receive when they receive care. It makes considerations for public and patient safety in the provision of care.

And Code of Ethics represents the conduct or the ethical conduct that's expected out of regulated members of the chiropractic profession in Alberta.
Q You engaged in a discussion with Mr. Kitchen about his comment or question that preventing public harm is

above the reputation of the profession. I just want to be clear, where does the reputation of the profession come into the College's functions?

A The way that -- the reputation of the profession is paramount. Practicing in a safe way is how we protect that. If we made decisions that put the public at risk, that would damage the reputation of the profession.

And that also comes in in the reputation of the profession in the way that council deliberates and discusses. Our council currently is comprised of 25 percent public members, 75 percent practitioners. That is going to be expanding to 50/50 representation once the Government's provided enough public members of council.

But that reputation -- and reputation is based on the idea that, you know, the College is providing a safe way, and we've spent a considerable amount of effort to ensure that things like advertising have been in line -- you know, and that's significant because some of the things that members of our profession say publicly have and potentially damaged the profession in Alberta, have damaged it in other provinces, and so the reputation is really, really key, and we do that by regulating the members to practice safely and practice within the guidelines of what we're given to do under

the Health Professions Act.

Q I just have one final question. You talked with Mr. Kitchen about the initial phone discussion you had with Dr. Wall I think in early March of last year, I might have the date wrong, my apologies, but it was --

A December last year.

Q Pardon me, thank you --

A Oh, sorry, March was the one that I had with you, Mr. Maxston, but December was the one I had with Mr. -- or was the email that I had with, prior to the pandemic, with Dr. Wall, and December 2nd was the conversation after we became aware that he was not masking in his practice.

Q Yeah, and I'm referring to that December 2 --

A Yeah.

Q -- conversation, and I think a difference of opinion or a different recollection that Mr. Kitchen explored with you between your recollection of that conversation and what Dr. Wall's anticipated testimony is. During your phone conversation with Dr. Wall, did you explain the risks to him of not complying with the Pandemic Directive?

A I did. I said, realistically, if he's not willing to comply, I would have to refer him to -- on to the Complaints Director and make the Complaints Director aware, and the Complaints Director would -- may

proceed.

And we -- I am very specific with that in my language, and we don't use -- I can't determine the outcome of something ahead of time, but I do inform members that this may happen. So, for instance, you may be suspended, you may not be able to practice, you may -- all of those would be the language. So those would have been the warnings provided to Dr. Wall in that phone conversation, that if we proceeded down this path, those are things that may happen or could happen as a result of his decision to not wear a mask.

MR. MAXSTON: Those are all my questions, Mr. Chair.

THE CHAIR: Okay, do Members of the Tribunal have any questions for Dr. Halowski?

MR. MAXSTON: Mr. Chair, I don't mean to tell you what to do, but do you need a break to canvass that? I don't know if you had done that before.

THE CHAIR: I am going to see if we do need a break. I actually may have a question, so I think we will recess for a couple of quick minutes just to check on if there's any further questions for you, Dr. Halowski, so please bear with us. If we could put the members of the Hearing Tribunal into a break-out room. Thank you.

(ADJOURNMENT)

THE CHAIR: We're back in session. The Hearing Tribunal has discussed the testimony of Dr. Halowski, and a couple of questions have come to mind, and I will ask Dr. Aldcorn to present these questions to Dr. Halowski.

The Tribunal Questions the Witness

Q DR. ALDCORN: Thank you. Dr. Halowski, you referred to the ThoughtExchange as an opportunity for members to perhaps share, discuss concerns that they had. My question for you is that ThoughtExchange anonymous?

A It is anonymous, yeah, we don't keep a record of anybody. The only thing that shows up in a ThoughtExchange is IP addresses, but we don't keep a record of anybody's personal IP address, and so we don't know who is there or who is commenting. We assume, because it's distributed to members, that it's regulated members of the profession in Alberta.

Q Thank you. And the second question I have is just a quick comment that was made by you on Thursday, and you had commented, we were going through the Alberta Health Services G-3 personal protection report, and you had commented that, at some point, you had reached out to Alberta Health Services to find out if there was any exceptions, but my question to you is just when did that happen?

A That would have been in and around the fall. Actually we started speaking about PPE with Alberta Health I would say in August, and part of that was driven at the time because we started hearing reports of members that didn't have eye protection being required to isolate, which wasn't in our practice directive.

And when they had originally issued the practice directive, they said masking would be adequate, and then we saw this shift in what was being communicated. So I continually tried to inquire around there and looking for guidance and, specifically, was eye protection required for our profession.

And then we did have one member of our profession last -- who's on mat. leave and, last summer, inquiring about, you know, they were finding it increasingly difficult to practice while pregnant and wearing a mask. And so, you know, we were looking for ways, and the same guidance was given, that there isn't a safe way for you to provide care to a patient without a mask within 2 metres.

Q So that was August approximately you would say?

A That member, I would say about August, because I think they're just getting ready to come back to practice now.

DR. ALDCORN: Thank you, that's all I have.

Q THE CHAIR: And just to follow up,

Dr. Halowski. You said it started in August. This was an exchange of consultation?

A Yeah, we continued consultation until December, when Alberta Health said that they wouldn't provide any guidance on the requirement for the eyewear, so we did make the -- and that's why we only ever made the recommendation; there was no indication it would be a requirement for practitioners to wear eyewear.

And for context, other professions had at the time, but we had not.

THE CHAIR: Thank you. Thanks, Dr. Halowski.

I would ask counsel, are there any questions arising from these most recent responses? None.

Okay, Dr. Halowski, thank you very much for your testimony over the past two days. Your presence here is no longer required, and we very much appreciate your expertise, and you can leave at this time.

A Thank you very much, Mr. Chair. I do appreciate the opportunity to have spoken, and for the care and concern and attentiveness of the Hearing Tribunal, as well as Mr. Maxston and Mr. Kitchen in their questioning as well. So thank you for the opportunity to be here as a witness for this Tribunal.

THE CHAIR: Okay.

(WITNESS STANDS DOWN)

fine with me.

MR. MAXSTON: Maybe we can just see where we get and invite comments from the Chair and the Tribunal Members. Oh, and Mr. Lawrence is just going into another room now.

I'm thinking as well, and I'm not going to, of course, hold you to this, Mr. Kitchen, do you have any sense about how long you'll be with Dr. Wall? Because I'm going to be a while with him, and I don't know if I want to start my cross-examination, let's say, at 2:00 tomorrow and leave it hanging. I want to use our time as effectively as possible. Having said that, maybe you can just give me a sense of what you think our day might look like tomorrow while we're on a break here.

And maybe we can ask -- we can go off the record, so Madam Court Reporter doesn't have to be --

MR. KITCHEN: I -- yes --

MR. MAXSTON: -- taking this down.

MR. KITCHEN: -- let's do that.

(DISCUSSION OFF THE RECORD)

THE CHAIR: Thank you very much.

Mr. Lawrence, we will turn you over to Mr. Maxston, but, first, I would ask that you be sworn in as a witness, and our court reporter will take you through that process.

DAVID LAWRENCE, Affirmed, Examined by Mr. Maxston

MR. MAXSTON: Give me one minute, Mr. Chair, I just have to locate a document. Thank you, Mr. Chair.

Q MR. MAXSTON: Good morning, Mr. Lawrence. I understand that you're the Complaints Director for the College. Can you tell me since when you've occupied that position?

A I am the Complaints Director since March of 2020.

Q And can you briefly describe your employment history or professional background before coming to the College?

A So educationally, I hold a Masters in Business Administration from Athabasca University, I have certification in Business and Human Resources from the University of Alberta, and I've spent 25 to 30 years in the management field in both public and private businesses.

Q Thank you, Mr. Lawrence.

MR. MAXSTON: Mr. Chair and Hearing Tribunal Members, for your benefit, I'm going to be asking Mr. Lawrence questions in three areas. The first area will be general questions about the College and its regulatory functions in the context of the Complaints Director's duties. The second area will be to, very briefly, review the two primary CMOH orders we've been talking about and, very briefly, review the Pandemic Directive. The third area I'll be asking questions on

is his involvement in terms of the Section 56 complaint that he made, the investigation, and the referral to hearing.

Q MR. MAXSTON: So I'll just go to the first area of my questions then, Mr. Lawrence, can you generally describe the College's regulatory function?

A Certainly. So under the Health Professions Act, the College duties set out by council is to establish Codes of Ethics, Standards of Practice, policies, directives for members to follow. And as part of the Complaints Director, my role is to hold members accountable when there are breaches of compliance.

So when standards, Codes of Ethics, or the HPA is not complied with, then my role is to, under Part 4 of the HPA, is to take appropriate action and -- rather, open, and if that is a complaint, an investigation, referral to hearing, whatever action that's required under the HPA.

Q Okay, thank you for that. I'll just get back and go back to the College's regulatory function. Are you familiar with Section 3 of the Health Professions Act?

A I am.

Q Can you tell me what that says, and I'll just ask you to tell me what that says?

A So under Section 3, it talks about the regulation of health professions; they're governed by legislation by

Codes of Ethics, by Standards of Practice, the directives that are set by government or the governing bodies; and in the ACAC's case, that's the ACAC council.

Regulated health professionals are mandated to comply with the section when delivering health services to patients. And certainly for any medical professional, it is about compliance and protecting the public from harm. And, you know, the most important thing is there is mandated compliance; it is not a question for members whether they do comply or not.

Q You spoke a little bit before about your role as Complaints Director and the handling of complaints. Are you familiar with Section 55 of the Health Professions Act?

A I am.

Q Can you tell me what that says in terms of your role as Complaints Director?

A Under Section 55 of the HPA, it lays out the responsibilities of what can and can't be acted on when a complaint is opened. So it talks about, you know, after you treat something as a complaint, there's a 30-day window in which to notify the members, notify the member of the action being taken, and then lays out the options available to the Complaints Director in managing a complaint.

Q I'm going to turn now to the second area of my questions for you, and I'm going to just very briefly take you through the CMOH orders. Are you generally familiar with Exhibits D-8 and D-9, which are CMOH Orders 38-20 and 42-20?
A I am.
Q Can you tell me, generally, what your understanding is of those CMOH orders?
A So in the -- the CMOH Order 38-2020 talked about the private social gatherings, talked about the masking, and talked about the areas of the province in Section 21, which was the Calgary metropolitan area, and the requirements for masking. It went on to the Edmonton area and talked about face masking.
Q And I'll talk with you about this in a little more detail in a few minutes, but you're aware of an exemption under paragraph 27(c)?
A I am.
Q When it comes to CMOH Order 42-20, can you tell me what your understanding of that order is? And that's Exhibit D-9.
A So under 42-20, Section 5 is appropriate to this, talks about masking as well, and the requirement for masking, as the previous order did.
Q So we talked about the exemption in CMOH Order 38-2020. There's a similar exemption, it might be word for word,

in paragraph 24(c) of CMOH Order 42-20, and it speaks of medical conditions.

When you were determining -- I'll get to this in greater detail in a few minutes -- but when you were determining what action to take concerning this complaint, did that exemption apply to Dr. Wall?

A I didn't feel so at the time. The -- I didn't -- I didn't believe Dr. Wall had an exemption, at least none was provided to the College. And also I do think that there was never an expectation for exemptions for medical health professionals, especially in close contact with patients. And the chiropractors are in very close contact with them during treatment, and so I don't think this exemption would apply in this case.

Q Mr. Lawrence, I'm going to take you, again very briefly, to the College's Pandemic Directive, and, again, I'm going to use the January 6, 2021 one as the reference document.

Can you tell me what your understanding was of the Pandemic Directive in terms of requirements on relating to chiropractors and how they would practice?

A So when the Pandemic Directive was initiated, the profession was closed -- or, sorry, shut down for practice except for emergency situations only. And when Public Health enabled chiropractors to return to practice, part of the expectation was that there would

a Pandemic Directive in place approved by Public Health, and so the Pandemic Directive was established so that chiropractors could return to practice in a safe manner to protect the public.

In regards to the masking, the PPE requirements were clear that chiropractors and clinic staff must be masked at all times while providing patient care, and so the masking requirement was very clear as part of the re-opening strategy to allow chiropractors to return to practice.

Q Dr. Halowski commented on the Pandemic Directive extensively, so I'm not going to take you through this in any great detail, but were there requirements for social distancing and plexiglass barriers?

A There were. And I should say for plexiglass barriers that was for, you know, clinic staff if they weren't masking.

Q Did the Pandemic Directive contain an exemption for masking when a chiropractor was providing patient care and was within 2 metres?

A It didn't provide any exemption for there. It gave some options for other modalities of care but not a direct exemption when you're within the 2 metres, no.

Q And to your understanding, why was there no exemption?

A The close proximity that chiropractors have with their patients at times is -- puts them in close contact and

can be a -- can cause transmission of the COVID-19 pandemic.

So similar to, you know, your dentist working around your mouth, chiropractors are very close, face to face. They can be very close to their patients, and so for patient safety, the masking was required.

Q So I'll go to the third area now that I want to ask you questions about, and that is your involvement in terms of the complaint relating to Dr. Wall, and I'll ask you to go to Exhibit A-3, which is a December 2, 2020 letter to you from Dr. Halowski.

A Okay.

Q I'll just wait a minute to make sure all the Tribunal Members have located that, and it's Exhibit A-3.

MR. MAXSTON: So, Mr. Chair, I'll just continue then.

Q MR. MAXSTON: Mr. Lawrence, can you tell me when you received this letter?

A So this was referred to me from the Registrar, dated December 2nd, and the Registrar said sent this to me as the Complaints Director.

Q And I'd like to ask you to go to Exhibit A-5, which is your December 21, 2020 letter to Dr. Wall.

A Okay.

MR. MAXSTON: Let everyone catch up and make sure we're there, that we're all on that same document.

Q MR. MAXSTON: So, Mr. Lawrence, the opening paragraph refers to Section 56 of the HPA. Can you tell me what that paragraph means?
A So under Section 56 of the HPA, if information is received by the Complaints Director that is deemed to be a complaint when there is no -- if there is no complainant, the Complaints Director can open a complaint and became the de facto complainant under this section.
Q And is that what happened here?
A It is.
Q If you look at paragraph 2, can you just explain the first sentence?
A So on the referral from the ACAC Registrar, so the Registrar sent me the December the 2nd letter. We received information that Dr. Wall was in breach of CMOH orders and the Standards of Practice, as well as the COVID-19 Pandemic Practice Directive, and that Dr. Wall would not be taking steps to come into compliance, so I had treated that as a complaint and opened the Complaint Number 20-20 under Section 56 of the HPA.
Q The second sentence in that paragraph says, and there's a question coming: (as read)

> On December 2, 2020, you advised the Registrar, and on December 3, 2020, advised

the Complaints Director that you would not be taking steps to become compliant with these requirements.

And those requirements are the COMH orders and Standards of Practice as mentioned above.

There's a reference to a December 3, 2020 communication or interaction between you and Dr. Wall; can you tell me what happened there?

A So after I received a referral from the Registrar, I called Dr. Wall to discuss the issue with him, and I let him know that this would be proceeding to a complaint and certainly, I'm sure we'll get to it, a request under Section 65.

And Dr. Wall had asked me if there was sort of any alternatives to that, which I let him know that he certainly, you know, could start complying and begin masking. And we had discussed the information that was received from Alberta Health about the discussion he had had with Heidi Ho.

Q What did he say about any steps he was taking to comply with the CMOH orders?

A He said, at that time, that he had an exemption, and he also said that, you know, the -- it's just -- it's like the flu or words to that effect, and either the recovery rate or the survival rate was I think he said 99 percent, but I'm not quoting directly.

Q Did he indicate whether he was masking?
A He said he was not.
Q Did he --
A And --
Q -- indicate whether -- oh, I'm sorry, go ahead.
A Yeah, he said he had tried originally and had feelings of anxiety and claustrophobia, and that he felt he was exempt from it.
Q Did he mention any other reasons for not masking at that time?
A I don't believe he did. I think he might have mentioned about human rights in that call, but like it was more about the low risk of COVID and that he was exempt.
Q Did he say anything about his staff masking?
A I think he had said -- no, I don't have a recollection of that, sorry, no.
Q Did he say anything about observing social distancing, the 2 metre requirement?
A He did not.
Q Did he say anything about his use of plexiglass barriers?
A Not that I recall, no.
Q I'm going to stop here, because you are -- pause for a second, because, as you alluded to, there's a bunch of things that are happening now in conjunction with the

complaint itself. We've talked about your choice to rely on Section 56 to initiate a complaint.

The second thing that was happening was also the Section 65 interim suspension request. Can you explain what Section 65 is, what it's designed for?

A So under Section 65 of the HPA, if there is a -- if the Complaints Director believes that there is a risk to the public, they can make application for a suspension of practice permit or restrictions placed on the practice of the member.

Q Sorry, Mr. Lawrence, I was just reaching for a document there.

I'll ask you to go to Exhibit B-1, as in Bob dash one, and that is a December 3, 2020 letter to a Dr. Linford.

A Yes.

Q And I'll just make sure everybody on the Tribunal has skipped ahead to B-1.

So can you explain to me who Dr. Linford is?

A So part of council's role is to identify and nominate people who can hear -- or members of the profession who can hear these types of requests and make decisions with legal counsel when these are provided, so Dr. Linford was one of the members that had been appointed by council to hear these requests.

Q Okay, and what are you asking for from Dr. Linford?

A So in the Section 65 request, I asked for an interim suspension of the practice permit until the completion of the complaint process.
Q And why were you asking for an interim suspension?
A Because I believed that there was a danger to the public for members to practice in close proximity without a mask as outlined by Public Health at that time.
Q I'll take you to the second page of the letter, and there's a Section entitled "Background".
A Yes.
Q And there's a couple of arrows that are indented. Can you explain what the background information is in those arrows?
A So at the time, there was no plexiglass barrier at the reception area, and the staff were not masking. And so in the Pandemic Directive, if people come in that if they breach the 2 metre distance, other clinical staff, they are to be masked or have a barrier protecting or separating them from the patients.

And the other point is that Dr. Wall was not masking during patient treatment even though he's in close proximity to his patients.

Q There's a paragraph a couple of -- well, I'll skip a paragraph and go to the next one, it says: (as read)

In my view, Dr. Wall was in violation.

Can you tell me what violation you were concerned about there?

A So in regards to the Pandemic Directive, when -- without masking, there were I believe Standards of Practice and Codes of Ethics that were being breached, as along with the Pandemic Directive, and so that's what that refers to.

Q There's a second sentence in that paragraph that begins: (as read)

> If there is a medical exemption applicable to Dr. Wall.

Can you tell me what you're saying there?

A It says: (as read)

> If there is a medical exemption applicable to Dr. Wall, there is no requirement for him to mask in his personal activities. However, to continue in his chiropractic treatment, the pandemic protocols of the ACAC and AHS must be followed.

And what I meant there was, you know, in a regulated member's personal life, that's their own business and their own decisions. The compliance in my role has just to do with practice and interaction with patients. So where I don't regulate, nor where the College doesn't regulate anything outside of practice while you're practicing chiropractic, you are responsible for

the mandates.
Q There are a couple of other exhibits after that, B-3 and B-4; I'll just ask you to identify those. Those are Mr. Kitchen's letters in relation to the Section 65 request you made?
A Correct.
Q If we go to Exhibit B-5, there's a December 18, 2020 letter to Dr. Wall from Dr. Linford. I'll just let everybody get caught up and be at B-5, and then I've got a couple of questions for you about that document.
So is this Dr. Linford's decision letter concerning your Section 65 request?
A It is.
Q On page 2, it's the third complete paragraph, it begins with "I have decided"; can you tell me what Dr. Linford's decision was ultimately?
A So Dr. Linford decided that, at that time, the suspension wasn't justified, and he instead decided to put conditions on Dr. Wall's practice permit to try to address the risk to the public.
Q Can you tell me what the -- I think there are four numbered orders, can you tell me what those orders were that Dr. Linford made?
A So number 1 was that Dr. Wall was to inform each client or patient that he sees that Dr. Wall has a medical exemption from the Public Health order that all persons

in a public place must wear a face mask.

He also ordered that Dr. Wall should obtain written confirmation that each patient would sign and the patient agrees to be seen and treated by Dr. Wall without wearing a face mask or a face shield, and that copies of those would be sent to the Complaints Director, to me, by 5 PM on Friday of each week, and that this stays in effect until the public order and face masks are in effect.

Number 2 talked about Dr. Wall directing any staff person assisting in his office, whether that's a volunteer, paid or unpaid, that they also comply with the current orders and that physical barriers must be up, social distancing must be adhered to, or they wear a face mask. The -- and then if anybody brings in an exemption for that, Dr. Wall was to consult with Alberta Health.

Dr. Wall was to maintain a log of screening questions asked and answered by all patients and daily screening of his staff and himself. And in the event that Dr. Wall has any symptoms or answers positively to screening questions, he would not see patients.

Q To your knowledge, did Dr. Wall comply with those orders?

A To my knowledge, he did.

Q So I'm going to ask you specifically, he was to send

you written confirmation by 5 PM on Friday of each week about certain matters. Did you receive written confirmations weekly?

A I did by email.

Q In terms of your statement, that you believe he complied with the other aspects of the order, on what information are you basing that?

A So the -- Dr. Wall had provided pictures that, following the request from Alberta Health, the barriers were put in place in the clinic, the protective barriers. And based on the screening questions that they were -- that was also part of the information he sent to me. And as I don't have any evidence that Dr. Wall had any symptoms or was answering positively on the screening questions, then I believe he was compliant with that one as well.

Q So the -- I talked with you about the fact that you initiated this Section 65 complaint. We talked about the Section 65 interim suspension request. As for the same time, there was a third thing going on, and Alberta Health Services became involved in terms of the operation of Dr. Wall's clinic; is that correct?

A It is.

MR. MAXSTON: Bear with me, Mr. Chair. I'm going to ask everyone to go to Exhibit D-1, which is an AHS Order of an Executive Officer Notice of Public

Access Closure.

Q MR. MAXSTON: So, Mr. Lawrence, are you able to tell me how this came into the possession of the College?

A So following the information provided to Alberta Health, they also do site visits and also the Alberta Health had discussion with Dr. Wall as well and had decided that, as the practitioner at that time was not wearing a face mask and was well within 2 metre distance from the patient and that could contribute to the spread of COVID-19, they also found that staff worked at the clinic were not continuous masking, and no barriers were up, they initiated a closure order against the clinic, and shut the clinic down under the -- from the Executive Officer of Public Health.

Q And if we go to page 2 of that document, paragraph 2 talks about: (as read)

> The owner [meaning Dr. Wall] immediately undertake to diligently pursue completion of the following work.

Can you describe what Dr. Wall was supposed to do?

A So Dr. Wall was the practitioner, which is Dr. Wall: (as read)

> ... must be masked when treating patients within 2 metre proximity to help prevent the spread of COVID-19; patients must be masked

when receiving a treatment from the practitioner; staff not working alone at the station must be masked at all times while working an indoor public space; staff working alone at a work station must also be observing physical distance, the 2 metre distance, from all other persons, otherwise, they must mask or a barrier must be up; and the complete the relaunch plan template [which is an Alberta Health document].

Q And I'm just going to digress for a moment. Exhibit A-4, I don't need you to go to this, is an ACAC Notice of Closure of Clinic. Can you tell me what that document is just very briefly?

A So once we received the closure order from Alberta Health, there was a statement put out to the rest of the membership about the closure of the clinic.

Q So I said before, a few minutes, ago I was going to pause because there was a lot happening, and I went through three areas with you, the complaint, the Section 65 request, and AHS's involvement.

I'm now going to take you back to your direct involvement and specifically the investigation that was conducted under Part 4 of the HPA. Did you act as the investigator?

A I did.

Q I'd ask you to go to and the Tribunal Members to go to Exhibit A-7, which is your investigation report.

MR. MAXSTON: Mr. Chair, I'll just assume that everybody is at document A-7 or is getting there very, very quickly.

Q MR. MAXSTON: Mr. Lawrence, did you write this report?

A I did.

Q Can you tell me when you wrote it?

A I'm going to say late January. I don't know the exact date, I'm sorry.

Q And is it your belief that it's an accurate reflection of your investigation?

A It is.

Q Okay, I'm going to ask you some questions about it. In the second paragraph of your investigation report, beginning with the phrase "On December 2, 2020", there's a reference to the discussions between the Registrar and you with Dr. Wall on December 2 and December 3, 2020. I'm not going to go through that in any greater detail, except the tail end of the paragraph. There's, about the fifth line down, there's a sentence beginning with: (as read)

> He indicated that he thought this was a human rights violation and that he was exempt from wearing a mask.

Does that refresh your memory in terms of your conversation with him?
A Yes.
Q And can you tell me what he might have told you then about a human rights violation?
A So when he had an exemption, the -- and I had talked about initiating the Section 65 and the following complaint, he thought his -- it was his -- under the human rights that he would be allowed to continue to practice and that the College was violating this right by taking these actions.
Q The next sentence says: (as read)

> He was informed that, as this was unsafe practice, it was the responsibility of the College to take action to protect the public.

Was it you who informed him?
A Yes.
Q The next --
A Oh, sorry.
Q I'm sorry.
A I think the Registrar had that discussion as well, but certainly I did, yes.
Q The next sentence begins: (as read)

> He indicated that he did not believe ...

Can you just read that sentence, read to the end of the paragraph and then tell me what you're conveying here?

A (as read)

He indicated that he did not believe he was endangering the public as the recovery rate from COVID is so high and asked if there could be any discussion on alternatives. He was informed that public safety is not for debate and that if he would not mask, we would proceed with a Section 65 request.

So as I said before, during the discussion, Dr. Wall had talked about the recovery rate from COVID, and I seem to remember it was 90, he might have even said 99 percent, I can't remember exactly, but very high, and that, you know, because the recovery rate was so high, he didn't think he was endangering people.

And the -- in my comment was that, you know, public safety is a requirement of the College, we're mandated to follow the legislation, and that we would need to proceed to a Section 65, which is the suspension request if he didn't mask.

Q The next couple of paragraphs talk about the -- Dr. Salem's letter and those types of things, and I'll get to those in a few minutes, but there's a paragraph that begins: (as read)

On December 16th, 2020, Dr. Wall provided a follow-up letter to David Linford indicating plexiglass barriers had been installed at the

front counter of the clinic.

How did you get that information?

A That was sent over by Mr. Kitchen, and Dr. Wall had provided pictures of the installed plexiglass barriers.

Q After you had initiated the complaint, I believe you received an undated response letter from Dr. Wall, and I'm going to ask you to go to Exhibit A-6.

A Okay.

Q And I'll ask the Tribunal Members to go to A-6 as well. This is a four-page letter, so I'm not going to ask you to go through it line by line, but could you summarize, to the best of your ability, what Dr. Wall was saying to you in this letter?

A So it starts out where that Dr. Wall had originally put on a face mask, and he believed that it was causing him anxiety and symptoms of claustrophobia, he said he decided to wear -- or to try a face shield, and he found that the same symptoms persisted and thought that this negatively impacted his dialogue with patients, and that he had decreased concentration levels.

So he said: (as read)

After enduring this for several weeks, I decided in late June of 2020 to not wear a mask or a face shield.

He went on to say that in his conclusion, the Pandemic Directive could not reasonably be interpreted to demand

the wearing of a face mask if doing so was harmful to a member, and it negatively impacted the member's ability to provide the best patient care.

So he said that patients had asked him about, you know, why he wasn't masking, and he said because he had mental concerns and limitations and said that the patients were understanding.

He said: (as read)

> At the time I did not think that I should or needed to obtain any sort of exemption to wearing a mask or shield such as -- from another health care practitioner such as a medical doctor.

He said: (as read)

> As time progressed, it seemed to me that my decision was reasonable in the circumstance.

So I think as we go through, what he's saying is that he has concerns of concentration levels, he has concerns of anxiety and feelings of claustrophobia, and thought that the Pandemic Directive wasn't accurate in mandating face masks, so he made the decision to discontinue wearing one.

Q When you received this letter from Dr. Wall, did it cause you to change your decision about referring the matter to investigation?

A It did not.

Q Can you tell me why?
A I think that when I look at the requirements of the legislation, the mandates or the compliance is not a -- it's not really an optional what you choose to comply with and what you choose not to comply with.

The legislation, the Standards of Practice, Codes of Ethics, whatever mandates under that, the chiropractors that are members of the profession are mandated to comply with them. And so what I saw here was the member deciding that he wouldn't comply, and so I didn't see anything that would prevent -- would change my mind on proceeding with the investigation.

Q On page 2 of your investigation report, there is a statement, it's the third complete paragraph: (as read)

> On January 25, 2021, Dr. Wall was interviewed by David Lawrence. ACAC Complaints Director, Dr. Todd Halowski, ACAC Registrar, Dr. Wall and his legal counsel were present for this interview.

I'm going ask you to skip a couple pages ahead here to page 4 of your investigation report, there's a statement at the top of that page that says: (as read)

> The key points of the interview.

And I'll just let everyone get to that page, again page 4 of the investigation report. So when you say "The

key points of the interview", was that your interview of Dr. Wall that occurred on January 25?

A It is.

Q And again, during that interview, Dr. Wall had legal counsel present?

A He did.

Q Okay, I'm going to ask you to go through each of these arrows or bullets and just tell me what occurred during the interview. And I know this may be a little bit lengthy but I think it's important to get a flavour for what was going on during the interview.

A Certainly. So as it indicates, the interview was done on January 25th, 2021. It was myself, Dr. Halowski, Mr. Kitchen, and Dr. Wall.

So we talked about that Dr. Wall said he had originally tried masking and that he had feelings of anxiety or claustrophobia and that he had also tried using a face shield but had the same feelings, and so at the end of June, he made the decision to stop masking. He said he felt the mask interfered with his concentration and his ability to interact with patients.

He's indicated that he felt the risk to him in wearing a mask was greater than not wearing one, as his feelings of claustrophobia and anxiety were something that he didn't want to deal with.

We asked him about if he had had these feelings previously, and he said he had not experienced these feelings prior to masking, he had no diagnosis of any condition, and the decision to not mask was made by Dr. Wall on how he felt and his comfort.

He indicated the ACAC Pandemic Directive does not give any room for exceptions, and so he made the decision to stop masking based on the feelings he was having. As he was -- as there was no exemptions in the Pandemic Directive, he talked about the CMOH orders that he was using for exemption.

His -- he indicated that his son was the only other person that was working at the clinic at the time, he had no other employees, and that -- yeah, since March of 2020, so during the COVID pandemic. He also indicated that he did not require his son to be masked and did not think it necessary to install any barriers. He said his son was -- completed transactions, he did not mingle with anyone and so did not think it necessary, and that his son was 17, he's young, healthy, and so he didn't think his son was at risk from COVID. He also responded that his son was not able to maintain physical distance at all times.

Dr. Halowski asked Dr. Wall if his son was provided the opportunity to mask, and Dr. Wall reiterated that he was a healthy individual and that he

did not want to wear one. When asked if he was presented with the facts and varying points about COVID, Dr. Wall indicated he was aware that he told his son about the Pandemic Directive.

When talking about compliance with the Standards of Practice or the Codes of Ethics, Dr. Wall indicated that the only area he believes he did not comply with was the ACAC Pandemic Directive. He believes it is unreasonable not to provide exceptions to allow him not to mask with his patients, and he indicated that he had a medical note regarding his mental limitation and concern.

Dr. Wall further indicated that under CMOH Order 38-2020, there is an exemption to mask wearing that he used to discontinue wearing a mask. Dr. Wall had indicated he stopped masking in June, and his medical exemption he did not get till December of 2020 from Dr. Salem.

The same order also indicates that physical distance must be maintained, so further down in the "Exceptions to masking", it does indicate that the 2 metre barrier must be maintained.

When we talked if Dr. Wall had talked to his patients about the dangers of him not being masked, he replied that people are aware of the dangers, and he did not need to explain any of the dangers to the

patients from him not masking. And Dr. Wall said that the people he sees, they either understand they are at high risk of getting COVID or they are not at risk. He said people fill out the screening questions, and if they answered "no" were considered low risk.

Dr. Wall stated that the feelings of anxiety he experienced were the only reasons that he chose not to mask, and there are no other reasons that he does not mask.

Dr. Wall discontinued masking in June, however, did not get a medical exemption until December 2020 when the public closure order was given. During that time, he sought no treatment for his condition, provided no communication to the ACAC and has no charting to show that he was advising patients of the risk they were facing by seeing an unmasked doctor. Dr. Wall indicated that he made the decision to stop masking due to the feelings of anxiety he was having.

Q I'll just ask you a couple of questions. During this interview with Dr. Wall, did he mention any objections to masking about his religious beliefs?

A He did not.

Q Did he mention anything, and we may have covered this, did he mention any about whether he thought masks weren't medically effective against spreading COVID?

A No.

Q Did he discuss whether he thought masks were or weren't necessary?
A He said that -- he said that he thought that they interfered with his ability to concentrate, and that he felt that it was giving him anxiety and claustrophobia but not unnecessary, no.
Q Okay, I'm going to switch gears a little bit here, and ask you about the letters from Dr. Wesam Salem. They are referenced -- this is referenced in your investigation report on page 3. So again the investigation report is Exhibit A-7, and page 3 has a heading "Dr. Wesam Salem".
MR. MAXSTON: And I'll just get everybody to turn to that.
Q MR. MAXSTON: At the same time, I'm going to ask you a question about Exhibit A-8, which is Dr. Salem's December 12, 2020 letter to Dr. Wall. So I'll just ask you, how did you get Exhibit A-8, the letter from Dr. Salem?
A So this was provided by Dr. Wall.
Q And do you remember roughly when it was provided to you?
A I think it was shortly after the date that it was dated on the letter.
Q And it's quite brief, so I'll ask you what does the letter say?

A The letter is dated December 12, 2020, and it says: (as read)

To whom it may concern, this letter serves to confirm that I have assessed Mr. Curtis Wall in my office today. Please be advised that due to medical reasons, he has been deemed to be exempt from mask wear and the use of a face shield.

Q When you saw that letter, how did you respond to it?

A I sent a follow-up request to Dr. Salem's office for more information.

Q And why did you do that?

A I found that it was a very just a general note that didn't really have a lot of detail to it, and I was looking for more information.

Q And if we go to Exhibit A-9, there's a January 8, 2021 letter on Dr. Salem's letterhead. Just let everybody get to document A-8.

THE CHAIR: A-8 or A-9, Mr. Maxston?

MR. MAXSTON: Oh, I'm sorry, A-9. Thank you, Mr. Chair.

Q MR. MAXSTON: So, Mr. Lawrence, was this the response you got from Dr. Salem?

A It is.

Q And if we look -- I'm sorry, I'm skipping around a little bit here, if we go back to page 3 of your

investigation report, it says: (as read)

Dr. Salem provided a written response related to the medical exemption. The following outlined the key points in the information from Dr. Salem.

MR. MAXSTON: And forgive me, Mr. Kitchen, here, I'm going to ask a bit of a leading question.

Q MR. MAXSTON: I'm assuming the outline of the key points you referred to are the key points from this January 8, 2021 letter?

A That's right.

Q Okay, I'll just ask you then to go through your investigation report on page 3, and those four stars, and there's a little bullet point at the bottom that says "Note", and if you can tell me what the key points were.

A So the -- Dr. Salem had provided the written responses we went through, so he indicated that, at his appointment on December 29th, that Dr. Wall harboured significant anxiety about masking and his inability to breathe. Then in his letter, he indicates that there were no other documents or tests conducted or any diagnostic information.

In my letter to him, I had asked for, you know, how did he confirm the diagnosis? Was there tests or any diagnostic information, of which he said there's

not.

Dr. Salem provided some medical history regarding Dr. Wall, which included that Dr. Wall takes no medication and is in good health. He indicated Dr. Wall tried to wear a mask and developed a tickle in his throat and felt anxiety and claustrophobia after wearing a mask. Dr. Salem further cites that Dr. Wall is pushing for exemption given his mental health impact.

Q You also have a note at the bottom, can you tell me what you're saying there?

A I'm sorry, where are you looking?

Q Just on your investigation report after those four bullets, there's an indented note, literally N-O-T-E: (as read)

It should be noted that.

I'm just wondering what you're saying there.

THE CHAIR: I'm not following. This is after the four bullet points regarding Dr. Salem?

MR. MAXSTON: Yes, that's -- oh, I'm sorry, that's my mistake, Mr. Chair. Yes, I'm sorry, that's my mistake.

Q MR. MAXSTON: After your investigation was completed, did you decide to refer this to a hearing?

A I did.

Q And can you tell me why?

A I do think there was significant breach of both the Standards of Practice and the Codes of Ethics, and these were I think most appropriate to be presented to a Hearing Tribunal for a decision on the disposition of the complaint, and so for that reason, I referred it to the hearing on the 4th of February.

Q We talked a little bit about this before at the beginning of your testimony, and I believe you indicated that when you talked with Dr. Wall on I think it was December 3, you said that compliance wasn't optional. What was your expectation if a member couldn't comply or was thinking of not complying with the Pandemic Directive?

A So if there's questions about compliance, I would expect that they would -- usually what members do is they reach out to the Registrar, and they talk about, you know, what the -- what options may be available or, you know, a question about, you know, if they're not sure about something, usually the Registrar fields those types of questions, and they reach out about that.

In my role, it's -- you know, compliance is mandatory, and so that -- usually the -- when there is questions about that, whether it's, you know, sometimes they'll reach out about is this advertising compliant, is this compliant, can I do this or can I do that, so

we get those questions quite frequently. And so my expectation would be that you usually contact the Registrar or that you comply until you question, or you step back from practice until you resolve the issue

Q So I'm just about finished with my questions for you, Mr. Lawrence. I just want to ask you about some other obligations at the College.

If there is a complaint sent to you, and you choose to investigate it, is a member required to cooperate with your investigation?

A They are.

Q And can a chiropractor choose to not cooperate?

A Well, they could choose to, but that is actually -- that would be an example of unprofessional conduct defined in the Health Professions Act.

Q Dr. Wall's conduct doesn't involve any sexual misconduct. This is a theoretical question I'm going to pose to you. Are you aware of Bill 21 Standards of Practice that the College has about prohibiting sexual relationships with patients?

A I am.

Q Is that part of your role, or enforcing that part of your role as Complaints Director?

A It is.

Q Are those standards mandatory?

A They are.

Q Are there any exemptions to them?
A No. There are -- there are guidelines provided about how to discharge from a patient care to enable a relationship to begin, but they are not -- they're not optional while a patient is under doctor care.
Q Are you familiar with the phrase "ungovernability" or "ungovernable professional"?
A I am.
Q Can you tell me what that means to you?
A So the mandate of the College is to hold regulated members in compliance with the mandates of practice and the self-regulation. Council is the deciding body on the conduct that members must adhere to in practice.

And so the role of the College or my role is to hold members accountable when they're not compliant, and when they are what's termed "ungovernable", it is when they are purposefully or deciding not to comply with the requirements of their practice.
Q How would ungovernability affect the profession?
A Well, I think if members are picking and choosing about what they comply with and what they won't, it doesn't really become compliance then; it's -- everything's just becoming a recommendation or a suggestion, so the profession basically isn't self-regulating at that point.

Discussion

MR. MAXSTON: Mr. Chair, those are all my questions for Mr. Lawrence.

I welcome Mr. Kitchen's comments, but I doubt he wants to start his cross-examination at 10 to 12. I wonder if this might be a good time to take a break for lunch, and come back perhaps at 10 to 1 or 1:00, and then Mr. Kitchen could conduct his cross-examination, I can do my redirect, and you can ask any questions that you have.

MR. KITCHEN: I prefer a slightly longer break for lunch. I'd like to come back at 1:15, one of the reasons being I don't think we are in jeopardy of not finishing today at a very reasonable hour. If we come back at 1:15, I suspect we'll still be out of here at 3:30 at the latest. So if that's acceptable to the Chair, that's what I would propose.

THE CHAIR: Mr. Maxston, any ...

MR. MAXSTON: Sorry, that's fine, and I think, Mr. Kitchen, we'd be moving ahead on the understanding we wouldn't start with your evidence then until tomorrow morning?

MR. KITCHEN: That's right.

MR. MAXSTON: Yeah, I'm fine with that approach.

THE CHAIR: Okay, if both parties are okay with that plan, we will now break until 1:15, so see

everybody back at 1:15. And, Mr. Lawrence, we just caution you not to discuss the case while not giving testimony.

A Yes, that's fine.

THE CHAIR: Thank you and see you at 1:15.

PROCEEDINGS ADJOURNED UNTIL 1:15 PM

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

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September 7, 2021	Afternoon Session

HEARING TRIBUNAL

J. Lees	Tribunal Chair
W. Pavlic	Internal Legal Counsel
Dr. L. Aldcorn	ACAC Registered Member
Dr. D. Martens	ACAC Registered Member
D. Dawson	Public Member
A. Nelson	ACAC Hearings Director

ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

D. Lawrence	ACAC Complaints Director
B.E. Maxston, QC	ACAC Legal Counsel

FOR DR. CURTIS WALL

J.S.M Kitchen	Legal Counsel

K. Schumann, CSR(A)	Official Court Reporter

(PROCEEDINGS RECOMMENCED AT 1:21 PM)

THE CHAIR: We are now back in session, and we will ask Mr. Kitchen to start with his

cross-examination of Mr. Lawrence.

MR. KITCHEN: Thank you, Chair.

DAVID LAWRENCE, Previously affirmed, Cross-examined by Mr. Kitchen

Q MR. KITCHEN: Good afternoon, Mr. Lawrence.

A Hello.

Q You are not a chiropractor, correct?

A I am not.

Q And I have it right that you started in this position as Complaints Director in March of 2020, correct?

A That's correct.

Q So you did not do this job prior to the onset of COVID? Is that --

A I did not.

Q -- (INDISCERNIBLE)? You agree that the most important principle for chiropractors to adhere to is the principle of protecting the public from harm, do you not?

A I do.

Q You agree that each patient of a chiropractor is a member of the public, do you not?

A I do.

Q You agree that each patient of every chiropractor is -- sorry, let me start again. You agree that the interests of each patient, each forms a part of the broader public interest, do you not?

A I'm not sure about public interest, but public safety, yes.
Q So you agree that the safety interests of each patient forms a part of the broader public safety interest, correct?
A That would follow, yes.
Q So then would you agree that the interests of each individual patient make up together the broader public interest?
A As it applies to the practice of chiropractic, each patient is part of the public.
Q You agree that chiropractors should protect members of the public from harm no matter what, do you not?
A Yes.
Q You agree, do you not, that the principle of chiropractors protecting the public from harm is more important than the principle of protecting the reputation of the chiropractic profession, do you not?
A More important. It's difficult I think from a compliance perspective. I think the priority of the College is the protection of the public, and so in that regard, yes.
Q You agree that there are other threats to the overall health and well being of chiropractic patients besides COVID-19, do you not?
A Yes.

Q You agree that there are other threats to the overall health and well being besides COVID-19 that are more severe than COVID-19, that are a greater threat, do you not?
A I'm not sure. It probably would be per threat, but, you know, a threat's a threat.
Q Do you think all threats are the same?
A I would think that there's many different kinds of threats, so I don't know where COVID would be in compared to a threat of something else. So in regards to legislation and compliance, public safety threats are public safety threats.
Q But you would agree some threats are more serious than others?
A If you could give me an example of what threats you're talking about.
Q Well, I don't want to give you a hypothetical, but let me ask you this: You believe that the threat of COVID-19 is more of a threat than the threat posed by wearing a mask; is that correct?
A I think the legislation in regards to COVID-19 is clear on the expectation of masking.
Q Okay, I didn't ask that, so I'll try again. You would agree with me -- sorry, you believe, do you not, that the threat of COVID-19 is greater -- that the threat of COVID-19 to a person's health is greater than the

threat to a person's health posed by a mask?
A I think, you know, my personal beliefs on --
Q I didn't ask you your personal beliefs.
A You did you asked me what -- if I believe that.
Q Right, but you are here as the Complaints Director.
A Correct, so my response is is that the legislation is what guides, not my personal beliefs.
Q You have discretion as the Complaints Director, do you not?
A I do.
Q You used the word "danger" to describe Dr. Wall not wearing a mask while treating his patients earlier today; is that correct?
A I believe so, yes.
Q So let's use the word "assessment", okay? Let's not use the word "belief", because you didn't use the word "belief". In your assessment, COVID-19 is more of a threat to a patient's health than wearing a mask, correct?
A In my assessment, the legislation and guidelines indicate it is more of a threat than wearing a mask.
Q So I want to make sure I have your position correct. You're saying that the legislation -- well, let me ask you this: By "legislation", do you mean the Health Professions Act?
A I mean all the mandates of practice.

Q And you would say the mandates of practice are legislation?
A I would refer to them -- and I use the term broadly, but I'm referring to whether the Code of Ethics, the Standards of Practice, directives, policies, legislation, and perhaps mandates would have been a more appropriate word than "legislation" to use in that context.
Q So you believe that the ACAC mandates state that COVID-19 is a greater threat to a patient's health than masks?
A I think the Pandemic Directive states that wearing a mask can reduce the risk of transmission between doctor and patient.
THE CHAIR: Mr. Kitchen, I was just going to say Mr. Lawrence is not a medically trained individual, so I'm wondering if we're asking him for medical opinions or medical --
MR. KITCHEN: I'm not. I'm not searching for a medical opinion.
THE CHAIR: Okay.
MR. KITCHEN: But I'm -- this question is -- he has said -- and I don't think he's trying to claim a medical opinion, and I'm not claiming that he is, he has said, I think Dr. Wall not wearing a mask and treating patients was dangerous to the public, that's

why I took action. That's what he said.

So what I'm trying to figure out -- and that wasn't a medical determination, that was a Complaints Director determination about public safety, which he has to make. So I'm asking him if he thinks one danger is more than another danger, and I think that's within his purview, not as an expert, not as an opinion, but simply he has to assess that, and he has been assessing that.

And I've asked the question four times, and he's refused to answer, so I don't see any point in asking it again; however, I will ask you, Mr. Chair, to either direct that he answer the question, or that he not, and I continue on because --

THE CHAIR: Well --

MR. KITCHEN: -- (INDISCERNIBLE) again.

THE CHAIR: Well, I think he did reply that he couldn't compare one to the other without knowing what they were and asking for examples, and I know you won't provide hypotheticals. Is there a possibility you could reword your question?

MR. KITCHEN: Sure. No, I did -- the example I provided was masking. I asked if he thought COVID was more of a danger to the health of patients than wearing a mask, and he has refused to answer.

THE CHAIR: I don't know. To me, that

would require some medical knowledge.
MR. KITCHEN: Okay.
THE CHAIR: I mean, in some cases, COVID is fatal, so there's all kinds of different ways to assess how dangerous COVID is. I don't want to get into your direct -- your cross-examination, Mr. Kitchen, I just wanted to just clarify that Mr. Lawrence is there in an administrative rather than a medical position.
Q MR. KITCHEN: Mr. Lawrence --
THE CHAIR: (INDISCERNIBLE)
MR. KITCHEN: Oh, sorry.
Q MR. KITCHEN: Mr. Lawrence, in assessing Dr. Wall as a danger to the public and not wearing a mask, are you not making something of a medical or scientific determination?
A The comment there is in regards to the Standards of Practice that apply by not masking that -- when you are not compliant, that is the danger. So when I look at the practice directive, and it says chiropractors and clinic staff must be masked at all times while providing patient care, when a member of the profession does not comply with that, then they are a risk.
Q All right, so if I have your position correct then, what you're saying -- and if you don't agree with me, tell me -- the source of the danger to the public in

Dr. Wall's actions are simply that he wasn't complying with what the ACAC said to do?

A In my position as Complaints Director, when members are not compliant with what they're supposed to do, my role is to hold them accountable to comply.

Q Okay. I didn't ask you what your role is. I thought I was asking a simple question because I was trying to repeat what you had said, I was just trying to clarify. Wasn't trying to trick, I was trying to clarify what you had just said just so I understood your position.

I thought you just said that the source of the danger to the public from Dr. Wall was that he was not complying with what the ACAC said to do; do you agree with that?

A I would say not complying with the ACAC and Public Health, yes.

Q So the noncompliance is the source of the danger, correct or not correct?

A Noncompliance -- noncompliance is the -- what's the term -- the noncompliance is the issue in the complaint. The actions are the danger.

Q And so and the action --

A Dr. Wall's actions, yes.

Q You would agree that by referring to Dr. Wall's actions, you mean his actions in not wearing a mask while treating patients?

A Correct.
Q You agree that chiropractors are obligated to comply with the ACAC's requirements of practice even if those requirements are harmful to the chiropractor, do you not?
A I wouldn't say that, no.
Q Okay. The ACAC is obligated to comply with the statutes of Alberta; isn't that correct?
A The statutes that apply to the profession, yes.
Q The ACAC is obligated to only impose restrictions on chiropractors that are consistent with the Canadian Constitution; isn't that right?
MR. MAXSTON: Mr. Chairman, I'm going to object there. We don't have a constitutional law expert. Mr. Lawrence is the Complaints Director, and I objected this question or line of questioning with Dr. Halowski, and I'll object again.
MR. KITCHEN: Sure. If I was asking whether or not Dr. Lawrence [sic] thought, in his opinion, that wearing a mask could possibly be a violation of Section 2(a) of the Canadian Charter of Rights and Freedoms, I'd be asking for his legal opinion. I'm not asking for his legal opinion. I'm asking for his confirmation, as Complaints Director, whether or not the Canadian Constitution applies to the body that he is the Complaints Director of. That is requisite

knowledge to do his job. It's not an opinion. That either does or doesn't, and he, by virtue of his position, must have that knowledge. I'm asking for him to confirm that knowledge, not to provide me a legal opinion.

MR. MAXSTON: I'm only going to make one other comment, and then you'll decide whether the question can be asked. That again is one of the ultimate questions that this Tribunal is going to be deciding on, what does and doesn't apply to the College's Pandemic Directive and other mandates, so ...

MR. KITCHEN: So, Chair, my question is I'm asking Mr. Lawrence to confirm that the Canadian Charter of Rights and Freedoms, being part of the Canadian Constitution, applies to the College; so I'm asking you to let me know if you're going to allow the question.

THE CHAIR: My thoughts on this are that we could recess and take advice from independent legal counsel, and I think Mr. Maxston's indicated his concern that this could be a central issue, so I think, as much as I'd like to keep things moving, we will take a brief recess so that the Hearing Tribunal and myself can take advice from counsel, so please bear with us for a few minutes. Thank you.

MR. KITCHEN: Okay, thank you.

(ADJOURNMENT)

THE CHAIR: Okay, we are back. We are still in session. We've had a couple of internet hiccups, a couple of freezing screens, so we'll just hope that this doesn't re-occur.

We have discussed the question you've proposed, Mr. Kitchen, and spoken to our independent legal counsel, and our decision is that we do not allow you to ask this question. We believe you're asking for an opinion from this witness, and as you've pointed out, this is likely -- or Mr. Maxston has pointed out it's likely to be a central issue in this hearing, so that question is not allowed.

MR. KITCHEN: Thank you, Chair.

Q MR. KITCHEN: Now, Mr. Lawrence, I'm going to take you to the Pandemic Directive.

A Okay.

Q Once again, there's three versions, so it's Exhibits C-20, C-21, and C-22, C-22 being the January 6th version.

Now, there's a Personal Protective Equipment section in the directive. Of course, that's what we've been talking about. Now, in that section, there is nothing discussing chiropractors contacting the ACAC if they have human rights concerns regarding the mandatory masking directive, is there?

A There is not.
Q And the ACAC has never had in place a process in which to reach a possible resolution whereby a chiropractor could practice without a mask; isn't that right?
A I think depending on the modality. So certainly I know when council had decided to make Telehealth a permanent modality for chiropractors going forward, and we received communication from I believe it was Green Shield and Blue Cross about how to bill for it. There certainly is practice under that which wouldn't require masking.

And in the earlier pandemic, there was if you can maintain 2 metres of distance while conversing with a patient, there was exception -- or there wouldn't be a required to mask.

Q The ACAC has never had in place a process by which there's a possible resolution that would allow a chiropractor to physically treat patients without a mask; isn't that right?
A In close contact, that's correct.
Q You called Dr. Wall December 4th, 2020, to inform him you were making a request to suspend his practice permit, did you not?
A I think it was December 3rd.
Q Okay.
A But yes.

Q Thank you for that. Dr. Wall asked you during that call about human rights accommodations, didn't he?
A I think he said something to the effect of, Isn't there a human rights part of this. I don't know exact words, but something to that effect, yes.
Q Okay. Dr. Wall said to you that the literature doesn't support mandatory masking, didn't he?
A I think he said that in his response letter. I don't know if it was during our call, but something to that degree, yes.
Q And you responded to him by saying that you were not going to debate the issues, didn't you?
A I said the patient's safety isn't up for debate, yes, and that compliance wasn't up for discussion -- or compliance wasn't up for debate, and that if he wasn't going to comply, I was going to initiate the Section 65 request.
Q But it wasn't public safety that you refused to debate, was it?
A Well, it's compliance.
Q It was the scientific efficacy of masks that you refused to debate, wasn't it?
A No, that's sort of beyond my purview. It's, you know, this is a compliance issue, so the mandates of practice were masking, and if Dr. Wall wasn't going to comply with the requirements, then I initiated the request.

Q Now, I'm going to put it to you that Dr. Wall is going to say that what you refused to debate was the scientific efficacy of masks; that's what he's going to say.
A Okay, I disagree with that, but okay.
Q And I'm talking in the context of this call, not talking anywhere else. In the context of this call, Dr. Wall's going to say that you said to him that you refused to debate the efficacy of masks.
A I don't believe -- "efficacy" isn't a word I would usually use. I think I probably talked more in compliance. I note he did talk about the recovery rate of COVID, and like I said before, I think he said something to the effect of it's 99 percent recovery or something to that regard, but it's not -- this was about compliance.
Q Do you disagree that Dr. Hu said that the recovery rate is 99 percent?
A I don't remember specifically, but I wouldn't disagree with that.
Q So you don't disagree that what Dr. Wall said when he told you the recovery rate is 99 percent is truthful?
A I don't know either way, so, no, I wouldn't disagree with that.
Q So you don't know if the recovery rate is 99 percent or not?

A I know it's quite high. I don't know what the exact percentage is, so -- but I know it's quite high.
Q But you did just say -- so you don't remember what Dr. Hu said; is that correct?
A I'm -- what I said was I believe he said something like that, and I have no reason to disagree with that comment.
Q So you have no reason to disagree with Dr. Wall when he said that the recovery rate's 99 percent?
A I don't.
Q You said in that call that you cannot make Dr. Wall wear a mask and that he was free to not wear a mask, didn't you?
A I think I was talking about in regards to, you know, in both his public life and in work. I can't, you know, make him do anything; all I can do is hold chiropractors compliant when their mandates of practice are not complied with and proceed in that way.
Q You said he was free to not wear a mask, didn't you?
A I think I was talking about in his private life.
Q Dr. Wall is going to say that there was no discussion in that call about anything to do with his private life but that the discussion was focused on his professional life.
A Okay.
Q So let me ask you again: You said in that call to

Dr. Wall that he was free to not wear a mask; isn't that correct?

A I think what I said was in regards to his private life. If we -- if I interpreted it differently, or he interpreted it difficulty, or there's misunderstanding there, or I don't know, I think what I was talking about was like I can't -- you know, I can't put a mask on him; all I can do is if he won't comply, I can take an action.

Q So you disagree with me that you said in that call that Dr. Wall --

A I don't have the transcript here, so I wouldn't disagree or agree at all because I'm not -- I don't know exactly the wording that was used.

Q So is your answer that you don't remember?

A No, my answer is that I believe what we were saying was in his personal life, and also that I can't make him do anything. My job is if he refuses to comply, then I take an action in regards to noncompliance.

Q So when Dr. Wall says that there was no mention of private life in that conversation, you're going to disagree with him?

A I don't have an answer to that. Like I said, I don't have a transcript. I don't have the call transcript here. I don't have a record of it, so, you know, it's based on what I remember, and that's it.

Q But you are convinced, are you not, that you --
THE CHAIR: Mr. Kitchen, if I could just interrupt, I believe Mr. Lawrence has indicated what he believes the conversation was about, and you've indicated that you have a witness that will testify differently. I don't know that we can get any more clarification than that.
MR. KITCHEN: Thank you, Chair. The only reason I continue to keep going is I keep getting contradictory answers, so I'm just trying to give the witness an opportunity to remove the contradictory answers.
THE CHAIR: I think he's been consistent in saying what he recalls the conversation was about. Thank you.
MR. KITCHEN: Thank you.
Q MR. KITCHEN: Mr. Lawrence, when Dr. Wall was faced with a choice of either wearing a mask or sacrificing his ability to earn an income as a chiropractor, his choice was not a free choice absent of a coercion, was it?
A I think there were alternatives he could have followed. He could have practiced Telehealth and -- which would have enabled him to continue practice and not wear a mask.
Q When Dr. Wall was faced with a choice of either wearing

a mask or treating his patients in a way that he thought was the only good way to treat them, his choice between those two things was not a free choice absent of coercion, was it?

A I don't agree with the way you're stating that. I think there's, in any mandate of practice, the compliance is obligatory. I think that in probably most cases in the legislation and in all the standards, there may be chiropractors that agree with some and disagree with others, but the obligation is to comply.

Q So that obligation imposes no coercion?

A That would be up to the drafters of the legislation. I think, you know, the compliance is not an option, so if non-optional compliance is coercion, then it's coercion.

Q By requesting the suspension of Dr. Wall's practice permit, you were, in fact, attempting to make Dr. Wall either wear a mask or stop treating patients in person, were you not?

A I think the purpose of that was to safeguard the public and protect the public from harm.

Q And the way that you protect the public from harm in that scenario is by making Dr. Wall either wear a mask when he's treating patients or stop treating patients in person?

A Correct.

Q Now, it was on December 3rd, 2020, that you submitted a request to suspend the practice permit of Dr. Wall; isn't that right?
A Correct.
Q Now, you said earlier it was on the same day, December 3rd, that you called him, correct?
A Yes.
Q So when Dr. Wall told you on that call that he was exempt from wearing a mask on medical -- he was medically exempt, you didn't believe him, did you?
A No, I don't believe that -- under the regulations, the health care workers aren't exempt from masking.
Q You didn't believe that he had a medical condition that exempted him, did you?
A I think that in regards -- from Public Health and the Pandemic Directive, I think that he was noncompliant with his requirements, and there was never an expectation for exemptions for medical health professionals.
Q Didn't ask you that. You didn't believe that he had a medical condition that exempted him from wearing a mask, did you?
A "Believe" is not really an appropriate term. It's compliance with or noncompliance with, and that's what guides the direction.
Q In your assessment, he wasn't being truthful with you?

A That's not what I said, no.
Q So you did believe him; you thought he was being truthful?
A I believe that there was never an expectation for medical health professionals to be exempt, and I believe Dr. Wall was noncompliant with his mandates of practice. You know, truth and not truth, that's not really appropriate I think.
Q Isn't it your job as Complaints Director to assess whether or not chiropractors are telling the truth?
A My job is to apply the legislation and the mandates of practice and hold them accountable when they've been breached.
Q And when you do that, you have to make assessments of whether or not chiropractors are telling you the truth about something; isn't that right?
A I have to look at their actions about what they're doing and whether their actions are compliant or noncompliant with the standards. Whether they lied to me or not, I -- you know, it's more on the actions towards compliance.
Q Isn't lying to the -- isn't lying to you in your capacity as Complaints Director in and of itself something worthy of investigation?
A Potentially, yes.
Q So in your work, you have to make determinations

occasionally on whether or not somebody's telling you the truth, correct?
A Yes.
Q So you made an assessment on December 4th, when Dr. Wall and you had that conversation on the phone, you made an assessment of whether or not he was telling you the truth about his medical exemption?
A No. And I think you're misquoting that. It's not about truth or lying or -- it's about compliance, and so the mandates of practice say, you know, this should happen, and if the actions don't follow those mandates, then that's the direction or the actions they take accordingly. It's not whether Dr. Wall was telling the truth or not. It's about whether he was compliant or not.
Q Well, and he clearly wasn't.
A Wasn't compliant? I agree.
Q Right.
A I agree he was not compliant.
Q So you don't think he had a medical condition that made him medically unable to wear a mask, did you?
A I think the question about the -- whether that is an exemption or not, it will be up to the Tribunal to decide. My position is he was not compliant, and as the Complaints Director, my job is to act when members are not compliant.

Q And I appreciate that, but I didn't (INDISCERNIBLE) --
A I understand what --
Q -- (INDISCERNIBLE) about --
A I understand what you wanted to say was Dr. Wall telling the truth or not, and it's compliance, so it's about whether he was compliant or not.
Q So you believed he was not compliant?
A I believe he was not compliant with his mandates of practice, correct.
Q And you believed he had no medical condition that made him unable to wear a mask?
A I don't know the answer to that.
Q Okay. You thought he was just saying that he was exempt because he didn't want to wear a mask, and he was being ungovernable, didn't you?
A I believe that he was not being compliant because what he was supposed to be doing, and when they're not compliant, members of every regulated health profession are to be held accountable. So this is a compliance question.
Q And you thought he had no medical basis for noncompliance?
A I believe there is no -- there wasn't an expectation for medical health professionals to have an exemption, and he was noncompliant with his expectations of practice.

Q Which is fine, I didn't ask you anything about exemptions.

Now, you received a letter from Dr. Salem, a Calgary medical doctor, stating that Dr. Wall was deemed by that doctor to be medically exempt from wearing a mask; isn't that right?

A Yes.

Q And you would have received that by December 14th; isn't that right?

A Do you mean the letter in follow-up or his December the 12th note?

Q The December the 12th note, you received that by December 14th, did you not?

A Correct.

Q And upon receiving that letter, you decided not to withdraw your request to suspend Dr. Wall's licence; isn't that right?

A Correct.

Q You doubted the accuracy of Dr. Salem's December 12th medical note, didn't you?

A I asked for more information about the condition in a follow-up letter to Dr. Salem.

Q That's not what I asked. So you didn't doubt the accuracy of that note?

A I don't know what you mean by "accuracy". Dr. Salem sent me this note, so I have no doubt to believe it

came from Dr. Salem, and he meant what he said.
Q So you don't doubt the accuracy of that note?
A I think that's accurate.
Q So when you received that note, you just said you decided not to withdraw your request to suspend, it didn't matter to you that Dr. Wall was medically unable to wear a mask, did it?
A At the time, I, as I said before, I don't think there was an expectation for exemptions for people in front-line medical health workers, and Dr. Wall was still not compliant with the Pandemic Directive and the Standards of Practice, so I continued, yes.
Q It didn't matter to you that Dr. Wall had a medical disability that potentially triggered the duty to accommodate in the human rights legislation, did it?
A I'm not familiar enough with human rights legislation to answer that.
Q So you didn't think about potential human rights accommodation after you received that letter?
A I think that in regards to proceeding with the investigation and the complaint, there was still concern about the risk to the public, so I continued with the complaint.
Q Great, that's greet. I didn't ask you that. I asked you if you thought about human rights --
A I --

Q -- (INDISCERNIBLE) --
A -- you -- this is --
Q -- either you did or you didn't.
A This is nine months ago. I don't know what -- every thought that went through my head then.
Q That wasn't important then; must not have been, you forgot about it. So was it important to you to consider human rights at that time or no?
A The consideration was in the protection of the public and the compliance of a regulated member to the mandates of the legislation. So, you know, that's what led to the complaint, that's what led to the Section 65 request, and that's what led to the continuation of the complaint.
Q And nothing else matters, right?
A Well, that's not what I said either, but ...
Q Okay.
A I'll agree with you. How about that?
Q When your December 3rd request for an interim suspension of Dr. Wall's practice permit was denied by Dr. Linford on December 18th, Dr. Linford relied upon Dr. Salem's December 12th doctor note, didn't he?
A You would have to ask Dr. Linford, but that would be a good assumption I think.
Q It's not an assumption. Let's take you over to the December 18th decision of Dr. Linford. That's Exhibit

B-5. I'll give you a chance to pull it up.
MR. MAXSTON: Mr. Kitchen, while Mr. Lawrence is looking for that, I'm going to tell you that I'll object to any questions about what Dr. Linford was thinking. I don't expect you're going to ask those questions because that's not within this witness's knowledge.
MR. KITCHEN: Right, you and I are on the same page there.
THE CHAIR: You said E-5, Mr. Kitchen?
MR. KITCHEN: B-5, 'B' as in Bob.
Q MR. KITCHEN: Now, Mr. Lawrence, do you have that in front of you?
A I do.
Q Now, do you see there, this is the very first paragraph, do you see where Dr. Linford says: (as read)
I have also considered the following?
A Yes.
Q And there's a list there of six things, okay? Then there's a paragraph that starts "I have also considered". Now, so at the very bottom of the page there, it says "Dr. Wall has provided". Do you see that there?
A Yes.
Q Now, this thing that Dr. Wall provided, was it a letter

from a physician, Dr. Salem?
A Yes.
Q And does Dr. Linford describe there what that note was about?
A Yes.
Q Dr. Linford states, I'm reading it here: (as read)

> Dr. Wall has a medical condition that prevents him from wearing a mask or a face shield as required under the CMOH orders.

A Yes.
Q You would agree that I've just read that accurately, correct?
A Yes.
Q So Dr. Linford referred to that note in making his decision; is that correct?
A Yes.
Q Now, in this December 18th decision, I guess we can call it Section 55 request for interim suspension of Dr. Wall's practice permit. So Dr. Linford didn't call it anything in particular, but, it's you would agree with me, that this December 18th document from Dr. Linford is Dr. Linford's written decision on your request, right?
A Yes.
Q So Dr. Linford decided December 18th to permit Dr. Wall to continue to practice in a manner that was

noncompliant with the ACAC Pandemic Directive, didn't he?

A He did until the completion of the complaint under Part 4 of the HPA, so until the complaint is completed, and that, in this case, will be the decision of the Tribunal, so once that is completed, he provided him an avenue to continue to practice.

Q So because of Dr. Linford's decision, Dr. Wall has practiced in a manner noncompliant with the ACAC Pandemic Directive for the last eight months since Dr. Linford's decision; isn't that right?

A Correct.

Q Now, the only two CMOH orders referred by Dr. Linford in his written decision on December 18th are CMOH Orders 38-2020 and 42-2020; isn't that right?

A That's correct.

Q Now, you would agree with me that in early December, December 7th, AHS issued a closure order to Dr. Wall's office, correct?

A That's correct.

Q And that was an oral order, it was followed up by a written order on December 8th; you wouldn't contest that, would you?

A No.

Q Now, you would agree with me that the only CMOH order referred to in that closure order is CMOH Order

38-2020; isn't that right?
A That's correct.
Q You might not have it in front of you, so I'll take you to Exhibit D-2, 'D' as in Deborah, D-2. This is the rescind notice, and I don't know that it has a date on it. It was issued on January 5th. Here it is, January 5th, it's right in the first paragraph.

Now, in that notice re-opening Dr. Wall's office, Dr. Wall was permitted by AHS to practice, to treat patients in person without a mask; isn't that correct?
A That's correct.
Q That January 25th interview that was conducted by phone, you questioned Dr. Wall, was there a transcript or recording of that interview?
A There is.
Q But it hasn't been entered as an exhibit as part of this case though, has it?
A No.
Q So in your investigation report, you discuss at length what Dr. Wall said to you. Those are your own words to describe what Dr. Wall said; isn't that right?
A I lot of it, yes.
Q Forgive me, I'm going to take you back to Dr. Linford's decision just one last time. I don't think you'll have to go there, but we can if we need to. Dr. Linford, in his written decision of December 18th, he did not order

that patients of Dr. Wall must be masked, did he?
A He did not.
Q Mr. Lawrence, you are the de facto complainant in this case; isn't that right?
A That's correct.
Q You appointed yourself as the lead investigator in this case; isn't that right?
A It's correct. Under the Health Professions Act, the Complaints Director becomes the lead investigator, and when other investigators are used, they are assistant investigators, but for this case, yes, I was lead investigator.
Q There's no assistant investigators in this case, is there?
A There is not, no.
Q And just to be clear, you made that appointment, appointing yourself as lead investigator, after opening the complaint and becoming the de facto complainant; isn't that right?
A Yes.
Q Dr. Wall has not harmed any member of the public or any one of his patients by treating them in person without wearing a mask, has he?
MR. MAXSTON: I'm going to object to that, Mr. Chair, that's beyond Mr. Lawrence's knowledge.
THE CHAIR: Agreed.

Q MR. KITCHEN: Mr. Lawrence, do you have any evidence that Dr. Wall has harmed any of his patients?
A I do not.
Q Do you have any evidence that Dr. Wall has harmed a member of the public by not erecting a plexiglass barrier in his office?
A I do not.
Q And just to be clear, you don't have any evidence that any of his patients have been harmed by him treating his patients in person, up close without wearing a mask, do you?
A I do not.
Q No member of the public has complained to the ACAC regarding the conduct of Dr. Wall in the period of time between March 2020 and today; isn't that correct?
A I believe the original concern that came from Public Health was initiated by a patient of Dr. Wall, but the ACAC has not received any, no.
Q The complaint you just referenced went to AHS, correct?
A Correct.
Q Not to the ACAC, correct?
A Correct.
Q And you've received no other complaints to the ACAC about Dr. Wall in the last 18 months, correct?
A Correct.
Q In fact, as far as you're aware, there had never been

any complaints to the ACAC about the conduct of Dr. Wall; is that correct?

A Not that I know of, that's correct.

MR. KITCHEN: Just give me one second. Those are all my questions.

A Thank you.

THE CHAIR: Okay, Mr. Maxston, any redirect, or would you like a few minutes? We can break for 5 or 10 minutes.

MR. MAXSTON: You know, I think I'm okay. I've got a pretty good idea of what I'm going to ask Mr. Lawrence, but I don't know if Mr. Lawrence needs a break or if the Tribunal needs a break. We've been going for just about an hour, so I'm in your hands. I think I will be 15 or 20 minutes, but, again, I'm in your hands.

THE CHAIR: I think that why don't we just break for 10 minutes, and then we can check to see if the Tribunal has any questions arising from the direct and the cross-exam, and we can do both those things while you prepare for your follow-ups, okay? So it's 20 after. Let's take a brief recess, and we'll reconvene at 2:30, and Members of the Tribunal, let's go to a break-out room with our esteemed counsel, and we'll just see if there's any questions arising that we can discuss. Thanks.

(ADJOURNMENT)

THE CHAIR: Okay, we're all back. Just a reminder everybody, the hearing is in session, and Mr. Maxston has some follow-up on the -- following the cross-examination of Mr. Lawrence by Mr. Kitchen.

MR. MAXSTON: Thank you, Mr. Chair.

Mr. Maxston Re-examines the Witness

Q MR. MAXSTON: Mr. Lawrence, you had a discussion with Mr. Kitchen, and his question was would you agree that chiropractors should protect patients from harm no matter what, and I believe your answer was yes. In your role as Complaints Director, do you decide those kinds of issues?

A No.

Q Who does?

A It's the legislation governs what our actions is, and so I'm led by the regulations or mandates of practice. So the drafters of the legislation, and then council also directs the Standards of Practice, Codes of Ethics, the Pandemic Practice Directive, any policies. The council of the ACAC determines how chiropractors will conduct themselves.

Q And a similar question, Mr. Kitchen asked you would you agree that the threat of COVID-19 is more than the threat posed by wearing a mask. Again, as Complaints Director, in your role under Section 55 of the HPA, do

you decide that?
A No.
Q And, again, who does?
A Again, that would be, in this case, I would assume Public Health, and they would set the direction for managing the pandemic during -- or managing COVID during the pandemic, and then council would apply practice directives or practice mandates to the members.
Q Mr. Kitchen asked you a question about when you are assessing whether Dr. Wall was a danger to the public, aren't you making a medical or scientific judgment. Is that the Complaints Director's role, to make a judgment?
A The judgment really is whether the mandates of practice have been complied with or not, and the -- apply the appropriate actions if noncompliance occurs.
Q Do you as Complaints Director make findings of unprofessional conduct?
A I do not.
Q Is that prohibited under the HPA?
A So the -- in this case, the Hearing Tribunal makes the determination of that. I don't assign guilt or innocence. That would be the purview of the Hearing Tribunal.
Q Does a Complaints Director assess a threshold of

evidence?

A No. I think really the role of the investigation is to gather evidence and then present the evidence to the Tribunal, and the Tribunal will determine its value and weight.

Q Okay. Mr. Kitchen asked you or stated there was -- asked you a question about there was no process for a chiropractor to practice without a mask. Were you ever asked by Dr. Wall as Complaints Director about that by Dr. Wall?

MR. KITCHEN: Hold on, hold on. Mr. Maxston, you asked that exact question in direct, and now you're asking it again. That's not a new issue. You're just re-going through your direct when you're asking that question.

MR. MAXSTON: Well, I think you asked whether there was a process for a chiropractor to practice without a mask --

MR. KITCHEN: Yes.

MR. MAXSTON: -- and I'm asking Mr. Lawrence whether he was ever asked --

MR. KITCHEN: Right.

MR. MAXSTON: -- about that process.

MR. KITCHEN: But you've already asked that question. Now you're just asking it again.

MR. MAXSTON: Well, I'm asking whether

Mr. Lawrence was ever asked about that. I'm not asking whether there was one or wasn't. I'm asking was Mr. Lawrence ever asked about the process.

MR. KITCHEN: You're asking if Mr. Lawrence was ever asked by Dr. Wall if there was a process?

MR. MAXSTON: I'll be even -- yeah, I'll be even more precise then.

Q MR. MAXSTON: Were you ever asked by Dr. Wall if there was a process?

MR. KITCHEN: Right, but you asked that in direct. This isn't new. This is redirect; it's new only. That's not --

MR. MAXSTON: Well --

MR. KITCHEN: -- new. You asked him; we have the answer to it.

MR. MAXSTON: Well --

MR. KITCHEN: You're going to get the same answer now, I don't dispute that, but I have an issue with you using redirect as Direct 2.0.

MR. MAXSTON: Well, your question was in the context of a human rights concern, and you then asked whether there was a process to address human rights concerns, and I'm going to ask Mr. Lawrence whether he was ever asked by Dr. Wall if there was a process to address human rights concerns, and that's new.

MR. KITCHEN: Well, I guess -- I don't think

it is. I think you asked something almost identical to that, maybe the exact words were different, but you, in substance, asked that question on the record.

MR. MAXSTON: Yeah, I asked him -- I asked him, Mr. Kitchen, about whether there was an exemption process. I didn't ask him whether someone had raised a human rights concern and asked about an exemption process.

THE CHAIR: I think we've been allowing some latitude in terms of these questions. I think I will allow this question with the inclusion of the specific reference to human rights, if that wording was not part of the first time this was raised.

MR. MAXSTON: So I'll ask a very precise question then.

Q MR. MAXSTON: Mr. Lawrence, did Dr. Wall ever ask you about whether there was a process to address any human rights concerns he had?

A No.

Q In fairness to Mr. Kitchen and his last comment, I'm going to ask a question, but if he thinks it was asked and answered, I'll invite him to refresh my memory.

Did Dr. Wall ever ask you for an exemption?

A No.

MR. KITCHEN: Again, we know the answer to that, but I --

MR. MAXSTON: I'm content to move on, Mr. Kitchen. I'm not going to pursue that any further.
MR. KITCHEN: Okay. Well, I have no issue with new questions, but you're asking the same questions you asked in direct. So regardless of whether we know the answer, whether it's controversial, I take issue with simply asking the same questions.
Q MR. MAXSTON: Mr. Lawrence, Mr. Kitchen asked you whether you refused to debate scientific efficacy of masking with Dr. Wall. Is debating that part of your role under the HPA as Complaints Director?
A It is not.
Q Mr. Kitchen asked you about the 99 percent recovery rate. Is recovery rates part of a charge in the notice of hearing?
A It is not.
Q Mr. Kitchen and you engaged in a discussion about your comment, alleged comment, to Dr. Wall during your telephone conversation where you allegedly said that Dr. Wall was not free to mask, and I believe you responded couldn't comment about his private life. Does the College have jurisdiction over a regulated member's private life in masking?
A It does not.
Q Were you concerned about Dr. Wall's private life and masking?

A No.
Q Mr. Kitchen made some comments to you about Dr. Wall being placed in a position where he could either choose between masking or earning an income, and that wasn't a free choice. Order 16-2020, about the relaunch of the profession, had required masking; is that correct?
A Yes.
Q Was this about a free choice for you as Complaints Director, Dr. Wall's alleged free choice?
A As the Complaints Director, compliance is a necessity or an obligation.
Q Mr. Kitchen engaged in a discussion with you about Section 65, and his words were that you were attempting to require masking or requiring Dr. Wall to force practice -- to stop practicing. Does Section 65 allow for interim suspensions for a member to stop practicing?
A Section 65 allows for an interim suspension, yes.
Q Mr. Kitchen talked about you coercing Dr. Wall into masking or, I guess his alternative, he did not practice; who made the Section 65 decision?
A Dr. Linford.
Q Did you have any involvement in Dr. Linford -- direct involvement talking to Dr. Linford about this decision?
A No.
Q You had a discussion with Mr. Kitchen about whether you

believed that Dr. Wall had a medical exemption. Was your belief relevant?

A No.

Q Can you tell me why?

A The -- my beliefs aren't relevant. The legislation is what's relevant, and so the -- and, sorry, I should clarify, when I say "legislation", what I'm talking about is the mandates of practice, and I just use that term as a catch-all, I guess. So I'm referring to the Standards of Practice, the Code of Ethics, directions that are provided by council for the members to adhere to, and my role is to ensure there is compliance to those requirements.

Q Mr. Kitchen brought you back to the Linford decision after leaving it for a few minutes, and he brought you back to it, do you ultimately decide whether a member's noncompliance is unprofessional conduct?

A I do not.

Q Who does that?

A In this case, it would be the Hearing Tribunal.

Q Did you have to make a determination about exemptions to refer this to hearing?

A No.

Q I'll ask you to go to Dr. Linford's decision letter and specifically page 2. And that again is Exhibit B-5, 'B' as in Bob, dash 5.

A Okay.
Q Just while you're finding that, Mr. Kitchen asked you to confirm a number of statements in this letter by reading them out to you and asking is that Dr. Linford's statement, and I'm going to ask you to go to the paragraph in the middle of page 2 that begins: (as read)

> I have decided that the interim suspension of Dr. Wall's practice permit is not justified at this point in time.

I'm going to read the next sentence to you, and there's a question coming: (as read)

> I have decided the conditions on Dr. Wall's practice permit will be sufficient to address the risk to the public by Dr. Wall not wearing a face mask or face shield when seeing and treating patients.

Is that Dr. Linford's statement?
A Yes.
Q Does he mention a risk to the public?
A Yes.
Q I'm going to ask you to go to the AHS rescind notice, that's the rescinding of the closure of (INDISCERNIBLE), and that is Exhibit D-2, 'D' as in dog.
A Okay.

Q So while everyone is finding that, Mr. Kitchen took you, I believe, to paragraph 3 of the rescind notice. There is a question coming, but paragraph 3 says: (as read)

> Prior to booking an appointment, Dr. Wall must inform the patient he will be unmasked [and so forth].

I'm going to ask you to read Order Number 1 in the rescind notice.

A (as read)

> Dr. Curtis Wall must follow the current re-opening practice guidance as set out by the Alberta College and Association of Chiropractors, as well as all future iterations of this guidance.

Q So the Pandemic Directive, the guidance, did it require masking?

A It did.

Q Is there a contradiction between Order 1 and Order 3 in your mind?

A I believe there is, yes.

MR. MAXSTON: Mr. Chair, this isn't a question, but I'll leave this as a final comment, I want to come back to something about the transcript and discuss that.

Q MR. MAXSTON: Mr. Lawrence, Mr. Kitchen

discussed with you how you decided to, after utilizing Section 56 to create a complaint, that you also acted as investigator. Do you have Section 55(2) of the HPA handy? And it's not crucial that you do, but if you do --

A 55(2)?

Q Yeah.

A Yes.

Q And I'm really looking -- I'm sorry?

A I do, yes.

Q And can you tell me what Section 55(2)(d) as in dog says? And I think you'll have to read the opening line on 55(2) for it to make grammatical sense.

A So 55(2) says: (as read)

> The Complaints Director may ...

And (d) of that says: (as read)

> May conduct or appoint an investigator to conduct an investigation.

Q Did you rely on this section when you conducted the investigation yourself?

A Yes.

Q Is that allowed under the HPA?

A It is.

Q Mr. Kitchen asked you whether you were aware of any other complaints about Dr. Wall's conduct in terms of masking.

MR. KITCHEN: Hold on, that's not what I asked. I did not qualify it in terms of masking.
MR. MAXSTON: Okay, well --
MR. KITCHEN: I left it unqualified.
MR. MAXSTON: Fair enough, well, I'm going to ask the question then a little bit differently.
Q MR. MAXSTON: Mr. Kitchen asked you about whether there were any complaints against -- other complaints against Dr. Wall; is that correct?
A Yes.
Q And I think your response was that you relied on Section 56. Do you need more than one complaint to direct that an investigation occurs?
A I do not.
Q Mr. Kitchen asked you a series of questions about whether you have any evidence of Dr. Wall harming patients because of not masking or social distancing or using plexiglass barriers; is that relevant?
A I don't believe so. I think in a -- when we're looking at compliance, it's not about the outcome, it's the action.
Q When you look at the Notice of Hearing -- the Amended Notice of Hearing, are there any charges about causing harm to patients?
A There is not.
MR. MAXSTON: So, Mr. Chair, I want to go

back to something I was going to address sort of in the tail end of my questions, in the middle of my tail end of my questions.

Q MR. MAXSTON: Mr. Kitchen asked questions about a transcript or a recording of the I believe it's the December 3 telephone conversation and --

A Sorry, I think it was about the interview that Dr. Halowski and I conducted with him.

Q Pardon me, thank you.

MR. MAXSTON: I think, and this is open to the Tribunal more than anything, but -- well, first, you're not bound by the formal Rules of Evidence. If Mr. Lawrence has a recording or a transcript, I think it's open to this Tribunal to ask that he produce it, and that we finish his testimony tomorrow by reviewing that with him.

And I don't think that's unusual or extraordinary. My friend brought up the matter of the transcript. And if you're concerned about what was or wasn't said, and I think Mr. Kitchen is, I think it's fair to ask that that transcript be or recording, whatever it is, be entered as an exhibit, and we finish with Mr. Lawrence tomorrow morning.

So I'm going to ask Mr. Kitchen if he has any comments on that, but my sense is it might clear up a lot of questions.

MR. KITCHEN: I disagree. I don't think it would clear up hardly any questions. I don't object to it coming in as an exhibit. I do object to Mr. Maxston having another opportunity to do a direct examination. That ship has sailed. He's had his opportunity. He's done it. He did not introduce that as an exhibit as part of that or inquire to that. He should not be permitted, it's procedurally unfair to permit him to have another chance to have a direct examination of this witness. We've had a direct, we've had a cross, we've had a re-direct, let's put in the transcript and leave it there.

MR. MAXSTON: I'm not really -- I don't think my re-re-direct, if I was to ask Mr. Lawrence questions about it tomorrow, would be anything other than, Is this a recording, did you make it, or is this a transcript, did you type it up or have someone prepare it. That's all I would want to do. If you're consenting to it being entered as an exhibit, Mr. Kitchen, then I don't intend to ask any further questions about it because I've asked those questions. But it occurred to me that if it's a concern for the Tribunal, they can certainly have it as an exhibit.

MR. KITCHEN: Yeah, I'm fine with it being an exhibit, just not with any further questioning.

MR. MAXSTON: I think what I would -- again,

what I would suggest is that I ask Mr. Lawrence, if that transcript or recording is provided, you know, Is it something you created. And I'd leave that today. I just don't want there to be any question about the bona fides or source of that exhibit. I don't intend to ask him any questions about it other than that.

MR. KITCHEN: Well, you can ask him that question now I mean. If there is a transcript, if one's produced, you can ask him how it was produced, who produced it. I've got no issue to go ahead and ask it now.

MR. MAXSTON: Yeah, and I think I'm only going to do that if we have, (a), the consent from you, Mr. Kitchen, that this can go in and, (b), the Tribunal wanting it to go in. It just struck me, as I was listening to your questions about, you know, what said and what wasn't said, and I heard Mr. Lawrence indicate that there was either a transcript or a recording, I thought, well, why wouldn't we put that to the Tribunal. Not intending to re-examine, that's why I stopped right there and didn't ask a question.

MR. KITCHEN: Well, I tell you what, if there's a transcript, there's a recording. I think the fair thing to do, if the Tribunal agrees, is we put in the transcript as an exhibit but that you provide to me a copy of the audio recording. That sounds fair to me.

MR. MAXSTON: Why don't we do this: I'm going to --

Q MR. MAXSTON: We're digressing here, Mr. Lawrence, with some legalese questions, and they're good questions, but maybe I can ask you a couple of questions, with my friend's consent, about the transcript and the recording, and then we can see how that might or might not go in.

MR. MAXSTON: Would that be fair, Mr. Kitchen?

MR. KITCHEN: Yeah, I think that's okay.

A Can I make one comment about --

Q MR. MAXSTON: Sure.

A -- that? It is a recording not a transcript.

Q Okay. Well, I'll ask you a couple of quick questions about it. Did you make that recording when you had the conversation?

A I did.

Q Has it been altered in any way, to your knowledge?

A It has not.

MR. MAXSTON: Okay, subject to Mr. Kitchen, and I think, in fairness, he should have a chance to ask you some very basic questions about it as well, I think we should provide the recording to the Tribunal and go from there.

THE CHAIR: Can I ask -- and I'll be

frank, we discussed this at our last break and the question as to why it wasn't entered. If it's a recording, is it -- are you proposing, Mr. Maxston, that it be played, or are you proposing that it be transcribed?

MR. MAXSTON: Well, I'm in Mr. Kitchen's hands because I really want to be fair to him. To be honest with you, I think it might be better to have it transcribed and put the recording in so everybody has a chance to look at, you know, both versions of it.

I'm really concerned here with getting this information into your hands. There's nothing devious here. I'm not -- again, in fairness to Mr. Kitchen, I'm not going to ask questions about it. I've asked questions about the discussion before. It just occurred to me that, particularly when I heard his cross-examination, and there were questions about what was said and what wasn't said in this particular conversation, I thought, well, let's just put it in front of you.

And to the extent that helps or hurts my case or helps or hurts Mr. Kitchen's case, well, so be it.

THE CHAIR: It's kind of out of order in terms of normally we get that, and then there's questioning direct and cross. So --

MR. MAXSTON: Well, again, Mr. --

THE CHAIR: Are --
MR. MAXSTON: Oh, I'm sorry.
THE CHAIR: -- we at the point where we've agreed that it could be entered tomorrow morning and that Mr. Maxston and Mr. Kitchen can ask a very -- very pointed questions to establish what it is, it's provenance, and then -- but not its subject?
MR. MAXSTON: I think I probably already did that with Mr. Lawrence. I'm not sure I need to redo that again.
MR. KITCHEN: What about this? We're going to have to come back to hear more evidence at some point, we don't know when, but that's -- we're probably looking at at least a few weeks I'd imagine, unless we can get ourselves all together again soon. Why not -- Mr. Maxston, let me know what you think of this -- why not, in that span of time, because it should be quite a bit of time, the recording is transcribed, and then when that transcription is ready, it gets -- you know, you can send it to me for me to have a look. Presumably, I won't object to it, I don't intend to, unless I see something fishy, which I don't expect to see. It can go in by consent -- well, it can go in by consent from counsel. We can, by consent, suggest that the Tribunal accept it when we reconvene a few weeks down the road to hear the rest of the evidence.

THE CHAIR: I would prefer that. I would much prefer to see a transcription. Then there is no -- since it's not going to be directly the topic of questioning at this point, then there's no panic to get it in tomorrow. Is that fair?

MR. MAXSTON: I didn't think it was providable tomorrow, if that's a word. I'm just suggesting that, you know, it's something that you might be interested in. And I'll be --

THE CHAIR: Who would transcribe it?

MR. MAXSTON: We could send it to a court reporter. We could ask someone internally at the College to do it. I'm a -- I want to make sure that Mr. Kitchen is comfortable with that process. Again --

THE CHAIR: I don't know --

MR. MAXSTON: -- I'm in your hands.

THE CHAIR: -- who has -- who has possession? The College?

A The College.

MR. MAXSTON: I don't --

THE CHAIR: Yeah. Okay, can we leave it with the College to make arrangements to have a transcription prepared?

MR. MAXSTON: (NO VERBAL RESPONSE)

THE CHAIR: Okay.

A Yes.

MR. KITCHEN: Now, I have to raise something. This was Mr. Maxston's idea, I've consented to it. In the event months from now, we get to a point where we're discussing costs, I'm going to object now, make it known, that I will object to the College claiming any costs for this transcription. Because as much as I'm consenting to it going in, it was not my proposal, it was not my idea, it was the College's idea to put it in.

So in the event the Tribunal rules against Dr. Wall, and the College, the Complaints Director seeks costs, I don't consent to the cost of this transcription being added --

THE CHAIR: Okay, that --

MR. KITCHEN: -- to those costs.

THE CHAIR: -- that's a -- your point's made. I think we're getting ahead of ourselves.

MR. MAXSTON: Yeah, and, Mr. Kitchen, let me be honest with you, if you don't think you want this in, then -- I mean it's really for your benefit in a sense, because you haven't questioned your client yet. I'm content to leave it out. I wanted to raise it. You seemed to, rightly so, have some questions about the interaction. If you don't want it to go in for either cost reasons or other reasons, I'm content to just leave things as is.

MR. KITCHEN: I'm indifferent. I'm content to leave it out as well. It sounded like it was your idea to bring it in.
MR. MAXSTON: Well, can I suggest this? Mr. Lawrence is in the sort of awkward position of being both witness and the client who gives me directions. Without discussing the contents of that tape at all or any questions about the discussion, because I can't do that, can I get instructions from him and let you know tomorrow what his preference is?
MR. KITCHEN: That's fine, yeah.
THE CHAIR: Okay, we'll table it till tomorrow.
MR. MAXSTON: Sure.
THE CHAIR: Mr. Maxston, were you finished with your examination -- your redirect?
MR. MAXSTON: Yes, I am. So I don't know if you want to take a break, Mr. Chair, and decide whether you have questions for Mr. Lawrence or you want to go ahead right now, but fine either way.
MR. KITCHEN: Mr. Chair, I propose I have a couple questions for recross. That was a pretty extensive redirect. That was a pretty extensive redirect that I think raised some new issues that I should be entitled to cross on.
MR. MAXSTON: I'm not going to object to

that, Mr. Chair, provided that I get the same courtesy if I have a couple of quick follow-ups on something down the road with my friend's witnesses.

THE CHAIR: Okay, let's proceed.

Mr. Kitchen.

Mr. Kitchen Re-cross-examines the Witness

Q MR. KITCHEN: Mr. Lawrence, just to confirm, you would not initiate an investigation unless there was at least a possibility of professional misconduct; isn't that correct?

A Yes.

Q In your discretion, before you initiate a complaint, you decide if there's actually any likelihood of a finding at the end of professional misconduct; do you not?

A I don't know about if there's a finding, but if -- because there might be what I would consider evidence of professional misconduct and then not a finding, but generally that's correct, yes.

Q You said in answer to Mr. Maxston that you're not concerned about the private life of Dr. Wall; is that correct?

A That's correct.

Q Then it's not likely, given that lack of concern, it's not likely that your comments in the call to Dr. Wall about being free to wear a mask were actually about his

private life?
A What I meant by that when I said that is the concern is, because I don't have any legislative authority over his private life, so that's what I mean, in his private life, he's free to do whatever he chooses; my concern is only as a member of the College.
Q Right, so considering you're only concerned with the professional life of Dr. Wall, it's not likely you would have made that comment about being free to wear a mask only in the context of his private life; it's not likely you discussed his private life at all, correct?
A I don't agree with that, but I believe what I was talking about was, you know, in his private life, he's free to do whatever he decides he wants to do.
Q Dr. Linford disagrees with the ACAC on how to respond to the alleged risk to the public of not wearing a mask, correct?
A I think Dr. Linford's decision was to allow practice with restrictions until the completion of the complaint so that the Tribunal could make a decision on how best to proceed.
Q That's not what he said in his December 18th decision though, is it?
A Well, he said that he directs Dr. Wall's practice permit is subject to the following conditions pending the completion of the process under Part 4 of the

Health Professions Act, and Part 4 is dealing with complaints.

MR. MAXSTON: Mr. Kitchen, I wasn't going to object before, but we are now going back to things you directly asked my client about. This isn't anything new, so --

THE CHAIR: Yeah, I agree.

MR. KITCHEN: I think I just have one more.

Q MR. KITCHEN: So I'm going to the rescind notice. My learned friend asked you a question about -- a redirect question about a contradiction between 1 and 3, between paragraph 1 and paragraph 3 of that rescind notice. Do you recall him asking you that just a few minutes ago?

A Yes.

Q Contradiction being, paragraph 1 says: (as read)

> Dr. Wall must follow the current reopening practice guidance as set out by the ACAC.

And then Section 3 says: (as read)

> Prior to booking an appointment, Dr. Wall must inform the patient he will be unmasked while providing services.

So just to confirm, you think there's a contradiction there, correct?

A Yes.

Q Would you agree that, at least in the short-term, at

least for the last eight months, Dr. Linford does not see a distinction there? That's based on his written decision. I'm not asking about his thought process. Based on his written decision, Dr. Linford doesn't see a distinction there?

MR. MAXSTON: I'm not sure that question can be asked, because that's not something that is even addressed in the Linford decision. So, Mr. Kitchen, I think we've gone about as far as we can here with your recross-examination. I think that goes beyond Dr. Linford -- what Dr. Linford was even talking about, so I'm going to object to that.

MR. KITCHEN: That's fine. That's fine.

Q MR. KITCHEN: Last question, and I only raise this because there seems to be some confusion about how many complaints to the ACAC that have been submitted on behalf of -- or about Dr. Wall.

Mr. Maxston said it doesn't take any more than one complaint against Dr. Wall for there to be a finding of professional misconduct, but just to be clear, there are zero complaints to the ACAC about Dr. Wall's conduct; is that correct?

A Except the one presently opened, that's correct.

Q So the only complaint is the one from yourself, correct?

A That's correct.

Q Okay, good, we're on the same page.

MR. KITCHEN: All right, that's it for me. Discussion

THE CHAIR: Okay, then that will conclude our session for today. We will resume, we'll convene for today and resume 9:00 tomorrow morning.

And I believe Mr. Maxston is finished with his witnesses, so you will have your at least one witness tomorrow morning, Mr. Kitchen?

MR. KITCHEN: I'm going to be calling Dr. Wall tomorrow morning, yes.

THE CHAIR: Okay.

MR. KITCHEN: Just to go back, so maybe I misheard, you don't have any questions then for Mr. Lawrence as the Chair, as the Tribunal?

MR. MAXSTON: I was just going to ask that actually.

THE CHAIR: We have -- we discussed that in the 15-minute break, and, at this point, I will say no.

MR. MAXSTON: Mr. Chair, I just want to make one other comment, Mr. Lawrence was the College's final witness, but you will recall, and I think this is -- there's an understanding amongst everyone here, but I want to just put it on the record again, I believe the Hearing Tribunal gave my client the ability to call a

response witness or response evidence to Mr. Schaefer's expert report. I don't know if that will happen, frankly, but I just want to put on the record that, although the College's -- the Complaints Director's case is closed, there's that one caveat. I don't know if we'll be calling anyone, but I wanted to remind everyone of that.

THE CHAIR: I don't think we'll be doing that tomorrow.

MR. MAXSTON: No, I'm not in a position to do that tomorrow. It would be, frankly, out of order. To use a phrase my friend and I are familiar with, at some point, I might say, Well, before we go on to the next witness, we have to finish up with a Complaints Director witness concerning Mr. Schaefer. Again, I'll let Mr. Kitchen know as soon as we've made any determination on that, but, typically, I'd be saying now, well, the Complaints Director's case is closed, that's accurate with that one caveat.

THE CHAIR: Okay --

MR. KITCHEN: That's fine.

THE CHAIR: -- fair enough. Okay, on behalf of all of us, Mr. Lawrence, thank you very much for your attendance and your testimony today.

A Thank you.

THE CHAIR: You are discharged or

dismissed, I'm not sure which is the appropriate term.

(WITNESS STANDS DOWN)

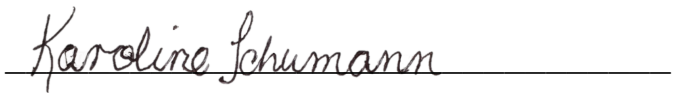
THE CHAIR: And we will, for the rest of those on the hearing call, we will see everybody 9:00 tomorrow morning.

PROCEEDINGS ADJOURNED UNTIL 9:00 AM, SEPTEMBER 8, 2021

CERTIFICATE OF TRANSCRIPT:

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

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



Karoline Schumann, CSR(A)
Official Court Reporter

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

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September 1, 2021 Afternoon Session

HEARING TRIBUNAL

J. Lees	Tribunal Chair
W. Pavlic	Internal Legal Counsel
Dr. L. Aldcorn	ACAC Registered Member
Dr. D. Martens	ACAC Registered Member
D. Dawson	Public Member
A. Nelson	ACAC Hearings Director

ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

D. Lawrence	ACAC Complaints Director
B.E. Maxston, QC	ACAC Legal Counsel

FOR DR. CURTIS WALL

J.S.M. Kitchen	Legal Counsel

K. Schumann, CSR(A) Official Court Reporter

(PROCEEDINGS RECOMMENCED AT 1:03 PM)

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

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

THE WITNESS: Sure.

DR. JIA HU, Sworn, Examined by Mr. Maxston

(Qualification)

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

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

A Yeah, Jia Hu.

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

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

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

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

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

A I am.

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

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

Q And those would be COVID-related?

A Yeah.

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

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

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

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

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

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

Also quite a lot of articles on sort of like lab

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A Yeah.

Q -- was involved there?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A Yeah.

Q -- two entries there?

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

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

to like carve out strategic direction and overall objectives.

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

Q Okay. Thank you very much.

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

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

MR. KITCHEN: Can you hear me?

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

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

THE CHAIR: Yeah.

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

to have some issues with how long that is?

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

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

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

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

MR. MAXSTON: I think I said preventive measures.

MR. KITCHEN: And other preventative measures.

MR. MAXSTON: Measures, yeah.

Mr. Kitchen Cross-examines the Witness (Qualification)

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

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

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

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

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

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

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

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

A Oh, okay.

Q Do you dispute that?

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

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

A Yes. Absolutely.

Q And you agree that some of this funding comes from

manufacturers of COVID vaccines, do you not?
A Yeah, some does. I would say most doesn't, but some does.
Q If everyone decided tomorrow that COVID-19 was not really that big of a deal and that we should all go back to life as we knew it before 2020, you'd have a lot less research funding, wouldn't you?
A Yeah, that's true.
Submissions by Mr. Kitchen (Qualification)
MR. KITCHEN: Those are my questions. I'll just briefly make some submissions on the qualification.

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

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

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

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

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

Mr. Maxston Re-examines the Witness (Qualification)

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

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

A Yes, for sure.

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

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

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

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

Mr. Kitchen Re-cross-examines the Witness

(Qualification)

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

A M-hm.

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

A Okay.

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

A Okay, that's fine.

MR. MAXSTON: Mr. Chair, I think, Mr. Kitchen, you're finished, I can --

MR. KITCHEN: Yes, I am.

Discussion

MR. MAXSTON: Yeah, thank you, yeah.

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

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

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

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

THE CHAIR: Okay, thank you, gentlemen. I

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

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

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

A Thank you.

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

A Okay.

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

A Great, thank you.

(ADJOURNMENT)

Ruling (Qualification)

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

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

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

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

THE CHAIR: That's --

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

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

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

MR. MAXSTON: Thank you, Mr. Chair.

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

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

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

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

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

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

than --

Q Outbreaks?

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

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

A Yes.

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

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

Q And again --

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

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

A Yes.

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

A Yes.

Q Can you describe that?

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

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

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

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

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

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

A Yes.

Q Can you describe that to me?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CMOH 38-2020.

A Yeah. This is CMOH 42?

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

A Okay.

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

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

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

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

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

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

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

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

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

includes the city of Calgary.

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

A Correct.

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

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

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

A Yes, yes, must, correct.

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

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

Are you familiar with that exemption?

A I am.

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

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

Exhibit D-9, and it is dated December 11, 2020.
THE CHAIR: Mr. Maxston, you said the date on D-9 was --
MR. MAXSTON: I think, Mr. Chair, I'm looking at page 9, it says December 11th, 2020.
THE CHAIR: Okay.
Q MR. MAXSTON: Okay, so, Dr. Hu, I'm looking at Exhibit D-9 then, CMOH Order 42-20, and there's a final "whereas" paragraph --
MR. MAXSTON: -- and, Mr. Kitchen, there's a question coming --
Q MR. MAXSTON: -- whereas having determined that measures in CMOH Order 38-2020 are insufficient to protect Albertans. Is -- to your understanding, was CMOH Order 42-2020 to strengthen masking and other measures?
A The primary reason for CMOH Order 42, so I'm going to wind this back, this is now November, December of last year when we were hitting about 2,000 cases a day, making us, at the time and as today, the hot (INDISCERNIBLE) sort of case count per capita jurisdiction in Canada, quite a long measure.
The original CMOH order had this sort of mask -- like a -- I say mandated masking in areas of the province with relatively high case counts, you know, primarily in the urban areas, Edmonton and Calgary,

Edmonton in particular.

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

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

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

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

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

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

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

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

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

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

A Could you repeat that question?

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

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

Q Provided that the CMOH orders were complied with?

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

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

A Okay, let me pull it up.

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

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

MR. KITCHEN: F-2.

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

MR. KITCHEN: Thank you.

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

(DISCUSSION OFF THE RECORD)

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

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

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

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

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

So that basically summarized this. So part of --

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

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

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

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

A M-hm.

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

A Yes, I can. Oh, sorry --

Q It starts off with "All staff providing".

A Yeah: (as read)

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

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

Q So this is --

A (INDISCERNIBLE)

Q Oh, sorry.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Is this a check and a balance?

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

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

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

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

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

A M-hm.

Q -- under this order?

A Yes.

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

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

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

A Yes, I believe so.

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

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

That's mandatory language?

A Yes, I think so.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. MAXSTON: Yeah --

THE CHAIR: -- 'C' folder?

MR. MAXSTON: -- C-22.

THE CHAIR: C-22, thank you.

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

MR. MAXSTON: Yeah.

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

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

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

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

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

MR. KITCHEN: I have no issue with that.

MR. MAXSTON: Yeah, okay.

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

A Yeah.

Q -- Pandemic Directive.

A Yeah, I'm there.

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

A M-hm.

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

requirements, are those acceptable, are those warranted?

A Yes.

Q Can you tell me why?

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

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

A Yes.

Q Can you tell me why?

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

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

You see more to another (INDISCERNIBLE)

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

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

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

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

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

Q MR. MAXSTON: -- Dr. Hu, I'll just ask you to call up my email to you which had those three documents attached.
A Yeah.
THE CHAIR: Everybody have them? I think we're good.
Q MR. MAXSTON: Okay, I'm just going to go to the first document, which is -- sorry, open my documents, my apologies.

The first document, which is "AHS Guidelines For Continuous Masking". It's kind of got a grey border or a grey heading, and it starts off with the word "Purpose". Do you have that in front of you, Dr. Hu?
A I do.
Q In the "Background" section, there's a reference to the "Public Health Agency of Canada". Can you please comment on the statements in the AHS guidelines and what they say about PHAC?
A Yeah, so basically "Background", there's evidence that asymptomatic, presymptomatic, or minimally symptomatic patients, that's like, let's say, a super -- like very like subtle runny nose, for example, can transmit COVID-19.

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

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

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

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

Do you agree with the statements in this document?

A Definitely, yes.

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

A Yeah. I have that.

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

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

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

Do you agree with that statement?

A Yes.

Q Can you tell me why?

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

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

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

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

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

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

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

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

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

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

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

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

On page 1 of that document --

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

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

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

Can you describe this dual purpose of masking?

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

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

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

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

A Yes.

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

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

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

A M-hm.

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

opinions consistent with those, to your knowledge, consistent with those of Alberta Health Services?
A Yes.
Q Are they consistent with the Public Health Agency of Canada?
A Yes.
Q And are they consistent with the Chief Medical Officer of Health's office?
A Yes.
Q Okay, your report is dated July 28th, '21. Since you've prepared your report, have you had any changes in terms of your opinions or conclusions?
A No.
Q Your report begins with a "Purpose" section, and I'll ask you just to briefly describe, again, what your purpose was and what the conclusion you reach at the end of this paragraph.
A Yes, the purpose of this report really is to talk about the -- the benefits or the effects of mask wearing to reduce the transmission of COVID-19 generally but specifically in the health care setting, and conclude that there is, frankly, an overwhelming body of evidence that supports that wearing masks does reduce COVID-19 transmission particularly in a health care setting.
Q There's a list of citations at the end of your report,

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

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

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

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

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

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

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

A Extremely high.

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

A I did, yes.

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

A No.

Q Okay, well, we'll get into those in a little while.
I'm looking at the "Introduction" section in paragraph 1, and you talk about: (as read)
Mask wearing, among other measures such as physical distancing, were clearly and demonstrably effective.
Why did you use those terms? What do they mean?
A You know, I get the sense the sometimes I used words that may have a legal implication. Again, I'm not (INDISCERNIBLE) of that, but, I mean, I just -- you know, clearly it means, obviously, demonstrably I sometimes throw that in and -- and, sorry, like and sometimes I change my language, and, you know, you catch onto words like "must", when I'm like, oh, I just, you know, use that, sometimes I don't.
But at the end of the day, you know, like what I'll say is that there -- again, I sound like a broken record, but like an overwhelming amount of evidence showing that masks reduce transmission in -- especially in a health care worker setting.
Q And I'll be clear for my questions, in as much as I'll invite your comments, I suppose, on legal use of terminology, I'm asking you questions from a clinical perspective --
A Oh --
Q -- and your training and knowledge in your field --

A Yeah, sorry, sorry, I misunderstood. I'll stop --
Q No --
A -- (INDISCERNIBLE) --
Q -- that's fine. The next paragraph says: (as read)

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

Is this is the dual affect we were just talking about before?
A Yes.
Q The next paragraph talks about the use of masks and other nonpharmaceutical interventions being recommended by World Health Organization. Can you tell me about the -- bear with me -- you talk about the use of masks, sorry, in SARS and influenza. Can you talk about the, briefly, the historical experience recently with the use of masks?
A Yes. And I apologize, again, to Karoline, I keep on talking over Blair, and I said I wouldn't, and I've really sorry about that.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And then: (as read)

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

What are you trying to communicate in that paragraph, Dr. Hu?

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

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

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

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

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

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

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

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

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

Q I'm looking at the next --

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

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

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

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

A Yeah.

MR. KITCHEN: Okay, that's fine.

Q MR. MAXSTON: The next paragraph in your report, Dr. Hu, says: (as read)

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

Can you comment on why physical distancing is important?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I take it that's still your conclusion?

A Yes.

Q And what's an AMSTAR rating?

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

Q Thank you.

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

think I'll be able to be finished with Dr. Hu today on that timeline.

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

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

(ADJOURNMENT)

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

So I'll turn it back to you, Mr. Maxston.

MR. MAXSTON: Thank you, Mr. Chair.

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

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

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

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

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

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

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

Q In the next paragraph, you talk about: (as read)
The evidence of the importance of mask use among HCWs is very robust, and there is an overwhelming body of evidence supporting the use of masking in health care settings to reduce COVID transmission.
Again, clinically, why did you choose the words "robust" and "overwhelming body of evidence"?
A This is -- I like to use the word "robust" once in a while. I could have used the word "strong". When I say "overwhelming", I just mean there's like lots of studies on it. You know, rarely do you have dozens and dozens of studies on the same thing, reporting the same, you know, benefit over and over again. I mean, not all the studies show the exact same benefit, but, yeah, like there's just like a ton of -- heaps, mounds of evidence.
Q In the couple paragraphs down, you talk about a study relating to the Massachusetts health care system that was reported in the Journal of the American Medical Association with -- I think involving 75,000 employees. Can you talk about the importance of that study?
A Yeah, so I mean this is just one of the sort of many studies. This is a fairly large study, right, I would say, given the sample size of the health care workers.
But, you know, essentially this study looks at,

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

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

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

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

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

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

A Yes.

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

your testimony, are using masks perfect?
A No. Nothing is perfect. Vaccines aren't perfect, seatbelts aren't perfect. There's nothing that is perfect, but it reduces transmission, and that's -- you know, by a fairly substantial amount, so -- but they aren't perfect.
Q I'm going to take you to the next part of your report, which is your response to the statements by the other experts, Drs. Warren, Dang, and Bridle, and I'm going to ask you about Mr. Schaefer's expert report, but that, of course, came in after you prepared this document.

When I took you through your report, we talked about a series of phrases, randomized control trials, the AMSTAR rating, the quality peer-reviewed evidence, systematic reviews, I think we talked about meta-analysis. Bearing that in mind as a reference and remembering the Journal of the American Medical Association and Lancet, how would you characterize the documents and studies cited by Drs. Warren, Dang, and Bridle?
A Yeah, so I mean a few comments, and one is that, you know, I -- when I read the reports, a lot of the reports sort of aren't necessarily specifically about masking in a health care setting and its effect on COVID-19, right? It's about like how bad COVID is or

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

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

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

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

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

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

institutions in the citations from the three other expert reports?

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

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

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

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

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

Can you comment on your thoughts to that statement?

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

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

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

Q Okay.

A -- 1 percent.

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

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

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

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

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

Do their reports not relate to health care settings?

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

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

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

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

Dr. Bridle argues that masking is not helpful

given the aerosol route of transmission.
And then a quote, and then you've got a paragraph about your response. Can you talk about your response in aerosol transmission?
A Yeah, and I sort of spoke about aerosol transmission a bit earlier, right, versus contact and droplet. I'll rehash that, I mean I think that -- people I think are perhaps under the impression that something that is airborne or has an aerosol -- airborne and aerosol have different -- just think of transmission occurring on a spectrum, right, where most of it happens within 2 metres through the cough -- like respiratory droplets, you know, like me talking on you, Mr. Maxston, and sometimes it can like aerosolize, which is probably defined as it staying in the air for an extended period of time or going beyond 2 metres.
Now, again, very hard to pin down the proportion of transmission due to aerosol spread versus contact and droplet spread, but we think it's pretty low. And, again, like it's just like none of those things matter in the face of the hefty evidence that shows once people start putting on masks in health care settings, transmission goes down, right. Like that is the -- that's all you need.
Q You've got a paragraph that begins: (as read)
Dr. Bridle's critique of how well masks fit

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

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

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

Why do you say that?

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

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

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

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

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

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

> Lastly, both Dr. Dang and Dr. Bridle make unsubstantiated claims that there are "numerous harms associated with masking".

And then you say: (as read)

> There are no known harms associated with masking.

Can you explain that?

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

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

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

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

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

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

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

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

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

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

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

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

MR. MAXSTON: And I just want to, Mr. Chair, be clear to the Tribunal that in asking these questions

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

Q MR. MAXSTON: You had a chance to read Mr. Schaefer's report?

A M-hm, yeah.

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

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

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

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

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

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

A No. For COVID transmission, no.

Q Yeah, for COVID and --

A No, no.

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

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

lots of areas to debate, you know.

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

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

Discussion

MR. MAXSTON: Okay, well, thank you, Dr. Hu.

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

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

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

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

My intention would be, after the completion of Dr. Hu, to have Dr. Halowski testify.

MR. KITCHEN: That's fine with me.

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

A Yes.

THE CHAIR: -- continue?

A Yes.

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

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

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

CERTIFICATE OF TRANSCRIPT:

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

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

Karoline Schumann

Karoline Schumann, CSR(A)
Official Court Reporter

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

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September 1, 2021 Afternoon Session

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W. Pavlic	Internal Legal Counsel
Dr. L. Aldcorn	ACAC Registered Member
Dr. D. Martens	ACAC Registered Member
D. Dawson	Public Member
A. Nelson	ACAC Hearings Director

ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

D. Lawrence	ACAC Complaints Director
B.E. Maxston, QC	ACAC Legal Counsel

FOR DR. CURTIS WALL

J.S.M. Kitchen	Legal Counsel

K. Schumann, CSR(A) Official Court Reporter

(PROCEEDINGS RECOMMENCED AT 1:03 PM)

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

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

THE WITNESS: Sure.

DR. JIA HU, Sworn, Examined by Mr. Maxston

(Qualification)

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

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

A Yeah, Jia Hu.

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

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

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

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

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

A I am.

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

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

Q And those would be COVID-related?

A Yeah.

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

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

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

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

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

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

Also quite a lot of articles on sort of like lab

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A Yeah.

Q -- was involved there?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A Yeah.

Q -- two entries there?

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

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

to like carve out strategic direction and overall objectives.

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

Q Okay. Thank you very much.

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

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

MR. KITCHEN: Can you hear me?

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

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

THE CHAIR: Yeah.

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

to have some issues with how long that is?

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

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

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

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

MR. MAXSTON: I think I said preventive measures.

MR. KITCHEN: And other preventative measures.

MR. MAXSTON: Measures, yeah.

Mr. Kitchen Cross-examines the Witness (Qualification)

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

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

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

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

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

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

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

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

A Oh, okay.

Q Do you dispute that?

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

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

A Yes. Absolutely.

Q And you agree that some of this funding comes from

manufacturers of COVID vaccines, do you not?
A Yeah, some does. I would say most doesn't, but some does.
Q If everyone decided tomorrow that COVID-19 was not really that big of a deal and that we should all go back to life as we knew it before 2020, you'd have a lot less research funding, wouldn't you?
A Yeah, that's true.
Submissions by Mr. Kitchen (Qualification)
MR. KITCHEN: Those are my questions. I'll just briefly make some submissions on the qualification.

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

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

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

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

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

Mr. Maxston Re-examines the Witness (Qualification)

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

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

A Yes, for sure.

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

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

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

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

Mr. Kitchen Re-cross-examines the Witness

(Qualification)

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

A M-hm.

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

A Okay.

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

A Okay, that's fine.

MR. MAXSTON: Mr. Chair, I think, Mr. Kitchen, you're finished, I can --

MR. KITCHEN: Yes, I am.

Discussion

MR. MAXSTON: Yeah, thank you, yeah.

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

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

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

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

THE CHAIR: Okay, thank you, gentlemen. I

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

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

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

A Thank you.

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

A Okay.

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

A Great, thank you.

(ADJOURNMENT)

Ruling (Qualification)

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

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

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

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

THE CHAIR: That's --

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

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

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

MR. MAXSTON: Thank you, Mr. Chair.

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

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

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

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

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

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

than --

Q Outbreaks?

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

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

A Yes.

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

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

Q And again --

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

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

A Yes.

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

A Yes.

Q Can you describe that?

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

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

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

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

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

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

A Yes.

Q Can you describe that to me?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CMOH 38-2020.

A Yeah. This is CMOH 42?

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

A Okay.

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

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

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

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

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

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

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

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

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

includes the city of Calgary.

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

A Correct.

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

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

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

A Yes, yes, must, correct.

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

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

Are you familiar with that exemption?

A I am.

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

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

Exhibit D-9, and it is dated December 11, 2020.
THE CHAIR: Mr. Maxston, you said the date on D-9 was --
MR. MAXSTON: I think, Mr. Chair, I'm looking at page 9, it says December 11th, 2020.
THE CHAIR: Okay.
Q MR. MAXSTON: Okay, so, Dr. Hu, I'm looking at Exhibit D-9 then, CMOH Order 42-20, and there's a final "whereas" paragraph --
MR. MAXSTON: -- and, Mr. Kitchen, there's a question coming --
Q MR. MAXSTON: -- whereas having determined that measures in CMOH Order 38-2020 are insufficient to protect Albertans. Is -- to your understanding, was CMOH Order 42-2020 to strengthen masking and other measures?
A The primary reason for CMOH Order 42, so I'm going to wind this back, this is now November, December of last year when we were hitting about 2,000 cases a day, making us, at the time and as today, the hot (INDISCERNIBLE) sort of case count per capita jurisdiction in Canada, quite a long measure.
The original CMOH order had this sort of mask -- like a -- I say mandated masking in areas of the province with relatively high case counts, you know, primarily in the urban areas, Edmonton and Calgary,

Edmonton in particular.

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

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

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

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

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

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

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

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

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

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

A Could you repeat that question?

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

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

Q Provided that the CMOH orders were complied with?

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

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

A Okay, let me pull it up.

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

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

MR. KITCHEN: F-2.

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

MR. KITCHEN: Thank you.

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

(DISCUSSION OFF THE RECORD)

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

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

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

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

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

So that basically summarized this. So part of --

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

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

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

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

A M-hm.

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

A Yes, I can. Oh, sorry --

Q It starts off with "All staff providing".

A Yeah: (as read)

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

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

Q So this is --

A (INDISCERNIBLE)

Q Oh, sorry.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Is this a check and a balance?

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

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

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

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

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

A M-hm.

Q -- under this order?

A Yes.

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

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

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

A Yes, I believe so.

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

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

That's mandatory language?

A Yes, I think so.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. MAXSTON: Yeah --

THE CHAIR: -- 'C' folder?

MR. MAXSTON: -- C-22.

THE CHAIR: C-22, thank you.

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

MR. MAXSTON: Yeah.

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

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

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

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

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

MR. KITCHEN: I have no issue with that.

MR. MAXSTON: Yeah, okay.

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

A Yeah.

Q -- Pandemic Directive.

A Yeah, I'm there.

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

A M-hm.

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

requirements, are those acceptable, are those warranted?

A Yes.

Q Can you tell me why?

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

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

A Yes.

Q Can you tell me why?

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

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

You see more to another (INDISCERNIBLE)

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

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

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

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

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

Q MR. MAXSTON: -- Dr. Hu, I'll just ask you to call up my email to you which had those three documents attached.
A Yeah.
THE CHAIR: Everybody have them? I think we're good.
Q MR. MAXSTON: Okay, I'm just going to go to the first document, which is -- sorry, open my documents, my apologies.

The first document, which is "AHS Guidelines For Continuous Masking". It's kind of got a grey border or a grey heading, and it starts off with the word "Purpose". Do you have that in front of you, Dr. Hu?
A I do.
Q In the "Background" section, there's a reference to the "Public Health Agency of Canada". Can you please comment on the statements in the AHS guidelines and what they say about PHAC?
A Yeah, so basically "Background", there's evidence that asymptomatic, presymptomatic, or minimally symptomatic patients, that's like, let's say, a super -- like very like subtle runny nose, for example, can transmit COVID-19.

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

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

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

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

Do you agree with the statements in this document?

A Definitely, yes.

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

A Yeah. I have that.

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

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

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

Do you agree with that statement?

A Yes.

Q Can you tell me why?

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

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

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

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

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

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

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

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

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

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

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

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

On page 1 of that document --

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

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

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

Can you describe this dual purpose of masking?

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

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

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

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

A Yes.

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

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

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

A M-hm.

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

opinions consistent with those, to your knowledge, consistent with those of Alberta Health Services?
A Yes.
Q Are they consistent with the Public Health Agency of Canada?
A Yes.
Q And are they consistent with the Chief Medical Officer of Health's office?
A Yes.
Q Okay, your report is dated July 28th, '21. Since you've prepared your report, have you had any changes in terms of your opinions or conclusions?
A No.
Q Your report begins with a "Purpose" section, and I'll ask you just to briefly describe, again, what your purpose was and what the conclusion you reach at the end of this paragraph.
A Yes, the purpose of this report really is to talk about the -- the benefits or the effects of mask wearing to reduce the transmission of COVID-19 generally but specifically in the health care setting, and conclude that there is, frankly, an overwhelming body of evidence that supports that wearing masks does reduce COVID-19 transmission particularly in a health care setting.
Q There's a list of citations at the end of your report,

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

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

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

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

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

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

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

A Extremely high.

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

A I did, yes.

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

A No.

Q Okay, well, we'll get into those in a little while.
I'm looking at the "Introduction" section in paragraph 1, and you talk about: (as read)
Mask wearing, among other measures such as physical distancing, were clearly and demonstrably effective.
Why did you use those terms? What do they mean?
A You know, I get the sense the sometimes I used words that may have a legal implication. Again, I'm not (INDISCERNIBLE) of that, but, I mean, I just -- you know, clearly it means, obviously, demonstrably I sometimes throw that in and -- and, sorry, like and sometimes I change my language, and, you know, you catch onto words like "must", when I'm like, oh, I just, you know, use that, sometimes I don't.
But at the end of the day, you know, like what I'll say is that there -- again, I sound like a broken record, but like an overwhelming amount of evidence showing that masks reduce transmission in -- especially in a health care worker setting.
Q And I'll be clear for my questions, in as much as I'll invite your comments, I suppose, on legal use of terminology, I'm asking you questions from a clinical perspective --
A Oh --
Q -- and your training and knowledge in your field --

A Yeah, sorry, sorry, I misunderstood. I'll stop --
Q No --
A -- (INDISCERNIBLE) --
Q -- that's fine. The next paragraph says: (as read)

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

Is this is the dual affect we were just talking about before?
A Yes.
Q The next paragraph talks about the use of masks and other nonpharmaceutical interventions being recommended by World Health Organization. Can you tell me about the -- bear with me -- you talk about the use of masks, sorry, in SARS and influenza. Can you talk about the, briefly, the historical experience recently with the use of masks?
A Yes. And I apologize, again, to Karoline, I keep on talking over Blair, and I said I wouldn't, and I've really sorry about that.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And then: (as read)

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

What are you trying to communicate in that paragraph, Dr. Hu?

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

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

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

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

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

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

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

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

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

Q I'm looking at the next --

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

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

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

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

A Yeah.

MR. KITCHEN: Okay, that's fine.

Q MR. MAXSTON: The next paragraph in your report, Dr. Hu, says: (as read)

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

Can you comment on why physical distancing is important?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I take it that's still your conclusion?

A Yes.

Q And what's an AMSTAR rating?

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

Q Thank you.

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

think I'll be able to be finished with Dr. Hu today on that timeline.

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

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

(ADJOURNMENT)

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

So I'll turn it back to you, Mr. Maxston.

MR. MAXSTON: Thank you, Mr. Chair.

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

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

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

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

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

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

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

Q In the next paragraph, you talk about: (as read)
The evidence of the importance of mask use among HCWs is very robust, and there is an overwhelming body of evidence supporting the use of masking in health care settings to reduce COVID transmission.
Again, clinically, why did you choose the words "robust" and "overwhelming body of evidence"?
A This is -- I like to use the word "robust" once in a while. I could have used the word "strong". When I say "overwhelming", I just mean there's like lots of studies on it. You know, rarely do you have dozens and dozens of studies on the same thing, reporting the same, you know, benefit over and over again. I mean, not all the studies show the exact same benefit, but, yeah, like there's just like a ton of -- heaps, mounds of evidence.
Q In the couple paragraphs down, you talk about a study relating to the Massachusetts health care system that was reported in the Journal of the American Medical Association with -- I think involving 75,000 employees. Can you talk about the importance of that study?
A Yeah, so I mean this is just one of the sort of many studies. This is a fairly large study, right, I would say, given the sample size of the health care workers.
But, you know, essentially this study looks at,

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

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

> If we look closer to home in Alberta, there is clear evidence of benefit to mask wearing in the health care settings.

And then you go on to make some comments about -- I guess in support of that statement. Can you summarize what you're saying there?

A Yeah, yeah, this is back to sort of like what I said earlier about the COVID ward example, and then so I won't rehash that -- sorry, I jumped around a bit -- but COVID wards, no vaccine, masks only really, and it worked pretty darn well.

Q And I think, in fact, you refer in that paragraph to over tens of thousands of interactions between COVID-19 infectious patients and health care workers, and there being only a handful of transmission events. Does that support your opinion in this report?

A Yes.

Q I want to ask you in terms of your expert report and

your testimony, are using masks perfect?
A No. Nothing is perfect. Vaccines aren't perfect, seatbelts aren't perfect. There's nothing that is perfect, but it reduces transmission, and that's -- you know, by a fairly substantial amount, so -- but they aren't perfect.
Q I'm going to take you to the next part of your report, which is your response to the statements by the other experts, Drs. Warren, Dang, and Bridle, and I'm going to ask you about Mr. Schaefer's expert report, but that, of course, came in after you prepared this document.

When I took you through your report, we talked about a series of phrases, randomized control trials, the AMSTAR rating, the quality peer-reviewed evidence, systematic reviews, I think we talked about meta-analysis. Bearing that in mind as a reference and remembering the Journal of the American Medical Association and Lancet, how would you characterize the documents and studies cited by Drs. Warren, Dang, and Bridle?
A Yeah, so I mean a few comments, and one is that, you know, I -- when I read the reports, a lot of the reports sort of aren't necessarily specifically about masking in a health care setting and its effect on COVID-19, right? It's about like how bad COVID is or

how not bad COVID is, and those things, right. And I mean, I won't comment on that, I'm just saying that stuff isn't directly salient to what we're talking about today.

I think when it comes to some of the studies they cite on masking, they -- you know, like they used studies that were sort of before, the pre-COVID era, and, again, I think that all I'm definitively saying is that masking is very good for COVID-19, probably works for other respiratory viruses, but like the overwhelming body of evidence is for masking for COVID-19. And I think these lot of older studies, you know, I think they do comment on the lack of, one of them, randomized control trials, but, again, I use my example of sometimes we can't do RCTs, like, you know, the parachute example. There's a lot of things we can't do RCTs, randomized control trials, for.

And then they use kind of -- you know, they use kind of like these -- like there's all sorts of lab studies, that, you know, some of them show these pictures of how masks are imperfect, and, you know, even if you have a mask, there's sort of like leakage, so to speak, right. And that's true, and masks are not perfect, right. We know that, you know, how well you put on your mask matters, how well the mask fits matters, all these things matter.

But, you know, the type of evidence that I think is the most compelling in this is what I call like an epidemiological study, that is a type of observational study that basically shows that, you know, in places where we implement the masking, like transmissions drop, right. And, you know, regardless of how imperfect they are, the net end result, which we care about, transmission or numbers of infections goes down.

And so I would, you know, essentially say that what their reports, to summarize, one, a lot of them don't talk about masking, so maybe not directly salient. Two, they refer to some -- a few studies, but they're pre-COVID, and so like it doesn't really matter. Like, again, like I only care about COVID studies and masks. And three, they comment on the imperfection of masking, and I don't disagree with the fact that masks are imperfect, but there's an update that shows masks do reduce transmission, and that's what we're interested in, that's what I'm interested in when, you know, I'm going around telling people to where masks in health care settings.

Q I asked you during my -- some questions a while ago about your level of confidence in the studies and reports that you had cited, and I think you said your level of confidence was high, and you referred to highly regarded institutions. Do you see those same

institutions in the citations from the three other expert reports?

A No. I mean, like basically, as you probably all know, like every Public Health organization recommends masking in a health care setting, right? We talked about some of them AHS, like PHAC, the Public Health Agency of Canada, US CDC, like all the ministries do -- and so I don't because they all recommend masking.

Q You've got a statement that your first comment here is in relation to Dr. Warren's statement about the risk of death due to COVID-19 in persons under 60 is very small, and you've got a response to that. Can you please comment on that response, what it means?

A Yeah. I mean, I think that this is an example of the statement is not directly salient to our discussion, right, which is that, you know, he's saying that not a lot of young people die from COVID. And it's true that if you're over, let's say, 80, your risk of dying from COVID is very, very, very high, but, you know, plenty of people under 60 have died in Canada, 1475 since June 2021. I think about 3,000 people under 18 in the United States have died of COVID. And so I acknowledge that COVID is less likely to kill you if you're young, I also acknowledge that COVID can kill you if you're young, but, lastly, like this doesn't -- it's not relevant.

Q Okay, I'm going to take you to your next comment where you've quoted Dr. Warren's report by saying: (as read)

> Asymptomatic transmission does occur, but the rates of transmission from asymptomatic persons is substantially less than from symptomatic persons and does not warrant being considered a significant contributor to the overall transmission burden.

Can you comment on your thoughts to that statement?

A Yeah, so I mean I think that maybe what he's saying, you know, asymptomatic transmission is not a big part of, you know, overall COVID transmission, asymptomatic or symptomatic. And I -- again, I acknowledge that people who are symptomatic are at -- more likely to transmit, you know, pound for pound than people who are asymptomatic. But that being said, you know, viral loads are actually the highest two days before symptom onset than -- for what it's worth.

Actually nailing down the proportionate transmission that's from asymptomatic versus symptomatic is actually quite difficult to do, and so I cite the CDC report saying it's about 60 percent. I mean, other -- the lowest found estimate that I've seen around asymptomatic transmission as a portion of total transmission is probably around 20 percent, right. And so whether it's 20 percent, whether it's 60 percent,

those are significant numbers, so, you know, it's not like --

Q Okay.

A -- 1 percent.

Q There's another quotation here from Dr. Bridle's report that begins with "Testing of asymptomatic people", and there's a four or five-line quote there, and then you've got another response there. Can you explain your response to what Dr. Bridle is saying?

A Yeah, I mean, once again, like a comment that is isn't salient to our discussion at all, but he's basically saying is that testing asymptomatic people doesn't make clinical or economic sense. I do know quite a lot about testing, and I've actually published quite a lot about testing, and I will say that asymptomatic testing makes a lot of clinical sense.

You know, like, for example, in AHS, we basically -- every patient who's admitted to hospital during the -- you know, during the peaks, you get tested whether you have symptoms or not, because we can't rule out asymptomatic -- like asymptomatic infection without testing. And so, yeah, like I again -- I mean, so I do think we can test asymptomatic and we can detect virus in meaningful ways when people are asymptomatic, but it's not salient to the masking discussion.

Q There is a bold type paragraph a little bit down in your report, and it talks about the factual errors in the above statements, and at the end, it says -- oh, pardon me, you have a comment: (as read)

None are actually salient to the question at hand around whether or not masks provide a benefit in a health care setting.

Do their reports not relate to health care settings?

A Well, a large -- like much of the reports don't, but if you read down, then I then comment on -- the above statements just don't talk about masking at all, right; one talks about how likely you are to die from COVID, right; one talks about asymptomatic transmission of COVID, like not just -- you know, one talks about whether or not we should test people for COVID who don't have symptoms.

Below that bold font section, I then respond to the parts of the other expert witnesses that actually talk about masking, for example.

So I guess what I'm saying is that above, they make some statements that aren't necessarily true, but like regardless if they're true or they're not true, like it's not relevant.

Q I'm skipping down a little bit in your report now. You've got a statement: (as read)

Dr. Bridle argues that masking is not helpful

given the aerosol route of transmission.
And then a quote, and then you've got a paragraph about your response. Can you talk about your response in aerosol transmission?
A Yeah, and I sort of spoke about aerosol transmission a bit earlier, right, versus contact and droplet. I'll rehash that, I mean I think that -- people I think are perhaps under the impression that something that is airborne or has an aerosol -- airborne and aerosol have different -- just think of transmission occurring on a spectrum, right, where most of it happens within 2 metres through the cough -- like respiratory droplets, you know, like me talking on you, Mr. Maxston, and sometimes it can like aerosolize, which is probably defined as it staying in the air for an extended period of time or going beyond 2 metres.
Now, again, very hard to pin down the proportion of transmission due to aerosol spread versus contact and droplet spread, but we think it's pretty low. And, again, like it's just like none of those things matter in the face of the hefty evidence that shows once people start putting on masks in health care settings, transmission goes down, right. Like that is the -- that's all you need.
Q You've got a paragraph that begins: (as read)
Dr. Bridle's critique of how well masks fit

and mask pore size being too large to screen out SARS-CoV-2 in no way negate the huge body of real-world ecological evidence that masks reduce transmission as we describe in our report.

And then you talk about masks not being a hundred percent effective. You then go on to say that: (as read)

It is clear they provide significant amounts of protection and dramatically reduce transmission.

Why do you say that?

A Well, I mean, I -- like there's a -- I think I do say this somewhere in my report, but there's a big meta-analysis in the Lancet, a highly reputable journal, looked at -- I mean, I think they looked at 200-plus studies, and that study basically showed there's about an 85 percent reduced odds of transmission when people have masks on. And like there's just so many studies like that over and over again, right. And when I say "real-world ecological", yes, masks are imperfect, yes, the pores might not be perfect, yes, there's like air released. Like putting on masks leads to reduced transmission, and we see that in the real world over and over again, they probably reduce transmission.

Q You've got a comment after a quote from Dr. Dang's report about his statement being false and not backed up by any evidence. Can you comment what you're saying -- about what you're saying in that paragraph?

A Yeah, like this is kind of interesting, right, so I mean this statement is basically like, how do I call this, this is a fallacy, ecological -- whatever it's called, so basically they're saying like if we implement a mask bylaw, cases still go up, right, writ large, but that just doesn't control for a bunch of confounding factors, right.

When we implemented the lockdown, like CMOH Order 38, which was pretty aggressive, followed by CMOH Order 42, cases still went up for a while, and then they went down, right. That doesn't mean the lockdown didn't work. There's so many factors that lead to transmission of COVID. Masks are one thing that like -- that is protective, but, you know if people all wear masks, but they then go around to basement parties and kiss each other, you're still getting a lot of transmission.

And so I think this is like what I call like -- it's called spurious causation, right. It's like a correlation, not causation. So I talk about all the things that can lead to like cases going up and cases going down.

Q There's a paragraph in your expert report that begins: (as read)

> Lastly, both Dr. Dang and Dr. Bridle make unsubstantiated claims that there are "numerous harms associated with masking".

And then you say: (as read)

> There are no known harms associated with masking.

Can you explain that?

A Yeah, so medical harms, like I'm not a respirologist, but like the Canadian Thoracic Society, which is the group of like -- you know, has a statement that basically says mask wearing is not known to exacerbate any lung disease, right. That's their statement. They are, I guess, the lung disease experts.

Probably the only harm that I'm aware of that masking brings is, you know, in people with extreme anxiety, right. It can make you anxious, right, but it doesn't make your asthma worse or your COPD worse, and that is from the, you know, the body that represents the respirologists and the lung experts in Canada.

You know, I will say, you know, earlier the CMOH orders, you know, they're like exemption clauses, right. Like you put in these exemption clauses because to like have a little way out, right. That exemption clause caused great chaos, certainly in the medical

field, because there actually is not a reason to have an exemption for a mask.

And so what ended up happening with a bunch of patients went to the family doctors to try and seek exemptions, and doctors were like, Is there a reason to get an exemption; and the answer was no, and we were caught in quite a bind. And that actually led to Dr. Hinshaw apologizing to the Alberta Medical Association for like not being clearer on, you know, what qualified as an exemption and (INDISCERNIBLE).

Q Let me ask you this: Should a health care worker in direct contact with patients be allowed to have an exemption for mask wearing?

A No, I don't think so. Certainly not now with the case counts where they're at, right? And like I mean -- I'll use a comparison, right, like I get why people don't want to wear masks. Like I personally find wearing masks quite uncomfortable and annoying, but like when it comes to a matter of obviously patient safety, then, you know, like you've got to do it because you don't want to harm your patients.

If I was a surgeon, you know, surgeons they have to operate in a sterile space, they have to scrub in, you know, like I would not give an exemption to a surgeon from scrubbing in and, you know, sterilizing his or her hands for operating even if they were, you

know, like in -- if they were allergic to that, like, you know, the particular sterilizers, and they use something else. If they were allergic to everything, they would not operate, because operating in a non-sterile condition poses too great a risk to the patient.

In the same way right now with COVID, you know, not masking is not -- like is a risk to the patient, and, again, and I will caveat this by saying if we had five cases a day in the province of Alberta, we would not need to do this probably I would say, right? Like, you know, the extent to which we need COVID masks to prevent COVID does depend on the risk of COVID. And the baseline risk of COVID depends on how many cases we have, right?

But like right now, Alberta a thousand cases a day, north zone 33 percent positivity rate, that's like as high as the highest US states ever were, right? That's like we have a lot of risk and -- yeah, so, no, like, you know, like you've got to wear a mask if you're seeing patients.

Q I'm going to ask you a couple of very brief questions about Mr. Schaefer's report, and I know you only received that a little while ago.

MR. MAXSTON: And I just want to, Mr. Chair, be clear to the Tribunal that in asking these questions

of Dr. Hu, I am again reserving my client's right to call further rebuttal evidence on that point, but I want to ask him about them.

Q MR. MAXSTON: You had a chance to read Mr. Schaefer's report?

A M-hm, yeah.

Q Do you have any comments generally about its validity and the opinions in it?

A Yeah, I mean, I think like the conclusion of -- in the report is more or less that it's not safe to wear a mask because it creates dangerously high levels of carbon dioxide and dangerously low levels of oxygen.

Now, practically, if that were the case, a lot of my friends would be really sick and/or unwell, because a lot of my friends wear masks all day long because they work in hospitals all day long, you know.

But, again, I -- again, I refer to the Canadian Thoracic Society, these other sort of experts, you know, basically said that like mask wearing is safe and fine. There's so much evidence, and like we've been wearing masks in hospitals every day for a year-and-a-half, and if it was that bloody dangerous, we'd have somebody passed out from low oxygen or too high C02, and that has not happened to any health care worker in Alberta in AHS that I'm aware of, right? And so like that's -- that's about all I'll say about that.

Q Okay, I'm just going to go to the end of your report, and you've got a "Summary" section, and you talk about the vast majority of expert reports focus on trying to downplay the seriousness of COVID-19 and various public health approaches we have used to contain the pandemic. You then talk about them not addressing the question at hand, which is the evidence of masking and reducing viral transmission.

Are you aware of -- and I'm going to apologize in advance for me butchering this word -- are you aware of any epidemiologically valid studies establishing that masks should not be worn by health care providers?

A No. For COVID transmission, no.

Q Yeah, for COVID and --

A No, no.

Q I don't have any further questions for you. I'm wondering if there's anything you want to add before I ask Mr. Kitchen if he wants to begin his cross-examination.

A Maybe I'll just say this, right, like I mean, like I've clearly reiterated over and over again that I think masking is very good for preventing transmission in a health care setting and that there's a lot of evidence for that, but, you know, I'll also say this: Like I'm not like somebody who's like hyper-ideological. Like, you know, when it comes to things like COVID, there's

lots of areas to debate, you know.

Like I think, oftentimes, people associate people -- like, you know, pro-masking with like pro-lockdown and all that stuff, and I guess what I'm trying to say is -- like I try to read the evidence. I'm fairly pro re-opening actually. You know, I was the Calgary Stampeded medical director and like managed to run that.

And so with that, you know, I do think what happens with a lot of these debates, you know, whether around masking or vaccine passports or lockdowns, people get into a bit of an ideological bent, a bit of a political bent, right; these issues have all been highly politicised, and I really try to steer away from those things and try to, you know, balance the benefits and the harms of any particular intervention. And when it comes to masking, like the benefits really, really, really, really outweigh the harms. There aren't a whole lot of harms other than them being a bit uncomfortable to wear I think, so ...

Discussion

MR. MAXSTON: Okay, well, thank you, Dr. Hu.

Mr. Kitchen, I don't know if you want a quick break before you start your cross-examination or whether you'd prefer to start tomorrow morning; I leave that up to you.

I think, and I should say in fairness I think just to the Tribunal Members and everyone involved, I still think we should shoot for shutting down today at maybe 4:15 or 4:30 just because people get a little saturated at a certain point.

MR. KITCHEN: I don't want to start and not finish, so if that's -- you know, we talked about this. You know, my primary goal for pushing to go today, if I was, was to try to get us ahead of the game. That's not going to help anyways with I think where we're going to go. So I have no interest in starting today, because I don't want to go too long and not finish. It should be done all at once. So I think tomorrow morning, hopefully 9:00 right away we'll get going. I think that's probably best for everybody.

MR. MAXSTON: Frankly, I would prefer that. I don't think my redirect will be very long at all. I anticipate the Tribunal might have questions, but I think it's better to do that in one block so everything's fresh in everyone's mind.

My intention would be, after the completion of Dr. Hu, to have Dr. Halowski testify.

MR. KITCHEN: That's fine with me.

THE CHAIR: Okay, Dr. Hu, you are okay for 9:00 tomorrow morning to --

A Yes.

THE CHAIR: -- continue?

A Yes.

THE CHAIR: We appreciate that very much, sir. Thanks, Mr. Maxston and Mr. Kitchen. It was a pretty full day, as we expected, a lot of documents, so I think we can adjourn for today with the expectation we'll start at 9 sharp tomorrow morning, and we'll try and have the site open a few minutes early so people can log on, and we'll get off to a flying start in the morning.

Okay, unless any of the Tribunal Members wish to meet and chat, if you do, stick your hand up. No? They're all heard enough of me for today, so we'll declare this meeting in recess for now, and we will reconvene tomorrow morning at 9. Thank you, everybody.

PROCEEDINGS ADJOURNED UNTIL 9:00 AM, SEPTEMBER 2, 2021

CERTIFICATE OF TRANSCRIPT:

I, Karoline Schumann, certify that the foregoing pages are a complete and accurate transcript of the proceedings, taken down by me in shorthand and transcribed from my shorthand notes to the best of my skill and ability.

Dated at the City of Calgary, Province of Alberta, this 27th day of September, 2021.

Karoline Schumann

Karoline Schumann, CSR(A)
Official Court Reporter

IN THE MATTER OF A HEARING BEFORE THE HEARING TRIBUNAL OF THE ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS ("ACAC") into the conduct of Dr. Curtis Wall, a Regulated Member of ACAC, pursuant to the Health Professions Act, R.S.A.2000, c. P-14

DISCIPLINARY HEARING

VOLUME 2

VIA VIDEOCONFERENCE

Edmonton, Alberta

September 2, 2021

TABLE OF CONTENTS

Description		Page
September 2, 2021	Morning Session	203
Discussion		204
Submissions by Mr. Kitchen (Application)		206
Submissions by Mr. Maxston (Application)		207
Reply Submissions by Mr. Kitchen (Application)		211
Reply Submissions by Mr. Maxston (Application)		213
Reply Submissions by Mr. Kitchen (Application)		214
Ruling (Application)		215
Discussion		216
DR. JIA HU, Previously sworn, Cross-examined		221
Mr. Kitchen		
Mr. Maxston Re-examines the Witness		286
Mr. Kitchen Re-cross-examines the Witness		292
Discussion		299
September 2, 2021	Afternoon Session	302
DR. TODD HALOWSKI, Affirmed, Examined by		303
Mr. Maxston		
The Chair Questions the Witness		403
Certificate of Transcript		406

EXHIBITS

Description	Page
EXHIBIT H-5 - Face Masks to reduce COVID-19 in Bangladesh RCT	216
EXHIBIT H-6 - Locally Produced Cloth Face Mask and COVID-19 Like Illness Prevention RCT	216
EXHIBIT G-1 - AHS - Directive Use of Masks During COVID-19	352
EXHIBIT G-2 - AHS - Guidelines for Continuous Masking	352
EXHIBIT G-3 - AHS - Personal Protective Equipment (PPE)	352

Proceedings taken via Videoconference for The Alberta College and Association of Chiropractors, Edmonton, Alberta

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September 2, 2021 Morning Session

HEARING TRIBUNAL

J. Lees	Tribunal Chair
W. Pavlic	Internal Legal Counsel
Dr. L. Aldcorn	ACAC Registered Member
Dr. D. Martens	ACAC Registered Member
D. Dawson	Public Member
A. Nelson	ACAC Hearings Director

ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

B.E. Maxston, QC	ACAC Legal Counsel

FOR DR. CURTIS WALL

J.S.M. Kitchen	Legal Counsel

K. Schumann, CSR(A)	Official Court Reporter

(PROCEEDINGS COMMENCED AT 9:03 AM)

THE CHAIR: I think the point we were at yesterday was that Mr. Maxston had presented or had direct examination of his expert witness, and we

adjourned for the day to enable Mr. Kitchen to start his cross-examination of the expert witness this morning. Is that where we're at?

Discussion

MR. MAXSTON: Mr. Chair, it's Mr. Maxston. I think that's accurate. I do have one quick housekeeping comment I need to make based on a discussion I had with the court reporter about exhibits. I also believe Mr. Kitchen has I'll call it something in the nature of a preliminary application to make concerning some documents he wants to place before Dr. Hu, which my client is objecting, and we'll have to ask Dr. Hu to be excused and put in a breakout room while we deal with that.

I wonder if I can just very quickly make my comment about exhibits, and then I'll let Mr. Kitchen speak about his application.

THE CHAIR: Okay.

MR. MAXSTON: Madam Court Reporter made a comment to me that yesterday when I was introducing documents to a witness, I did not stop and ask for each one of them to be formally marked as an exhibit, and the reason I didn't do that was because of the agreement between Mr. Kitchen and myself, that the exhibits were agreed on. I'm happy to do that if you prefer. I, frankly, don't think it's necessary, given

the agreement between Mr. Kitchen and myself. I see him nodding, so I'm hoping that perhaps we can dispense with that, all on the understanding that all of the documents when they're referred to are formally entered by agreement as exhibits. Mr. Kitchen, do you have any thoughts on that?

MR. KITCHEN: I have no objections to that. I think that's fine. We've already identified them in the files with letters and numbers, so ...

THE CHAIR: Okay, and just for Karoline's clarification, those are in the folders that are marked 'A' to 'F', and then we have Folder 'H', which we dealt with, and I don't know that there ever was a Folder G. So, okay, that's -- you're okay with that, Karoline?

THE COURT REPORTER: (NO VERBAL RESPONSE)

THE CHAIR: Good. So then --

MR. MAXSTON: Mr. Chair, my apologies, I think it's time to turn this over to Mr. Kitchen, but we are going to have to ask Ms. Nelson to move Dr. Hu into a breakout room I think for a relatively brief period of time, but I think we need to do that first.

THE CHAIR: Okay. And just before Mr. Hu departs, I will just remind him that he is -- well, he's gone. Okay. We have to remind him that he's still under oath from yesterday.

Okay, Mr. Kitchen.

Submissions by Mr. Kitchen (Application)

MR. KITCHEN: So, The Chair, the purpose of this is I have two documents. They are PDF screenshots of web pages, and obviously I'm going to have to provide them to you, but I approached Mr. Maxston about providing these to the witness, and I take it from his comments, and this reflects something I had proposed to him, that the best way to do this is for me to make an application, he will oppose it, and then you'll be provided with the documents. I can send those to Ms. Nelson, and then you can make a ruling whether or not to admit them.

What these two documents are, very briefly, they're simply evidence of the existence of one randomized -- well, RTC, they're clinical trials, randomized clinical trials. One ended in June, one is ongoing; that's what these two documents are. They simply show the existence of these trials, simply what they are, where they are, what they're called, who is doing them, et cetera. That's what they are.

The purpose for my putting them in is to give them to Dr. Hu and give him a chance, an opportunity, to respond before I ask him any questions about those or before I would ask any questions to my experts, as, of course, that wouldn't be fair if he hasn't had a chance

to see them and comment on them.

Again, the only purpose I'm putting it in is not substantively for anything to do in the trial; it's simply that the trials exist. He had said that it would be unethical to do so. I'm simply putting those in to show on the record that those trials are being done currently and have been done.

THE CHAIR: Mr. Maxston?

MR. MAXSTON: Just so I'm clear enough, I didn't understand you correctly, Mr. Kitchen, were you proposing that those documents be provided to the Hearing Tribunal as they consider this issue or only after they hear submissions from us?

MR. KITCHEN: After they hear submissions, I'll provide -- I propose that I provide them to Ms. Nelson so that she can provide them to the Tribunal, and they can have those documents in front of them to make a decision on whether or not they should be admitted as exhibits.

Submissions by Mr. Maxston (Application)

MR. MAXSTON: Okay, well, then I will make my submissions.

Mr. Chair and Hearing Tribunal Members, the Complaints Director strongly objects to these documents being provided. I will speak about this in a few minutes in greater detail, but there is an element of

fairness that has to be a core element of this hearing, fairness not only to the member but fairness to the Complaints Director.

Just by way of background, I received -- or I opened my emails this morning and say an email from 12:11 AM from Mr. Kitchen attaching these two studies. Again, my client strongly objects to these going in; it's highly prejudicial. I haven't been able to print, much less read, these studies. Mr. Lawrence hasn't been able to read them, and certainly Dr. Hu hasn't been able to read them.

Mr. Kitchen has had Dr. Hu's expert report since July 28 of this year and has had more than enough time to prepare any rebuttal documents or any type of exhibit package he wanted to enter. He has not three but now four experts to present his client's case, and providing these studies immediately before cross-examination gives Dr. Hu no ability to properly read them, to engage in an informed analysis of them, and to responsibly engage in any kind of discussion about them.

I know Mr. Kitchen says they're only being tendered to reflect the existence of these studies, and I have no idea about the history or background of these, but Dr. Hu may have very strong comments about the validity of the studies or the status of them, any

myriad of elements of those studies, he might have very, very considerable questions and thoughts on those.

So, again, no time for Mr. Lawrence or I to read and review these, certainly no time to consult with Dr. Hu to allow him to provide a fulsome and informed response.

The answer is not to say, Well, let's take an hour break and let Dr. Hu review them. I think that is not the answer for a number of reasons. First of all, it's just not fair. Dr. Hu is under the gun. He's looking at these, trying to formulate a response on very, very short notice. It takes up valuable time which we could be using on other things. Frankly, the witness's, his order is potentially disrupted. He's only available till noon today. It just is a very, very troubling development.

Again, there are four expert reports that have been tendered with citations and documents in support of them, and I would say to you that the Complaints Director has been very, very accommodating and very generous in terms of not objecting to three experts and not objecting to other documents and information that have been provided in support of those documents.

I think, Mr. Chair and Hearing Tribunal, this also speaks to the larger question of how this hearing is

going to be conducted, and as I said before, there certainly has to be fairness to the member, to Dr. Wall, but there also has to be fairness to the Complaints Director. A phrase I like to use, and I can't remember where it came from, but I used it over the years is these types of hearings are not argument by ambush. It's not a surprise gotcha moment that we're looking for, and we need to avoid that.

We had the Schaefer report come in I would say very, very briefly before the hearing, which was of concern to my client. You've made your decision; we've got some remedies to call rebuttal evidence, but that was concerning. I know that the cases I received from Mr. Kitchen in support of his preliminary application were sent to me at 12:44 AM on Wednesday. I sent my cases about my preliminary application, my supporting document to him the day before. I don't think it's fair to expect Mr. Lawrence and I to check emails at all hours and to be on-the-fly and be ready to accept documents and information in that manner. Mr. Kitchen is obviously trying to be an advocate for his client, and that's certainly his role, but this goes beyond that.

We need, Mr. Chair and Tribunal Members, we need direction from you, not just to refuse to allow this document to go in but to set parameters about how

documents and case law are going to be provided, because, again, this isn't argument by ambush.

So my client strongly objects to these being provided. If they have any probative value, it's minimal, and it's highly prejudicial to the Complaints Director. Those are my submissions.

Reply Submissions by Mr. Kitchen (Application)

MR. KITCHEN: Chair, if I may respond. These have been provided to my friend, he knows that I'm not tendering studies. There's no content here. He knows that all I've provided is a record that's a couple pages long that such studies are being done. They haven't been written out yet. There is no report. There's no peer-reviewed article. They're simply at the clinical phase of being done. We're simply tendering them for the evidence that these studies are being conducted. So there's nothing to read.

You know I'm literally going to -- if these are admitted, I'm literally going to take Dr. Hu to the point in which it describes what the study is, and I'm going to ask him that. That's it.

So all of this argument about the time it's going to take is completely without merit. There is no time involved. There is no actual study to read. There is simply a document showing that such clinical trials are ongoing or have been conducted a few months ago.

That's it.

I have no disagreement with my learned friend about fairness or avoiding a trial by ambush, which is why I provided it to them, I asked him his position. It's almost as if he thinks this is unusual; it's unusual to put documents to a witness in cross-examination after his examination-in-chief reveals that there are certain things that would be useful. That's not unusual. It's not unusual to provide cases. In fact, if it were in person, it would not be unusual to hand the cases up at the beginning of a hearing. That they're provided the night before is not unusual.

I don't think it's appropriate to be commenting on what time of the day my emails come in, as if I expect everybody to be awake at all hours of the day to read my emails and immediately comment on them. I think that's a red herring.

You're going to see these documents I have, and you're going to see that they are as I've described them, and they are not actual articles that need to be read. I think that's very important to understand, and I think any description of that is completely missing the point. Those are my submissions, Chair.

THE CHAIR: Can I ask you, Mr. Kitchen, you said there's one study that's been completed?

MR. KITCHEN: Yes.
THE CHAIR: Has it been published?
MR. KITCHEN: Not that I know of.
THE CHAIR: And the other study is ongoing.
MR. KITCHEN: The other study is ongoing to be completed I think in October.
THE CHAIR: Okay --
Reply Submissions by Mr. Maxston (Application)
MR. MAXSTON: Mr. Chair, I wonder if I might just have an opportunity to make one or two very brief comments in response to what Mr. Kitchen said.

I have looked at these document very, very briefly. They may well be not in-depth studies. They may not have a lot of meat on the bone, but it's the larger principle. Again, Dr. Hu is at a complete disadvantage. He has seen these on-the-fly. He is not able to go and make his own inquiries about them. It doesn't matter that Mr. Kitchen is going to be very brief with them he says. It simply puts Dr. Hu in an awful position, because he can't respond properly whatsoever.

And I would suggest, I'm not a fan of this, but -- or I can't tell Mr. Kitchen how to run his case, but certainly he's got his own experts, he's got four of them. There is ample opportunity for him to have his

experts testify to these matters. I don't see that putting Dr. Hu in this position is at all fair to my client.

Reply Submissions by Mr. Kitchen (Application)

MR. KITCHEN: Sir, I just want to make a comment. Fairness seems to be an issue here, and as I've said I have no issue with that.

I will say, out of fairness, it's typically, procedurally the way we do things is if somebody makes an application, they make the application, the other side has a chance to respond, and then the person who -- the party who made the application has a chance at rebuttal, and then that's the end of things.

And twice now in these proceedings, Mr. Maxston has come in after I've given a rebuttal, and he's made comments, and I haven't objected to that out of fairness, but since fairness is becoming a real issue here, I note that that's not normally how things are done.

And if we're going to get really about the book about this, which seems the Complaints Director is going in that direction, I'm going to find myself objecting any time Mr. Maxston is coming in after I've given a rebuttal and is trying to make comments, because that's not actually normally how things are done.

THE CHAIR: Your comments are noted, Mr. Kitchen. That's -- I will take responsibility for that. I know the rule of three is the generally accepted process, and I will do my best to adhere -- or to follow that.

I think at this point, we'll caucus while we discuss -- can I just ask one more question? Is Dr. Hu involved in these studies? Is he an author or a ...

MR. KITCHEN: No, he is not.

THE CHAIR: He is not, okay, thank you.

MR. KITCHEN: And what I'm doing is I'm just -- I haven't provided these documents yet, so I'm just providing them to Ms. Nelson so that she can provide them to you.

THE CHAIR: I think what we were talking about is that -- okay, we will caucus now, and we'll be back to you shortly. Please bear with us, thank you.

MR. KITCHEN: Thank you.

(ADJOURNMENT)

Ruling (Application)

THE CHAIR: Okay, we'll reconvene. The Hearing Tribunal with the advice of counsel has considered the two documents in question. I will give you our decision and then some comments before we move any further.

We have decided to allow these within certain

limitations, and we've noted that these are overseas trials, that these are in progress or just recently completed. Neither of the two documents contains any results, and they've not been published.

So our view is that, Mr. Kitchen, if your desire is just to establish that these trials exist, that's the direction we're prepared to allow. If the questioning or the discussion goes into any depth regarding the trials themselves, I'm sure we will hear objections at that time.

MR. KITCHEN: Thank you, Mr. Chair. I appreciate that. That makes perfect sense to me.

EXHIBIT H-5 - Face Masks to reduce COVID-19 in Bangladesh RCT

EXHIBIT H-6 - Locally Produced Cloth Face Mask and COVID-19 Like Illness Prevention RCT

Discussion

MR. MAXSTON: Mr. Chair, in light of your decision, and I hope Mr. Kitchen will be comfortable with this, we're going to bring Dr. Hu back in. I think he needs to have a little bit of time to look at these documents, and I don't mean 2 minutes on-the-fly, and I don't mean two hours, but I think he's got to be given a reasonable opportunity to see these documents and be able to read through them.

I understand the narrow parameters you've placed

on the questioning, but I'll be candid, I think all that he can say is, Well, I guess these are documents that shows studies being done. I'm still kind of puzzled why Mr. Kitchen can't do that with one of his experts, but, again, I think he has to be given the opportunity to at least read these.

THE CHAIR: I agree, and I suggest that we take -- it's 20 to 10, one's a six-page, one's a seven-page document, there's not a lot of information in them; I think if we said we'll reconvene at 10:00, people can take an early coffee break now, stretch, grab a coffee, and we'll give Dr. Hu 15 minutes to review them, if that --

MR. MAXSTON: Can I --

THE CHAIR: Yeah?

MR. MAXSTON: I welcome Mr. Kitchen's comments on this, but I wonder if we could bring Dr. Hu back in and let him know exactly what they're being tendered for, because if we simply give them to him, and he's thinking I've got to go off and check sites, I've got to research these, I've got to -- it's entirely different to say he's being -- You're going to be asked about whether these are ongoing or not. And I don't want to spoil Mr. Kitchen's questions, and he may have a few more questions than that, but I mean if I send these to him and say you're going to be examined

on these, he's going to say, Well, to what end and in what nature.

MR. KITCHEN: So, again, all I'm -- well, if I had have asked him, you know, these studies exist, don't they, that would have been improper, because they're not before him. I'm literally going to ask him, Do you deny that these studies exist. And now that he's had an opportunity to see them, he can actually make an informed answer on that, it's not ambush, and then that's only fair.

And, you know, that's why I can't bring it in with my experts, that's not fair to do that because then the Complaints Director's expert hasn't seen it. We're probably talking about, you know, 90 to 120 seconds of questioning at most on that, and that's it.

So -- and I'm fine, you know, with giving him the time to break until 10, but I'll say that if we do that, and we come back at 10, I would ask that we just go straight through until noon, if I take that long without any breaks, because I want to have the time I need for cross-examination, and I understand Dr. Hu has to get going as well.

MR. MAXSTON: And, Mr. Kitchen, of course, I may have redirect and the Tribunal may have questions as well, so, again, I can't tell you how to run your cross-examination, but we have some timelines here that

are tight.
THE CHAIR: Yeah, we --
MR. KITCHEN: I don't expect to go beyond an hour-and-a-half, I really don't.
THE CHAIR: Okay, let's bring Dr. Hu in please then, and I'll give him an explanation. Do we have a copy of the documents for him?
MS. NELSON: I can send those to him via email right now.
THE CHAIR: Could you send them, please.
Dr. Hu, we're back. Dr. Hu, can you hear me? Can you hear me?
A Oh, yeah, now I can, sorry. I was just -- yeah.
THE CHAIR: Yeah, okay, thanks, Dr. Hu, sorry to keep you waiting.
A That's okay.
THE CHAIR: We're very respectful of your time and our commitment to get you out of here at noon. An issue --
A (INDISCERNIBLE) all good.
THE CHAIR: -- an issue has come up, and we're going to be breaking here momentarily, and we're providing you with summaries of -- well, two documents that contain summaries of clinical trials. It's a six-page summary put out by the NIH US National Library of Medicine. So --

A Yeah.
THE CHAIR: -- we have allowed these documents to be entered by Mr. Kitchen. Neither of these studies have been published, one has just been completed, the other is still in the data collection.
A Okay.
THE CHAIR: We are only allowing Mr. Kitchen to question on the actual existence of these. Because there are no results, there's no findings, there's no publication, there's nothing to discuss there, but Mr. Kitchen will deal just with the actual existence of these.
We're going to give you until 10:00 to read through them --
A Sure.
THE CHAIR: -- so that you're familiar with it. I don't anticipate there will be very many questions on this, but we don't want you having to respond to something you haven't read.
A Yeah, yeah, I'm all good. I always like more, more science, so happy to -- yeah, that's good, cool.
THE CHAIR: Have you got them; have you checked your email?
A Let me just hit "refresh" again. Oh, yes, I just got them, okay. Cloth masks and face masks reduce COVID-19 (INDISCERNIBLE).

THE CHAIR: Okay, we will recess now, and we will reconvene at 10:00 with Dr. Hu and Mr. Kitchen.

A Thank you.

THE CHAIR: Thank you.

(ADJOURNMENT)

THE CHAIR: Okay, the session is -- obviously, we've reconvened, just to remind everybody, and the floor is Mr. Kitchen's to cross-examine Dr. Hu.

MR. KITCHEN: Thank you, Chair.

DR. JIA HU, Previously sworn, Cross-examined by Mr. Kitchen

Q MR. KITCHEN: Dr. Hu, I'm mostly going to be questioning you on your report, so I'll be taking you to various portions of it at times.

Just to start off on your first page of the report, you refer to the Manchurian plague. I note that you neglected to mention that plague is caused by bacteria. The Manchurian plague was caused by a bacteria; isn't that right?

A Yeah. Yes.

Q And bacteria are hundreds of times larger than viruses; isn't that right?

A Yes.

Q In your report, you regularly refer to masks without any qualifiers, and I think twice to what you call medical-grade masks, and by either of these terms, you

are referring to the so-called surgical or blue masks that are specified in the ACAC Pandemic Directive; isn't that right?

A Correct -- well, it depends. I mean, the report talks about a number of different things, right, and like, first of all, that introduction around Manchurian plague, think of that as like a fun introduction. Like, once again, I only care about COVID and masks; I don't care about anything else in masks.

There's some studies that I talk about which are -- which talk about sort of masks in the community, right. And when I talk about masks in the community, it's a mishmash of like surgical-grade masks, but primarily probably cloth masks and sort of that mix of masks changes based on where you are and access to medical-grade masks.

Very early on, people didn't really have access to medical-grade masks. Now, probably people have more access to those. But within the health care setting, I think we can broadly assume that, in Alberta, like, you know, we have medical-grade masks, so yes.

Q Okay, now that was a bit long, I just -- and, again, I'm not trying to trick anybody, I want to make sure we're all on the same page about what is a medical-grade mask. Now, would you agree that a medical-grade mask is the same as a surgical or blue

mask?

A Yes, so I would say a medical-grade -- like, when it comes to mask terminology, you know, we often say surgical mask, procedure mask, or medical-grade mask. Within the categories of medical-grade masks, there's sort of different levels, like, you know, like tier 1, tier 2, tier 3 masks, and these are not the same as N95 masks, which are different.

Though to your question about like what I talked in my report, you know, like I report about types of like community type studies, and those are more going to be like a mishmash of mask types that just ...

Q Right, but a lot of times in your report, you use the term "masks", and when you use the term "masks", you're not referring to cloth masks; you are referring to --

A No --

Q -- let's call them surgical masks?

A No, it -- no, and I should have probably applied more specificity in the report, but like -- I mean, we can go by study by study, and we talk about the types of masks being used in those studies, but like I -- it depends on the study in question, right.

So, for example, by and by, if I refer to a study around, you know, like some of the studies around this reduces community transmission, so masks used -- any study that describes mask wearing and its ability to

prevent COVID outside of a health care setting, you know, we don't necessarily know what masks are being used, but I would broadly assume, in that setting, we're not using medical-grade masks. Like, you know, some people might have them, like I would, you might not. But when we begin to talk about the studies in health care settings, those are almost all medical-grade masks, but -- so I use the term "masks" like generally, but it would depend on the study in specific.

Q Now, just to confirm --

A M-hm.

Q -- I think, I believe you said this, when you use the term "masks", you are not referring to N95s?

A That is correct.

Q Okay, thank you. Now, would you agree that the surgical or blue masks, and those are the ones that are specified as being -- or medical masks --

A M-hm.

Q -- (INDISCERNIBLE) as being specified in the ACAC pandemic [sic], and the reason I'm mentioning this is the ACAC pandemic says cloth masks are unacceptable, all right, and --

A Yes.

Q -- there's no trickery here, right? We're talking about --

A Yeah.
Q -- a classification of masks between N95 and cloth. Would you agree that's what we're talking about, when we're talking about what's acceptable for the ACAC Pandemic Directive, we're talking about masks that are not cloth and not N95 but in that surgical category in between? Would you agree with me on --
A Yes.
Q -- that? Okay.
A Yes. Although, I'm not entirely -- like I think that like if somebody wanted to wear an N95 mask like in the, you know, clinical setting, like ACAC in a chiropractor's office, I mean you could mask, I would say an N95 is better than a cloth mask -- like, sorry, than a medical-grade mask, which serves different purposes, but it's not inferior, I'll say, to a medical blue mask.

Yeah, so -- and I don't think there's trickery, I'm trying to explain, because I wasn't specific in my report around what I mean by "masks", so yeah.
Q Well, and that's just it, I don't want us to talk at cross-purposes.

Now, would you agree that these medical or surgical or blue masks are of low cost?
A What do you mean by "low cost"?
Q I mean that they are not expensive; would you agree?

A I don't know. I mean -- so the price of a medical-grade mask before the pandemic started was around, I think in bulk procurement prices, 6 cents a mask. In the midst of the first wave, that price went up to 60 cents to $1 a mask, given our shortage of masks, right? And so I mean -- and then I think it's gone down again, but I would say that 6 cents a mask is pretty cheap. I would say that during the pandemic, a 10X increase in price is not insignificant, but, yeah, those are the prices. So now you know what the prices are.

Q Thank you, and, you know, that's -- I wasn't asking you about supply and demand. So let me ask you again, would you agree that surgical blue medical, would you agree that those are low-cost masks?

A I would, relative, yeah, sure. If we think that 50 cents a mask is low cost, then that's low cost.

Q Thank you. And, Dr. Hu, you're proud of the work you've done for AHS during COVID, aren't you?

A Generally, I mean, I think I've made mistakes, but I think I've done some good things hopefully as well.

Q You're glad to defend the COVID public health restrictions in the CMOH orders, aren't you?

A Which restrictions are you referring to specifically, like in which CMOH orders? And not being at cross-purposes, there's things I agree with and things

that I don't. I would defend the masking one for sure.
Q And you would defend the distancing one?
A Yes.
Q When it comes to COVID, you think information is more likely to be scientifically accurate if it comes from a government public health source than if it comes from some other source, don't you?
A What is the "other source" referring to?
Q Exactly that, an other source, other than government public health source.
A Yeah, I mean, I would say that I -- yes, with the caveat that I think government and public health sources tend to aggregate the, you know, hopefully the studies and what we know about COVID sort of at the time, and so I would say stuff like that, or, you know, things published in high quality peer-reviewed journals are good, but, yes, I would agree broadly with the statement that I trust those sources a fair amount, but we've also been wrong, right? So ...
Q What I'm asking you is do you trust government public health sources more than any other source?
A I mean not -- like it depends, right? And so like here, I'll give you an idea of things that I trust, right? So I generally trust things that AHS comes out with, right? I generally trust things like the meta-analysis and the Lancet, you know, that I refer to

in my expert report.

I generally trust less, you know, any one-off study, right? Like, you know, I tend to trust like conglomerate-like aggregation studies, but, yeah, that would be sort of what I trust and don't trust.

And then what I'm looking for is like a convergence of evidence, right? Like when I say what governments do is we try to -- I'll say what public health bodies do is they try to synthesize the evidence, right, and so what they're drawing on -- like the data they draw from are published studies, right, and one -- you know, I would say that you can look at the quality of any one published study, and, you know, some are better than others, but, you know, I -- you know, because there are so many studies, you try to look at like what do the majority of those studies say, but they -- yeah, but, yes.

For example, I'll give you a counter example, right? So, you know, I could argue that, you know, in a lot of US states, the governments have been very anti-mask, right, and so, you know, like the State of Texas, like no masking, right, State of Florida, no masking. So I don't necessarily trust that, right, just because it's coming from a government.

I trust more I think if that's -- the source is sort of informed primarily by the available scientific

evidence, because, again, governments can say lots of different things because they have other considerations, like political ones.

Q Anyone who disagrees with your position on masks is anti-mask; is that correct?

A No, I mean -- I think I'm actually quite -- what's the word -- I'm quite open to chatting with people about these things. You know, like I said at the end of the last testimony, I'm quite un-ideological, right? Like I have lots of chats with people about things like Ivermectin, which Public Health doesn't really agree with. You know, I have chats -- and so I --

And the word "anti-mask", I think, carries with it like a certain -- like I don't like it, just like I don't like the word "anti-vaxxer", right? Like, you know, I think people are generally trying to do the best thing for themselves and their patients. I may disagree with what the best thing for themselves and the patients are, but like I like -- you know, like I'm always down, game for discussion about these things.

Q You just said you don't like the term "anti-masker", and yet you just used that term to describe two states in the United States of America; isn't that right?

A Sure, well, my bad then, but I -- I mean, maybe what I'm saying is like -- I think right now when we call somebody anti-mask or anti-vax, I think it carries with

it an implication that they're like a bad person in some ways, right? And I don't want that -- I don't want that to be implied, right?

I think, you know, people are trying to do the best, like, with the knowledge they have. I may disagree with their perspective, but I don't want to be, what's the word, judgy, right? So anyways.

Q You would agree that the term "anti-mask" is a pejorative term, would you not?

A Yeah, it is pejorative, yes. I mean, it's -- it's both pejorative -- like it's an interesting -- because -- you know, like being anti-something does not necessarily, in and of itself, make a term pejorative. But being, you know, in the current environment, I would say being anit-vaxxer can be pejorative, being anit-masker can be pejorative. Anyways, I don't know if I want to talk about sort of these like linguistic interpretations.

I guess what I'm saying is that, I mean if you use the statement, people who are against wearing masks, right, that sounds less pejorative than anti-mask, and it sort of defines like, characterizes what they like -- you know, a position is. And so I just don't want to be too judgy, you know.

I think it's very important that we always sort of listen for new evidence, right? Like -- and not like

judge people or malign people like for not -- like the nature of people for having these different perspectives, even though I may disagree with them.

Q You said argument "against masking", in the very last sentence of your report, you say that: (as read)

> Nobody would argue against masking in a health care setting.

That seems to me a curious thing to say. Nobody is arguing against masking in any context, are they?

A Well, I would say it's an inaccurate statement, because clearly people are arguing against masking in a health care setting, and so, again, the precision of my language is not there. I would say the vast majority of people in the health care sector would not be against masking in a health care setting.

Q Can you identify for me somebody that's arguing against masking?

A I mean, I sometimes see protesters that say like "no masks", right? I -- you know, I've received a lot of emails around, you know, may have -- you know, the Calgary school boards are implementing masking, mandatory masking for school-age children, that's where it starts, and, you know, I've commented on it, and I've gotten lots of emails saying that, like, kids shouldn't be masked. I would say that's an example of arguing against masking. I don't know if it's many

people arguing against masking in the health care setting, but I'm sure there's more than one somewhere in the world.

Q Let me narrow that, and I apologize that I didn't, nobody's arguing against masking in any context in this case, are they?

A Not -- I'm -- I thought that we were talking about not wearing masks in like the chiropractic setting, but if I'm -- yeah. Is that not what we're talking about?

Q There are individuals in this case that are arguing against the case for mandatory masking; isn't that right?

A Can I ask the ACAC for like -- like what is the actual argument here?

Q Well, "argument" isn't really the right word. I guess -- and I've only used that word because you have. What I'm getting at is you said in your report that people are arguing against masking.

A M-hm.

Q You haven't identified anybody, other than some unspecified anti-masking groups. It just strikes me as a strange thing to say. I guess what I'm asking is would you agree with me that, from your perspective, from your perspective --

A M-hm.

Q -- is it not true that what anybody in this case is

arguing about is against mandatory masking?
A If that's the case, like I'm not sure actually, but if, it's helpful to note, so the issue is against the policy of mandatory masking, good to know, we can talk about that, but pardon my ignorance, yeah.
Q No, I know. I'm asking you, the question is to you --
A Well, I don't know.
Q -- would you agree with me that what individuals in this case are arguing --
A M-hm.
Q -- against mandatory masking? You can disagree or agree. It's up to you. Please --
A No, I'm not -- like I'm -- sorry, I talked over you again, I'm not sure, but it sounds like that's the case based on what you're asking, so that's good for me to know, and we can talk about that.
Q The experts adduced by Dr. Wall, if they're arguing for anything, they're arguing against the efficacy of masks and the supposed harmlessness of masks.
A M-hm, yes, I agree with that, yeah.
Q Nobody is arguing that people shouldn't wear masks if they want to, are they?
A Correct, I agree with that.
Q And, again, do you have a copy of your report in front of you?
A Yeah.

Q Okay, excellent. I'm at the end here -- or I should say the end of the main section, so this is page 5.
A Okay.
Q And you say: (as read)

> While there does exist [in quotation marks] anti-masking movements in Alberta and Canada and all across the world [et cetera].

You provide no independent source to verify your claim about these so-called anti-masking movements, do you?
A No, but I can just pull up an article from, you know, like the news. There was a group called Masks not -- Hugs Not Masks [sic] as I recall. I thought they had quite a catchy name, and -- but I mean -- and I think the point of that line was to say that when I look at the masking debate, so to speak, let's say the debate around mandatory masking, right, I think there's a lot more contention around mandatory masking in, say, public spaces, indoor public spaces, versus the debate around masking in health care settings, generally speaking, right? So, yeah, I can give you sources if you like.
Q You said yesterday that the final decision on the content of the CMOH orders lies with the Cabinet of the Alberta Government; isn't that right?
A Yes, I would say so.
Q You agree that cabinet is a political body, do you not?

A I do, yes.
Q Yesterday, you said that COVID public health restrictions, including mandatory masking, have become politicised; isn't that right?
A Correct.
Q Now, Dr. Hu, chiropractic offices are not true health care settings; isn't that right?
A I mean, I think they're health care settings. You're providing treatment to a person. You spend like a -- you know, I'm a -- sometimes a family doctor, right, you know, what I do is, you know, talk to patients, do a physical exam once in a while, prescribe medications. Yeah, I think chiropractors, you know, do much of the same, but I think they spend probably more time with a patient than I normally would, like, you know, so I think that they're a health care setting.
Q Chiropractic offices really are community settings; isn't that right?
A I mean, I believe I call it a community health care setting in the same way that a family doctor's office is a community setting, as opposed to a hospital setting, right, but health care is provided in a community setting. A dialysis clinic is a community setting if it's outside of the hospital, right, like -- but, yeah, health care is provided, and sometimes it's provided in the community, as in not in the hospital,

and sometimes it's in the hospital, but they're all health care settings.

Q Chiropractors are more like office-based professionals than front-line health care workers, aren't they?

A No. I disagree completely. I mean, if you're saying chiropractors aren't front-line health care professionals, like, that see patients, then family doctors aren't either. Are you -- sorry.

Q In a health care setting such as a hospital, a large number of symptomatic people are regularly and predictably present; isn't that right?

A Yes.

Q In fact, in a health care setting such as an emergency room or hospital ward, most patients could not accurately be described as healthy, could they?

A Correct.

Q In a health care setting, such as a hospital or a drop-in clinic, workers such as nurses and doctors will regularly interact with symptomatic people that possibly have an infectious illness; isn't that right?

A Yes.

Q Front-line health care workers like nurses and doctors actively and knowingly treat many symptomatic people that are possibly ill with an infectious illness; isn't that right?

A Yes.

Q On a daily basis --
A (INDISCERNIBLE) --
Q -- isn't that right?
A Oh, no, it's true, yeah. I mean, I -- although I mean I kind of see your questioning, but I'll just say that, you know, family doctors often -- like I would say when it comes to, you know, let's -- I'll talk about a community family doctor practice, right. You know, you see patients that are actively ill; you take those precautions that you can. You also see people who don't have symptoms, right, or don't have respiratory symptoms, and you see them for other things, as a chiropractor would, right? Like it's a family doctor who sees somebody for lower back pain, a chiropractor sees somebody for lower back pain, no symptoms, no respiratory symptoms.

But this is where the whole asymptomatic transmission of COVID comes into play, right? And so I have definitely seen examples in a family doctor setting where patients did not have symptoms when they presented, no respiratory symptoms, ended up having COVID and ended up, you know, infecting health care workers, right. And that just shows that, you know, the absence of symptoms, in and of itself, does not mean that you do not have COVID, which you know.

I will agree that there are higher risk settings

than a chiropractor's office or a family doctor's office. I think a long-term care is probably the highest risk setting possible, right, based on what we've seen.

But you know I would still say that the risk of, you know, getting COVID or like the risk of seeing a COVID patient in a family doctor's office or even a chiropractic office is higher than, you know, walking around a mall, and that is for a few reasons, right? Like let's assume everybody who comes in is, you know, asymptomatic, you know, and you do your best to do symptom screening ahead of time. But even with that, you know, the duration of contact with a person matters quite a lot. And for much of this pandemic, we have been in lockdown, you know, I don't think we've been generally close with lots of different people for an hour at a time, right? Most people haven't enjoyed that, like (INDISCERNIBLE) to be hearing that. And when you have that intensity of -- like when you see a bunch of people, patients, and we see a bunch of people for long periods of time in close proximity, you're naturally at higher risk of getting COVID-19.

Q Health care settings like hospital emergency rooms and drop-in clinics are designed to receive symptomatic patients potentially ill with an infectious illness; wouldn't you agree?

A Yes.
Q In fact, people, who think they might be ill with an infectious illness, intentionally set out health care settings like hospital ER rooms and walk-in clinics to get the medical health care they need; isn't that right?
A Yes. And you're talking about "symptomatic" as in respiratory symptoms, right, like COVID symptoms that -- correct? As opposed to, say, what I might see a chiropractor for or a family doctor for, right, so -- but you're -- I assume you're talking about respiratory symptoms here?
Q Yes --
A Okay.
Q -- and just so it's fair to you, I wasn't trying to name symptomatics, as in any symptoms, what I meant was visibly symptomatic with a cold, flu, respiratory type, runny nose, coughing, et cetera.
A Okay.
Q In health care setting such as hospitals or medical doctors' offices, a wide range of interventions, treatments, and tests are likely to occur on a regular basis; isn't that right?
A Yes.
Q Now, community office settings, such as the types of offices where chiropractors typically work, it's quite

rare that a symptomatic person is regularly present; isn't that right?

A Yes. However, I will say this, you know, one of the most difficult things -- and this, like, and I would say is quite rare actually for symptomatic patients, and at various points, for them to even go to a family doctor's office, right, because we try to like screen that quite a lot.

But, you know, and this is actually a cause of a lot of transmission actually, because what is a symptom, right? And this is why COVID is tricky. You know, if you've been having a, you know, a headache for much of your life on and off, right, and then you have a headache again, that could be your old headache, that could be COVID, right, and that's, you know, a type of symptom that's hard to sort of assess.

If you're tired, right, you're fatigued, another COVID symptom non-specific, you know, you come in, you're kind of tired, you know, do you think that -- like, and you're a bit more tired today than yesterday. Was that because you, like, didn't get enough sleep, or could it be COVID.

And then you have like what I call like very like possi [phonetic] low-grade symptomatic people, and so really -- and this happens a lot in real life and kind of makes it difficult, right? So you have a runny nose

for 5 minutes this morning, right, so you had a symptom, and then it goes away. You probably think it's nothing, and it most likely is nothing, but that could actually herald, you know, COVID-19.

And this is -- you know, these are the things where, you know, it's not like always -- like obviously if you have like a raging fever and shortness of breath, you know, it's very clear, you're very symptomatic. But it's a lot of these sort of like -- well, I've talked about asymptomatics already but these like sort of low-grade symptoms and/or, you know, you just think it's something you've always had, these people have symptoms at the baseline that become very tricky.

And those types of events have led to actually, you know, transmission events actually in hospitals, oh, for sure, yeah.

Anyways, keep going.

Q Symptomatic people who expect they are ill with an infectious illness usually avoid community settings like chiropractic offices; wouldn't you agree?

A Yes, you're right, if they suspect they have an illness. But here's my example, and I'll say it again, right, like, you know, let's say you're going to see your chiropractor, right, tomorrow, and then tomorrow morning, you have a runny nose for about 5 minutes,

right. Like, you know, are you like, oh -- and you feel well otherwise; is that a symptom? It is technically, but, you know, you might not think it's a big deal.

I can tell you for sure that like this happened at, you know, the Peter Lougheed Hospital. We have staff coming in. To like have that type of symptom, you don't think it's a big deal, and then you end up having COVID, you end up inadvertently like maybe infecting some other people.

But you're right, that, by and large, if you have like very clear overt symptoms, you will avoid, correct, but there's all these like low-grade-type symptoms and/or, you know, like if you have chronic symptoms actually, you know, let's say you have like chronic allergies, right, like, and then your allergies start up again; you know, like you may not think that's a sympton of COVID, and you can't really actually differentiate by the symptoms alone whether it's your allergies or COVID, and this has actually been very, very tricky. And it's a cause of -- yeah.

Q You said yesterday that sick people generally avoid community settings; isn't that right?

A Yes, but we need to like get deeper into the word "sick", right? But you're right. So here's what I'll -- and thank you for questioning me on the sort of

specificities of my language. I would say people who clearly have like what I call overtly obvious respiratory symptoms will not go to, I imagine, a chiropractor, will tell them ahead of time, right? So totally agree with that. You know, if you have trouble breathing, you have a fever, you have like a day of runny nose, day of sore throat, yeah, I imagine you would not go see your chiropractor. I imagine, you know, when you book in, there's some screening that happens to try to like, you know, suss out, you know, like you don't have those symptoms.

But it becomes a bit trickier when like what is sick is kind of what I'm saying, right? Like this happened to me a number of times during this pandemic, right, like in the sense of, like, I had for like 30 minutes, and then I go get tested. And, you know, like -- and then the runny nose goes away. But like ten times this happened, ten times I've been tested, but, you know, they've all been negative, but like I know people where you have that, and you test, and it's positive. So it's not quite so black and white, unfortunately.

And I wish it was, because if it was -- we -- anyways, keep going. Sorry, I am long-winded, but I think it's important to impress, you know, the like -- there's a difference between like really, really

like -- it's a spectrum of what sick is and what people perceive as sick.

Q Would you agree with me that it's accurate to call someone who is asymptomatic healthy?

A Are you, again, talking about asymptomatic with respiratory symptoms not having or cold-like, flu-like symptoms being -- not having cold or flu-like -- like not having like a viral infection?

Q Let me ask you again. Would you agree with me that it's accurate to call somebody healthy if they do not have any visible cold-, flu-type symptoms?

A What do you mean by "healthy"? They could still have COVID. Right now you know can be asymptomatic of COVID. We know you can be asymptomatic of COVID and get pretty sick tomorrow.

Q You would agree with me though that it would be accurate to describe most people at a chiropractor's office as asymptomatic?

A Yes. I would, most. Yes, I would agree.

Q Chiropractors don't actually interact with people infected with COVID any more than in a typical day than members of the public, do they?

A This I disagree with. I mean, I don't know how many patients the average chiropractor sees in a day, but like, yeah, I'm going to assume your appointment's an hour long, half an hour.

Am I allowed to ask the chiropractor people how many people they see in a day? If I'm not, I'm just going to speculate, sure.

So, let's say, you see eight people a day, right, like it could probably be more sometimes than that. I would say during the course of the pandemic, most people did not see eight new people every day, right, like that would be really bad, and so you are at high risk. And they also didn't see eight people in such close indoor settings, right? Like how many people did -- well, you've see during the pandemic when we were like in lockdown, right; I doubt you were close in a room with eight new people every day.

Q No front-line treatment of suspected infectious illnesses occur at chiropractor offices, does it?

A I don't think so, but I imagine not.

Q A chiropractic office is actually much more akin to any other office where a professional service is provided than it is to a true health care setting like a hospital or a walk-in clinic; isn't that right?

A What do you mean by other professional services? Like a retail bank or something?

Q Let me ask you --

MR. MAXSTON: Mr. Chair, Mr. Chair, it's Mr. Maxston, and I apologize for interrupting my friend's questions here, but I'm going to have to

object to this line of questioning. Dr. Hu is not a chiropractor. He can't characterize what a chiropractic office is or isn't. He can't have any understanding of what the patient load is for a chiropractic office. These are questions that are far afield from his expert report, and I've given my friend some leeway here, but I have to put on the record that we object to these questions.

THE CHAIR: I think I have to agree, Mr. Maxston. Dr. Hu is qualified as a public health expert and not a chiropractor, so if we could focus the questioning.

Q MR. KITCHEN: A chiropractic office is a public place under the Public Health Act, is it not?

A I would say it's a health care setting under the Public Health Act. Well -- yeah.

Q Pursuant to the CMOH orders, a chiropractic office is a public place, is it not?

A I mean. It is a public place, as is in a family doctor's office, it's public, like people can go in, but it's also a health care setting, yeah.

I mean, like I actually have a -- like I don't know that much about the specifics of chiropractor, but what I need to be able to do in my line of work is like try to assess risk, right? And so I will tell you this right now your risk of COVID increases the more people

you interact with, right, and your risk of COVID increases the longer you interact with those people, right, and the closer you are with those people, right? Like I think we can all sort of agree with that.

The average person in society during this pandemic was not interacting with a whole lot of people, new people, I imagine. They weren't interacting with a whole lot of people in very close quarters indoors as well. And so, you know, I get the sense what you're asking, you're trying to sort of like say that a chiropractic setting is closer to a public setting like you said professional services than a health care setting.

Whereas what I'm arguing is that, no, I would say a chiropractor's office is more akin to a health care setting or any community family practice than that -- than, you know, like a retail bank or something. Where, you know, in a retail bank, what do you do, right, you go, you see teller for like 15 minutes, there's like a big like plexiglass barricade, and you'll -- yeah, and so I mean there's other sort of measures, so anyways.

Q You would agree that in CMOH Order 16-2020, chiropractic offices are called "community health care settings"; isn't that right?

A Yes.

Q Going to go back to your report, I note in your report that you did not respond -- actually, and I'm going to refer to Dr. Dang's report. Do you want me to give you a moment to get that up?
A Yeah, let me just pull it up. Yeah, I have it up.
Q Thank you. Now, I note, in your report, that you did not respond to the 2015 study and 2014 Cochrane review that were cited by Dr. Bao Dang on the first page of his report, and these -- both of these conclude that there's a lack of evidence to support the effectiveness of masks even in a health care setting like an operating room. You don't contest the existence of these studies, do you?
A No, but what I will say is that 2014, 2015, COVID did not exist, and I think what I care about is masks in a COVID setting, right? So I abide what's in those studies, right, but we live in a different world with COVID.

And so earlier, I did comment on the fact that, you know, like whatever studies we had pre-COVID are not as salient as studies around masking and COVID, because COVID is its -- is a unique novel virus with its own transmission dynamics.

Q Now, you just said that you only care about masks in a COVID setting; is that right?
A I -- yes.

Q And yet, you specifically put in your report a reference to masks during the Manchurian plague?
A Yeah, that was like a -- think of that as like fun introduction, I mean, you know, a historical preamble.

You'll see that, in my report, most of it is around masking during COVID, whereas in the expert reports, I don't think many of them comment around masking during COVID at all. My report is full of citations around masking during COVID. I'm providing some historical background. It's not salient as well, I agree.

Q You don't think it's fun that bacteria are hundreds of times bigger than viruses, do you?
A Say that again?
Q You don't think it's fun; you used the word "fun", did you not?
A Yeah, I'm sorry. Yeah, I shouldn't have used that, my bad. Very casual.

I think that if you want to disregard that section of my report entirely, feel free to do so. It is -- you know how I was critiquing the other expert reports for having a lot of sections that were not relevant to the question at hand, I have some sections in my report that are not relevant to the question at hand, and this is one of them.

Q You would agree with me then that it's not relevant to

talk about infectious illnesses that are caused by bacteria when it comes to --

A Correct, a hundred percent, I would agree with that.

Q You said yesterday that there's no good reason to have any exemptions to mandatory masking except maybe severe mental health reasons such as anxiety; do I have that right?

A Yes, correct, and that is based on a Canadian Thoracic Society statement. Again, I'm not a respirologist, but, you know, they basically say that, you know, it doesn't really exacerbate any underlying lung disease, so, yes.

Q You said yesterday that nobody should be exempt from wearing a mask except maybe those few people with anxiety; do I have your position right?

A Are we talking about in a health care setting? Because I think I've been referring to a health care setting.

Let me put it this way: I think that like if you're going to work in a health care setting, right, like you generally have to wear a mask, right. And by "generally", I mean I can think of almost no exceptions to, you know, wearing a mask in a health care setting where you're providing care to patients and you see more patients, and, you know, you're at risk of getting COVID more, and patients are at risk of getting COVID more.

Q I'm going to ask you the question again, because this is my memory of what was said yesterday.
A M-hm.
Q And if you disagree with me you tell me. You said yesterday that nobody should be exempt from wearing a mask except maybe those few people with anxiety.
A Yeah, and I'll add in like in a health care setting especially.
Q Okay, especially.
A M-hm.
Q But help me out here --
A Yeah, that's fine.
Q -- I'm not trying to trick you, I just -- I want to know --
A Yeah.
Q -- did you say yesterday, because that's what I have written down, you said yesterday that nobody should be exempt from wearing a mask except maybe those few people with anxiety?
A I did say that, and I -- like what I was referring to in a health care setting. And like, let me explain that, right, like -- the riskier the setting, the more important it is to wear a mask, right? And so do I care if you're wearing a mask outside in public, you know, in a park? No, I don't really care if you wear a mask there or not, because the risk of transmission is

very low.

In a health care setting during COVID, and -- your risk is much higher, so there should be -- like, yeah, I would agree, like basically like no exemptions or almost no exemptions. I'm sure -- yeah.

Q So you would agree that there should be no exemptions in what you call to be -- in what you say is a health care setting?

A Yes.

Q And would you agree -- well, would you agree with me that your position is that no one should be exempt from wearing a mask, except maybe the anxiety people, in a community setting, community indoor setting?

A More flex there. Community indoor, non-health care setting is what you're talking about, right?

Q Well, let me ask you again.

A Okay.

Q Is it your position that there -- you said flex, so let me ask it this way --

A M-hm.

Q -- you said -- or, sorry, your position is that there should be exemptions for people to not wear a mask beyond just anxiety in an indoor community setting, yes or no?

A I mean, I -- I would say that in certain indoor community settings, you don't need to wear a mask at

all.
Q Okay.
A Now, I'm defining community indoor like as separate from community health care. Community indoor would be a mall, a restaurant, you know just not a place where you receive health services.
Q So is it your position then that in a place where health services are received, regardless of what the health service is, nobody should be exempt from wearing a mask?
A Yes, while they're providing care to a clinic -- you know, while they're providing, you know, like patient care, I mean, that's also in all the orders, right? Yes.
Q And that includes --
A (INDISCERNIBLE)
Q And that includes --
A Pardon?
Q -- and that includes the patients, correct?
A Well, I'm focused more on the health care worker side right now, but, again, I would say patients sort of should wear like a mask in those settings, and, yeah, but like, sure, yes.
Q Just to clarify, because I asked you, in fairness --
A Yes.
Q -- to you, I asked you in a setting where health care

services are being received, I asked you if anybody should be exempt, and you said no, and then I asked you does that include patients, and you changed your answer. So let me give you an opportunity -- listen --

A Yeah, I mean --

Q -- listen carefully to the words that I use -- when I say "nobody" --

A Okay.

Q -- okay -- you know, I'm really not trying to trick you, okay?

A Okay, no, I know, I'm just, yeah --

Q Let me ask you again: Your -- look, you want your position to be understood, so do we.

A Yes.

Q In a setting where health care services are being received, it's your position that nobody should be exempt from wearing a mask except for those few with severe anxiety?

A And thank you for clarifying that. I mean, I will say there are like times, as a patient, you would take off your mask in a health care setting. If I needed to, for example, look at the back of your throat, I don't know if that's considered an exemption, but you would take your mask off to receive certain medical treatments, right?

And, again, I think the focus is on what health

care workers should do, right? There are very few -- you know, like, and I think there -- I'll say this: In a community health care setting, I think that health care workers should always wear a mask. In a community health care setting, I think patients should almost always wear a mask, but there are times when they -- you know, you've got to take that mask off for the patient.

Q Is it your position that patients should not be allowed -- is it your position that in a setting where health services are being provided --

A M-hm.

Q -- regardless of the health services, is it your position that patients should not be exempt such that they're allowed to never wear the mask?

A Such that they're exempt that they're never allowed to wear a mask. I mean, it is more complex with patients I think, right, for a few reasons.

Number one, if I had a patient coming in, and they're having a heart attack, and they don't want to wear a mask, like would I turn that patient away? No, right, because it's sort of our duty as health providers to like treat the patient for what they have. This is actually why it's all the more important for health care workers to wear masks so they can sort of take that extra layer of protection for themselves and

for those, you know, patients.

You know, another type of patient, you know, somebody with some, you know, psychosis, right; they may not like walk -- people walk in the emerg, you know, they may not have a mask on, they may like be agitated and not want to wear a mask, we should not at all like deny care for those patients, I don't think, right?

And so there's, yeah, the patient side is a little more complex, but I think if you are able to wear a mask, you should wear a mask as a patient. Most community health care settings have these policies where if you come in, you should wear a mask. But, again, you know, I don't think -- and this is where there's more of a, you know, a balance. I know some physicians, who, you know, like won't see patients unless their patients are wearing a mask, right, and I know some, you know, who are more flexible on it, right? It just -- you know, like but, generally speaking, the rule is patients should wear a mask if they can, right, if they're able to.

Q You said "able to". Do you think religious beliefs are a good enough reason for a person to not be able to wear a mask?

MR. MAXSTON: Mr. Chair, I have to object to that question. This is far beyond the purview of what

Dr. Hu has been called to testify on. That's -- if anything, that's a legal issue. It's certainly not for an expert, like Dr. Hu, to comment on.

MR. KITCHEN: Chair, Dr. Hu, yesterday, gave a lot of opinions on the CMOH orders. He gave a lot of opinions on mandatory masking; okay, mandatory masking he gave opinions on.

A M-hm.

MR. KITCHEN: So we're not just talking about masking itself; we're talking about mandatory masking. So I am exploring his positions on mandatory masking. It's relevant, and it goes to what he said yesterday.

MR. MAXSTON: You're not exploring, Mr. Kitchen, clinical positions, you're exploring religious beliefs. I'm going to strongly object to that.

THE CHAIR: I have to agree with Mr. Maxston, that's a protected ground. I don't think we need to get into that.

Q MR. KITCHEN: Dr. Hu, you think that the CMOH orders would have been better if they did not allow for exemptions to mandatory masking, correct?

A What do you mean by "better"?

Q Well, that's the word I heard you use yesterday. Yesterday, did you not say that it would have been

better if those exemptions were not in there that Dr. Dean Hinshaw had in her orders?

A Well, no, I mean actually -- from a policy perspective, I think what I said -- I may not remember, but here, I'll -- my position on this looks, like, looks like this, right: Normally when governments like make these recommendations, they tend to like have a carve-out for exemptions, because, it's just -- you know, you can't necessarily think of all the million things that somebody could have an exemption for, right, and so you tend to want to be a little bit flexible.

The issue that -- you know, when you say there's some exemptions to this is the CMOH order cannot provide guidance on what those exemptions -- like what would qualify as an appropriate exemption, and they -- I think they added that intentionally a bit. And that let to a lot of confusion, you know, with family doctors being like, okay, so people are asking for exceptions, like what qualifies as an exemption, right?

And so it would have been better if they probably qualified what would -- if they sort of described what an exemption would actually -- what would qualify for an exemption.

Q From a Public Health policy perspective, you support mandatory masking policies, correct?

A Yes. M-hm, yes.

Q From a Public Health policy perspective, you support the Alberta Chiropractic College's mask mandate, correct?
A Yes.
Q You think the Alberta Chiropractic College got it right by not permitting exemptions; isn't that right?
A This is for health care workers, right?
Q Yes. From a policy perspective, you support mandatory vaccination, don't you?
A Define "mandatory vaccination". I mean, this is a very, yeah, complex topic, right?
Q I define it exactly the same as I define mandatory masking.
A Sorry, you're talking about do I support mandatory vaccination of health care workers who work in health care settings? Is that what you mean by mandatory vaccination?
Q Well, I'll ask you again. From a Public Health policy perspective, do you support mandatory vaccination of all health care workers?
A I do, yes. But as somebody who also like works a lot in like trying to create having this policy, you know, you can't -- I think it would be wonderful if all health care workers were immunized. I think that what you want to do is not use a mandate if you can convince people to be immunized without a mandate, right? You

always want to be as non-coercive as possible initially, right?

I think that when it comes to, you know, like when it comes to mandatory vaccination policy, for example, right, there will be exemptions, right, there's carve-outs for exemptions. But I think, broadly speaking, I view mandatory vaccinations, like a policy like that, is something you do once you find that, through other means, you cannot get a sufficiently high number of people immunized in health care, like, for example, health care workers immunized.

And, you know, I -- the mandatory vaccination thing is really interesting because I think that a lot of people like view it as a way to increase vaccine uptake, which, you know, is obviously an effect of mandatory vaccination.

You know, the primary reason for a vaccine mandate in a particular setting is to keep that setting safer, I think, right? So I almost definitely support mandatory vaccination in a long-term care setting, right, because, again, that's the -- by far, the highest risk. You know, I think hospital settings are also, you know, pretty high risk.

But, you know, you want to -- yeah, like, and so I'm like shading this a little bit, because it's not like just like "yes", "no", right? Like, and we go

down this road because it's a complex topic for a mandatory vaccination: When you should do it, like when's best, who should apply for it, what exemptions you should have, et cetera, et cetera.

Q I'm going to move on to something different. You said yesterday that more health care workers died in Italy in the spring of 2020 because they weren't wearing masks; do I have that right?

A No, I think what I said was they ran out of like -- sorry, what happened is they didn't have enough like good PPE, and, sorry, if I meant that, right? I think they were reusing masks. They like were -- and these masks were -- like their masks were not providing sufficient protection -- or the PPE was not providing sufficient protection. That can happen by not wearing masks, so I think they were wearing masks, or just by using the same mask over and over and over again for days. Right?

Q You don't have any scientific reports or peer-reviewed studies to support that conclusion, do you?

A I don't, but I can find some.

Q You didn't include them in your report, did you?

A Correct, there's lots of things I didn't include in my report that I've been talking about.

Q You weren't a health care worker in Italy in the spring of 2020, were you?

A No, I was not.
Q I'm looking now at the second-to-last paragraph on page 4 of your report where you discuss health care workers in Alberta.
A M-hm.
Q That paragraph starts with "If we look closer to home". You cite no scientific reports or peer-reviewed studies in that entire paragraph, do you?
A Yeah, because nothing has been like peer-reviewed yet on this, yeah, but you're right.
Q You provide no independent sources to verify your claims regarding the number of infections between COVID-19 infectious patients and health care workers in Alberta, did you?
A No, but I can provide them.
Q You provided no independent sources to verify your claims regarding the number of transmission events, did you?
A No, I did not.
Q Everything discussed in this paragraph is simply your assessment of what happened, is it not?
A My assessment in discussion with a bunch of other people, like Workplace health and safety, Alberta Health Services, you know, hospital management, leadership, and all that, but, yes, you're right, I do not cite anything, that is true.

Q You've not worked as a doctor in an emergency room or hospital ward treating COVID patients, have you?
A No -- I'm trying to think, because like I spent a fair amount of time in the hospitals to manage some of these outbreaks, but you're right I wasn't providing direct clinical care to patients in the COVID wards or the emerges, but I was extremely involved in developing, one, policies around preventing transmission of COVID-19, and, two, managing any outbreaks that emerged in hospitals and emerges.
Q Now, I note it's 10:58, which means you've got to leave in 2 minutes.
A M-hm, yes, thank you for reminding me.
MR. KITCHEN: Mr. Maxston, I can tell you I'm at least half way through.
MR. MAXSTON: I think we should let Dr. Hu go, and maybe we can chat about, after he's gone, just take 5 minutes of that 15-minute break to chat about the balance of the day.
MR. KITCHEN: Sure.
THE CHAIR: Before we do that, Dr. Hu, you mentioned that you might be a little more flexible on the noontime if you're able --
A Yeah --
THE CHAIR: -- to deal with it.
A -- yeah. Yes, I can be. I like jigged things around a

little bit, so ...

THE CHAIR: Could we take 1:00 as a target --

A Yes.

THE CHAIR: -- time to be done? Does that work for you, Mr. Maxston, Mr. Kitchen, if needed?

MR. MAXSTON: Yeah, I have a -- I think that would be as far as I would want to go without having people take a lunch break, frankly.

I am concerned we're not going to finish with Dr. Hu today though if we -- just nothing critical of anybody, but I have a fair number of questions, and the Tribunal should be able to ask questions too, and that shouldn't be rushed, so I think we should just press on here and try and get done as much as we can.

THE CHAIR: Okay, let's break, we'll reconvene we'll go into recess now, and we'll reconvene at 11:15, when Dr. Hu returns, and we'll press forward. If it looks like we can wind up somewhere around 1:00, we'll press through. If not, Mr. Maxston, I take your comments to heart; we will find time in there for a proper lunch break for people to replenish, and we'll go from there. So, thank you, we'll see you in 15.

(ADJOURNMENT)

THE CHAIR: So we will reconvene, and Mr. Kitchen is continuing with his cross-examination of

Dr. Hu.

MR. KITCHEN: Thank you.

Q MR. KITCHEN: Now, Dr. Hu, you said yesterday that it would be unethical to perform RCTs on people jumping out of planes without parachutes as a part of a scientific investigation to determine the effectiveness of parachutes; is that right?

A Yes.

Q The overall survivability rate of jumping out of an airplane is zero, is it not?

A Well, it's close to zero, but -- very close to zero, but you're right, it's like basically near zero, yes. I think a --

Q (INDISCERNIBLE)

A -- I think a few people have survived in the history of it, but it is very close to zero, I agree.

Q The overall survivability rate of COVID is 99 percent; isn't that right?

A Yes.

Q RCTs --

A (INDISCERNIBLE) -- oh, sorry.

Q -- RCTs regarding the efficacy of masks have been conducted and are currently being conducted, are they not?

A In the community setting, yes, not in the health care setting really.

And maybe I'll just explain, so, I mean, I used the parachute example just like -- just to describe certain situations where you can't do an RCT, but I believe I -- I used a term yesterday called "clinical equipoise", and that basically means that when you do an RCT for anything, medication, intervention, right, like, you can't do it if you think that like one -- like the placebo, if the treatment is like -- you think is like definitely better than the non-treatment placebo group, right?

And I think right now it would be probably not ethical to do an RCT of mask wearing in a health care setting, because there's so much evidence supporting masking in health care setting. Now, in a community indoor setting, it's a bit different, right? There's a lot more sort of debate around that one.

Q So RCTs regarding the efficacy of mask and mask wearing in community settings --

A Yes.

Q -- are being conducted and has been conducted?

A Yes.

Q Thank you. Now, on the top of page 3 of your report -- forgive me, I put it down -- the top of page 3 of your report --

A Yeah.

Q -- you cite to a study sponsored by the World Health

Organization that is authored by Chu et al., so I'm going to call that the Chu study.
A Sure.
Q You know what I mean by that?
A Yeah.
Q And you discuss this same study in the second paragraph of page 4. This study was published in June 2020, correct?
A Yeah.
Q Now, this study is also discussed by Dr. Thomas Warren on page 6 of his report in the second-to-last paragraph of his report. Dr. Warren --
A Okay (INDISCERNIBLE) --
Q (INDISCERNIBLE)
(INDISCERNIBLE - OVERLAPPING SPEAKERS)
Q MR. KITCHEN: Let me know when you've got it.
A Yeah. This is page 6 of his report.
Q Right, that's these -- the paragraph there at the bottom that starts with: (as read)
Finally, a comment should be made.
Dr. Warren refers to a Cochrane review that was evidently published after the Chu study. This Cochrane review is found at footnote -- or I should say, sorry, end note 62 of Dr. Warren's report. The first author listed for this report is Jefferson.

A Okay.
Q Jefferson/Cochrane review.
A M-hm.
Q Dr. Warren quotes directly from this Jefferson/Cochrane review, in which it is stated that the Chu study, quote: (as read)

> Has been criticized for several weeks. Use of an outdated risk of bias tool, inaccuracy of distance measures, and not adequately addressing multiple sources of bias, including recall and classification bias and, in particular, confounding.

My question is you don't deny the existence of this Jefferson/Cochrane review cited by Dr. Warren, do you?
A No.
Q You don't contest that the portion of the Jefferson/Cochrane review quoted by Dr. Warren was quoted accurately, do you?
A No.
Q And you don't disagree with Dr. Warren that Cochrane systemic reviews are widely recognized in the medical community as authoritative, do you?
A Yeah, they are. I agree.
Q I note --
A I'm trying to download this Cochrane review; is that okay? Can I like crack it open?

Q Well, yes, because it's part of the record, it's --
A Yeah, just trying to --
Q It's in Dr. Warren's report.
A Is it one of the -- it's not one of the exhibits, right? I'm just trying to download the PDF of it right now.
THE CHAIR: It's in E-7.
A Oh, it's in E-7, okay, thank you. (INDISCERNIBLE)
(INDISCERNIBLE - OVERLAPPING SPEAKERS)
Q MR. KITCHEN: (INDISCERNIBLE)
A The paper itself, the Cochrane review itself.
Q So just so you know, Dr. Hu, I'm not going to question you any further on the report, so ...
A I'm just reading that study right now, the Cochrane one where -- I mean, so they talk about medical surgical masks compared to no masks, but I think that what they're looking -- and they basically in that study say that wearing a mask may make little or no difference to the outcome of influenza-like illness if not wearing a mask. And so what we're trying to look at is if like what they're looking at is general influenza-like illness for COVID specifically.

So, now, this Cochrane review was published initially in 2007, and then -- as Cochrane reviews often are, right; you have an initial one on masking, and then updated in 2009, '11, '17. And so I mean I --

again, I kind of wanted to look at it just to see if the studies this Cochrane review talks about, which -- Cochrane reviews are very good -- refer directly to the transmission of COVID and masking to prevent that.

The comments around criticizing, you know -- you know, with the Lancet paper, I mean, yes, you can always critique these meta-analyses, but it really is seen as like a, you know, a fairly good study. No study is perfect, but -- oh, thanks for flagging the -- the -- yeah, yeah, I'm just reading this document right now. I'm going to -- keep going though.

Q I note that in your report, you state no less than six times that the evidence in support of masking is, quote, overwhelming. Do you --

A Yes.

Q Do you today remain of that opinion?

A Yes, for health care -- for prevention of COVID in a health care setting, yes. I do.

Q You state on page 8 of your report that the efficacy of mask wearing is beyond doubt; do you stand --

A (INDISCERNIBLE)

Q -- by that statement?

A Yes, in a health care worker setting, yes.

Q So it's not beyond doubt in a community setting; do I have your position right?

A Yes. I mean, I will say the other thing that like

affects this is like the number of cases you have, right, of COVID.

And so, for example, like -- and this is quite -- I think I may have talked about this yesterday, but if we had zero COVID, we wouldn't need to wear masks, right; like I fully support that, right. And so, like, a lot of what I'm trying to say is that, you know, when you wear -- like -- and zero COVID is a type of, you know, like if there's no COVID cases, your risk is very low of getting COVID. I think that, you know, your risk is sort of determined by a number of factors, including, you know, the prevalence of COVID but also what you're doing exactly.

But I will stand by my fact that right now, like, yeah, like, beyond doubt people should wear masks to prevent COVID-19 in health care settings. If there was no COVID for ten years, I would take that back, right? But, you know, that's -- these are all important things that I, you know, actually even think about. The community setting is very, very different.

For example, do I think people should engage in indoor masking in -- let me pick an area with very few COVID cases -- in, I don't know, there's a big outbreak in the Northwest Territories -- like in Nunavut, right, where I don't really think they have many cases right now. Like, no, not in, you know, a community setting.

It's really important to make a difference between a health care setting and a community setting. They're completely different.

Q When -- well, I want to make sure I have your position correct --

A M-hm.

Q -- so you --

A (INDISCERNIBLE) again?

Q Sorry?

A Do you want me to say my position again --

Q No, no, sorry, I'm going to ask you a question, I apologize.

A Okay, yeah, no problem.

Q So you would say that the evidence of the effectiveness of masking in what you call a health care setting is overwhelming, correct?

A Yes.

Q It's not overwhelming in what you would call a non-health care setting?

A Correct. I think there's lots of evidence for it; it's just not as overwhelming, right, like -- but yes.

Q And, again, embellish me, you would say that the evidence for the efficacy of mask wearing in what you would call a health care setting --

A M-hm.

Q -- beyond doubt --

A Yes.
Q -- (INDISCERNIBLE)
A And I will --
Q -- and you would say it's not beyond doubt in what you would call a non-health care setting?
A I would say that -- and, you know, these terms are not very specific, right, beyond doubt, overwhelming. So let me try to describe these terms.

When I say "overwhelming", what I mean is that in a health care setting, basically every study on -- pretty much every study or the vast majority, let's say 95 percent plus studies have been done on masking in a health care setting during COVID which show that it provides benefit, right, and so that's pretty overwhelming, I think.

And now when I talk about studies around masking in a community setting, again, there's a lot of studies that show, you know, masking previously, like in a classroom, for example. That's probably one of most interesting ones right now. Like it's also strong, but like the effect size is not as strong. By "effect size", I mean the extent to which like the proportion of like -- the risk reduction of transmission is not as high in the community settings as in a health care worker setting. And so while there's lots of studies supporting it, like the magnitude of the risk reduction

does matter as well, so, yeah.
Q Going to take you to page 8 --
A M-hm.
Q -- of this report, now we're in the response sections --
A Yeah.
Q -- I guess this is the last page. You make a comment on this page, page 8 --
A Yeah.
Q -- in response to Dr. Bao Dang's statement regarding mask mandates in other countries. You say that Dr. Dang's remark about Sweden is, quote, false and not backed by any evidence. However, you do not refer to any study or other evidence that supports your claim that Dr. Dang's Sweden remark is, in fact, false, do you?
A You're right. And let me explain that, maybe I didn't use my words, like language correctly, but Dr. Dang's real-world data from various countries shows that cases increased after masked mandates were enacted, and countries that had no mask mandates did just as well or better than other countries with masked mandates.
You know what, my -- like I will -- I like -- my main critique with that is, you know, I'll give you an example, right, like China after the first wave as of, let's say, June of 2020, no longer had any

restrictions, right, because they had no COVID anymore, because they managed to suppress it completely. You know does that mean masking doesn't work? No, because there's no COVID, so you don't like necessarily need to mask.

I think that when we're looking -- and this is what I was talking about like a -- like spurious, you know, causation, a lot of factors drive up cases. Masking can reduce transmission, but like a lot of things can reduce transmission and a lot of things can increase transmission as well, right? And I would say the biggest predictor overall case counts in a particular country, you know, is just the total number of -- you know, actively interaction between people.

And so, you know, you can't just like make like -- it's kind of like -- yeah, you know what I'm talking about when you have like a -- like a spurious like, you know, causation like -- correlation versus causation are very different.

I think the example I used yesterday was -- and, you know, November -- like late November, we implemented some strict measures, and then in December, in Alberta, we implemented stricter measures, but cases kept on going up. They eventually started falling, but I can say that, you know, the implementation of measures in November, December, like initially led to a

rise in cases, right, and like -- and so you'd be like, oh, so maybe your like lockdowns don't work.

But, you know, it's factually true, the cases went up after we implemented lockdowns, right, for a bit. That doesn't mean lockdowns don't work. I'm just saying lots of other factors determined, you know, what our case counts are.

Q So you would say that when cases went up after what you called the lockdown --

A M-hm.

Q -- you would say it's just correlation; it's not causation?

A Yeah, I mean, like, sorry, like if you're like correlation like, you know, like mathematically, statistically is like there's a -- like something happens, and something goes up or down, right? It's just like a direct -- this immediately -- how do I define correlation? Like correlation just describes the relationship between sort of like two variables, right?

And so whereas causation is more like, okay, so what our action -- what is driving, you know did lockdowns lead to lower cases in the end? Yeah, they did, but it took some time for that to happen, right; but if I took a slice of time, like a week after, cases were still high. Anyways --

Q So you --
A -- (INDISCERNIBLE) say.
Q You would say the relationship between cases going down after what you call the lockdown is causation not correlation?
A Yes.
Q So you would agree that the lockdown caused those cases to go down?
A Yes. And then let me like -- and we have to like get into more specifics like because many, many things like lead to a decrease in cases, right?

What did the lockdown actual -- okay, for just a fun public health discussion, right? So, again, you know, just illustratively, what was causing our cases to be very high in the late fall was indoor private social gatherings, right? The lockdown really said you couldn't do those things, and, you know, that led to a decrease in the number of indoor private social gatherings that occurred, as in people going to people's houses, or we think it did.

And that is sort of like the causal link, because, you know, when you say "causation" -- like establishing causation, as you know, can be very difficult, but, you know, the reason why I think lockdowns generally -- and there's a whole set of criteria and epidemiology to, like, try to determine causation.

But I would say that I guess point one is you can't just look at correlation; point two when you're trying to assert causation, you know, you have to consider a number of factors, you have to have an understanding of like, you know, the sort of like the drivers of transmission, the things that make it worse, the things that make it better.

Q Now, I'm going take you back to -- I know you just talked about a lot of stuff, but I'm going to take you back to exactly what we were talking about before, okay --

A Yeah.

Q -- we're talking about this Sweden reference here.

A Yeah.

Q Okay, so you've got your sentence here where you say, And this statement is false and has not been backed up by any evidence.

Now, in the very next sentence, you state in your report: (as read)

> The use of masks has decreased the transmission of COVID-19 across every country that has imposed them.

Q That's what you state in your report. You do not cite or refer to any study or other evidence at the end of that sentence to back up that claim, do you?

A No. But I can give you some citation.

Q On page 6 of your report, you accuse Dr. Warren of committing a factual error in stating that 1,010 COVID-related dates says, as of April 16th, 2021, our last deaths than the 1,191 motor vehicle accident deaths in the year 2018. Do you today stand by that accusation?

A I do. Sorry, like -- like I think what Dr. Warren put in is accurate, right? Like I'm not arguing that. Like I think what I'm trying to articulate is that, one, it doesn't really matter for the purposes of our discussion to talk about again, which is, you know, whether or not which of these masks can be in a health care setting, right, and whether or not that reduces, you know, transmission.

You know, the spirit of I think what, you know, Dr. Warren is talking about is basically like COVID isn't that serious, and, you know, whether or not you think COVID is serious or not, right, like -- like, again, like the focus of this is, you know, health care -- like use of masking in a health care setting to reduce transmission, right?

And I think one of the issues that I have with a lot of the expert reports -- and, you know, like I can actually chat at length actually about how serious or not serious I think COVID is. You know, there's a lot of room for discussion, I think, frankly, right? Like,

lockdown I think is actually -- you know, more people have died from non-COVID causes than COVID, you know, during like our -- the last 18 months in terms of excess mortality.

But, you know, at the end of the day, it's just not relevant, and, you know, I think with a lot of the expert reports, like a lot of their reports are spent like just talking around the issue -- or like around COVID, but not around masking. There's very little in the reports about masking as a portion of the total report.

And I made that error too, I talked about the Manchurian plague thing, which is also not relevant, so point taken.

Q Now, that was a long answer, and I want to make sure I have your answer, okay?

A Okay.

Q You stand by the accusation that Dr. Warren made a factual error in stating that 1,010 COVID deaths as of April are less than the 1,191 motor vehicle accident deaths in the year 2018?

A Yeah -- no, I don't. Like his statement is accurate --

Q No, you don't -- hold on, like I don't want to interrupt you, but, no, you --

A Okay.

Q -- don't stand by your accusation?

A Sorry, what I'm saying -- okay, like what he says is that, in Canada, there have been a thousand COVID deaths in people under 60 as of April 2021. In Canada, in 2018, there were 1191 motor vehicle fatalities. And what I say is that as of June, so like two months later --

Q But I didn't ask you what you said --

A Okay.

MR. MAXSTON: Mr. Chair, Mr. Chair, Mr. Kitchen may not like the answer Dr. Hu is giving, but he's got to let him finish, and he should be allowed to finish his answer.

Q MR. KITCHEN: Okay, you go ahead, Dr. Hu.

A So I mean, I think that Dr. -- that is what Dr. Warren said, right, and he's basically saying there were fewer COVID deaths than motor vehicle deaths, you know, as of April 2021. What I say is, as of June 29, there were more COVID deaths than motor vehicle deaths, right, and so that's it, and both are factually correct statements, right?

And, yeah, so you're right, the point where I say, notwithstanding the factual error, I mean, like it's not his fault, because like at the point he cited it, there were more motor vehicle deaths than like there -- than COVID deaths, and two months later, there are more COVID deaths than motor vehicle deaths, but like --

but -- and when you like pick a point in time for looking at COVID deaths, right?

Q Now, I feel like I've gotten two answers from you, and I want to make sure everybody's got this right, because you just said -- you just said that there is a factual error --

A Yes, the factual error is that --

Q -- you stand by the claim that Dr. Warren made a factual error?

A Okay, let me be precise here. So at the time of him citing, you know -- picking April -- like so he says two things really, right? He says as of April 16th, there were more motor vehicle deaths than COVID deaths, right? And that's true. And then he goes on to say so the risk of death due to COVID in persons under 60 is less than the risk of death due to a motor vehicle fatality. So, I mean, I think that part is not true based on, you know, by June 2021, you know. There have been 1400 COVID-related deaths under 60, right?

And so what I'm saying is like the first part of his statement is accurate, right, like numbers of deaths at this point versus number of motor vehicle fatalities, but the second part, the risk due to COVID in a person under 60 is less than death to a motor vehicle fatality, because like if you go like two months later, you see that the number of COVID deaths

is quite a bit higher than the number of motor vehicle deaths, right?

Q So what he said was accurate on April 16th?

A Yes. But --

Q (INDISCERNIBLE)

A -- as of June, it is no longer accurate, right, and so there's a factual error there, right?

Q But Dr. Warren didn't say June, he said April; isn't that correct?

A That's true. Yeah, but like he did, so you're right, at that time, he was correct, but like two months later, he was no longer correct, right?

Q There are --

THE CHAIR: Please --

Q MR. KITCHEN: -- (INDISCERNIBLE)

THE CHAIR: -- Mr. Kitchen, I'm wondering if Dr. Hu is referring to the second -- he said there were two parts to the answer, one, what happened in April, and then a broader generalization. I think, Dr. Hu, were you not saying that it's the broader generalization that's not true?

A Yeah, so the generalization he makes is -- I mean, and like we can move off this, like I -- is like so the risk of death due to COVID in persons under 60 is less than the risk of death due to a motor vehicle fatality. And while that was true in April, it is not true now,

because we had a lot more COVID deaths, right? And so that is like the sort of factual error. I mean, regardless, I will -- yeah.

Q MR. KITCHEN: Let me ask you this, Dr. Hu: There are 12 months between April 16th, 2020, and April 16th, 2021, are there not?

A Yeah.

Q And there were 12 months in the year 2018, were there not?

A M-hm. Would you like me to calculate like a death by month rate because -- okay, so, here, let's do this --

Q Now, Dr. Hu, look, I didn't ask, and Mr. Maxston can chime in here, I didn't ask you a question.

A Sorry, my bad.

Q You're asking me, Can I do this, and then you're talking, and, you know, I've let you do that a lot, I don't generally have an issue with that, but --

A Sorry, but --

Q -- the idea is that you --

A -- (INDISCERNIBLE) --

Q -- I ask a question and you answer it. And that's exactly why Mr. Maxston rightfully stepped in and said, Well, you know, look, my witness --

A Yeah.

Q -- is answering a question that you asked.

A Right, that's fair.

Q Now, in the next sentence, you accuse Dr. Warren of lacking, quote, a basic understanding of disease patterns. Do you today stand by that accusation?
A Well, it's a little bit general accusation. I don't know, like I -- maybe I won't say that anymore, right? Like I don't know Dr. Warren well enough.
Q So you don't stand by that accusation; do I have that right?
A Yes. I don't anymore. It's too general. It's too like general in my writing.
Q It must surprise you that someone who you up until just now said has no basic understanding of disease patterns has written a seven-page report about COVID that contains 98 citations to academic literature, doesn't it?
A No, I mean, like -- like I said, like I -- I will retract my statement as I think he has no understanding of disease patterns, and, fair. I mean I think he has a lot of citations, but I think, yeah, when it comes to the whole masking thing, which is the thing we should be focusing on, which is the purpose of this discussion, right, I disagree with, you know, his findings.
Q So it doesn't surprise you that he's created a seven-page report with 98 citations to academic literature about COVID?

A No. Does it surprise me? No, because -- yeah.
Q Your report contains 22 citations to academic literature; isn't that right?
A M-hm. Yes.
MR. KITCHEN: Those are my questions.
A Thank you. Sorry, for being so long-winded again, Mr. Kitchen.
THE CHAIR: Thank you, Dr. Hu. We will now turn the floor back to Mr. Maxston for his -- any redirect.
MR. MAXSTON: Thank you.
Mr. Maxston Re-examines the Witness
Q MR. MAXSTON: I'm just going to start with a question, Dr. Hu, about the Pandemic Directive, which is Exhibit C-22 --
A Okay.
Q I'll let you just get to that, and I'm looking at -- in specific, I'm looking at page 8. While --
A Yeah.
Q -- you're getting to that, there was a discussion between you and Mr. Kitchen about the type of masks that are -- really, you're referring to, and I think a discussion about the blue medical clinical mask. I'll just take you to the heading "PPE Requirements" and --
A Yeah.
Q -- the first black dot says: (as read)

Surgical or procedure masks are the minimum acceptable standard.

And you'd agree that's appropriate?

A Yes.

Q There was a discussion between you and Mr. Kitchen about how the CMOH orders come about and Cabinet and other considerations, regardless of the development process of CMOH orders, they're to be followed, aren't they?

A Yes. They are legally binding, I believe, so ...

Q There was, I found, a surprising comment, a surprising question from Mr. Kitchen that chiropractic offices aren't true health care settings, and I think you responded pretty vigorously to that, but I just want to be clear, is there any doubt in your mind that chiropractic offices are health care settings?

A No.

Q Patients are treated, diagnoses --

A Yes.

Q -- diagnoses are made, and that, in fact --

MR. KITCHEN: Chair, hold on a second, I -- this was the same line of questioning that I was doing that Mr. Maxston objected to on the basis that, ultimately, Dr. Hu doesn't know what goes on in a chiropractic office, and he's not qualified as an expert to comment on what goes on in --

MR. MAXSTON: I'll skip on, I'll skip on.
Q MR. MAXSTON: You made comments about there being a higher risk -- pardon me, that there are higher risk settings in the health care world that -- than there are in the community setting; is that correct?
A Yes.
Q You talked about things like duration of contact is important, the number of patients you might see, and although you're not a chiropractor, you used an example of eight people a day as a patient load. If any health care professional, whether it's a chiropractor or a dentist or whoever, sees 16 or 32 patients, the risk would go up for COVID transmission, wouldn't it?
A Yes.
Q So if someone like Dr. Wall was seeing 32 patients a day would be different -- more risky than if he was seeing 8 patients, just to use your hypothetical?
A Yes.
Q You talked about there is a spectrum about what sick is, and I think, very importantly, you said, And what people perceive as sick. And I'm going to suggest to you that people may not know when they're sick; that's the whole concept of asymptomatic?
A Yes, definitely.
Q And isn't that why we have things like what are called universal precautions, so that when someone comes into

a dentist's office, the dentist says, I'm going to assume you've got Hep B, Hep C, or whatever, we always use universal precautions?

A Yes, yeah, that is a term used in infection prevention and control, just the basics for everybody.

Q You made a statement, and I'm going to paraphrase here, but I think I've got the wording right, the more people you interact with and the longer you interact with them and the closer you are, the greater the risk of COVID transmission; is that correct?

A That's correct.

Q So if I'm a dentist or a physician or a chiropractor, and I have closer contact, see more people, have a longer duration with them, the risk of COVID is going to increase?

A Yes.

Q Or transmission, okay.

A Yeah.

Q There was a discussion you had with Mr. Kitchen about bacterial infection references and some historical references in your paper, but I want to be clear, your paper focuses on masking and COVID and efficacy of masking?

A Yes.

Q There was another lengthy exchange between you and Mr. Kitchen about exemptions to masking, and I just

want to be absolutely clear on this point, because I think the discussion boiled down to one comment on your part -- or one theme on your part, there should not be exemptions to masking in health care settings in the overwhelming majority of situations?

A Yeah, but I will take -- Dr. -- that Mr. Kitchen's projective for health care workers, right, like a lot of patients can't wear masks or, you know, their mental -- like, you know, so I'm not going to deny treatment to an acutely psychotic person coming into the emerg without a mask on, right?

Q Yeah, and let me be more clear, there should be no exemptions for health care workers in health care settings?

A Yes.

Q You had a discussion with Mr. Kitchen about -- and, again, I'm going to paraphrase -- it would have been better if the CMOH orders had provided more detail about exemptions; is that your recollection?

A Yes.

Q Ideally, you would want, I'm assuming, some criteria for what a medical exemption is?

A Yes.

Q And a process for getting it, who you get it from, and who that person is and how qualified they are?

A Yes.

Q I think you, would it be fair to say that when you get a medical exemption, you would want some rigour involved in that exemption process?
A Yes, ideally.
Q You would want testing, diagnosis, interaction with the patient?
A Yes, ideally.
Q You'd want to avoid quickie, one-line diagnoses or exemptions?
A Yes.
Q Would it be fair to say that a physician, for example, shouldn't self-diagnosis his own or her own exemption from COVID?
A Yes, for various reasons, but yes.
Q Okay. And, particularly, let's say if it was a physiotherapist, a nonphysician, that person shouldn't be self-diagnosing their medical exemption for COVID?
A No.
Q And can you tell me why?
A Well, I mean, I -- in the same way that I, you know, generally do not know very much about the practice of -- you know, like the skill set, knowledge of being a physiotherapist or a chiropractor, you know, so too I imagine most physiotherapists don't know as much about, let's say, providing medical exemptions for masks, respiratory illness, all those things as compared to at

the doctor or a physician, it's just how you're trained and what you do.

Q So if you had someone who thought they might have an anxiety disorder, they should get that diagnosed by someone who has knowledge and training and experience in anxiety disorders?

A Yes.

MR. MAXSTON: Those are all my questions, Mr. Chair.

MR. KITCHEN: Mr. Chair, there were some new questions there that weren't in response to my questions. I'd like a chance, and this is what I'm going to ask you, I'd like a chance just to ask one or two questions based on what I saw as new questions that were not in response to my questions.

MR. MAXSTON: I wouldn't have a problem with that, Mr. Kitchen.

THE CHAIR: Okay.

Mr. Kitchen Re-cross-examines the Witness

Q MR. KITCHEN: Prior to May 14th, 2021, nothing in the CMOH orders said that a third-party diagnosis was required for those who felt that they fell within the exemption clauses in the CMOH orders as far as masking is concerned; is that correct?

A I believe you. I'd have to go into the CMOH orders and just double-check, but I think you're right from my

experience.
Q Why don't I put one to you.
A Sure.
Q I've got to find one here, that's only fair, and I think May 14th is the right date upon which the CMOH issued a new order specifying who can grant exemptions and the criteria for granting them and all of that. Would you agree with me that it was on or around May 14th that happened?
A Do you have the CMOH order that did that?
Q No, I don't.
A Oh, well, I (INDISCERNIBLE) --
Q But what I have -- but what I do have is CMOH orders prior to May 14th, 2021. Find one here. So, for example, CMOH Order 38-2020; are you familiar with that one?
A Yes, we talked about that one yesterday, I believe.
MR. MAXSTON: Mr. Kitchen, that's actually an exhibit, if you want to go to that, it's D-8.
MR. KITCHEN: It is? Thank you. It's D-8.
Q MR. KITCHEN: Yes, we talked --
THE CHAIR: 'D' or 'E'?
MR. KITCHEN: 'D', it should be 'D', should be D-8, that sounds familiar. I've got my exhibit book over here. Yeah, it's D-8.
Q MR. KITCHEN: Okay, so this is the first

CMOH order that brings in province-wide mandated masking, and Dr. Hu, if I could just take you to, and you were here yesterday, I believe --

A M-hm.

Q -- Part 4 says "Masks", if we go down to Section 27, it says: (as read)

> A person must wear a mask at all times.

Do you see that there?

A Yeah, section -- this is on page 6 of 8 of the --

Q That's on page 6, and we're at Section 26, it says: (as read)

> Subject to Section 27, a person must wear a mask.

And then Section 27 says: (as read)

> Section 26 does not apply to a person attending an indoor public place if the person ...

And then there's above, I don't know what, about ten -- eight or ten different exemptions there, one of which is 'C', it says: (as read)

> Is unable to wear a face mask due to a mental or physical concern or limitation.

You see that there, correct?

A Yeah.

Q Now, would you agree with me that in this order and subsequent orders up until around -- on or around May

14th, 2021, there was no requirement in the CMOH that anybody who is unable, pursuant to Section 27(c), "unable to wear a face mask due to a mental or physical concern or limitation" get third-party authorization for that inability?

A Can I ask you a question about this actually? So my read of Section 27, like this is a broader thing to sort of indoor public places, right? I think we should look at the CMOH orders that talk about community health settings as opposed to general --

Q Yes, that's right.

A Yeah, and so 27 is indoor public places, which is not the same.

Q That's right, that's right. And so what I'm asking you about is 38; I'm not asking you about 16.

A Okay.

Q I'm asking you about 38-2020. So you would agree with me in 38-2020 and in 40 -- I think it's 40-2020, 42-2020, 02-2021, et cetera, all the way up until May 14th, 2021, you would agree with me that there was no requirement in the CMOH orders for a person saying they're unable to wear a mask to get any type of third-party medical verification of that inability?

A I trust you. Like, I mean, I -- like I don't -- I would have to read in greater detail all these orders, but let's assume I agree with you. I mean, I -- yeah.

Q Well, you did speak at length yesterday about the CMOH orders, correct?
A I did, yes, but they're quite long, and I don't remember every single clause in the CMOH order.
Q I understand, but you did say you are fairly familiar with them, generally speak --
A Yes.
Q And you're familiar with the mandatory mask portions of the CMOH orders?
A Yes, and I'm familiar, in particular, with actually the problems that were caused by not providing guidance around what constitutes an exemption and how to get one. I'm more familiar (INDISCERNIBLE) --
Q And that's (INDISCERNIBLE) --
(INDISCERNIBLE - OVERLAPPING SPEAKERS)
A -- yeah.
Q Go ahead.
A I just don't remember what date, like, that was changed, but you're right, I'm familiar with the fact that like in -- on the series -- I agree with you, in the series of initial CMOH orders, they talk about the exemption, they didn't provide like criteria for an exemption or like who to get an exemption from. It was broadly assumed that people would have to go to their family doctor to get an exemption. Family doctors were getting lots of questions about exemptions, and they

were confused about what to do, and that caused a bit of chaos.
Q And by the way, it's okay to answer my questions with, I don't know. If you --
A Yeah, okay.
Q -- do, I'll leave you alone, if you give me that answer --
A Yeah, yeah, yeah.
Q -- (INDISCERNIBLE) with you because you know a lot, but if you do --
A Yeah, no, but I don't know, you're right, I don't know, so there you go --
Q Okay, so your answer is to -- my question was is there a requirement in CMOH Order 38-2020 to get the third-party authorization of that inability to wear a mask, is your answer yes, no, or I don't know?
A I don't know, but I'm flipping through this, and I'm going to assume -- like I trust you that I -- I don't know, but I believe that you -- like I trust you that I don't think there is one based -- because you're saying there isn't.
Q Well, no, I'm asking you.
A Well, I don't know, but now I'm just --
Q If your answer is, I don't know, that's okay, but your answer shouldn't be you trust me.
A Oh, really? Okay, well, I don't know then. But now

I'm reading it. Okay, I mean, now I would say, yes, there's no like specific criteria. I just like scrolled through the whole order again.

Q And you would agree with me that it was in the month of May 2021 that that new criteria came in?

A I don't know. I'm trying to look through the actual CMOH order that led to that one, but I don't know, and I'm trying to find the CMOH order specifically.

Q I don't know if it's an exhibit in this case. It wouldn't -- I don't think it would be difficult to make it one; it's a CMOH order.

A Yeah, yeah, it's not. I'm just looking for it in the list of CMOH orders.

Q Well, if you have -- I have a list, but you might have a better one.

A This is from the Alberta Health website.

Q I remember the date, but not the number of the CMOH order.

A They're hard to track, just so many of them. Anyways --

MR. MAXSTON: Mr. Kitchen, it's Mr. Maxston, I'm not going to take issue with this point, the CMOH orders are the CMOH orders. If I can respectfully suggest, you can go on with your questions, you're not going to hear from me later on there wasn't a CMOH order that spoke at some time, at some date with some

type of criteria if you produce that order, so I -- just in the interest of time, I thought I'd make that comment.

MR. KITCHEN: Well, maybe I'll produce it, because it seems like it's probably going to be good to. No, that was it. That's all I wanted to ask.

A Thank you.

THE CHAIR: Okay, Dr. Hu, thank you very much. I would ask you to just bear with us; we're going to have a brief recess while the Hearing Tribunal Members caucus to see if we have any questions of you, so --

A Sure.

THE CHAIR: -- just give us a couple minutes here, and we will be back. Get up and have a stretch if you want. We'll be back before long. Thank you.

A Thank you.

(ADJOURNMENT)

Discussion

THE CHAIR: Dr. Hu, the Hearing Tribunal has met, and we do not have any further questions for you, so I will take this opportunity to thank you very much for your time and your testimony. I'm sure you're a busy man, and I'm sure we all wish you continued success in dealing with this particular problem at this

time. And I will also apologize if I mispronounced your name. I apparently called you Dr. Ho, which is unforgivable. But anyway, thank you, and you're free to go, and hopefully we won't need to call you back.

A Yeah, no, no, thank you so much for having me, and I'm sorry for talking over people, Karoline, and it was a pleasure to meet you all, and sorry for being long-winded and all that jazz, but have a good day.

THE CHAIR: Thank you, take care.

A Bye.

THE CHAIR: Bye.

(WITNESS STANDS DOWN)

THE CHAIR: So it's 12:15. Mr. Maxston, is your next witness available for 1:00, or do we know that?

MR. MAXSTON: He is. I can certainly make him available for 1, and that would be Dr. Halowski.

THE CHAIR: Yes, I think that's the next step; is that correct? So why --

MR. MAXSTON: Yes.

THE CHAIR: -- don't we meet -- did you have any thoughts, Mr. Kitchen?

MR. KITCHEN: Well, I prefer an hour for lunch, but I think most people prefer to have a quick lunch and get out of here sooner, so I'm fine with that.

THE CHAIR: If we want to take an hour, we can take an hour, that's ...

MR. MAXSTON: I have no problem, neither does my client with taking an hour break. We had a pretty intense morning, so we're in your hands, Mr. Chair.

THE CHAIR: Okay, well, let's reconvene at 1:15 with Dr. Halowski. I think you're right, it was a fairly full morning, and it would be good to get away from the computer screen and the pen and paper for a little while. So thanks everybody, we'll see you at 1:15, and we are now in recess until 1:15 for the record.

PROCEEDINGS ADJOURNED UNTIL 1:15 PM
